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Letter from the Executive Board
Kelly Granger, Grace Cheney, Savanna Erwin, and Lauren Nelson

The Ethical View is released annually by the Medical Humanities Program of Davidson College in an effort to raise awareness about healthcare issues and their ethical ramifications.

The theme of the publication corresponds to that of the Frederick Womble Speas Symposium (see page 13). The event will bring disciplinary experts together on campus to discuss a particular healthcare theme, which this year is Cancer Care: Science, Practice and Ethics.

The articles in this publication were written by Davidson students and professors. The subjects cover a broad range of topics in bioethics, including but not limited to cancer care.

How should physicians interact with drug representatives? What exactly does the ACA mean for the future? What does informed consent truly mean? These questions, along with several others, are addressed within these pages.

To respond to any article or issue presented in this publication, please see the contact information on page 13.

Sincerely,

The Bioethics Society

President:
Kelly Granger
Grace Cheney

Vice President:
Lauren Nelson

Treasurer:
Savanna Erwin
Immunotherapy in Oncology: When Therapy Leads to New Disease

Greg Swan ‘13

The current predicted lifespan of a person with stage IV metastatic melanoma is between 4-6 months. Chemotherapy and radiation therapies have been shown to be largely ineffectual, leaving the patient with little options even for palliative care. Because of the dearth of treatment options there has been a push by the medical and scientific community to find alternative treatments. In the last five years, three drug mechanisms have become available. Of particular interest are immunotherapies which harness the power of the immune system to fight disease without the toxicity of cytotoxic antineoplastic drugs. However, immunotherapies today are imperfect and often directly lead to immune related adverse events (irAEs) which for the most part are not curable and potentially life threatening. This leaves physicians with the ethical question of whether controlling one disease is worth inducing another.

Ipilimumab, marketed by Bristol-Myers Squibb as Yervoy, is an anti-CTLA-4 antibody designed to increase the activity of cytotoxic T-lymphocytes (CTL). In normal T-cell activation, two or more signals are required: the primary signal interaction, MHC-I or II on an antigen presenting cell interacting with T cell Receptor on the T-cell, and at least one additional secondary signal, a co-stimulatory receptor/ligand interaction. When both the primary signal and secondary signal is received by the CTL, it becomes activated, proliferates, and gains effector function. Effector CTLS can induce necrosis of infected and neoplastic cells by releasing the paracrine cytotoxins granzyme-B, perforin, granulysin or apoptosis through FAS/FASL interaction. CTL’s can be highly destructive and therefore to down regulate their response after being activated they express CTLA-4 which binds with higher affinity to B7, a secondary signal receptor on CTLS, than CD28, its ligand. By competitively targeting the same receptor, CTLA-4 blocks further activation of the CTLS leading to anergy. Simply, once “turned on” through primary and secondary signaling, CTLA-4 appears to act as the “off switch.” The purpose of Ipilimumab is to remove the off switch by disabling CTLA-4’s ability to interact with B7. Thus you create a hyperactive immune system that is more responsive to all antigens including those found on neoplasms and virally infected cells.

However, there is a complication that any first year immunology student would realize, with hyperactivation of the immune system automatically comes autoimmunity. Ipilimumab had autoimmune reactions including seven patients which had fatal reactions. Common autoimmune responses to ipilimumab are colitis, autoimmunity to the adrenal glands, to the pituitary gland, Hashimoto’s thyroiditis and autoimmunity to the skin. These immune related adverse events (irAEs) have occurred in upwards of 40% of patients in two clinical trials and the authors agree that more irAEs may occur with increased length of treatment.

Ipilimumab is the first drug used widely whose mechanism of action is to disable a check point in the immune system, and while other immunotherapies are becoming available, clinical trials have indicated that these drugs are also plagued with high rates of irAEs.

This brings me to a patient that I saw while shadowing Dr. Asim Amin, of the immunotherapy division of the CMC Charlotte’s Levine Cancer Institute. The 54 year old female had been diagnosed with metastatic melanoma with brain, lung, and abdominal metastasis five years prior. She was one of the first patients to receive Ipilimumab at CMC and the halt in disease progression was remarkable. For five years she has lived with a fairly high quality of life, which for a disease that normally has a 4-6 month survival is astounding. Two days prior she had come to the ED with fatigue, headache, muscle weakness, and muscle spasms and upon receiving blood work was diagnosed with severe hyponatremia (low sodium) as well as hypothyroidism. Upon admission and a full work up she was diagnosed with Addison’s disease and Hashimoto’s Thyroiditis. With two endocrine autoimmunities she can be classified has having autoimmune polyendocrinopathy which greatly increases her risk of acquiring more endocrine related autoimmunities. Her current hospitalization would be able to end when her sodium levels returned to a level in which her risk of brain edema had returned to normal; however there is no cure for either Addison’s Disease or Hashimoto’s Thyroiditis. When asked, Dr. Amin indicated that both auto-immunities were most likely related to her Ipilimumab treatment five years prior and that she was a lucky patient. While a strong proponent of Ipilimumab due to its effect on survival time, he had treated multiple patients that developed fatal cases of colitis.

“For her to receive all of the benefits of Ipi [Ipilimumab] while suffering from controllable autoimmunity is the best we can do right now.”

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When a medicine, in providing durable treatment, induces new disease, it complicates the concepts of beneficence and non-maleficence. Sure many medications have side-effects but there appears to be a significant difference since irAEs are positively correlated with efficacy of Ipilimumab and since they occur in such a large number of patients. Also, side-effects normally end when the patient stops taking the medication while autoimmunity is currently incurable. I guess comparisons can be drawn to alternative anti-psychotics and their induction of Tardive Dyskinesia or chemotherapy's induction of peripheral neuropathy in 30-40% of patients and that you can look at the benefit and harm from a utilitarian perspective and say that patients are living years longer. When these points are taken into account Ipilimumab can be seen comparable to many other drugs and these irAEs could be considered normal side effects that are found in world of imperfect medicine. I think Ipilimumab made me realize on a level that I hadn’t before that doctors may have to knowingly inflict a level of harm to provide maximum benefit to the patient. I am sure that if I asked Dr. Amin’s patient whether taking Ipilimumab was worth it, she would give a wholehearted yes. But despite justifying irAEs as just another side effect that patients willingly accept in the hopes of increased survival time, I still find myself wondering if Ipilimumab is contrary to medicine’s number one unofficial and nonsensical rule “primum non nocere.”

