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BENO

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a) *Dr. Bob Taylor (right), Board member, talks to attendees at the 22nd Annual Conference.*

b) *Attendees at the conference take a moment between presentations to discuss issues and points of learning.*

c) *Past Presidents Drs. Allyson Robichaud (left) and Ellen Bernal enjoy an opportunity to reconnect.*

22nd Annual BENO Conference

On Friday, April 27, 2012, more than 130 doctors, nurses, clergy, chaplains, social workers, attorneys, occupational, physical and respiratory therapists, and students gathered in Dublin, Ohio, at The Conference Center at OCLC for BENO's 22nd Annual Conference. This marked the third consecutive year the conference was held at this facility.

Some highlights of the conference included Dr. Leslie Whetstine, who offered the keynote address, examining the role of casuistry in medical ethics and the potential challenges that casuistry presents, especially in relation to other forms of moral reasoning. Dr. Barbara Daly offered a plenary session regarding limit-setting with families who request ongoing treatment of patients when those treatments are deemed to no longer be efficacious. Dr. Mark Aulisio moderated a panel that included Father Thomas Blau, Rabbi Edward Sukol, and Dr. Eyad Nashawati, examining different questions and issues that may arise in medical ethics from the Roman Catholic, Jewish, and Islamic perspectives. Past-president Dr. Allyson Robichaud, offered an analysis of the role of advanced directives in health care and medical ethics, the gaps that still exist, and the efforts of the Honoring Wishes Task Force to move the Medical Orders for

....continued on page 2

CONTENTS

The Editor's DESK

As we enter the heat of Ohio's summer, we also begin to see the heat increasing in the political arena. In spite of the "cooling" effect that the most recent Supreme Court decisions might be viewed as offering – bringing clarity to questions of whether or not the Affordable Care Act can proceed in its legislated form – it is far more likely to

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offer fuel to candidates of both political parties as they try to engage constituents and create significant debate and controversy in most – if not all – of the federal races.

In that regard, in this issue, we examine the intersection of two of the most contested issues in modern society: immigration and health care. How the various provisions of health regulations impact the care that is provided – and can feasibly be offered – to immigrants, both legal and illegal, is an enormously challenging question. While not offering any clear-cut solutions, the article will, hopefully, create more civil dialogue about the problems that are faced, solutions that might be offered, and advocate for additional deliberation and consideration about what legislative solutions might yet need to be created.

We also celebrate a very successful annual conference and remind members to reserve the date for the 2013 conference. We ask that members invite others to the 2013 conference – our 23rd – and spread the learning and collaboration that BENO seeks to provide. As we continue to grow, both in numbers and in knowledge, we will be able to provide a more robust service to our members and the facilities, providers, and patients that they serve!

Corey Perry
Editor

d) *Attendees review notes from the previous presentation while waiting for the next session to begin.*

e) *Anne Lovell, MSN, CNP, and a past Board member, leads a breakout session on conflicts in surrogate decision-making in pediatric ethics consultations.*

CONFERENCE *...continued from page1*

Life-Sustaining Treatment (MOLST) forward in the legislative process in Ohio.

The conference, again, enjoyed very positive feedback. After thoughtful deliberations at its meeting the night before the conference, the Board voted to keep the conference in Columbus for 2013.

Given the central location of Columbus, the ease of access to the venue and the positive feedback, the organization will depart from its tradition of "moving" the conference around the state. It is hoped that, by doing so, the conference will continue to enjoy growing support and we will see increased registration and attendance. The Board noted that the conference is, perhaps, the single greatest service that the organization provides to its members and those engaged in medical ethics across the state. We hope that you – our members – will continue to publicize the conference, the quality of information and education that occurs there, and encourage colleagues and counterparts to join BENO and attend the conference.

To that end, the 23rd Annual Conference will be held on April 26, 2013, at The Conference Center at OCLC, in Dublin, Ohio. Additional details – including speakers and content – will be forthcoming. In the meantime, please mark your calendars and make a note to recruit others to attend. We look forward to seeing even more people next year!

