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**OKLAHOMA STATE  
UNIVERSITY**

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The background of the slide is a photograph of a large, multi-story university building with a central clock tower, surrounded by a well-manicured garden with a central path. The entire image is overlaid with a semi-transparent orange filter.

# **2021 NATIONAL BIOETHICS BOWL CASES**

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\* Please Note: This packet contains ten cases, with three questions following each case. At the National Bioethics Bowl competition, only one of the three questions will be selected. Teams will only answer the single question read by the moderator during each case. Not every case will be read in the competition.

### Case 1: Mr. Nabokov's Threats

"I guess I get what the psychiatrist is saying, but can this patient *really* have capacity if he's making such terrible decisions?" Lauren, the bedside nurse, had called the clinical ethics consultation hotline to discuss one of her patients, Mr. Nabokov. As the ethics consultant picking up the case, you walked to the unit to speak with Lauren to hear what she's worried about.

"The patient is only in his 30s," Lauren starts, "but he's in bad shape. I guess he was involved in something pretty nasty, because when they brought him in they said he had been hit by a car – twice. They say it may be gang related. Anyway, he's real hard to work with, swearing at everyone and generally being difficult. But he's been here for a couple weeks now and keeps refusing basically everything. He won't let us turn him, or clean his wounds, or change his dressings – even getting vital signs is a huge battle. And according to the orthopedic surgeons, he's refusing their recommendation to fix this pelvic fracture he has...though they probably wouldn't take him right now anyway. Refusing everything has left him way too unstable.

"I asked the team, and our psychiatrist says that, yeah, he's got some issues, but that he understands what we're saying, so he has the capacity for decision making. But can that even be true if he's refusing all the things that will actually get him better? I'm afraid we're just watching him kill himself in our hospital. What can we do?"

You call Dr. Gopar, the psychiatrist working with Mr. Nabokov. She says, "I get why nursing is having such a hard time with this guy. He's really unpleasant and probably has an underlying personality disorder, which has got to make caring for him difficult and makes it harder to understand the logic behind what he's saying and doing. And I also really wish he wasn't making the decisions he's making. But, based on my assessment, he understands the risks and benefits of his decisions. I definitely don't think that his refusal is a good idea, in an objective sense, but...I mean...he came in because he was hit by a car—twice—after some sort of gang altercation, so I don't know that his decision-making skills were that sharp to begin with. This just may be the way he lived his life...and the way it may end, and we have to be okay with how much we can – or can't – do for him. We can fix his body, but we can't try to undo who he has been, and is, his entire life."

Next, you call the attending orthopedic surgeon, Dr. Price. She laughs when you tell her why you're calling, and says, "Oh, Mr. Nabokov threatens to fire me every time I walk in the room and refuses to talk to me once I bring up the pelvic fracture and our insistence that we need to fix it. Look, if we don't get that fixed, he's definitely never going to walk again, and the chances of infection are so high that if we discharge him without the surgery, I'm almost positive he won't go more than a few months before he comes back here with a massive infection and dies.

“I honestly think that even if he has capacity, which is already borderline given how much he’s refusing our very reasonable offers to help, something is blocking him from making the right decision here. We’ve all tried convincing him, but he’s just so angry at everyone and everything that I don’t think he even hears us anymore. His wife also seems to think that it’s not even worth trying to get through to him anymore, and that the surgery is really important. Can’t we get his wife to consent, put him under, and get this done? I really think that he’ll thank us for saving his life, if we could just go ahead and do it.”

#### **QUESTIONS:**

Q1: Can it ever be the case that the act of refusing a physician’s recommendations is *sufficient* proof that a patient lacks decision making capacity? What might be a standard to use in these sorts of cases?

Q2: Would it be ethical to do what Dr. Price is suggesting, and have Mr. Nabokov’s wife sign the consent for surgery so that they can attempt to fix his pelvic fracture?

Q3: If Dr. Price is right, and Mr. Nabokov would ultimately be glad if they did save his pelvis, does this make a difference? Does it matter that the patient will look back in hindsight and feel positively towards something the patient did not consent to?

## Case 2: Dying with Developmental Delays

“Mrs. Thomas keeps saying that she doesn’t want her daughter to suffer anymore. That’s fine. We get that! But then she starts telling us to give her morphine, and to let her go to God. I don’t know. That just feels... off.”

The resident, Dr. Salarin, speaks quickly and Dr. Salarin’s voice is taut through the telephone line. You listen carefully as Dr. Salarin describes Ms. Eliza Thomas, a 32-year-old woman with significant developmental delay (mental age around 18 months) who presented vomiting blood and having bloody stools. Her mother was hysterically wailing in the emergency department about a tumor coming back and killing her daughter.

As Ms. Thomas was admitted and worked up for gastrointestinal bleeding, her mother calmed down enough to share her daughter’s medical history. Ms. Thomas had congenital developmental and cognitive delays, PICA – where she eats non-food items like dirt, plastic, and her own feces – and is completely dependent for all activities of daily living (ADLs). Mrs. Thomas reported a similar episode of bleeding and vomiting a year prior, during which the doctors discovered a large desmoid tumor obstructing her daughter’s small bowel. The tumor was removed, and though her recovery was complicated by post-surgical infections, Ms. Thomas returned home to her parents’ care, after a brief stay in a skilled nursing facility. This time, barely a year later, when her daughter again showed signs of a swelling abdomen, bloody stools, and vomiting, Mrs. Thomas knew the tumor was back and knew it was the end.