Greg Swan ’13 is a Biology major from Woodbridge CT. Next year he will be participating a research fellowship at the NIH.

The Modern Hippocratic Oath

I swear to fulfill, to the best of my ability and judgment, this covenant:

◊ I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

◊ I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

◊ I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug.

◊ I will not be ashamed to say “I know not,” nor will I fail to call in my colleagues when the skills of another are needed for a patient’s recovery.

◊ I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

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◊ I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

◊ I will prevent disease whenever I can, for prevention is preferable to cure.

◊ I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

◊ If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

http://www.pbs.org/wgbh/nova/doctors/oath_modern.html
The first human genome was sequenced in 2001. In 2009 an article appeared in the New York Times about direct-to-consumer genetic tests that for $300 to $3,000 a person can determine if her genome contains mutations that puts her at a higher risk for a certain disease (Brody, 2009). This past summer Stanford University developed a procedure to sequence a fetal genome using only a maternal blood sample (Stanford University Medical Center, 2012). As science and technology rapidly advance, society is struggling to keep up. New questions arise with each new discovery and genome sequencing and genetic testing come with several major issues. The increased accessibility and decreased physical risk of genetic testing and genome sequencing carries significant ethical implications including, but not limited to, the process of obtaining informed consent in field of medical genetics.

In the state of North Carolina, informed consent involves the disclosure by the health professional to the patient of the nature of the medical condition that is to be tested for, alternatives to the suggested testing procedure, the objective of the proposed test, the reasons for the proposition, and make clear the option of no test, all with associated risks and benefits. This disclosure must be communicated to the patient in language that a reasonable person could understand (N.C. Gen. Stat. ch. 90, §21, 2008). Issues arise for medical genetics cases with the methods by which the medical condition to be tested is explained, the explanation of reasons for conducting genetic tests or genome sequencing, as well as the explanation of the risks and benefits associated with each testing option.

In the case of an adult patient who comes into a genetics clinic with an unknown disorder and is looking into testing options, the medical professional should go over the presented symptoms that would indicate the need for genetic testing or genome sequencing. The medical professional should also explain some basic principles of genetics so that the patient can understand how or why he/she may have a genetic disorder. For a pediatric patient, the medical professional should engage in a conversation with the parents about symptoms that the child has presented that cause concern and lead to a need for further analysis. Again, basic genetics should be explained so that the parents have an idea of what information is to be gained from genetic testing or genome sequencing. In prenatal genetics, abnormal ultrasound results would probably lead a woman to seek genetic testing or genome sequencing so the abnormalities of the ultrasound should be explained as well as some basic genetics to inform the woman of why testing is required to know more about the presented abnormalities.

One problem faced by medical professionals trying to obtain informed consent for testing is that many such professionals do not have adequate knowledge of genetics and thus cannot appropriately inform the patient of the medical condition to be tested. According to Bailey et al. (2008), primary care physicians are not well trained in genetics and these are the medical professionals who often have the first contact with patients in need of genetic testing. Additionally, there are currently 3,026 board-certified genetic counselors in the United States (American Board of Genetic Counseling, 2012). This is approximately one genetic counselor for every 135,000 people. There are also fewer than 3,000 board-certified clinical geneticists in the US (American College of Medical Genetics, 2012). Overall, there is a great need to increase the number of medical professionals who are educated in genetics. One solution, proposed by Lessick and Faux (1998) is that nurses should become more involved in counseling patients and families on and informing people about genetic testing. This could be a temporary solution while the fields of genetic counseling and medical genetics continue to grow, but a focus should be placed on expanding those fields in order to adequately support future healthcare involving more genome sequencing and genetic testing.

Another problem of conveying information about genetic conditions to patients is that there is a significant lack of information available to these people outside of the office of a medical professional. Materials such as comprehensive handouts or online materials would be helpful resources for patients to refer to before or after they visit a medical professional. Bailey et al. (2008) revealed families of children with genetic diseases face a serious lack of information. It is important that such information be made easily accessible to patients, not only so they can be fully informed to give consent, but also to increase the effectiveness of communication between the medical professional and the patient.

Informed consent also requires the disclosure of reasons for testing and the option of not having a test performed. It is important to recognize that there is not a standard way to communicate this information, especially with such a sensitive topic as genetic testing, as patients in this situation are different on a case-by-case basis. In fact, a study found that there is an underlying assumption from healthcare providers that genetic testing offers information that people not only should, but also need to know (Hamilton and Bowers, 2003). This assumption is a dangerous one to make in that not every patient will be of the same opinion as the health care provider they are talking to about genetic testing. One patient, Sarah Benedict, chose to undergo comparative genomic hybridization during pregnancy because, as she stated “I like to have information and be able to plan for things… I just wanted to know everything was OK, especially at age 44… for me, it was a question, not if I was going to prenatal testing, but which one was right for me” (Chicago Tribune, 2012). Alternatively, sometimes patients chose not to undergo testing “because the patient would not benefit or is not interested once they have a thorough understanding of the test, the benefits, and possible limitations” (Rochman, 2011). Medical professionals who are responsible for conveying the reasons for undergoing genetic testing or genome sequencing should be sensitive to the patient’s perspective and not make assumptions about this perspective.

