MEDICAL ETHICS ADVISOR®

For 24 years, your practical guide to ethics decision making

AHC Media LLC

IN THIS ISSUE

Statement of Financial Disclosure: Arthur R. Derse, MD, JD (Board Member), Karen Young (Managing Editor), and Russ Underwood (Associate Publisher) report no consultant, stockholder, speakers' bureau, research, or other financial relationships with companies having ties to this field of study.

JANUARY 2010
VOL. 26, NO. 1 • (pages 1-12)

U.S. law is clear, but ethical issues abound in organ transplantation centers

Medical tourism, illegal donors pose dilemmas

While it is illegal for an individual to sell his or her organs to transplant recipients in the United States and in most other countries, experts indicate the selling of organs is widespread in certain developing countries.

Some of those organs make their way to the Unites States, those involved in research and transplantation medical care say.

The practice of medical tourism — or patients on the transplant waiting list in the U.S. going abroad to essentially purchase organs, often from financially desperate donors — has become more common as the supply of available organs for transplant outstrips the supply.

Alternatively, donors who are willing to sell organs sometimes come to the United States for transplant in this country.

"I would say it is clearly not legal to do so in the United States — that's clear," says **Ann Mongoven**, PhD, MPH, of the Center for Ethics and the Humanities in Life Sciences at Michigan State University in East Lansing, MI. "The question about whether it happens in the Unites States, I think, is a more open question. We certainly know of cases where it did. And the question, then is: How widespread is that? It's very hard to know, because it's illegal. So, it's hard to track.

"I think in many of the cases we're aware of, someone was brought in from overseas, and in order to provide an organ, they were posed as a relation or friend of the recipient but actually were there on a paid basis."

The organization she credits with having done the greatest amount of tracking of illegal practices in organ donation is Organ Watch, headed by medical anthropologist Nancy Scheper Hughes, a professor at the University of California, Berkeley. But proof is hard to come by.

Some who spoke to *MEA* told of transplant centers being "hoodwinked" by individuals who came to this country specifically to sell an organ. Mongoven says one such donor from Israel even made a documentary of his experience titled "Kidney Beans."

"Because they are posing themselves as a personal supporter or friend of the recipient . . . this is why, in some instances, it can, in fact, be difficult for a transplant center to know, because the would-be donor is saying all the right things," Mongoven says.

View from the inside

New York City transplant surgeon **Thomas Diflo**, MD, FACS, who published an article in 2001 in the *Village Voice* on the practice in China of executing prisoners — some of them political prisoners — to obtain their organs illegally, tells *MEA* that certain illegal practices related to organ donation have been "going on probably as long as we've been doing transplants."

"Certainly, it's been going on for at least the last 20 years," he notes. That's about the time anti-rejection drugs for organ transplant recipients became available, making it easier and more successful from a medical perspective for transplant hopefuls to receive donations from individuals other than close family members.

Diflo, associate professor of surgery and director of the Surgical Skills Lab, at New York University School of Medicine, agrees that "it's hard to tell," despite extensive screening processes in place at most transplant centers, whether or not these practices are increasing.

According to **Michael E. Shapiro**, MD, FACS, chief, organ transplantation, at Hackensack University Medical Center, and professor of surgery, Touro University College of Medicine, there was tremendous attention on a case from the summer when a Brooklyn rabbi was alleged to have been trafficking in organs with Israeli donors.

"Obviously, there was a lot of press…which is, as near as I can tell, the first arrest in the United States for someone trafficking in organs," says Shapiro, who is also chair of the ethics committee for the United Network for Organ Sharing (UNOS), and he spoke to *MEA* in that capacity.

"That's something that many of us have been concerned about happening for some time now, but this is the first time that they've ever caught somebody," Shapiro tells *MEA*.

And while he says that some in the transplant community may have suspected this was taking place, "none of us, I think, had the kind of evidence that you [would] want to call the FBI about."

"But many of us have seen people over the years where you just had a very uncomfortable feeling that you weren't getting the straight scoop from a donor and a recipient," he says. "And some of us, on occasion, have turned folks away [because] we felt so uncomfortable . . . "

Physicians and surgeons are within their rights to turn patients away in such instances.

"Like any other physician, you can choose who you wish to treat or not treat, unless you're in an emergency situation," Shapiro says.

But again, actual numbers are difficult to obtain, experts say.