Here Dr. Salarin’s voice becomes thoughtful, almost puzzled. “One the one hand,” Dr. Salarin explains, “it makes perfect sense. The tumor has grown back quickly, with extensive fibromatosis. It’s again obstructing Ms. Thomas’s bowel, and Ms. Thomas is not tolerating enteral nutrition. We checked with surgical oncology and they said they *could* take out some but not all of the tumor, given its location – and with incomplete debulking, it was near certain to grow back even more quickly. So, it is *technically* feasible, it’s just a question of whether a patient is willing to undergo another surgery now, knowing there are more surgeries down the road until the tumor invasion is finally too much. The surgeon said they’ve had some patients who choose to continue on with interventions as long as possible, and others who find the repeated surgeries too burdensome. It’s really about individual goals, values, and preferences. We were really hoping for a clear yes-or-no from them, but they said both surgery and medical management are within standard of care – surgical intervention decisions in these cases are guided by patient preference. But we have a patient who cannot speak for herself.

“Mrs. Thomas keeps insisting that this is all too much – that her daughter has suffered long enough, that if she can’t even eat then this is not a life worth living. It’s not fair to keep dragging out her dying; she needs a natural death. We’ve offered to connect her with home hospice, to discuss plans for caring for her daughter at home, with support for the end of her life, but the mom gets hysterical again any time someone raises the idea. She says she can’t take her back home. If she does, her daughter will suffer. And she doesn’t want her to die at home. We understand how uncomfortable the patient looks and that this tumor will keep

coming back. Furthermore, we know that some families can't handle home hospice – it is *hard*, no matter how ideal people make it sound. But... the way she talks? It almost sounds like the mom wants us to 'snow' her daughter with morphine. I know there's a thing called 'terminal sedation,' but this isn't the same, right? This feels like she's asking for, I don't know, active euthanasia? So, we wanted ethics to help us figure out what to do."

### **QUESTIONS:**

Q1: Ought the patient's developmental disability figure into discussions of suffering, burden of interventions, or quality of life? Why or why not?

Q2: How might you address the nuances and distinctions between palliative care, allowing natural death, terminal sedation, and euthanasia with the team and staff? With the patient's mother?

Q3: What moral dimensions of this situation might be important to identify and address with the team and staff? With the patient's mother?

### Case 3: Baby in a Bag

It might sound like something straight out of a science-fiction novel, but babies “grown in plastic sacs” is real. For decades, scientists have been trying to create viable artificial wombs, but in 2017, Dr. Frankenstein rolled in his grave as Surgeon Alan Flake of the Children’s Hospital of Philadelphia successfully brought eight fetal lambs to term via an artificial womb dubbed the “Biobag”.<sup>1</sup>

The biobag resembles an oversized Ziploc bag, filled with a fluid replete with all the vitamins and minerals gestation requires. Key components included barriers between the fetal lambs, a system that exchanges carbon dioxide and oxygen, a mechanism to circulate electrolytes and blood, and a synthetic amniotic fluid that was chemically identical to what would be found in an ‘organic’ uterus.<sup>2</sup> By every scientific account, this adds up to a perfect proxy for successful incubation.

Among other goals, Flake and his team aim to create a more ‘natural’, ‘womb-like’ environment for premature fetuses to continue the vital stages of their development. Currently, the lives of premature infants are sustained through methods such as IVs providing nutrition and fluids, mechanical ventilation, and various medications. If life is sustained for the infant in the intensive care unit, the infant still faces the risk of encountering health complications due to the underdevelopment of vital organs in the uterus.

For instance, here in the U.S. roughly 10% of infants are born prematurely.<sup>3</sup> Premature birth can result in infant death and disability, as the final weeks and months of pregnancy are vital to the development of the liver, brain, and lungs. In 2018, preterm birth and low-weight birth alone accounted for roughly 17% of infant deaths. It is also noted that one-third of medical conditions such as cerebral palsy can be attributed to premature birth.<sup>4</sup> These premature births also come with significant health risks to those having them, too.<sup>5</sup>

In addition to creating an environment more conducive to survival for premature infants, scientists have speculated that gestation via artificial means could be impactful in other ways. It has been determined that roughly 10 to 20% of pregnancies end in miscarriage, yet medical experts believe that this number may be higher.<sup>6</sup> Although miscarriage is a common

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<sup>1</sup> <https://www.bbc.com/news/health-39693851#:~:text=The%20plastic%20%22biobag%22%20womb%20contains,support%20and%20protect%20the%20foetus.&text=The%20premature%20lambs%20in%20the,develop%20normally%20in%20their%20bags.>

<sup>2</sup> [https://www.nature.com/articles/ncomms15112?utm\\_medium=affiliate&utm\\_source=commission\\_junction&utm\\_campaign=3\\_nsn6445\\_deeplink\\_PID100084481&utm\\_content=deeplink](https://www.nature.com/articles/ncomms15112?utm_medium=affiliate&utm_source=commission_junction&utm_campaign=3_nsn6445_deeplink_PID100084481&utm_content=deeplink)