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Explain the risks and benefits of a genetic testing procedure also comes with ethical concerns. First of all, in order to obtain informed consent the risks and benefits of the procedure itself should be conveyed to the patient undergoing the testing and to parents if the patient is a child. Secondly, it is also important that the risks and benefits of the results of the tests are explained thoroughly to the patient. However, in the case of genetic testing and genome sequencing, said “patient” is not the only person who could be affected by the results. As both a mother’s and a father’s genetic makeup influence a person’s genome, parents, siblings, and other relatives of the patient could be affected by information revealed through genetic testing or genome sequencing.

This circumstance raises ethical issues in all areas of medical genetics. For example, in the case of a couple wanting to sequence the genome of their fetus, results may reveal information about a genetic predisposition to an adult-onset condition. If the couple decides to continue the pregnancy, there is the issue of when and if the child should be informed of his/her genetic makeup and specifically this predisposition. Should the physician let the parents decide if and when to reveal this information their child? Yes, because medical professionals have an obligation to respect patient autonomy, a patient’s right to decide for himself what is in his best interest and parents have the right to assume this responsibility for their children. What if the parents decide not to tell the child? Is it ethical to let the parents decide to withhold this information? A person has “the right to know their genetic heritage…one’s genetic information can have a great impact on an individual’s medical and life choices” (Schroeder, 2009). Thus, it would be important for the child to know the information, especially if the predisposition is to a life-threatening condition. However, it is not the duty of the medical professional who is consulting the parents to make this call. Should the information be passed to the pediatrician of the child and then to the primary care physician once the child is an adult? Or would this be a violation of his/her privacy? All of these are questions that have yet to be answered definitively. This is just one example to show that there is a need to establish standards for the privacy of a person’s genetic information as well as a standard for how such information is revealed to those to whom it is relevant.

Another issue surrounding genetic testing and genome sequencing and informed consent is that of what information should be revealed to a patient. People are better prepared for information that they know they are going to receive a verdict on than information they have not been warned of (Schroeder, 2009). In order to be properly informed about a health care procedure such as genome sequencing, the patient must be made aware of the risks associated with the results of the procedure. Thus, it is important for the medical professional or testing company to come to an agreement with the patient about what information the patient would like to know from the given test. The possibility of uncovering more information than what is the primary focus of the investigation should be conveyed to the patient. Prior to testing, the medical professional should describe the range of possible findings that could come out of the test or the genome sequencing and a conversation should take place in which the patient clearly defines what information he/she wants to know.

With recent advances in genetic technology, the question arising for many individuals is should I get my genome mapped? Prenatal genetic testing used to be considered a “search and destroy” mechanism that parents would use to determine if there was something wrong with the fetus and if there was, they would abort it (Chicago Tribune, 2012). This stigma has deterred many patients from pursuing genetic testing and genome sequencing. Many wonder, why do I need to know this information? It won’t change my outlook on life, or I can’t do anything to change it so what is the point of finding out if something is wrong? Still others find that knowledge is comforting in that the discovery of a certain mutation that indicates a disease or a predisposition to a certain condition will allow for appropriate planning. Overall, genetic testing and genome sequencing have their benefits and drawbacks, and people see those in different lights, but society needs to catch up to science. Standards of care regarding informed consent must be established and medical professionals must be educated in these standards so that individualized medical treatment involving genome sequencing can be a realistic goal for the future.

Savannah Erwin ‘14 is a Psychology major from Houston, TX and the Treasurer of the Bioethics Society.

References
Physicians and Drug Companies: A Re-Examination
Ashley Parker '13

The Sunshine Act, a part of the Affordable Care Act, is on its way to being put into action. It will require manufacturers to submit reports of physicians and hospitals that received gifts of $10 or more or multiple gifts of less than $10 that in total exceed $100. Manufacturers must also report the physicians or any family members that hold ownership stake in their companies (Sullivan, 2012). The hope in implementing this law is to identify the relationships between drug companies and manufacturers and the physicians who prescribe their products in order to generate a conversation regarding why these relationships exist. In a response to the act, the American Medical Association (AMA) says that such an act will make the Centers for Medicare and Medicaid Services (CMS) appear as “the ethical police of the profession” (Sullivan, 2012). Furthermore, a published, publicly accessible list of physicians and hospitals that do receive gifts may give the impression that these people and institutions are involved in “ethically or legally suspect” behavior and thus hurt any favorable relationships between physicians and drug companies (Sullivan, 2012). Nevertheless, this is one step the federal government is making to move beyond guidelines published in the past.

In 2002 the Office of the Inspector General of the Department of Health and Human Services (HHS) issued a set of guidelines similar to those issued by the Pharmaceutical Research and Manufacturers of America (PhRMA) severely limiting gifts from pharmaceutical companies to health care providers (Vivian, 2002). (This was later updated and strengthened in 2008.) By limiting gifts to physicians and hospitals the HHS attempted to prevent any physicians from unethically prescribing medications under the influence and bias of pharmaceutical companies. However, representatives from drug companies are still allowed to communicate with physicians and disseminate small gifts such as pens and candy, as well as sponsor continuing medical education (CME) conferences. Such allowances beg ongoing ethical conflicts that were not eliminated with the guidelines from 2002. Listening to the detailing of drug representatives or attending commercially-sponsored CME conferences illuminates conflicts between physician autonomy in prescribing medications and the risk of bias on the physician’s prescribing habits that could potentially harm the patient. Another conflict at stake here is between the physician’s responsibility to educate him/herself on drugs from drug representatives or CME conferences and the risk of the patient’s welfare being compromised by a biased physician. On a larger scale, we can see the conflict between patient welfare and corporate profits. I have formulated my argument by considering the conflicts involved in this issue. Physicians should not refuse to listen to drugs representatives or to attend commercially-sponsored continuing medical education (CME) conferences because doing so would violate the physician’s autonomy in making decisions for the best interest of their patients.