"People aren't terribly up-front about it," Diflo says. "It's not something that they really like to talk about — with rare exceptions. So, it's hard to

Medical Ethics Advisor® (ISSN 0886-0653) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Medical Ethics Advisor***®, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 18 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for acute care physicians, chiefs of medicine, hospital administrators, nurse managers, physician assistants, nurse practitioners, social workers, and chaplains. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.- 4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

Managing Editor: **Karen Young**, (404) 262-5423, (karen.young@ahcmedia.com).
Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Production Editor: **Ami Sutaria**.

Editorial Questions

Questions or comments?
Call **Karen Young**
at (404) 262-5423.

get a handle on the numbers."

Instances like the rabbi allegedly trafficking organs and the documentary "Kidney Beans," may not be anomalies.

"Again, these are the sort of famous cases that come to public attention, and the question is, how many of these cases are coming to public attention?" says Mongoven. "I think the answer is we don't really know. We have every reason to believe there are patterns there, but we don't know how big they are."

UNOS policy/public comment period

In 1984, the National Organ Transplantation Act was passed, which made it illegal to traffic in organs. Shapiro notes that the legislation itself uses the term "valuable consideration," which is interpreted as meaning a financial payment for an organ.

"So, many of us have always told patients that the gift from a living donor, in fact, has to be a gift . . .," Shapiro says.

But a cash payment isn't the sole possibility to fall under the legal term "valuable consideration," he notes.

"One might be concerned about an employee donating an organ to a member of his employer's family . . . from the point of view of coercion that we would want that donor making that donation voluntarily and not feeling pressure. It's hard in that sort of power relationship," Shapiro says. "One would also be concerned that there had been some sort of offer made. You know, give my daughter a kidney, and in six months, we'll promote you kind of thing — which would also [be considered] valuable consideration."

Currently, UNOS is accepting public comment on a proposed policy to require transplant centers to obtain a signed document from donors indicating that they are aware and understand that selling organs in a federal crime in the United States.

Due to recent media attention regarding trafficking practices globally and in the U.S., Shapiro says that the UNOS living donor committee "felt that it would be important for transplant programs to inform donors and recipients that it's illegal to do this. Almost all of us already do that. And to document . . . the donor and recipient understand. "…You can document that they say they understand, but unless you give them an exam, I'm not sure you can document their understanding."

In terms of what would be accomplished by having both the donor and organ recipient document this, Shapiro explains, "That's a good question, and I'm not sure I know the answer to that."

"You could say that you're doing that because it's important to inform donors, because they might not know," he continues. "I have to tell you that I would be terribly surprised [if] there has ever been these Perry Mason moments. I can't believe you would say to a donor, 'You know, it's illegal for you to get paid for an organ, and the donor would jump up and say, 'Oh, my gosh, I never knew that. You know, they were offering me money; I guess I have to leave.' I'm not that naïve."

Shapiro says that the FBI transcripts from the Brooklyn case show that the alleged organ trafficker "went on at some depth about how they prepare these donors for their donor interviews, and they coach them, and obviously they have to lie.

"So, I am sure that in the setting of a poor Brazilian, Pakistani, [or] Filipino selling his organ that they may or may not know that it's illegal. I don't believe that Israelis coming to the United States and selling their organs don't know that what they're doing is illegal and haven't been told that they need to lie when they're asked," Shapiro says.

Diflo agrees that "these people know what they're doing is illegal — it's not a big surprise to them. Having them sign a UNOS-required form that says it's against the law is not going to make any difference."

Requiring documentation, he suggests, is "not going to change anything."

Is treating illegal recipients also complicity?

Another ethical issue arises when transplant recipients in the United States engage in medical tourism by going to a foreign country to seek an organ and undergo the transplantation procedure abroad, as well.

A dilemma is created for many transplant surgeons when that patient returns to the United States seeking the necessary continuing care for transplant recipients from their U.S. physician. What's a physician in these circumstances to do?

"That's a very difficult dilemma for the physician, because they certainly want their patients to get good follow-up care and don't want to abandon a long-standing patient, but at the same time, they may not wish to participate in the international organ trade," Mongoven tells *MEA*. "So, the question becomes: If I provide follow-up

care, am I not actually becoming complicit in this whole trade?"

In previous years, Diflo said he had such patients who had gone abroad for organs return to the U.S. and seek out his care.

"This is where we're obligated to take care of the people who seek us out, but I was kind of in a moral quandary about these patients . . .," Diflo tells *MEA*. "My eventual conclusion was that I was just going to continue taking care of them, as I had before, but I decided to be more proactive about it, and anybody who expressed interest in going abroad and obtaining an organ, I told them beforehand that I thought it was not a good idea. "Second of all, I told them that if they did that, then we would sever our relationship with them, and we wouldn't care for them when they came back. That's how we decided to address it."