<sup>3</sup> <https://www.who.int/news-room/fact-sheets/detail/preterm-birth>

<sup>4</sup> <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm>

<sup>5</sup> <https://www.mayoclinic.org/diseases-conditions/premature-birth/symptoms-causes/syc-20376730>

<sup>6</sup> <https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298>

occurrence, the burden of miscarriage has been known to prove detrimental to both the physical and emotional health of the pregnant individual.<sup>7</sup>

Pregnancy mortality has also played a role in the desire to implement artificial womb technology in the future. It has been determined that roughly 700 people die each year in the U.S. while giving birth.<sup>8</sup> Globally, roughly 250 thousand individuals died in childbirth in 2017.<sup>9</sup> Importantly, here in the U.S., a person's chances of dying from pregnancy or delivery-related complications are disproportionately elevated for people of color, being roughly 2 to 3 times higher than those of white patients.<sup>10</sup>

This technology seems to sit at the intersection of fetal health, parental autonomy, and – potentially – the mitigation of disparities seen in the treatment of people of color, as well as those with varying health issues that make traditional pregnancy and childbirth untenable. Yet, many argue that wide-spread use of this technology could result in people “playing God” by encouraging “unnatural” births that otherwise would never happen. Others argue that the high cost of artificial wombs would make them a privilege of only the wealthiest, creating further class disparities surrounding pregnancy and childbirth. Needless to say, the implications of implementing the use of artificial wombs for human fetuses is ethically complex and multi-faceted.

## QUESTIONS:

Q1. In what ways does this technology complicate the pro-choice vs. pro-life rhetoric?

Q2. Given the statistical disparities between the success of wanted pregnancies in people of color vs. white people in this country, do you believe that the wide-spread use of this technology would actually serve to mitigate the difference, or could it prove to exacerbate it?

Q3. Almost all childbirth today relies on some degree of technological and ‘artificial’ assistance, whether that be drugs, vitamin supplements, incubators, surgery, etc. Does artificial womb technology cross an ethical line? If so, what is it, and how does this technology differ in kind from current birthing technologies? If not, how does this technology match current ethical standards?

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<sup>7</sup>[https://www.sciencedirect.com/science/article/pii/S1521693406001568?casa\\_token=3SmRG\\_szaQAAAAAA:c3pxpT6BJX5XWCjbD5Qi53HE\\_-1XXzgoEowyNSY21hgKe33bUAz5C3uFEKJq5Z5iviFN8XnyYL7x](https://www.sciencedirect.com/science/article/pii/S1521693406001568?casa_token=3SmRG_szaQAAAAAA:c3pxpT6BJX5XWCjbD5Qi53HE_-1XXzgoEowyNSY21hgKe33bUAz5C3uFEKJq5Z5iviFN8XnyYL7x)

<sup>8</sup> <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm>

<sup>9</sup> [https://www.who.int/maternal\\_child\\_adolescent/epidemiology/stillbirth/en/](https://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/)

& <https://www.who.int/data/gho/data/themes/maternal-and-reproductive-health>

<sup>10</sup> <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>



#### Case 4: A Right to Which Life?

Due to religious beliefs, a prominent politician is opposed to abortion. One of this politician's primary campaign stances is that abortion should be outlawed with no exemptions. This would mean no abortions even if the pregnancy endangers the mother's life and no abortion in the case of incest or rape. The politician also opposes the use of any federal funds to support stem cell research.

The U.S. government's scientists are currently banned from using fetal tissue from elective abortions, and there is increased scrutiny for NIH proposals from nongovernmental scientists that use fetal tissue, which serves to deter researchers from doing the research or seeking federal funding.<sup>11</sup> NIH spends about \$40 billion on medical research every year.<sup>12</sup> Research from fetal tissue through other means such as miscarriages are difficult because miscarriages may occur due to problems with the fetus, which could lessen the quality of the material, and miscarriages are not planned, so the tissue collection process is less likely to be successful.<sup>13</sup>

In the midst of the COVID-19 pandemic, the politician downplayed the seriousness of the virus, comparing it to influenza. This politician also spread misinformation about testing and treatment, including promoting treatments that had been proven unsuccessful for COVID-19 treatment.

The politician contracted COVID-19 and was sent to the hospital for a few days of treatment. As a part of the treatment, the politician received an antibody cocktail. While the efficacy of the treatment is not fully known given both the novelty of the virus and thus the novelty of the treatment, it is believed the cocktail limits the effects of the virus by mimicking natural antibodies. While the antibody cocktail treatments are available, they are not commonly being used because they require IV infusion, and ideally, they should be given to people who have recently contracted the virus, not individuals who are already requiring hospitalization.

This antibody cocktail was developed using tissue from an aborted fetus, which is the type of research the politician is opposed to. After recovering from the illness, the politician has continued to campaign and legislate against the use of fetal tissue for medical research. Because of the politician's prominence, the politician's treatment was disclosed publicly, and it is publicly known that the antibody cocktail was developed using aborted fetal tissue.

The politician, because of their importance to government functioning, received priority treatment, even though the politician's case was not as severe as others in need of treatment.

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<sup>11</sup> <https://www.the-scientist.com/news-opinion/scientists-grapple-with-us-restrictions-on-fetal-tissue-research-67205>

<sup>12</sup> <https://www.nih.gov/about-nih/what-we-do/budget>

<sup>13</sup> <https://www.the-scientist.com/news-opinion/scientists-grapple-with-us-restrictions-on-fetal-tissue-research-67205>

The concept is called 'continuity of government', which is also why legislators received COVID-19 vaccinations before the vast majority of the public.