● Strangers in a Strange Land: The on-going dilemma of caring for immigrants in the American health system

Corey D. Perry, MDiv, JD, OhioHealth

In the midst of a heated political climate and Supreme Court decisions, two issues continue to hold the attention of candidates and the electorate: immigration and health care. Debates rage over how to address both issues, who is responsible for addressing the issues, and what, ultimately, is "The Answer" for each. Ironically enough, though, it is in the intersection of both issues that we see the problems and pitfalls in each. It is, especially, in the practice of "medical repatriations" that we see the greatest dilemmas.

In February 2000, Luis Alberto Jimenez, an undocumented immigrant from Guatemala working in Florida, suffered a severe head injury after the vehicle he was riding in was struck by a drunk driver. The two passengers riding with Jimenez were killed. Jimenez was transported to a not-for-profit hospital, Martin Memorial Medical Center. He remained in the hospital until June 2000, at which time he was transferred to a skilled nursing facility. During this time, a circuit court judge deemed Mr. Jimenez to be incompetent and appointed his cousin, Montejo Gaspar Montejo, Mr. Jimenez's guardian.[1]

On January 26, 2001, Mr. Jimenez was readmitted to Martin Memorial on an emergent basis. In November 2001, while still a patient at Martin Memorial, Mr. Montejo filed a guardianship plan for Mr. Jimenez, indicating that he would need twenty-four hour care for at least the next twelve months. Martin Memorial intervened in the guardianship proceedings, claiming that Montejo had not acted in Jimenez's best interests by allowing him to remain in the "inappropriate residential setting of an acute care hospital".[2] Martin Memorial sought permission to discharge Jimenez to a facility in Guatemala. Martin Memorial was informed that they would need to demonstrate that there was appropriate medical care available for Jimenez in Guatemala, which the hospital provided. Following a hearing on June 27, 2003 – three and a half years after his initial injury – the circuit court granted Martin Memorial's petition. Martin Memorial then, at its own expense, placed Jimenez on a plane to Guatemala on July 10, 2003.[3]

It is, especially, in the practice of "medical repatriations" that we see the greatest dilemmas.

Mr. Jimenez's case is, by no means, unique. Nor is the issue of providing care to immigrants "merely" an issue of whether they have immigrated to the United States through formal channels: there are significant issues with documented immigrants, as well. Hospitals and other care settings have used various means to contend with the issue, including medical deportations. However, the options remain limited.

Does the issue of "documentation" matter?

The answer to that question would likely depend on whom you ask. There are certainly distinctions in what can or cannot be done with immigrants who are within the United States through formal documented channels. However, there are financial realities about those patients that are as vexing as the issues with undocumented immigrants. The realities – both for patients and providers – are even more challenging for those who do not enjoy a documented status.

Ultimately, the constraining issue for most medical providers – especially hospitals – is federal regulatory provisions. For hospitals, the most constraining regulations are the Emergency Medical Treatment and Active Labor Act (EMTALA), Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and Medicaid.[4] EMTALA establishes a requirement that any hospital with an emergency department that receives federal funding screen any patients arriving at the hospital for an emergent medical condition and, if one is determined to exist, stabilize the condition and provide

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any treatment necessary to assure that no deterioration occurs during the transfer of the individual. Hence, any patient presenting to an emergency department – including undocumented immigrants – would trigger the statutory requirements if they presented in an emergent condition.

PRWORA attempted to "remedy" the nexus between welfare benefits and immigration. Passed in 1996, PRWORA segregated immigrants into two groups: "qualified" and "unqualified". Qualified immigrants are defined as those who are: admitted for permanent residence under the Immigration and Nationality Act; admitted under asylum; a refugee admitted under specific circumstances; an alien whose deportation is being withheld. There are several other lesser criteria for qualification, as well, but the aforementioned criteria comprise the majority of cases.[5] Unqualified immigrants are those who, by definition, are not qualified. PRWORA specifically prohibits using Medicaid funds for health care of illegal immigrants.[6] However, some funds may be available under the exceptions listed in 8 USC §1611(b)(1)(A), allowing for Medicaid funds to cover emergent conditions. Funds for long-term care are not available from federal sources, though, as a result of these regulations.

California and New York have sought to bridge the gap that exists between limited funding for the stabilization of emergent conditions and the long-term care of undocumented immigrants. Medi-Cal, California's Medicaid program, spends $20 million a year on long-term care for undocumented immigrants. The Health and Hospitals Corporation of New York City also provides some funding for long-term care for undocumented immigrants, as well.[7] However, both of these programs continue to face political and economic challenges.