Although the issue did not come up frequently in previous years, and does not come up frequently now, Diflo says, "we try to dissuade them and give them all the rationales for not doing it — sub-par care, not really know what the situation is with the donors and things like that."

Depending on the country where the organ is obtained abroad, "it could [increase the risk of] transmission of things like hepatitis, even HIV, or things like that from donors who aren't terribly well-screened. So, there are potential risks to the recipient that [he or she] might not anticipate," Diflo says.

UNOS policy on organ-related "tourism"

Shapiro notes that there are UNOS policy guidelines from its ethics committee for physicians regarding medical tourism patients returning to the U.S. for care. In such cases, Shapiro says the UNOS ethics paper on this issue notes it is advised that "In emergent situations, patients should be evaluated and treated according to the standards of care . . . while there may not be an obligation on the part of individual physicians to care for such patients in non-emergent situations, the medical community has an obligation to care for these patients."

The guidelines also suggest that if a physician declines to treat patients in these cases, citing conscientious objections, "the physician should help the patient locate an alternative physician, and may terminate the physician-patient relationship in accordance with local professional practice."

Mary Ann Baily, PhD, an economist and former research scholar at The Hastings Center in Garrison, NY, tells *MEA* that "this is such a difficult topic and such a can of worms. I wish this situation didn't exist, but it does. And it's really beginning to be clear that it really does, and it's getting worse," she says. ■

SOURCES

- **Mary Ann Baily**, PhD, former research scholar at The Hastings Center, Garrison, NY.
- **Thomas Diflo**, MD, FACS, Associate Professor of Surgery; Director, Surgical Skills Lab, Chairman, NYU Institutional Review Board. NYU School of Medicine, New York City. E-mail: Thomas.diflo@nyumc.org.
- **Ann Mongoven**, PhD, MPH, Center for Ethics and the Humanities in the Life Sciences, Michigan State University, East Lansing, MI. E-mail: ann.mongoven@ht.msu.edu.
- **Monir Moniruzzaman**, Assistant Professor, Department of Anthropology and Center for Ethics and the Humanities in the Life Sciences, Michigan State University, East Lansing, MI. E-mail: monir@msu.edu.
- **Michael E. Shapiro**, MD, FACS, Chief, Organ Transplantation, Hackensack University Medical Center, Professor of Surgery, Touro University College of Medicine. E-mail: MShapiro@humed.com.

Organ sellers suffer in many developing countries

Many risk stigma, continuing poverty

Monir Moniruzzaman has seen the kind of poverty that would drive a desperate individual to sell his or her organ.

Conducting ethnographic research, he has interviewed 33 sellers of their kidneys, all in Bangladesh, one of the poorest countries in the developing world. Most of the transplantations were performed in India in those cases.

"Basically, I'm writing about their experiences, how they sold their kidneys and how basically they engage in this trade . . . and how they're exploited in the black market; there's exploitation, and they are subject to sufferings," says Moniruzzaman, an assistant professor in the department of anthropology and Center for Ethics and Humanities in Life Sciences at

Michigan State University in East Lansing, MI.

When *Medical Ethics Advisor* spoke to Moniruzzaman, he was preparing to complete his thesis on this topic in December.

The most prominent form of global organ trafficking, he says, is individuals engaging in medical tourism and traveling to Third World countries.

"The easiest way to get an organ is when the recipients are going overseas and transplantation is done [in another country]," he explains.

Selling organs, he says, is "illegal in almost every part of the world."

"It's illegal except Iran is the only country where [a government-sanctioned, regulated organ market is] happening," Moniruzzaman tells *MEA*.

Still, the illegal black market thrives, he indicates, driven primarily by wealthy recipients who can afford to pay for an organ and a transplant in a foreign country.

"The law is there, but its practice is problematic . . . I found that there are people from India and China and Bangladesh — you know, they're American, but Bangladeshi-born or Indian-born Americans," he explains. "They are going to their home country, and they are getting an organ from a poor donor or seller."

Because the organ trade is illegal and U.S. laws and the transplant system are more strict, U.S. patients who are on transplant waiting lists and perhaps also desperate for an organ, then go overseas. But when these patients travel abroad for organs, "the American federal law cannot protect the people [who are selling their organs]," Moniruzzaman says.

"How far can we go?"

When an individual pays for an organ, there often are several negative consequences for the donor, particularly those donors who are poor.