**QUESTIONS:**

Q1. Is it ethical for politicians be given priority over the general population for medical treatments for the sake of continuity of government?

Q2. Is it ethical to knowingly accept a medical treatment when one has campaigned against the kind of research used to develop that treatment? Is it ethical to continue campaigning against that kind of research after knowingly benefitting from that kind of research?

Q3. What role – if any – should religious beliefs play in the development of policy affecting medical research and treatment?

## Case 5: Not Dead Yet

In 1994, disability rights activist Alice Mailhot wrote, “If I were listing the most dangerous people in the U.S. today, bioethicists, aka medical ethicists, would top my list – way above skinheads, whose beliefs they appear to share.”<sup>14</sup> It should be noted that Mailhot’s criticism of bioethicists (and bioethics) is not uncommon in the disability rights community, and the critiques are general, practical, and individual.

In general, there are fears that financial pressures may push ethicists to argue that scarce health care dollars and resources are better spent on those who can make the most of them – i.e., not the permanently sick or disabled. In practice, bioethics has already effectively sanctioned the process of screening for genetic abnormalities for fetuses still in utero, leading to the elective termination of pregnancies that would have, save the genetic abnormality, resulted in healthy babies. In addition, it has all but blessed the withdrawal of life-sustaining interventions for those medicine thinks not worth keeping alive under the guise of arguments about “futile” treatment.

On an individual level, disability rights activist Harriet McBryde Johnson wrote this about the influential utilitarian philosopher, Peter Singer, after meeting and debating him: “He insists he doesn't want to kill me. He simply thinks it would have been better, all things considered, to have given my parents the option of killing the baby I once was, and to let other parents kill similar babies as they come along, and thereby avoid the suffering that comes with lives like mine, and satisfy the reasonable preferences of parents for a different kind of child.”<sup>15</sup>

Not Dead Yet, one of the nation’s largest disability advocacy groups, has a name which pithily encapsulates the group’s stance in opposition to professional bioethics. As they state on their website, the group “opposes legalization of assisted suicide and euthanasia as deadly forms of discrimination against old, ill and disabled people.”<sup>16</sup> Driving this statement is the concern that bioethics is often utilized as a qualitative evaluation of which lives are, or are not, worth living (and thus saving). According to disability rights activists, the focus of medicine – and thus of bioethics – should be on helping people flourish within their own circumstances, while acknowledging the social determinants of disability.<sup>17</sup> Medicine should not concentrate on “fixing” whatever is “wrong” with a person, then abandoning them to “medical futility” whenever they can’t be fixed.

Yet those who subscribe to the medical model of disability state that it is immoral to allow children to be born with congenital defects that could be identified and screened out (whether by not implanting certain embryos during IVF or terminating a pregnancy with an identified abnormality).<sup>18</sup> For if medicine has created the technology to eradicate or cure

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<sup>14</sup> <https://www.cilt.ca/wp-content/uploads/2017/01/Bioethics-Introduction-to-theories-from-hell.pdf>

<sup>15</sup> <https://www.nytimes.com/2003/02/16/magazine/unspeakable-conversations.html>

<sup>16</sup> <http://notdeadyet.org/about>

<sup>17</sup> [https://en.wikipedia.org/wiki/Social\\_model\\_of\\_disability](https://en.wikipedia.org/wiki/Social_model_of_disability)

<sup>18</sup> [https://en.wikipedia.org/wiki/Medical\\_model\\_of\\_disability](https://en.wikipedia.org/wiki/Medical_model_of_disability)

certain disabilities, isn't it a societal obligation to do so? After all, who could argue that eliminating smallpox and polio from the world isn't an objective good? Shouldn't we do the same for cystic fibrosis, Huntington's Disease, and Down's Syndrome?

On the other end of the life spectrum, many medical professionals and bioethicists believe that as patients age, the goal of medicine should be to cure disability and disease as best it can, and to not prolong those disabilities and diseases it can't cure. When cure is no longer possible, it is in fact incumbent upon medicine not to prolong death and to make decisions about withholding or withdrawing life-sustaining treatments it views as no longer effective. If the medical model of disability is right about any of this, it seems that the role of the bioethicist, in fact, is to help medicine think through how to figure out when a disease or disability burden is so great that medicine ought to avoid or relieve the suffering associated with that burden.

Perhaps Mailhot is right when she wrote that bioethicists "teach medical professionals and community elites to decide who lives and who dies... Bioethics see cost savings in cheap and early death."<sup>19</sup>

#### **QUESTIONS:**

Q1: Between the medical and social models of disability, which one is more appropriate in response to disability?

Q2: Can one do bioethics without making qualitative judgments about topics like disability?

Q3: Should one make qualitative judgments about topics like disability?