Documented immigrants can have access to Medicaid funds, once they have waited the requisite five years. States have the option of waiving the five-year rule. However, if they do so, they must use their own funds to cover the expenses. Only 15 states have elected to do so.[8] Hence, even for many of those documented immigrants entering health care facilities during the five-year waiting period, the expenses incurred in those encounters may not be covered and will either constitute charity care on the part of the organization or saddle the immigrants with extensive medical expenses.

For providers, therefore, the picture looks like this: Any patient presenting to an emergency department must be assessed for an emergent medical condition, regardless of qualifying immigration status. If a condition is diagnosed, the hospital must then offer the appropriate treatments that will assure that the patient's condition does not deteriorate in transfer. This includes assuring that the hospital is transferring the patient to a facility or treatment setting that can appropriately meet the patient's needs, pursuant to 42 CFR §482.43(d). Some federal funds may be available for care that was necessary to stabilize the patient's condition when it was emergent. However, if the patient is not a qualified immigrant or is a qualified immigrant with fewer than five years in the country, there are typically no funds available to cover any long-term medical needs the patient may have. Hence, there are very few settings – if any – that will accept the patient long-term. Given the statutory requirements, hospitals do not have the luxury of simply releasing the patient back into the society without the appropriate care for their needs. So, what, then, do they do?

Among some of the options that care providers have explored – apart from medical repatriation – is the reporting of undocumented immigrants to the Department of Homeland Security.

Some of the "options"

Among some of the options that care providers have explored – apart from medical repatriation – is the reporting of undocumented immigrants to the Department of Homeland Security (DHS), the federal Department tasked with providing immigration-related services through the Citizenship and Immigration Services (CIS).[9] While some experts contend that such reporting would allow for a more formal and legal process for any potential deportation – over and against hospitals taking unilateral action themselves – some states and municipalities have passed laws that expressly prohibit hospitals from reporting patients' immigration status to DHS.[10] New York City and San Francisco both have ordinances that prohibit public employees inquiring as to a person's status, absent special circumstances.[11]

However, this is now juxtaposed against Arizona's Support Our Law Enforcement and Safe Neighborhoods Act. While the law requires law enforcement personnel to enquire as to immigration status when there is reasonable cause to due so during a "lawful stop, detention or arrest", it does not require medical personnel to do so. It then requires law enforcement personnel to notify federal authorities of the individual's status. While it currently does not apply to medical personnel, it is conceivable that the law could be extended – in the future – into the medical community, as well.

Another option that has been employed – distinct from medical repatriation – is "voluntary" repatriation: meaning, the hospital is able to "convince" the patient or surrogate decision-maker to approve of a transfer to an appropriate facility in the patient's native country. While this practice may seem to be no different than securing the consent of a patient or surrogate to transfer a patient to any other