Pharmaceutical companies frequently sponsor speakers, programs, or panels at CME conferences, assisting the conference organization in funding their conference. Many are concerned that such sponsorship will cloud the vision of the physicians attending the conferences, blinded by the influence and unseen bias of the drug companies (Ellison, 2009). However, in a study analyzing perceived commercial bias after online commercially-sponsored CME activities, 93% of physicians claimed to perceive no bias after the activity (Ellison, 2009). In another study by Kawczak et al., the investigators also found “no evidence that commercial support results in perceived bias in CME activities” (Kawczak et al., 2010). Furthermore, bias and conflicts of interest are quite challenging to avoid completely. We see bias and conflicts of interest present all the time in medical journals, newspapers, magazines, presentations, lectures, and so on. Bias can be found based on the source of data and the information presented. So how can all bias be completely eliminated from any sort of publication, whether publicly funded or industry funded? The hope lies in those who receive the information. Physicians are trained and quickly learn how to distinguish reputable information from misleading information, just as they learn how to check the sources of the information they are receiving. Evaluating data in medical journals and determining the strength of the study utilizes the same skills as determining the trustworthiness of studies presented at CME conferences. Just as physicians have to decide whether or not to prescribe a drug they read about in a study in a medical journal, they have to decide whether or not to prescribe drugs they hear about in CME conferences. To insist that physicians refuse to attend commercially-sponsored CME conferences would mean following the parallel and insisting that physicians refuse to read industry-sponsored drug studies as well. We need to respect physician autonomy and physician training to determine which drugs to prescribe based on what would be best for the patient. This does involve a lot of trust in the medical community, trust that may be broken or scarred by those physicians who abuse their power and authority. But on the whole, physician autonomy should be respected to allow doctors to make the best decisions in deciding what would be best for their patients.

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In a similar vein, it is the responsibility of the physician to educate him/herself on the new drugs available in order to stay current with the ever-changing field of medicine. One physician says, “I stressed my need to learn as much as I can, in the limited time I have, in order to stay current with the most up to date diagnostic and treatment options” (Segal, 2011). To do this, this physician proudly takes lunches with drug company representatives to hear what they have to say about their new products and continues in saying, “I believe my business lunches are time well spent. I will continue to accept samples on behalf of my patients” (Segal, 2011). Opponents of my thesis might argue that although drug representatives are educating the physician on new drugs and treatments available, they are also subtly influencing physicians at the same time. Familiarity with a name, holding a pen with a drug name on it, or the memory of a good lunch out may influence a physician when he/she has a prescription pad in front of him/her. However, if all drug companies are handing out pens and bagels, these small gifts are “unlikely to have a major impact” (DeMaria, 2007). This author, Dr. Anthony DeMaria, the editor-in-chief of the *Journal of the American College of Cardiology*, further doubts that “any individual company could gain much influence by providing the same tokens as everyone else” (DeMaria, 2007). He is further troubled that focus on this minor issue will pull attention away from other problems in industry-physician interaction (DeMaria, 2007). I am of the opinion that the small gifts given by drug companies are not as big of a concern as some may believe. Here, in the conflict between a physician’s responsibility to educate him/herself and the risk to patient welfare, the physician’s education of new drugs will better benefit the patient in the long run than not hearing about the new drug or treatment.

The final conflict I will examine here is between patient welfare and corporate profits. We must first understand that industry support of the medical profession is ubiquitous. Advertisements are prolific in medical journals, on posters, on television commercials, and via word of mouth. Industry is everywhere and all of these advertisements have an influence on their viewers, otherwise the companies would no longer use them. As the field of medicine expands into the social networking system and finds a home on the Internet, patients have more and more opportunities to learn about drugs and treatment options for their medical conditions. If one were to argue that the detailing of drug representatives and attending commercially-sponsored CME conferences have a substantial impact in creating bias on the part of the physician, then it could also be argued that repeated exposure to advertisements of drugs on television, in magazines, and in medical journals has the same, if not a stronger, effect. Industry profits from drug representatives speaking with physicians who then prescribe their medications, but it also profits from patients asking physicians about a certain medication and from word of mouth of certain drugs.

This leaves us with two options. One, we can ban all drug representatives from speaking with health care providers; ban all commercially-sponsored CME conferences; ban all advertising on the radio, on television, in medical journals, newspapers, and magazines; ban all gifts, no matter the size, to health care providers; and ban patients from suggesting medications or treatments that they have heard about from advertisements to their physicians. The second option is to continue the way we have been, trusting the education and training of our country’s physicians to use their best judgment in prescribing medications and hoping that drug representatives can do their job in educating physicians on the new products available. To follow the course of the first option would mean putting a lot of medical journals, magazines and conferences out of business. These organizations get a good amount of money from their advertisers and removing that source of income could severely limit their abilities to publish. Of course, there may be some middle ground, something that may appear with the enactment of the Sunshine Act, but that discussion is beyond the scope of this paper. Until a more definite solution is found (or experimented), I think the benefits of education from commercially-sponsored CME conferences and the detailing of drug representatives outweigh the small risk of potential harm to patients.

In considering these three ethical conflicts involved with industry-sponsored CME conferences and drug representatives detailing product information to physicians, physician autonomy and responsibility to further their education outweighs the minimal risks to patient welfare. Furthermore, to eliminate corporate profits from drug representatives and sponsored CME conferences, we should also ensure physicians are not influenced by advertising in other realms, including ads in medical journals and commercials on television. Therefore, I do not think physicians should refuse to hear the detailing of drug representatives or to attend commercially-sponsored CME conferences because in doing so they would compromise their ability to learn about new medications and treatments that may benefit their patients.

Ashley Parker ’14 is a French major with a Medical Humanities concentration from Warwick, RI. Last summer she did ethics research as the Van Fellow at the Mayo Clinic in Rochester, MN. This summer she will be taking physics classes and working as a research assistant for an OB/GYN back home.