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<sup>19</sup> <https://www.cilt.ca/wp-content/uploads/2017/01/Bioethics-Introduction-to-theories-from-hell.pdf>

## Case 6: Who's up for Shots?

In 1960, Belding Scribner had a revolutionary idea that was to transform the treatment of chronic kidney disease, which had theretofore sentenced its sufferers to a lingering death. His idea consisted of a Teflon shunt – the Scribner shunt – that could be inserted into a patient's arm and prevent the clotting of the blood that had until then prevented hemodialysis from becoming a lifesaving treatment, as it allowed, for the first time, a machine to fully take on the function of the kidneys.<sup>20</sup> Between 1960 and 1961, Scribner and his team constructed three dialysis machines at Swedish Hospital in Seattle, Washington. The process itself took roughly twelve hours, meaning that one machine could serve at most two persons in a twenty-four-hour period. For the first time in history, there was now a viable treatment for chronic kidney disease that would allow patients to live so long as they had access to one of three dialysis machines. This situation created a new type of problem that in many ways constitutes the birth of modern bioethics: someone must be tasked with deciding who should have access to these machines, knowing that withholding such access meant death.<sup>21</sup>

This resulted in the creation of the Admissions and Policies Committee of the Seattle Artificial Kidney Center at Swedish Hospital—better known at the time as the “God Panel”<sup>22</sup>—which would consist of seven individuals who would judge applications. The members were a medical doctor, a stay-at-home mom, a lawyer, a labor leader, a minister, a state official, and a banker.<sup>23</sup> These seven people were tasked with determining the criteria by which applications would be judged. The criteria chosen included the exclusion of children, anyone over the age of 45, and further considered sex, marital status, number of children, net worth, income, emotional stability, and a variety of other traits that one might sum up as constituting “social worth,” meaning that those who were expected to contribute most to society would get to live.<sup>24</sup>

The results of this selection process were predictable. The lucky few were predominantly high-status upper-middle class white men. Indeed, the “God Panel” is now regarded as an example of what not to do. So much so, in fact, that later planning panels faced with a similar sort of situation, were told specifically not to consider “social worth,” income and many of the key criteria of the original God Panel.<sup>25</sup> Indeed, with the perfect vision of hindsight,

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<sup>20</sup> Will Ross, “God Panels and the History of Hemodialysis in America: A Cautionary Tale.” *AMA Journal of Ethics* 14/11 (2012): 890-896.

<sup>21</sup> Shana Alexander, “They Decide Who Lives, Who Dies.” *Life*, November 1962.

<sup>22</sup> Mark P. Aulisio, “Why Did Hospital Ethics Committees Emerge in the US?” *AMA Journal of Ethics* 18/5 (2016): 546-553

<sup>23</sup> Pamela Warrick, “Questions of Life and Death: Who Lives? Decision by Committee.” *Los Angeles Times*, August 4, 1991. DOI: <https://www.latimes.com/archives/la-xpm-1991-08-04-vw-25-story.html>

<sup>24</sup> Carol Levine, “The Seattle ‘God Committee’: A Cautionary Tale.” *Health Affairs*, November 30, 2009. DOI: <https://www.healthaffairs.org/doi/10.1377/hblog20091130.002998/full/>

<sup>25</sup> Sheri Fink, “Whose Lives Should Be Saved? Researchers Ask the Public.” *New York Times*, section “US”, August 21, 2016. DOI: <https://www.nytimes.com/2016/08/22/us/whose-lives-should-be-saved-to-help-shape-policy-researchers-in-maryland-ask-the-public.html>, retrieved on 1/14/2021.

the activities of the “God Panel” laid bare some uncomfortable truths about healthcare and access to healthcare in the United States.

In 2021, our society once again faces such a dilemma. As COVID-19 ravages our communities, having killed to date some 397,994 Americans at the time of writing,<sup>26</sup> it has not escaped the attention of researchers that, like many other afflictions, this deadly disease has disproportionately affected African Americans. Fortunately, several effective vaccines have been developed and are beginning to become available in communities around the country, creating once again the need for triage: who will get access to these rare doses of a life-saving vaccine?

It has been suggested that this constitutes an opportunity for us to right a social wrong. An advisory panel of the CDC has recommended that access to vaccines should not be arranged to minimize deaths, but to favor historically oppressed groups, and thus to place essential workers ahead of the elderly. The logic is that due to lower life expectancy of most minority groups, favoring the elderly would *ipso facto* favor white individuals who are simultaneously more likely to have accumulated wealth. Essential workers, on the other hand, are more likely to be members of minority groups and lower socio-economic status. Favoring them over the elderly would thus correct injustices by protecting the socio-economically vulnerable over the medically vulnerable.<sup>27</sup> This approach, in favoring essential workers, would also have the likely effect of slowing rates of infection. As the New York Times reported:

“Harald Schmidt, an expert in ethics and health policy at the University of Pennsylvania, said that it is reasonable to put essential workers ahead of older adults, given their risks, and that they are disproportionately minorities. ‘Older populations are whiter,’ Dr. Schmidt said. ‘Society is structured in a way that enables them to live longer. Instead of giving additional health benefits to those who already had more of them, we can start to level the playing field a bit.’”<sup>28</sup>

## QUESTIONS:

Q1: Should the CDC prioritize the maximization of the preservation of human life? Or should it aim to slow the rate of infection, allowing for a speedier resumption of relative normalcy at the cost of the lives of a number of ailing elderly people?

Q2: Does it make sense to eschew “social worth” in determining who gets access to scarce life-saving treatments?