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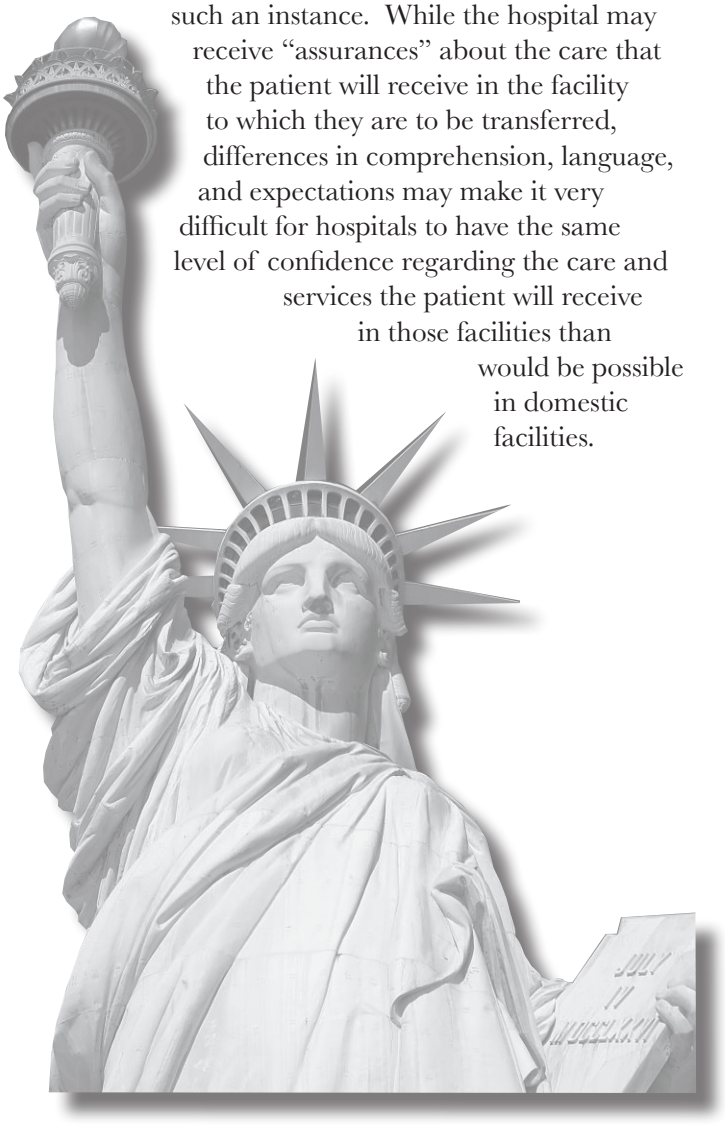
facility, this practice with undocumented immigrants is much more complex than would be the case for citizens or qualified immigrants, for ethical – if not legal – reasons.

Such a transfer – as with many other decisions – would require the informed consent of that patient or surrogate. However, it is debatable whether the hospital can actually satisfy the elements of informed consent in such an instance. While the hospital may receive "assurances" about the care that the patient will receive in the facility to which they are to be transferred, differences in comprehension, language, and expectations may make it very difficult for hospitals to have the same level of confidence regarding the care and services the patient will receive in those facilities than would be possible in domestic facilities.



Further, patients should be advised of the immigration implications of the transfer/deportation, as well, i.e., something that the hospitals are probably ill-equipped to do.[12]

While the Supreme Court has typically viewed deportation as a civil – not a criminal – action and, therefore, not dependent on the same levels of knowledge and voluntariness that would be required in a criminal proceeding, that view is changing. The Court has viewed deportations as tantamount to "banishment". Further, the Court has found that the failure of criminal defense attorneys to apprise defendants of the immigration consequences of accepting a plea can be found to be constitutionally deficient under the Sixth Amendment.[13] The Court, in Padilla v. Kentucky, went so far as to say that "the importance of accurate legal advice for noncitizens accused of crimes has never been more important. Deportation is an integral part – indeed, sometimes the most important part – of the penalty that may be imposed on noncitizen defendants who plead guilty to specified crimes."[14] Given the significant burden or cost that the Court perceives deportation as bearing on criminal defendants, it is hard to see how a thorough explanation, understanding and consent could be significantly less for a patient or surrogate consenting to the transfer of the patient to another facility in the patient's home country, where the very life and health of the patient may be in jeopardy.

The Jimenez saga revisited

When Mr. Jimenez was returned to Guatemala, he was accompanied by a nurse from Martin Memorial who oversaw case management and discharge planning. When they arrived in Guatemala, the nurse took Mr. Jimenez to Guatemala's National Hospital for Orthopedics and Rehabilitation, stating that the facility "could have taken care of me any day."[15] (Interestingly enough, in 2008, the Guatemalan foreign ministry claimed that it knew of 53 other repatriations by American hospitals in the previous five years.)[16]

Once he had arrived in the hospital, Mr. Jimenez's common-law wife was notified and asked to come and get her husband. A television network arranged for her to leave her home city and travel to Guatemala City to pick up her husband since, on her earnings of $6 per day, she could not afford to do so herself. The network filmed their reunion. The doctors at the National Hospital for Orthopedics and Rehabilitation informed Ms. Jimenez that her husband needed to be transferred to another public hospital, San Juan de Dios, to make