"The simple solution — if you just give them money and they are selling their kidneys, it creates a lot of problems, including exploitation, commercialization of the human body — it never happened in human history; we don't sell [body parts]," Moniruzzaman says.

He notes that it is accepted practice to sell blood, but he explains that blood regenerates. On the other hand, "an organ is a solid organ; the body has never been commodified in that sense," he says.

"Speaking in many cultural contexts, the body is integrated [as a] whole," he says. "Why do only the poor people sell their body parts for the wealthy people . . .? We cannot create a system where body parts are in the market, and give money to the poor people and take their body parts," he says. "How far can we go? Like now, it started with the kidney, and whose body is it? It's the poor people's bodies," Moniruzzaman says. "You [would] create a society where only 1% of the population [is] selling their body parts that wealthy people can afford to prolong their life."

Also, he notes, in some cultures, giving up an organ is "one of the most humiliating acts a person can do. So, in many societies, they consider this a shameful and regretful act."

Although the first rule of medicine in the U.S. is "first, do no harm," Moniruzzaman says there has been very little investigation and research into the harm that comes to people who sell their body parts for what they think will be economic gain.

"But I found [that there are] devastating consequences to the seller," he explains. "The harm is not only physical harm — bodily harm where the seller experiences bodily dysfunction, but [also] the psychological harm is devastating…think about ourselves: if we sell a body part or one of the parts of my body, and how that psychological experience would be."

Legalize the market?

Ann Mongoven, PhD, MPH, of the Center for Ethics and the Humanities in Life Sciences at Michigan State University in East Lansing, MI, explains that there are arguments being made — even in "the academic and scholarly medical community" — that the U.S. should legalize the organ trade.

"There are different possible responses [to the illegal organ trade], and some people say the response should be to legalize the market, because since it's happening anyway, it's less likely to be exploitative if it's legalized," Mongoven says.

"Then, we can have transparency and make sure that the prices are good and that the people who donate get appropriate medical care and not just the [organ] recipients, who are almost always, of course, of a higher socioeconomic standard than the donors," she says. "That's one possible response, and there is some possible interest in that in some corridors."

Moniruzzaman strongly opposes the legalization of the kidney trade, because it has negative economic consequences for the sellers. Often, the

SOURCES

• **Ann Mongoven**, PhD, MPH, Center for Ethics and the Humanities in the Life Sciences, Michigan State University, East Lansing, MI. E-mail: ann.mongoven@ht.msu.edu.

• **Monir Moniruzzaman**, Assistant Professor, Department of Anthropology and Center for Ethics and the Humanities in the Life Sciences, Michigan State University, East Lansing, MI. E-mail: monir@msu.edu.

sellers are stigmatized, Moniruzzaman's research has shown, as well.

"The harm is like an economic harm, where the seller's economic situation is worse than before," he says. "Throwing $1,500 to someone cannot change their economic situation. [When] the money is gone, the seller's gone back to [his or her] old job, and they basically cannot earn the money the were earning before [when their health may be impaired]."

'Do no harm' would be set aside

Mongoven says her instinct is against a legalized market for the living donors, because first and foremost, it would totally nullify the first rule of medical ethics, the "First, do no harm" principle.

"You're harming a healthy person," she says. Still, she says that "clearly what we have now is terrible. So, the question can become , in some ways, what's the lesser evil? But my instinct is against the market. . . I think that the kind of conversation — the continuing conversation you would have to have in order to consider a legal market — has never happened. For example, what is the real experience of donors on the paid market? Does the payment actually make them better off? What are the actual risks and benefits of donation?" ■

Financial incentives considered for the deceased

It may depend on the type, degree of incentive

To many who observe the organ transplant arena, it's both a simple and yet complex reckoning of supply and demand. Simple, in that supply and demand is the bedrock rule for economics. Complex, in that it forces the players in the organ transplant system in the U.S. to think about how one could meld health care with market forces in a way that achieves fairness to both the organ recipient and the organ donor.

Mary Ann Baily, PhD**,** is an economist and former research scholar at The Hastings Center in Garrison, NY, and also served in 2005-2006 on an Institute of Medicine committee of thought leaders in medical ethics who developed the IOM report: *Organ Donation: Opportunities for Action* in 2006.

When discussing the possibility of financial incentives for donors, she concludes that the problem isn't a question necessarily of appropriate and fair financial incentives, but the lack of supply that would exist regardless of the incentives offered.