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<sup>26</sup> Numbers retrieved from: <https://ncov2019.live/>

<sup>27</sup> Abby Goodnough and Jan Hoffman, “The Elderly vs. Essential Workers: Who Should Get the Coronavirus Vaccine First?” *New York Times*, section “health,” December 5, 2020. DOI: <https://www.nytimes.com/2020/12/05/health/covid-vaccine-first.html>, retrieved on 01/14/2021

<sup>28</sup> “The Elderly vs. Essential Workers.”

Q3: While the original concept of social worth emphasized the importance of economic contributions to society, any decision to favor historically oppressed groups over the elderly based on their accumulated wealth and whiteness also constitutes a life-and-death decision based on race and socio-economic status: does the previously ethically dubious practice of making decisions that determine life and death on the basis of race and socio-economic status become ethical once the directionality of those determinants is reversed?

## Case 7: There Can Only Be One

Imagine you are a member on the ethics committee of a local hospital that's still under construction but has been forced to open early because of the Covid-19 pandemic. Despite only having been open a few weeks, the emergency care unit is already overrun with Covid-19 patients, stretching supplies and personnel thin.

Most patients in the intensive care unit are improving. Nonetheless, four with respiratory failure are not responding to treatment. This urgently requires intubation and ventilation. Unfortunately, only one ventilator is available, and a decision must be made immediately.

In the medical community there is broad agreement that decisions regarding the allocation of scarce medical resources should be determined by a carefully considered institutional policy, and not by those providing direct care to patients. Sadly, due to the premature opening of your facility, no such policy is in place.

Looking to similar kinds of hospitals and their policies, you can see that some focus on the equal dignity and worth of every patient and try to preserve that equality in the form of giving each patient an "equal chance" to get therapy, and when a lack of resources make that impossible, to employ a fair lottery to determine who gets care. Others try to maximize benefits to the larger community of which the hospital is a part. The question then becomes how to justly take account of the facts of these patients' lives to predict which of them, if they recover, will benefit the community the most. Some hospitals have even tried to blend these two approaches.

Regardless, you and the rest of the ethics committee need to make an *ad hoc* recommendation today. Here's what we know about the four patients in urgent need of intubation and ventilation:

Patient 'A' is a 53-year-old male, currently unemployed because the restaurant he worked at was shuttered because of Covid-19 fallout. A permanent resident of the U.S., he is single and has no living relatives left in the country, although he claims that he has "lots of cousins with lots of land" in another one. Well known to the local police on account of some misdemeanor public intoxication charges, he is nonetheless widely considered to be harmless. And he claims that he is not alcohol dependent and can "quit whenever he wants to." There's also no evidence of liver or other alcohol-related health damage. Patient A began suffering from significant shortness of breath after he "caught a cold," but he did not want to go to a hospital for fear that they would "treat him like dirt". An ambulance brought him to your Emergency Department after he collapsed on the street.

Patient 'B' is a 41-year-old female. She is married and the mother of three children aged 15, 12, and 5. She is a successful interior designer who has donated her services to various



community organizations. She suffers from amyloidosis, an unusual and little understood disease of unknown cause characterized by the extracellular accumulation of amyloid--i.e., - nonfunctional protein fibers--in the organs and tissues of the body. There is presently no known cure or treatment for this disease. It is ordinarily fatal over time, depending on which organs or tissues are affected and at what rate; but no dependable life-expectancy statistics are available to apply to her case. Patient B became sick shortly after volunteering in a local soup kitchen. "I knew there was some risk," she explained, "but those people need all the help they can get." When her condition worsened, she immediately came to your Emergency Department.

Patient 'C' is a 29-year-old female. At age 3 she suffered cerebral hemorrhage after a blow to the head from a fall and has been severely developmentally disabled since then. Her mental age is approximately that of a three-year-old. She resides in a state home for the developmentally disabled. Her mother is a 62-year-old widow who has no other children and whose only income is her husband's social security survivor pension. Theresa was visiting her mother at her home when Theresa came down with a cold accompanied by fever and her mother's PCP said she should be taken to your Emergency Department. Her mother has visited her on several occasions and has spoken of the joy she brings to many friends and family members.

Finally, patient 'D' is a 41-year-old male. He is single and works as a radiation technologist at another local hospital, where he's been for the last nine years. An avid sports fan, prior to this he was in otherwise peak physical shape, and spent his spare time coaching a local little league team – something he's been doing for years now. In fact, it was during a league game in the fall that he caught a chill and woke up the next day with what he kept telling relatives was just a "cold or flu". Patient D refused to believe that Covid-19 was real or a mortal threat, and by the accounts of his own family members he has been extremely careless with respect to abiding by pandemic restrictions. Relatives called 911 after he developed a fever and shortness of breath and couldn't get out of bed.

### **QUESTIONS:**

Q1. Does an "equal chance", lottery, 'maximized benefits', or some other approach give us an ethically better way of deciding who gets the last ventilator in this situation?

Q2. Which, if any, of these patients is most obviously deserving of care, and which one is most obviously undeserving of it?

Q3. Are there any significant details missing from each of these patient descriptions that would help you to decide more easily? What bias(es) might the introduction of such details create?

## Case 8: Caring for the Covid-Denier

“Can I intubate him anyway? He refuses to accept that he has COVID-19. He doesn’t ‘believe in’ COVID-19. He thinks it’s a hoax and insists his low oxygen saturations are from his asthma. He won’t let us give him remdesivir or dexamethasone. He knows those are COVID-19 therapies and thinks we’re trying to experiment on him because he’s black. But he’ll accept prednisone because it’s for asthma, and he’s had that before for exacerbations. This is nuts.”