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room for other patients. When Mr. Jimenez's brother visited him at that hospital several weeks later, he found Mr. Jimenez "lying in the hallway on a stretcher, covered in his own excrement. So, we cleaned him up and we brought him home."[17] When he was visited by a reporter in 2008, he was found to live inside a one-room house, high in the hills of Guatemala, lying in a twin bed. His treatments consisted of Alka-Seltzer and prayer and his primary care-giver – his 72 year-old mother – noted that, over the past year, his condition had worsened: he had routine violent seizures, each being characterized by falls, protracted convulsions, loud gurgling sounds, vomiting of blood, and collapse into unconsciousness.[18]

While Mr. Jimenez's clinical condition worsened in Guatemala – interestingly enough – Martin Memorial's legal battle over his care worsened in Florida. The day before Martin Memorial placed Mr. Jimenez on the plane back to Guatemala – July 9, 2003 – Mr. Montejo had filed a notice of appeal and a motion to stay the court's order of June 27, 2003, granting Martin Memorial permission to transfer Mr. Jimenez to Guatemala. Martin Memorial was given until 10:00 a.m. on July 10 to file a response. However, sometime prior to 7:00 a.m., the hospital had already transported Mr. Jimenez to the airport by ambulance.[19]

On behalf of Mr. Jimenez, Mr. Montejo sued Martin Memorial for civil damages arising out of a claim of false imprisonment. Mr. Montejo first appealed the initial ruling by the court on June 27. Martin Memorial claimed that the matter was moot, given that the patient was already transferred back to Guatemala. However, on the appeal, the appellate court found that it was not, since the hospital had placed the patient on the plane before the motion for stay could be heard.[20] The court further found that the initial order of June 27, 2003, granting Martin Memorial permission to transfer the patient to Guatemala should be reversed since "(1) there was no competent substantial evidence to support Jimenez's discharge from the hospital, and (2) the trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jimenez to Guatemala."[21]

When Mr. Montejo then made his claim for civil damages under an action for false imprisonment, the trial court dismissed the claim, asserting that the guardian lacked standing to sue on behalf of the patient and that the hospital had relied upon the courts order from June 27 in transferring the patient. Mr. Montejo, again, appealed the ruling. The trial court's decision was overturned and the appeals court found that the guardian – Mr. Montejo – did, indeed, have standing to sue on behalf of Mr. Jimenez. Further, the court held that "where the object of the detention (i.e., false imprisonment) of an individual is for the protection or enforcement of a private right, the person procuring the detention has no immunity from a claim for money damages where the court issuing the order has exceeded its jurisdiction."[22] The appeals court then remanded the case back to a trial court for trial on the facts of whether or not Martin Memorial was deemed to have falsely imprisoned Mr. Jimenez in his medical deportation back to Guatemala.

How, then, are providers to handle immigrants, both documented and undocumented?

The answer, with regard to documented, qualified immigrants, is quite simple, albeit not financially appealing: If the patients lack Medicaid or other coverage, treat them just as you would any other uninsured citizen. Admittedly, this has limits and options that might otherwise be available to the patient or surrogate may not be available to those patients.

However, with regard to undocumented immigrants, the answer is much more complex. While they enjoy the same protections under law with regard to emergent treatment and stabilization of conditions – and the facility can expect some small recompense – there are very few options for long-term care placement for those patients. The "safest" course for long-term care placement would likely be finding a way to locate an appropriate facility in the patient's home country, thoroughly reviewing the options for discharge with the patient or surrogate – ensuring that the discussion

took place in the patient's or surrogate's native language – and thorough documentation of their consent to such transfer. However, even as was shown in Montejo, the

Medical repatriation, even as a means of last resort, though, is highly inadvisable.

letter that the discharge planning committee at Martin Memorial received from the Vice Minister of Public Health in Guatemala, Dr. Julio Molina, was "not nearly specific enough to satisfy either the federal regulations or the hospital's discharge procedures".[23] Hence, it would be necessary to thoroughly vet what the capabilities of any receiving facility would be and whether or not those would meet the patient's needs.

Medical repatriation, even as a means of last resort, though, is highly inadvisable. As the court in Montejo noted and as the Supreme Court has asserted in even its most recent decisions, deportation actions are strictly and solely the purview of federal authorities. For a hospital – or any other state actor – to presume to have the authority to authorize such moves, it hazards federal and civil actions that could jeopardize further operations.

Until such time as a more thorough immigration policy and program is reconciled to the current health care regulations... providers are very limited in what options can be exercised in treating undocumented immigrants long-term.