References


Myriads of articles with graphs and statistics attempt to explain how the bill will affect doctors, hospitals, small businesses, and insurance companies—but very little on how the Affordable Care Act (ACA) will affect you and me. Three years after passage, 57 percent of Americans reported that they did not have enough information to understand how the ACA will affect them. This article is intended for individuals over 26 years-of-age whose family income level is between the Federal Poverty Limit (FPL) and four times the federal poverty limit.

I will start by highlighting what I believe is the most important outcome of this part of the ACA, making insurance companies more accountable for their costs. As of 2010, insurance companies are required to report the proportion of premium dollars spent on clinical services, quality, and several other costs. Companies that spend less than 85 percent of coverage on their employer-based enrollees are mandated to give a rebate. Plans covering individual and/or small coup cap the limited coverage at 80 percent. Companies must also justify hikes in premiums before an independent panel. Additionally, insurance plans must cover ten “Essential Health Benefits” including hospitalization, ambulatory services, maternity care, mental health, prescription drugs, pediatric care, and several other categories at 60 percent of the average person’s medical costs. These provisions maintain a high standard of care while preventing undue spikes in premiums and ultimately aim to control market prices.

### Insurance Options

Employer coverage is not available to the family is guaranteed access to insurance through an exchange and is eligible for tax credit.

If the employer offers coverage that covers at least 60 percent of health expenses on average and the employee pays more than 9.5 percent of his or her income for the premium in the employer plan, then the employee can choose coverage in the employer plan or buy insurance through an exchange and be eligible for tax credit.

If the employer does not cover up to 60 percent of the average health expenses, then the employee can choose coverage in the employer plan or buy insurance through an exchange and be eligible for tax credit.

Business owners and those who choose to “opt out” of employer-based health insurance can locate a plan through their state’s Health Insurance Exchange sites—which is essentially a “shopping mall” for coverage. Health Insurance Exchange menus explain plans in plain English and are intended to make insurance companies compete fairly under strict rules. If you are already privately insured and are satisfied with your coverage, you may “grandfather” it and continue without penalties.

### Payment Options

The government steps in after you choose the best health insurance plan. The federal government subsidizes a percent of an individual’s premium depending on their income level (Table 1).

Conversely, those who are not eligible for subsidies and cannot find coverage that costs less than 8 percent of their income are not required to buy coverage. In other words, individuals who earn over 400 percent of the FPL will not face a fine for going without a health plan.

### Penalties:

Starting 2014, individuals will receive a form from their employers or insurance providers to serve as proof of insurance. These forms will be submitted to the Internal Revenue Service as part of taxes, and any penalty you incur will be deducted from the tax refund. Penalties will be phased in: $95 in 2014, $325 in 2015, and $695 in 2016 as a flat fee or 1.0% taxable income in 2014, 2.0% taxable income in 2015 and 2.5% taxable income in 2016. There are exceptions to the penalty—individuals who experience a three-consecutive-month lapse in coverage, facing financial hardship, incarcerated individuals, those with religious objections, among others, will not face any punishment.

While it is impossible to foresee the future of the healthcare reform, it will be fascinating to see how the implementation of this reform affects the American population.

#### Table 1

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premium as a Percent of Income</th>
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<tr>
<td>&lt;133% FPL</td>
<td>2% income</td>
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<tr>
<td>133-150% FPL</td>
<td>3-4% income</td>
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<tr>
<td>150-200% FPL</td>
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<tr>
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<td>6.3-8.5% income</td>
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<tr>
<td>250-300% FPL</td>
<td>8.05-9.5% income</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>9.5% of income</td>
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### References


Kliff, S. “Readers have questions about Obamacare’s penalties. We have answers!” WashingtonPost.com 1 Apr 2013. Web. 9 Apr. 2013.

Reproduction is an inherently tricky business, it requires contemplating three individuals: a sperm provider, egg provider and a child. When the interests of these beings come into conflict, their triumvirate relationship poses fundamental problems. The genetic materials necessary for the child's creation come from two different bodies with two completely independent minds. A child can only come into existence when an action taken on behalf of the parent(s) makes the fusion of these gametes possible. Since a baby does not ask to be brought into the world, society agrees that a child deserves support and care. But the public disagrees about who should provide this aid. Lawyers like Laura Morgan believe that all biological fathers should be held strictly liable for child support. Strict liability means that one is legally responsible for their acts regardless of fault; if a child exists its father must pay child support regardless of how it was conceived. Conversely, others such as Michael Higdon argue that the courts should not hold a man liable for child support if he was non-conscious or non-voluntary in the act of insemination. A man should have the opportunity to exempt from paternity if the mother conceived via a criminal act. In these cases a woman usurps a man's right to procreative choice, disregards his autonomy and ignores his right to bodily self-determination. The state acts unjustly if it burdens victims with the same penalties it assigns to men who had the opportunity to exercise these rights.

Morgan presents a convincing argument for holding men liable for paternity when they engage in sexual intercourse. In this scenario both parents have the liberty to choose when, where and who they sleep with and thereby both exert their right to reproductive freedom. Two consenting autonomous adults who engage in a sexual union understand and accept that their sexual liaison has procreative potential. They are aware that exercising their right to reproductive freedom comes with responsibility and each individual has the opportunity to weigh their desire against the risk of a pregnancy. By consenting to have intercourse, both parents legally accept the possibility that they may have to pay child support. Since a baby cannot protect itself, parents cannot bargain away the rights of a child to suit their own needs. The state has taken on a societal responsibility to ensure that parents generally act in the best interests of the child. Obviously, a baby cannot will its own birth and therefore bears no responsibility for its existence. The duty to adequately support the child falls solely on the parents, for without their intercourse the baby would not exist. The state has ruled that both parents must financially support their offspring in order to provide at least a minimum standard of security and opportunity. Since the child was innocent in the circumstances of his creation, his right to financial support outweighs his parent's right to privacy and reproductive freedom. Even if the mother misrepresented her use of birth control, the father can still be held liable for child support. Since contraceptives are never “100% effective,” Morgan writes that men should have “take precautionary measures” on their own (Morgan 2). The article and the courts clearly state that any competent adult who engages in consensual intercourse accepts the risk of having to pay child support.