"From the deceased donor point of view, it's a bit technical, because the point is that everyone is so sure that if you just offered money — that the real problem is people don't agree to donate their organs after they die — if you would just offer somebody money, those organs would be freed up, and suddenly you would eliminate the waiting list," Baily tells *Medical Ethics Advisor*.

"That's not true, because the problem isn't so much that people are unwilling to donate," she says. "It has much more to do with the process by which you obtain organs and who you can get them from."

Those deceased individuals who can donate organs are limited.

"Typically, the classic source of donor organs is people who are declared brain dead," Baily says. "Now, of the millions of people who die in the United States, very few die in circumstances where they are on mechanical support. Those are the only kind of people historically from whom you could get the organs. There are not that many."

According to the UNOS web site, as of Dec. 21, 2009, there were 105,451 recipients on U.S. waiting lists, and 10,916 organ donors from January through September 2009.

Baily maintains that this and the complex process involved in getting a donor organ to a recipient is a tremendous hurdle that limits the number of recipients who get organs for transplant. Then there is another matter of how many solid organs transplant centers can retrieve from each willing donor, with five being the traditional maximum.

"In order to get those organs, you have to have in place a very elaborate system of identifying [potential organ donors], ideally before they die, or while they're brain dead, and you have to mobilize the organ retrieval [system] — and those people have to be told, 'Be ready to take the organs,'" Baily explains.

"Who would you pay?"

Offering financial payments for organs could actually have the opposite of the desired effect: It could decrease willing donors.

Organ donation historically has rested on altruism, i.e., that an organ is a gift.

"Some people would be very put off by the payment, and other people might be offended [by the practice of payment] and not donate," she says.

Also, the amount paid would have to be high.

"Most ordinary people would [then] say, 'Now, wait a minute, we could use the money, too. And if it is the federal government paying for it, why shouldn't we get it, too," she notes.

New York City transplant surgeon **Thomas Diflo**, MD, FACS, suggests that some degree of financial incentives for deceased donors "is probably not a bad idea."

While it might improve the organ supply slightly, Diflo tells *MEA* "it wouldn't improve things enough that we would [eliminate] all the people on the [organ] waiting lists."

"I think the details have to be worked out, you know, funeral expenses — or some people have recommended tax breaks," he says. "….[B]ut I think maybe the details could be worked out, and I would not object to some sort of small type of incentive for the donors and the donor families."

Financial incentives for health care workers

Regardless of whether the organ donor is a deceased or living donor, Baily believes that those who work in the transplant health care arena also should receive, if not necessarily financial incentives for their work, then the necessary resources and motivation to participate in the system.

She notes that the clinicians who work in hospitals and in intensive care units are very busy and may feel overwhelmed when faced with the organ retrieval/donation process.

"Let me put it this way: I think a hospital should realize that they don't lose money by doing this," she says. "Hospitals are under a lot of financial pressure, and it's important that they [send] the right signals. I think it's dangerous to argue that hospitals do and should totally focus on financial incentives and never do anything good for the patient unless they're definitely not going to lose by it. It's up to them to be professional, and sometimes that means making decisions that are not necessarily profitable," she says. ■

SOURCES

- **Mary Ann Baily**, PhD, former research scholar at The Hastings Center, Garrison, NY.
- **Thomas Diflo**, MD, FACS, Associate Professor of Surgery; Director, Surgical Skills Lab, Chairman, NYU Institutional Review Board. NYU School of Medicine, New York City. E-mail: Thomas.diflo@nyumc.org.

EOL group "alarmed" at revised Catholic directive

Compassion & Choices, an end-of-life rights group, says that it is "alarmed" by a newly revised Ethical and Religious Directive approved in November by the United States Conference of Catholic Bishops.

In a Nov. 5 news release announcing the vote that would take place later that month, the USCCB quoted **Bishop William Lori**, chairman of the U.S. Bishops' Committee on Doctrine, as saying that the directive, prior to revision, stated, "There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient."

The approved directive #58 states, "In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and irreversible conditions (e.g., the "persistent vegetative state"), who can reasonably be expected to live indefinitely if given such care.

"Medically assisted nutrition and hydration

become morally optional when they cannot reasonably be expected to prolong life or when they would be 'excessively burdensome for the patient, or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed.'

"For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort."

Father Thomas Weinandy, who oversees the Bishops Committee on Doctrine in Washington, DC, told *Medical Ethics Advisor* that the committee "consulted widely with various health care groups and ethicists [on this matter]. And it took us about three months to come up with the wording that everybody could agree on."