Until such time as a more thorough immigration policy and program is reconciled to the current health care regulations, to say nothing of changes that may be coming with the Affordable Care Act, providers are very limited in what options can be exercised in treating undocumented immigrants long-term. It is hoped that – with health exchanges – more states may offer Medicaid coverage to qualified immigrants, as the federal government is likely to provide more funds to the states to assist in increased Medicaid costs.[24] However, there will likely still be a shortfall with those patients, to say nothing of the long-term costs of treating and caring for the immigrants who do not enjoy a qualified status.

Post-script

The action against Martin Memorial, claiming false imprisonment of Mr. Jimenez, went to court in 2009. The jury returned a verdict on July 20, 2009 – over nine years after Mr. Jimenez's initial injury and six years after his deportation – finding that they did not believe that Martin Memorial had acted unreasonably in transferring Mr. Jimenez back to Guatemala and, hence, not liable for any claim of false imprisonment.

It is believed that Mr. Jimenez continues to lie on that twin bed, day and night, in the one-room house in the Guatemalan hills with his mother and family…

Endnotes

1 Montejo v. Martin Memorial Medical Center, Inc., 935 So. 2d 1266 (Fla. Dist. Ct. App. 2006).

2 Ibid.

3Ibid.

4Vincent S. "Medical Repatriation: A Fourteenth Amendment Analysis of the International Patient Transferring of Illegal Aliens." Houston Journal of International Law, 2010; 33(1): 100-104.

5 8 USC §1641(b).

68 USC §1611(a).

7Sontag D. "Immigrants Facing Deportation by U.S. Hospitals." The New York Times, Aug. 3, 2008.

8 Cheney K. "Immigration status is a health policy challenge." http://www.politico.com/news/stories/0512/76353.html.

9Nessel L. "The Practice of Medical Repatriation: The Privatization of Immigration Enforcement and Denial of Human Rights." The Wayne Law Review, 2009; 55:1745-1749.

10 Ibid.

11 Ibid.

12 Ibid, at 1738.

13 Ibid, at 1737.

14 Padilla v. Kentucky, 130 S. Ct. 1473, 1475 (2010).

15 Sontag.

16 Ibid.

17 Ibid.

18 Ibid.

19 Montejo, 935 So. 2d at 1268.

20 Montejo v. Martin Memorial Medical Center, Inc., 874 So. 2d 645 (Fla. Dist. Ct. App. 2004).

21 Ibid, at 658.

22 Montejo, 935 So. 2d at 1271.

23 Montejo, 874 So. 2d at 658.

24 Cheney.

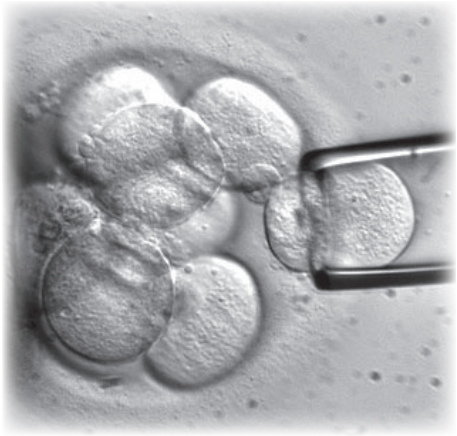
Ethics in the News

The state of Michigan is the first to create a statewide directory, known as the Peace of Mind registry, that will allow citizens to voluntarily load their advance directives onto a website. The legislation – known as Public Act 179 of 2012 – will create a secure database that will allow health care providers the ability to access the documents directly, eliminating the need for patients to carry those documents with them or rely upon practitioners having copies from previous admissions or visits. The database is being created with funds from Michigan's Gift of Life Foundation, thereby incurring no additional cost to Michigan taxpayers. Many herald the law's passage and signing and consider it to be a model for other states seeking to pass similar legislation. For further information, see: http://giftoflifemichigan.org/news_events/latest_news/details/48.