The ICU attending, Dr. King, is visibly struggling on the video call with you, and you nod encouraging them to continue the story behind this consult request. “I mean, I know people can refuse treatments. I know they can make bad decisions and show poor judgment. I mean, that’s a right people have, right? But he’s denying that COVID *even exists*. He’s denying the two positive COVID tests we showed him are real! Isn’t that a sign that he’s not processing? I mean, I think it’s crazy, and it burns me that I’ve got to spend this time and have this ICU bed filled by someone who doesn’t even understand that we’re trying to help him. He refused to be intubated because he doesn’t believe he’s got a disease that could kill him! But he won’t accept my recommendations for a Do Not Attempt Resuscitation order either – he wants to remain full code status. That’s inconsistent! It just doesn’t make sense! How are you supposed to code someone if you can’t intubate them?”

Dr. King is known for being one of the most un-flappable, cheerful clinicians on the ICU team. Fifteen years of experience as faculty, Dr. King is always the calm center of the storms that blow through the unit. Today, in the rising surge of pandemic patients, Dr. King is no longer calm, and in the pressured speech that leaves no room for interruptions, you can hear all the frustrations of months of caring for those sick and dying from the coronavirus and its complications.

Dr. King continues: “Then – then! – when I asked if he had a surrogate I could talk to if he wasn’t able to make his own decisions, he got even more defensive and said no one was going to decide anything but himself. I assured him that we would talk with him if he was able, but that I was worried his breathing was getting worse, so we’d need some help. The chart has his sister listed as his emergency contact, but when I asked about her, he said we couldn’t call his sister. We weren’t to bother her about this.”

Dr. King pauses long enough to take a gulp of the coffee sitting on the edge of the workstation and grimaces. You wonder how long that cup has been sitting there, cold. With a more measured pace, the core question emerges: “Here’s the thing. I’ve been struggling to figure out if this guy really has capacity to refuse treatment because some of what he said was coherent – even if it was stupid and factually untrue. But some of it was just inconsistent. Even if he truly believes COVID-19 is a hoax, he started to sound paranoid and strange. He was claiming I was ‘taking his oxygen’ with the facemask and ‘just giving him hot air to dry him out’ instead. What does that even mean? Then he said his friends were going to get him ‘real oxygen’ and a wheelchair so he could go home. He didn’t want us to keep him for ‘more

experiments.' That's when I decided we needed Ethics help. I'm too tired! I can't make it make sense any way I look at it. What should we do? How can we help him?"

**QUESTIONS:**

Q1: Explain what ethically supportable actions are available for the physician and ICU team to take and why:

- a. If the patient's capacity is still in question?
- b. If the patient is determined not to have capacity?
- c. If the patient is determined to have capacity?

Q2: How might the clinical ethics consultant respond to the physician's distress – is it moral distress? Why or why not?

Q3: Describe the potential influences of historical or current events on the patient and physician interaction, and how the clinical ethics consultant might respond.

## Case 9: Pay-to-Play – Hunting, Hiking, and the Environment

One of the leading causes of species endangerment is destruction of habitat.<sup>29</sup> With a growing population that requires both increased housing and increased agricultural production, habitat destruction and endangerment is going to be an ongoing issue. With a growing population and increasingly threatened natural areas, conservation efforts are needed, and conservation efforts require funding.<sup>30</sup>

In the U.S., including Oklahoma, hunting, fishing, and trapping permits are one of the primary funders of conservation efforts. Proponents of hunting point out that without hunting, many of these animals lack natural predators. This is often because the predators have themselves been hunted in an excessive manner and because of habitat destruction limiting their ability to range.<sup>31</sup>

Put simply, conservation is often a pay-to-play model. Hunting, fishing, and trapping fund the efforts needed to keep the animals alive, which are then killed via hunting, fishing, and trapping. But by maintaining those habitats, other species are likely benefiting from the conservation because no animal lives in a vacuum.

But this model has two notable downsides. The first downside is that the number of hunters in the U.S. has been declining over the past 30 years, which means funding suffers as a result.<sup>32</sup> To replace this funding, taxes could be used to fund conservation efforts instead of a fee-based structure, but that would mean either raising taxes or cutting public funding to other programs. For example, in Oklahoma, increasing taxes is difficult. For the legislature to pass a tax increase, it requires a three-fourths majority in both chambers of the state legislature or for the legislature to refer it to a direct vote by the people of Oklahoma. Since that policy was approved in 1992, only two revenue bills have successfully raised taxes, once by the legislature and once by the state's voters.

The second downside is that the act of hunting is considered by some to be inherently cruel. Animal rights often prefer to let nature take its own course for controlling animal populations. This would mean letting wildlife populations ebb and flow without human interference.

While hunting, fishing, and trapping have been declining, there are other users of natural spaces. This includes those who hike, go mountain biking, birding, kayaking, and so on. In other words, they also use natural space, but they do not kill the animals in the process.