The genesis of the revision in the Ethical and Religious Directives for Catholic Health Services, according to Weinandy and to the news release, was based on Pope John Paul II's March 2004 *Address to the Participants in the International Congress on Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas.*

The revised language was also based on the Congregation for the Doctrine of the Faith's August 2007 *Responses to Certain Questions of the United State Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration.*

"Within the Catholic Church, it's the bishops who are the formal teachers, when it comes to issues of faith and morals," Weinandy says. "So, what the Pope and the bishops have to say on the issues are ultimately authoritative."

The news release also quotes Bishop Lori as saying prior to the revisions that "It would be useful to update the Ethical and Religious Directive by inclusion of references to these authoritative documents as well as by incorporation of some of their language and distinctions.

"It is particularly appropriate to do so since the recent clarification by the Holy See has rendered untenable certain positions that have been defended by some Catholic ethicists," Lori says in the statement.

The USCCB said the revision was undertaken with the collaboration of the Committee on Pro-Life Activities and in consultation with the Task Force on Health Care Issues, the Catholic Health Association, the Catholic Medical Association, the National Catholic Bioethics Center, and the National Catholic Partnership on Disability.

Power to ignore advance directives cited

Compassion & Choices suggests that the revised ethical directive's language will essentially allow any Catholic health provider to override individual advance directives.

But Wainandy disagrees that it gives Catholic Health Services greater authority to overrule advance directives.

"Not any more really than before," Weinandy tells *MEA*. "If somebody comes to a Catholic health care institution and has advance directives that would be contrary to what the Catholic Church teaches, the health care institution would have to say, 'Well, if you want your directives to be carried out, you're going to have to go somewhere else for this to take place.'"

But Compassion & Choices spokesman **Steve Hopcraft** tells *MEA* that this is part of the problem — that some individuals in the U.S. are in communities where the only available health care is provided by CHS — thereby limiting those individuals' ability to choose the type of health care they prefer.

According to data provided in a news release by Compassion & Choices, Catholic institutions provide more than 30% of patients' health care in Washington, South Dakota, Iowa, and Alaska, for example.

Charles Camosy, PhD, assistant professor of Christian Ethics at Fordham University in Bronx, NY, notes that "The Catholic Church has a 500-year-plus history of making a distinction between euthanasia and removal of . . . extraordinary treatment. If it's ordinary [treatment], the Catholic Church is going to say it's required, and if you forego it, that's the equivalent of euthanasia. But it could be extraordinary. If treatment is extraordinary, that means that even if you foresee, but don't intend that it will result in death, it's not necessarily euthanasia, because you don't have to preserve life at all costs," Camosy says.

Directive #59, the USCCB approved the following language: "The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching." ■

SOURCES

- **Charles C. Camosy**, PhD, Assistant Professor of Christian Ethics, Fordham University, Bronx, NY. E-mail: Camosy@fordham.edu.
- **Steve Hopcraft**, Hopcraft Communications (for Compassion & Choices), E-mail: steve@hopcraft.com.
- **Father Thomas Weinandy**, United States Conference of Catholic Bishops, Washington, DC.

Why the legal aspects of medical ethics matter

States enact legislation related to abortion

As *Medical Ethics Advisor* reported in December, one of the sessions held at the annual conference in Washington, DC, of the American Society of Bioethics and Humanities in October was on the top developments in bioethics in 2009.

The organizer of the panel discussion, **Thaddeus M. Pope**, JD, PhD, of the Widener University School of Law in Wilmington, DE, indicates that it is imperative that clinicians and others involved with such issues as end-of-life decision-making and other types of decisions have familiarity with the legal aspects and parameters within which those decisions can be made.

Noting that most medical ethicists are involved in end-of-life discussions, Pope says, "That's [an area] heavily, heavily regulated by the law — everything about advance directives; who is a surrogate; who is a guardian; what is the scope of the authority of the guardian; what's a DNR order; what is the scope of an advance directive; or what is a POLST form? Not that the law is the sole answer . . . but a lot of the relative questions and the relevant answers to a lot of things that occur in clinical practice at the bedside are governed by the law, whether it's state law or federal law," Pope tells *Medical Ethics Advisor*. "And there's a pretty big ignorance level out there, meaning that people don't know the law, and they would like to know the law."

That was the one of the primary reasons he proposed the legal panel discussion for conference attendees. That — and the fact, he says, that much of the law is changing, and attendees need to know when there are either current or proposed changes in the law.