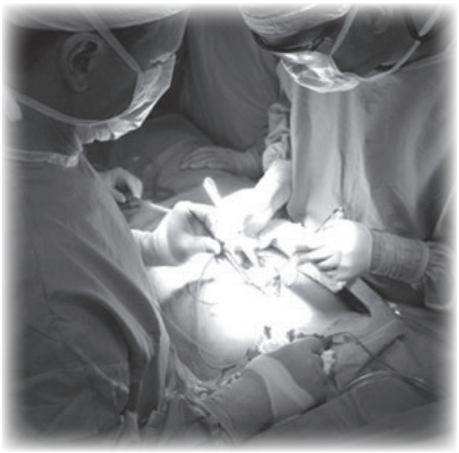
In a move that has brought strong reactions from both sides of the debate, the administration of Mayor Michael Bloomberg proposed a ban on the size of sugary drinks that could be sold in New York City restaurants, sports and entertainment

venues and street carts. Advocates of the ban claim that it is justified, given the contribution that such drinks have toward obesity and the city's use of bans on smoking, use of trans fats in restaurant foods, and placing of caloric information on menus. Opponents of the ban – which, at this time, include a majority of New Yorkers sampled in various polls – believe that such a ban is an undue infringement on economic and personal liberty. Further, opponents have voiced concerns – given the number and extent of bans that the Bloomberg administration has established – about where continued efforts to "force" citizens to make healthier decisions may lead. The New York Board of Health has opened a three-month public comment period where input will be sought from experts and the community on the impact of such a ban. The Board will then vote in September to determine whether or not to move forward with the ban. Other municipalities – such as Cambridge, Massachusetts – are now considering such a ban, as well. For further information, see: http://articles.cnn.com/2012-06-12/justice/justice_new-york-soda-ban_1_sugary-drinks-sugar-sweetened-beverages-obesity?_s=PM:JUSTICE and http://www.dailymail.co.uk/news/article-2161419/Sugary-drinks-ban-Cambridge-Mayor-Henrietta-Davis-proposes-ban-similar-Michael-Bloombergs-New-York.html.

In a sign that health care is increasingly becoming an international market, an investigative report conducted by CNN found that an increasing number of Americans are traveling to India to receive experimental stem cell treatments. These treatments – oftentimes costing as much as $25,000 – are sought because of a lack of any approved embryonic stem cell therapies in the United States. However, experts and researchers claim that many of these cases are questionable given that there is no clinical evidence that any of these treatments or therapies have any beneficial effect. Many patients, however, are seemingly willing to undertake the risk and cost of such efforts in the hope that some benefit will occur. For further information, see: http://www.cnn.com/2012/05/19/health/embryonic-stem-cell-therapy/index.html.



After years of increasing pressure from human rights groups, the People's Republic of China announced in March that it plans – in the next three to five years – to cease the practice of recovering organs from executed prisoners for the purposes of transplantation. China faces an overwhelming shortage of organ donors. Currently, this source of organs accounts for nearly two-thirds of China's transplant organs. With over a million people awaiting kidney transplants and only just over 5,000 receiving one in 2011, China has resorted to measures that many



have questioned, including a fairly robust illegal market for live kidney donations. China announced that it hopes to create a more robust voluntary dead-donor system when it discontinues its current practices. However, it has also been noted that those leaders who are promising an end to the current practices are preparing to retire, so that the burden of discontinuing those practices and creating a viable and effective alternative will fall to their successors, who may be inclined to reverse the course indicated by the current leaders. In related news, the World Health Organization (WHO) announced that it estimates that an illegal kidney is sold every hour. These kidneys – which may go for as much as $5,000 – are typically transplanted in China, India and Pakistan. However, the practice is not limited to those countries alone: ten persons – including a physician – were recently arrested in Israel on suspicion of dealing in illegal organs. For further information, see: http://www.guardian.co.uk/world/2012/may/27/china-kidney-donor-shortage-crime; http://www.nytimes.com/2012/03/24/world/asia/china-moves-to-stop-transplants-of-organs-after-executions.html?pagewanted=all; http://www.guardian.co.uk/world/2012/may/27/kidney-trade-illegal-operations-who.