Morgan's piece dictates clear cut rules: regardless of the circumstances at conception— if a baby exists the biological father has a responsibility to support it. Building off risk-responsibility reasoning she asserts “by virtue of biology… men must exercise their rights not to bear children earlier than women” (Morgan 7). She argues that a man always has an opportunity to exercise this right, and can therefore be held strictly liable for paternity in any circumstance. This line of reasoning has no exceptions, the courts charged men to pay child support in cases where: 1) a child was conceived by a woman who engaged in sexual intercourse with a man who was “passed out” 2) a woman who became pregnant by inseminating herself with sperm collected from a sexual act other than intercourse. In these unusual cases Morgan supports her position with substantial legal precedent, but sparse moral contemplation. Her article presents logically sound views but, court rulings do not always equate with ethical justice. This assumption constitutes a naturalistic fallacy; just because something “is” (in this case a law) doesn't mean it “ought” to be (the law's existence doesn’t guarantee its morality) (Sugarman and Sulmasy 7). The Jim Crow laws represent a compelling example of this fallacy. Although the government legislated segregation, these laws didn’t automatically make it ethical to segregate people by race. Furthermore, historical facts do not necessarily result in normative conclusions; showing that “this is the way things are and have been” doesn’t provide adequate validation for moral correctness (8). For example, the fact that slavery existed in the past doesn’t mean that it was a virtuous practice. Asserting that courts in the past have ruled paternity under strict liability does not prove that they are right in doing so. Since Morgan offers only sparse justification for her position on these extreme cases, these naturalistic fallacies significantly weaken the legitimacy of her article. These un-yielding rules exhibit an unsophisticated understanding of reproduction. It should not be governed by blanket statements.

More importantly, the court rulings offer hypocritical legal reasoning. judges have long ruled on paternity through a unilateral strict liability approach. However, with the advent of in-vitro fertilization and artificial insemination, in more recent years the courts have made specific exceptions for these practices. IVF and AF explore the legitimacy of strict liability rulings. In the three example cases mentioned the courts argued that biological paternity automatically made a man liable for child support no matter what circumstances lead to conception. However when ruling on reproduction technologies, the courts relieve the genetic father (the sperm donor) of paternity if the procedure meets appropriate criteria. Judges justified strict liability rulings because no matter how the child was conceived, it was always in the best interests of the baby to have both parents providing financial resources. Yet hypocritically, the courts do not prevent a single woman, who only has a single income, from conceiving a child through use of reproductive technology. It seems that the court exempts certain men from paternity largely because they feel reasonably assured that the female who utilize reproductive technology can adequately financially support their offspring. Since IVF and AF do not burden the public welfare the state has chosen to set aside strict liability.

Since the state has made some exceptions to strict liability, the father’s culpability suddenly becomes relevant. Morgan’s ethical justifications for paternity have strong foundations in cases where the act was consensual vaginal intercourse, but her logic does not hold in more ambiguous circumstances of conception. She chooses to ignore questions about the father’s culpability and therefore fails to contextualize the circumstances of the child's conception. As a result Morgan argues that the father was blame-worthy to non-analogous situations where the father did not commit any fault. Higdon presents compelling arguments for evaluating paternity based on culpability. In the three examples the women become pregnant by fundamentally violating the men’s autonomy and preventing them from self-governing or expressing their will. Since the mothers deprived the fathers of the chance to choose whether they wanted to engage in sexual intercourse and assume its incumbent risks, the men should not be held liable for child support.

The first scenario represents the most compelling situation for relieving a male from paternity. When a female has sexual intercourse with a man who is unconscious (from alcohol or a “date rape” drug) she violates his bodily integrity by physically forcing herself upon him without his consent. This action completely disregards his right to exercise bodily self-determination about whether to engage in sexual intercourse or not. If a man is unconscious, he lacks autonomy and therefore is incapable of dictating his will or giving consent for sexual interactions. The men were acted upon by an outside force (the woman), and through her agency alone the baby came into existence. It seems ridiculous that the courts hold a man culpable for a decision that was forced upon him without his knowledge or consent. In this scenario the woman commits not only sexual assault but rape. Higdon points out that the courts have ruled that “if the sexual intercourse which results in the birth of a child is involuntary or without actual consent, a mother may have 'just cause'… for failing or refusing to support such a child.” (Higdon 24). Higdon proposes that regardless of gender, criminal actions should have the same consequences for the perpetrator and victims of crime should have the equal access to remedies. If the United States truly believes in gender equality then men who are raped should have the same rights to recourse as women who are raped. Although the courts acknowledge the criminal nature of a woman sexually assaulting a man, stereotypes about male sex drive prevail and the courts refuse to acknowledge that rape should have an impact on paternity. Higdon points out that the state has chosen to punish the “victim of a violent crime for being a victim” (23). Continued on page 11
The second scenario presents a more nuanced situation that doesn’t lend itself to an immediate ruling. In accepting the woman’s offer for oral sex, the man voluntarily consented to a sexual act and exercised his right to bodily self-determination and autonomy. However, his consent only applied to specific sexual acts; he did not offer consent to vaginal intercourse or for his sperm to be used for self-insemination. He did not bargain away the rights of the child because he engaged in the act with the understanding that there was no possibility for conception. This case is different from vaginal intercourse where pregnancy always presents a possible risk. The mother had to actively inseminate herself, which she did without the father’s knowledge or consent. Morgan says that since the actions of the man were “sexual” and “resulted in his deposit of sperm with the mother” he must pay child support (Morgan 5). However, in this case, the man technically deposited his genetic material into the condom, not into mother. She surreptitiously stole his sperm from the condom in order to become pregnant. Genetic material is the property of the person it came from, the courts certainly would press charges if a woman stole sperm from a sperm bank. She did not allow him to exercise his right to reproductive choice; he never had a chance to refuse the use of his sperm for self-insemination. The courts should not hold the father culpable (and therefore liable) for the actions and choices of the mother.