State legislation meets court opposition

Presenter **Nadia Sawicki**, assistant professor of law, Beazley Institute for Health Law and Policy, Loyola University Chicago School of Law, tells *MEA* that she chose to discuss certain states' legislation impacting abortion, "One, because we have been seeing a lot of state action in the realm of limiting abortion — making it more difficult to obtain abortions, and imposing these sorts of procedural or consent requirements before allowing doctors to provide abortion."

Much of that activity has taken place in the last two years; however, she says that she was "surprised" that in the last two or three months, "the courts have looked at these state limitations and essentially rejected them either on procedural grounds or substantive grounds, or asked for another opportunity to review. "I highlighted this issue, because I think it's one we should be watching as we go forward," Sawicki says.

South Dakota requiring disclosures

Sawicki notes that in South Dakota, legislation was enacted in 2005 that required physicians to disclose certain information to the woman seeking the abortion before being allowed to proceed. One such disclosure stated that "an abortion is going to end the life of a living human being, and then there are other things . . .," Sawicki says.

"The interesting thing about this law is that these kinds of disclosure requirements are really grounded in really traditional informed consent theory," she explains. "So, for the entire modern era, we've been talking about how important it is that patients have all the facts on the table before they go ahead and make a medical decision. You know, people from liberal to conservative are all in favor of providing information to patients, so that they can make their own decisions."

Although the legislation was framed as providing informed consent, Sawicki notes that based on everything she's read about the case, "the motivations of those who proposed this legislation are sort of uniformly on the pro-life side — not that that there's anything wrong with that in and of itself."

Those who opposed the legislation argued,

Sawicki says, that the types of disclosures that were required by the legislation are "not in the same scope as medically necessary or medical relevant disclosures that we traditionally talk about in informed consent."

For example, the opposition also stated, she notes, that the medical profession doesn't know if there is actually a link between abortion and suicidal ideation, but that, in any other context, we would not be requiring doctors to make this sort of disclosure."

So, the legislation forced physicians providing abortions to make these disclosures, regardless of their own clinical opinions. Some physicians also spoke out against the legislation, she says.

"A lot of the opposition to these laws is by the physicians on First Amendment grounds, saying, 'I am a doctor; I have a right to provide informed consent to my patients in whatever manner is appropriate for them.' And for the legislature to really lay down the law and say, 'You must disclose factors x, y, and z,' especially when there's some question about the validity of those disclosures or the accuracy of those disclosures, doctors are saying that interferes with my right to have a communicative relationship with my patient." The South Dakota legislation was passed in 2005, but shortly thereafter, it met opposition from both physicians and women's rights activists **(See the December 2009 issue of *Medical Ethics Advisor* for a related story on legal action in this case by Planned Parenthood.)**

One aspect of the original legislation that the court has rejected pertains to the disclosure of "a constitutionally protected relationship between the mother and the child, which is irrevocably harmed as a result of the abortion. "The court rejected that saying, 'That's just not accurate; we cannot uphold a piece of legislation that is forcing doctors to provide inaccurate information," Sawicki says.

North Dakota's abortion legislation

North Dakota passed a statute requiring physicians who were to provide abortions to first offer an ultrasound and a heart-tone auscultation. The latter part of the legislation was challenged by medical clinics who said that equipment necessary to provide heart-tone auscultation was so expensive that legally mandating this step would essentially put them out of business.

"So, the court ended up upholding the legislative requirement but specifying that the only thing that the clinics are required to do is offer heart-tone auscultation — they don't actually have to be able to provide it," Sawicki explains.

If the patient says yes, then the clinic still has an obligation to refer that patient to a provider who can provide that procedure. ■

SOURCES

• **Thaddeus M. Pope**, Widener University School of Law, Wilmington, DE. E-mail: tmpope@widener.edu.
• **Nadia N. Sawicki**, Assistant Professor of Law, Beazley Institute for Health Law and Policy, Loyola University Chicago School of Law, Chicago. E-mail: nsawicki@luc.edu.

NEWS BRIEFS

CMS to offer HIV screening to Medicare beneficiaries

The Centers for Medicare & Medicaid Services announced in early December 2009 its final decision to cover Human Immunodeficiency Virus (HIV) infection screening for Medicare beneficiaries who are at increased risk for the infection.

The decision includes women who are pregnant and Medicare beneficiaries of any age who voluntarily request the services.

The decision was effective immediately.

CMS said that under the recently passed Medicare Improvements for Patients and Providers Act of 2008, CMS now has the flexibility of adding to Medicare's list of covered preventive services, if certain requirements are met.