Legislative Update

The Supreme Court of the United States announced its decision, in *Astrue v. Capato*, to deny Social Security benefits to the twin children born of a deceased biological father. The children were conceived from sperm that the father had frozen while undergoing treatment for esophageal cancer and were born eighteen months after his death. The children's mother made a claim to the Social Security Administration, claiming that the children should receive survivor benefits. The Social Security Administration denied the claim, causing the mother to file suit on the children's behalf. The Court determined that the rules of intestacy of the state where the father was domiciled at the time of his death – in this instance, Florida – should govern whether or not they would be covered by the survivor benefits of Social Security. The Court examined Florida's laws regarding intestacy and found that children born posthumously to a decedent were only eligible to inherit if they had been conceived during the decedent's lifetime, which had clearly not been the case in this instance. Given the now-routine nature of assisted reproductive technology and the those undergoing aggressive treatments that may render them infertile, many more patients are undertaking such measures to ensure their ability to procreate in the future. However, in instances where treatments have been unsuccessful and survivors may yet consider having children, it will be important to consider how such a decision may impact their abilities to receive benefits. For further information, see: http://www.scotusblog.com/case-files/cases/astrue-v-capato/.

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Please submit your article electronically to **bioquarterly@gmail.com** for consideration.
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Donna F. Homenko, PhD
President

Corey Perry, MDiv, JD
Editor

MEMBER Recognition

WELCOME to the following new members and thank you for joining the Network and contributing to the work of the organization.

INSTITUTIONS

Remington-Davis Clinical Research, Columbus, OH

INDIVIDUALS

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Parmie Herman, Wapakoneta, OH

Charles P. Kilgore, Cleveland, OH

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Joyce Thomas, LSW, Columbus, OH

Tammie Thompson, MSN, Louisville, OH

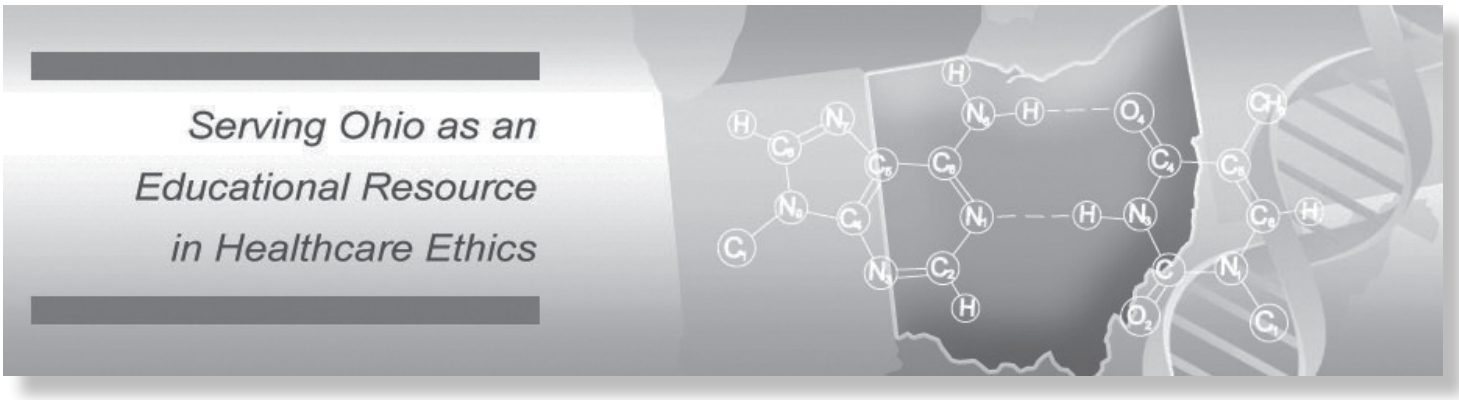
Kelly Waugh, RN, Gallipolis, OH

Upcoming Conferences

August 6 – 10 – **25th Annual Summer Seminar in Health Care Ethics;** University of Washington; Seattle, Washington. For more information, see: *http://depts.washington.edu/cme/live/course/MJ1301*

September 10 – 11 – **Judaism, Medicine, and the Formation of Clinicians;** The University of Chicago; Chicago, Illinois. For more information, see: *https://pmr.uchicago.edu/events/judaism-and-medicine-conference*

September 28 – **Justice in Health Care: The Utilization of Changing Resources;** The University of Texas MD Anderson Cancer Center; Houston, Texas. For more information, see: *http://www.mdanderson.org/education-and-research/education-and-training/schools-and-programs/cme-conference-management/conferences/cme/conference-management-justice-in-health-care.html*



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