The courts have ruled that the child is “innocent” and therefore deserves support regardless of the circumstances of its conception. Yet aren’t the men in the two scenarios “innocent” victims of the mother’s actions as well? Theoretically, government was created in order to protect the rights of all its citizens and punish those who unfairly trespass upon them. A perfect government would protect the rights of both the child and the father, not one at the expense of the other. But as Higdon reveals, the state does not possess a perfectly altruistic definition of the “public good.” The state has decided that the public good calls for “provid[ing] support for children without making excessive demands on the public coffers” (Higdon 4). This aspiration presents a classic conflict of interests, the state’s desire to financially support the child clashes directly with its attempts to reduce the cost of doing so. Forcing someone else to pay for child support presents the easiest way to meet this goal and minimize state expenses. While America boasts of its egalitarianism, this value system seems expressly utilitarian. By charging genetic fathers to pay child support regardless of the circumstances of conception, the state has chosen to burden innocent individuals in order to protect the public coffers and thereby secure the “greatest good for the greatest number.” Instead of striving for moral correctness, the courts currently define the public good in respect to the child’s best interests and the state’s best interest; they not only refuse to protect the father’s rights, but violate them by forcing him to pay for costs he did not incur. While the government should be attempting to deter women from committing rape, the rulings in essence support and reward them for criminal actions. If society has decided that the child’s welfare is an entity it wants to protect, it has collectively assumed the responsibility and can not shift costs to an innocent victim because it is convenient to do so. Higdon shows that the law traditionally has not held citizens responsible for the “financial costs of their victimization;” in other circumstances citizens feel willing to “share the cost and risk of victimization” and believe the government “has a moral responsibility” to those who have been harmed under its watch (22). The state willingly assumes responsibility for children who are born when a male rapes a female and therefore should do the same when a female

Higdon presents arguments with far more compelling logic than Morgan, but the higher moral ground comes with practical complications. Although excellent as a theoretical ideal, protecting men from unjust paternity charges opens up a Pandora’s box of issues. Higdon admits many men would attempt to use the special cases as a legal loophole for paying child support and would be far more likely to try and sue in order to escape paternity. Increased amounts of litigation would incur significant financial costs and time burdens upon the judicial system. Funds that could have been spent supporting a child might instead be spent to cover the costs of keeping the courthouses open more often. Some also fear that the number of children who might fraudulently be deprived of their rightful child support might greater than the number of men who would be protected from unjust paternity. Although the exemptions would introduce new issues, the possibility of new potential problems does not justify ignoring old existing problems. Even if they only are a “few” that would be protected, justice calls for the courts to protect the rights of all its citizens and not to “brush [them] aside in the name of efficient court dockets” (20). Every person has the right to a fair trial regardless of what inconvenience it might cause the state. If a man can prove that he (in Higdon’s words) “did not consent to the act of sexual intercourse (or, in the case of home insemination, to the act of self-insemination) that resulted in the conception of the child” then he should not be held liable for paternity (36). Every man has a right to express his right to reproductive freedom and exercise bodily self-determination, the state has a duty to protect these rights and should not punish a man for choices he did not make. If society claims to place such importance on providing every child with financial support, it should be more than willing to collectively provide it when legitimate need arises.

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References


Responding to Haig’s “The Ethics of Erasing a Bad Memory”  
Lauren Nelson ‘13

Summary of “The Ethics of Erasing a Bad Memory” by Scott Haig, published in TIME.  
Scott Haig is an orthopedic surgeon in the New York City area. Several years ago, a difficult ethical dilemma arose from failed basic technology. Haig’s patient, Ellen, had requested not to be fully sedated during a biopsy procedure, with the fear of not waking up. Haig agreed to perform the procedure under local anesthesia, but required that an anesthesiologist be present during the procedure in case things were to go wrong or the patient was in “too much pain.” Dr. Haig noted that his patient did agree to “some sedation” if [he] thought it was necessary.” After the biopsy had been taken and sent off to the pathology lab for preliminary results, the pathology lab called over the intercom to the operating room, where the patient was under local anesthesia and still cognizant, and asked if they could put the pathologist on. Dr. Haig replied that the patient was under local anesthesia, and that they would need to call on the phone. However, the basic intercom technology was not functioning, and the pathology lab could not hear Dr. Haig’s response. Therefore, they continued on and gave a report of the biopsy: that it was a “really, really bad” type of cancer. As soon as the word “cancer” was uttered by the pathologist, the anesthesiologist administered propofol, an anesthetic that erases the last few minutes of a patient’s memory, to Ellen. This simple act avoided the patient becoming panicky on the table and potentially causing herself harm, and allowed Dr. Haig to prepare to give her the bad news. However, Ellen had vehemently requested not to be put under general anesthesia unless absolutely necessary. Dr. Haig’s article ends by questioning whether it was better to tell his patient that her memories of a few minutes time had been lost, even though the anesthesia was administered to avoid a risky situation, or simply to tell her the procedure went smoothly, as she had no knowledge that she had been fully sedated during the procedure. The article brings into question exactly what information physicians should be required to divulge, as divulging certain information may not ultimately benefit the patient’s well-being. Below is my response to Dr. Haig’s ethical quandary. Dr. Haig’s original article may be found at: http://www.time.com/time/health/article/0,8599,1671492,00.html.