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<sup>29</sup> <https://sciencing.com/causes-animals-becoming-endangered-6564385.html>

<sup>30</sup> [https://science.sciencemag.org/content/356/6335/260.abstract?casa\\_token=piOEhD8MdlEAAAAA:mDNM2yLRa d4zCCOZdQTsbMqBGelzERxPAi-LU8Op-IKY2yp5nRmOksVfgq0imj32WptkA4b8bdnYC2M](https://science.sciencemag.org/content/356/6335/260.abstract?casa_token=piOEhD8MdlEAAAAA:mDNM2yLRa d4zCCOZdQTsbMqBGelzERxPAi-LU8Op-IKY2yp5nRmOksVfgq0imj32WptkA4b8bdnYC2M)

<sup>31</sup> <https://www.livescience.com/9716-loss-top-predators-causing-ecosystems-collapse.html>

<sup>32</sup> <https://www.npr.org/2018/03/20/593001800/decline-in-hunters-threatens-how-u-s-pays-for-conservation>

States could create a pay-to-play model for these other outdoors activities, which could then be used to maintain natural areas. State parks in Oklahoma already require an entrance fee, but private landowners can also set their properties up as agritourism destinations. While that might increase space for wildlife, there is no guarantee that these efforts would be uniform within and across states, or that private landowners might not kill off species they consider to be problematic but are necessary for that local ecosystem to thrive. There also becomes a lack of centralized effort because landowners could take varying strategies, but fish and wildlife are not beholden to property lines. But a case could be made the landowners are going to know what is right for wildlife on their property and in their local area to thrive more so than policymakers in the state capital.

### **QUESTIONS:**

Q1. What is the ethical case for funding conservation efforts that ostensibly aim to keep animals alive through efforts that depend on the deaths of animals?

Q2. Given that it is unlikely that taxes would be increased to fund conservation efforts, what could be a new pay-for-play model look like to fund conservation efforts?

Q3. What would be the ramifications of ending the pay-for-play conservation funding model entirely without replacing those funds with taxes? In other words, what is the case for letting nature take its course with no government intervention?

## Case 10: We've Got a Runner!

"I can't believe it! Ms. Carter is out on the sidewalk in her wheelchair, wearing a hospital gown, and heading down the street! She's got a giant pressure ulcer and is incontinent, which only makes her infections worse. She's refusing to come back in. And hospital security said they would have to use force. However, that could be seen as battery if we don't have clear documentation that she lacked capacity. And we don't. Someone let her leave against medical advice! The security team also said they don't think the police will be able to help her, to take her in for grave disability because of mental illness, because she *sounds* rational when they were talking to her. What can we do to help? Can you help us?"

Clinical ethics consultations almost always start with a fragment, a moment in time requiring you to fill in the back story. Conversation with the key players involved in Ms. Carter's care reveal helpful – and confounding – information. First, you realize that her name sounds familiar and when you look in the records for the Clinical Ethics Consultation Service (CECS), you see Ms. Carter has been followed by every member of your team at least once in the more than five years since the first ethics consultation request. In that time, she has had more than 30 admissions for infections from significant osteomyelitis in her left foot to, more recently, the sacral decubitus ulcer that developed when she started to use a wheelchair full time.

At various times, across these numerous admissions, Ms. Carter has been determined to have capacity, and at other times not. She has no known family or friends to speak for her, and no primary healthcare access – the emergency department is her first stop for any medical concerns. She has left against medical advice multiple times and has repeatedly refused amputation of her left leg during multiple admissions, explaining that she knew it was the source of her infection and why she got so sick, but that it would be even harder for her to live on the street if it was amputated. She has consistently insisted she does fine on the street and doesn't want help with placement in a shelter or a nursing facility.

Ms. Carter has so far been able to seek medical care when she starts feeling worse, and though she is suspicious and guarded when in the hospital, she allows for medications, food, and wound care until she starts feeling better. However, nothing is ever smooth. She often tries leaving before she's finished a course of antibiotics, or when physicians strongly recommend wound debridement or amputation. Ms. Carter will only accept so much from her healthcare team and can often give a clear explanation of her limits and preferences. Yet, as one of the many physicians who has cared for her noted during one admission, "What may be considered poor judgment does not necessarily mean a lack of capacity for a particular decision."

In this particular instance, Ms. Carter was deemed to have the capacity to leave against medical advice, but given her weakness and debilitation from her infection, neither the overnight resident physicians nor the nurses thought she would be capable of getting to her wheelchair and out of the door to her room, let alone the hospital door. They were mistaken. As she has done before, Ms. Carter defied expectations, making her way to the street corner

across from the hospital's entrance. She was now sitting in her wheelchair, willing to talk with anyone who approached her, but unwilling to return to the hospital.

In the multidisciplinary discussions with the teaching team, nursing leadership, the psychiatry liaison, risk management, and the unit social worker, several suggestions are raised and considered for helping Ms. Carter. They include (1) returning her to the emergency department by force; (2) contacting the local police to evaluate for a psych hold for grave disability; (3) sending a hospital psychiatrist to evaluate her on the sidewalk and perhaps determine she doesn't have capacity after all; (4) requesting local homeless outreach coordinators to invite her to a shelter; or (5) not intervening at all, since she has previously demonstrated her ability to seek medical assistance when needed.

**QUESTIONS:**

Q1: Which of these five options sound most reasonable? Consider legal, ethical, practical, and interpersonal factors.

Q2: Are any of these options unconscionable? If so, on what grounds?

Q3: Is there a particular strategy that could have been employed *before* Mrs. Carter left the hospital that could have prevented this incident from happening? What kinds of protocols should have been in place here?