According to CMS, prior to this law, Medicare could only cover additional preventive screening tests when Congress authorized it to do so.

"[This] decision marks an important milestone in the history of the Medicare program," said

HHS Secretary Kathleen Sebelius. "Beginning with expanding coverage for HIV screening, we can now work proactively as a program to help keep Medicare beneficiaries healthy and take a more active role in evaluating the evidence for preventive services." ■

Study: Nurses unfamiliar or unprepared for QI

A new study published in the January 2010 issue of *The Joint Commission Journal on Quality and Patient Safety* explains that despite the strong focus on quality improvement in hospitals, 38.6% of novice nurses thought they were "poorly" or "very poorly" prepared in their nursing education programs to implement QI measures or "had never heard of" the term QI.

The researchers analyzed the survey responses from 436 newly licensed registered nurses from 34 states and the District of Columbia (69.4% response rate). While many nurses may observe problems and understand the need for improvement, many felt unprepared to undertake the actions necessary to do so.

QI is a systematic, data-driven set of activities designed to bring about immediate improvement in the delivery of health care and ultimately in patient outcomes. ■

Study: Patients unable to ID hospital meds

In a new study designed to assess patient awareness of medications prescribed during a hospital visit, 44% of patients believed they were receiving a medication they were not, and 96% were unable to recall the name of at least one medication that they had been prescribed during hospitalization.

The findings were published in December in the *Journal of Hospital Medicine.*

"Overall, patients in the study were able to name fewer than half of their hospital medications," said lead researcher **Ethan Cumbler**, MD, assistant professor of medicine at the University of Colorado Denver. "Our findings are particularly striking in that we found significant deficits in patient understanding of their hospital medications even among patients who believed they knew, or desired to know, what is being prescribed to them in the hospital." ■

CME objectives

After reading each issue of *Medical Ethics Advisor*, you will be able to do the following:

- Discuss new developments in regulation and health care system approaches to bioethical issues applicable to specific health care systems.
- Explain the implications for new developments in bioethics as it relates to all aspects of patient care and health care delivery in institutional settings.
- Discuss the effect of bioethics on patients, their families, physicians, and society. ■

COMING IN FUTURE MONTHS

- The ethics of neuroimaging
- Advantages of the POLST form
- Financial incentives for living organ donors
- A 25-year history of *MEA*

CME Questions

1. U.S. law forbids and makes illegal the exchange of organs for "valuable consideration" in this country.
   A. True
   B. False

2. What U.S. legislation passed in 1984 makes organ trafficking illegal?
   A. The National Organ Transplantation Act
   B. The Organ Trafficking Act
   C. The Organ Donor Act
   D. The UNOS Act

3. Currently, UNOS is accepting public comments on a proposed policy to require transplant centers to obtain a signed document from donors indicating that they are aware and understand that selling organs is a federal crime in the U.S.
   A. True
   B. False

4. The revised directive #58 of the Christian and Ethical Directive instructing Catholic Health Services indicates that "in principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally (e.g. the persistent vegetative state), who can reasonably be expected to live indefinitely if given such care."
   A. True
   B. False

Answers: 1. A; 2. A; 3. A; 4. A.

AHC Media LLC

AHC Media's Message to Subscribers about Copyright Law

Your newsletter is a copyrighted publication. It is protected under federal copyright law.

It is against the law to reproduce your newsletter in any form without the written consent of AHC Media's publisher. Prohibited under copyright law is:

- making "extra" copies of our publication for distribution in your office;
- posting newsletter articles on your facility or practice web site;
- downloading material to an electronic network;
- photocopying, e-mailing, or faxing newsletter articles.

Site licenses, which allow you to e-mail, fax, photocopy, or post electronic versions of your newsletter and allow additional users to access the newsletter online, are available for facilities or companies seeking wider distribution of your newsletter.

High-quality reprints of articles also are available at reasonable prices.

To get information about site license or multiple copy arrangements, contact Tria Kreutzer at (800) 688-2421, ext. 5482 (tria.kreutzer@ahcmedia.com); or for reprints, contact Steve Vance at (800) 688-2421, ext. 5511 (stephen.vance@ahcmedia.com).

Thank you for your cooperation,

Donald R. Johnston
Senior Vice President/Group Publisher
AHC Media LLC

N #4005

3525 Piedmont Road NE
Building Six, Suite 400
Atlanta, Georgia 30305-1515
Tel (404) 262-7436
Fax (404) 262-7837
www.ahcmedia.com