“Stealing Memories”  
The issue of what doctors should be required to disclose to their patients has long been debated (Beauchamp and Childress 288). In recent years, there has been a push toward the doctor being more open and honest with the patient in terms of their care, but how much information is too much information (Beauchamp and Childress 288)? Should information be shared when it will only exacerbate the patient’s condition but the new knowledge will not benefit them in any way? Should physicians have the right to pick and choose what they divulge to their patients about the patient’s care? In this essay, we will explore the reasoning behind why, ethically speaking, Scott Haig had a duty to disclose the errors that occurred during his patient’s procedure that lead to her loss of consciousness and the erasure of ten minutes of her memory.  
In consultation with Dr. Haig before her procedure, Ellen made clear her wish to remain conscious during her procedure because she was afraid of the possible complications that could result from the use of full anesthesia, even though Dr. Haig had explained the unlikelihood that there would be complications. They agreed to conduct the biopsy under local anesthesia, with Ellen consenting to “some sedation” if it was deemed necessary by the physicians in the operating room. In the operating room, however, due to a series of events that unfolded because of a faulty inter-com, the results of Ellen’s biopsy came blaring back from the pathology lab for everyone, including Ellen, who was only under local anesthesia, to hear. The news was terrible, grave, and terrifying. Any patient on the table would have been devastated by the news. Upon hearing the word “cancer,” the anesthesiologist, Dr. Frank, promptly injected propofol, a general anesthetic that also has the effect of wiping out the last few minutes’ memory. This action met with mixed reactions in the operating room, leaving the staff and doctors wondering, “was that ethical?”  
Ellen’s primary objection was to loss of consciousness, which the team respected. Ellen had, however, consented to “some sedation,” and Dr. Frank had deemed full sedation, after the turn of events, necessary. Thus, he seems to have been within his scope of rights given our incomplete understanding of the degree of sedation to which Ellen actually consented. The propofol would calm Ellen, preventing her from causing any harm to herself while in a panicked state on the table. Erasing Ellen’s memory of having heard the news would also allow Dr. Haig to confirm the results and set up the appropriate course of appointments for her treatment before giving Ellen the results. Although Dr. Frank’s intentions seem benevolent, if complications with the intercom had not occurred, and everything in the operating room had been working properly, Ellen would not have heard the news for the first time in this manner and would not have “needed” the anesthesia that she clearly stated was against her wishes.  
One line of thinking says that it was not necessary to tell Ellen about her state of full sedation in the operating room because no complications ensued and no harm came to her. It was necessary for Dr. Haig to consider whether disclosing that she had been under full anesthesia would cause her more distress and anxiety than omitting this detail. This idea of not informing Ellen of the events in the operating room could be supported by Henry Sidgwick’s idea of “benevolent deception,” in which doctors do not disclose upsetting news with the hope of not demolishing the patient’s hope of recovery (Beauchamp and Childress 290). In Ellen’s case, the news that she had been under anesthesia could have been upsetting, because she knew that her wishes had been violated and could cause her distress about consenting to future procedures and not knowing whether the terms she consented to would be followed. The propofol being pushed at that particular moment allowed Dr. Haig the luxury of telling Ellen the news of her diagnosis at a more appropriate time. However, would the addition of knowing her wishes had been violated while in the operating room add to the difficulty of dealing with the diagnosis? The concept of benevolent deception makes the argument that what you do not know will not hurt you. However, does this idea overshadow other ethical principles that would support the notion that Dr. Haig needed to inform Ellen of the events in the operating room?  
Many ethical principles indicate that in this situation, Dr. Haig did have a duty to tell Ellen about the events that unfolded in the operating room that day. First and foremost, the physician-patient relationship is built on trust (Beauchamp and Childress 289). The patient trusts the physician to make decisions with his or her best interest in mind, and, whenever possible, to protect his or her interests. Disclosing the details of the procedure did not conflict with any interest that would warrant Dr. Haig not sharing the information. Because the injection of propofol, and the problems with the intercom, was not Dr. Haig’s fault or under his direction, revealing the circumstances of the operating room would likely not have compromised Ellen’s trust in Dr. Haig’s future decision making concerning Ellen’s treatment and care.  
Continued on page 12
While Ellen did consent to “some sedation” if necessary, the sedation, especially in the way it was given where she did not need it in order to ease the pain but, rather, because of mistakes that were made and the gut instinct of the anesthesiologist, violated Ellen’s initial wishes. Because Ellen expressed her consciousness to be of utmost importance to her well-being, I believe that she had the right to know that propofol was used and that she did not remain conscious throughout the procedure. Ellen had the right to know what her body was subjected to in the operating room. Additionally, Ellen deserved to know that memories were taken from her, because they were her memories. While the memories were erased to protect her, it still seems fair for her to know that this event occurred. Of greater concern than Ellen’s “right to know” about her own health is the concern of what exactly the physician-patient relationship stipulates. In addition to being built on trust, the physician-patient relationship implies a respect for the patient, a respect greater than simply acknowledging the patient’s autonomy and right to consent (or not); it implies a respect for the person as a human being who is greater than the sum of her or her cells and chemical reactions (Beauchamp and Childress 289; Haig).

Although Dr. Haig did not personally violate Ellen’s wishes of remaining conscious by injecting the propofol, thus causing her to lose consciousness and erasing approximately ten minutes of her memory, I believe he had the responsibility to inform her of the events that occurred in the operating room. While an argument can be made that Dr. Haig was shielding Ellen from further distress by not telling her of her loss of consciousness, I believe respect for the patient trumps the idea of “benevolent deception,” and while not a pleasant piece of news, would have fostered the sense of trust between Ellen and Dr. Haig because he was willing to admit that there were errors. As Ellen’s physician, Ellen and Dr. Haig had entered into a contract, dictated by the stipulations of the doctor-patient relationship: respect, protection of interest, and trust.

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References

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