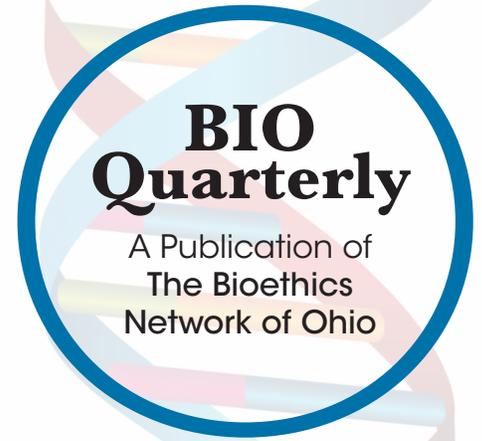


BENO



From the PRESIDENT

Donna F. Homenko, PhD/ Prof., Dental Hygiene and Bioethics, Cuyahoga Community College



As a member of the Board since 1996, I have served in various capacities from chairperson of the Annual Conference to strategic reorganization, to Treasurer, then Vice President and now President - my distinct privilege! These positions have provided me with an overall perspective of this organization and its critical role in health care today. Our Mission: *To foster knowledge, understanding and awareness of bioethics in Ohio* only begins to highlight the key components of our existence.

The daily demands of providing quality care can become overwhelmed by the increasing interdisciplinary opportunities for medical professionals to collaborate...

To foster knowledge is perhaps the essence of BENO as an educational resource network. During the past twenty-five years, which I have spent in academic and clinical activities, I have witnessed the informational and technological age transcend the way we improve content,

update skills and deliver evidenced-based education to both students and patients. The daily demands of providing quality care can become overwhelmed by the increasing interdisciplinary opportunities for medical professionals to collaborate and when institutions forge partnerships. In all situations, this requires knowledge by providers who are cognizant of the medical, ethical and legal needs inherent in the provider/patient relationship. BENO can help!

Understanding and awareness are integral to patient care, whether a case is presented to an Institutional Ethics Committee for consultation or when a member of the health care team speaks to a patient's family about palliative or end-of-life choices. We, as providers, must be empathic. Perhaps this empathy comes from our 'calling' to the medical profession, but BENO can help to enhance our skills through the dialogue that occurs with colleagues at the annual conference, case consultation coursework and the Bio-Quarterly publication.

continued...

CONTENTS

New Bio Quarterly

3

Member Recognition

4

Legislative Updates

8

Save the Date

12

Bio Quarterly

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Submissions

to Bio Quarterly are encouraged. Manuscripts may be original material or reprint with permission. Appropriate subject/topics include: issue analysis, cases, report of institutional activity or programs, legislative and policy commentary and book reviews. Please submit your article electronically to bioquarterly@gmail.com for consideration. Quarterly deadlines are the 15th of February, May, August and November.

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Donna F. Homenko, PhD
President

Corey Perry, MDiv, JD
Editor



From the PRESIDENT *continued...*

Finally, *bioethics in Ohio* completes the mission statement. Indeed, BENO can help us stay informed about current legislative issues, court cases and decisions that affect how we function in our respective roles. Members of the BENO Board serve on statewide committees that monitor MOLST orders and national trends to certify consultants in bioethics. They share pertinent details on policy issues and updates on regulations from state agencies with the membership.

This year, we would like to grow the BENO network. Please take a few minutes to share this newly re-designed issue of Bio-Quarterly with a compeer....someone that BENO can help to *foster knowledge, understanding and awareness of bioethics in Ohio!*

Please take action now to:

- A) Invite a colleague and/or student to become a member of BENO
- B) Mark your calendars for April 27, 2012—Annual Conference
- C) Offer your involvement to BENO—write an article, submit a course
- D) All of the above**

** This is the correct response!

Join the 2012 Board of Trustees as we advance the mission of BENO. Your participation will strengthen our initiatives and ensure our continued success.

Professional Regards,

Donna F. Homenko

Donna F. Homenko, PhD

The Editor's Desk

It can be challenging, at times, to not miss the forest for the trees. What I mean is that in the midst of the busy-ness of ethics consultations, teaching classes, grading papers, attending committee meetings, and performing clinical work, it can be easy to overlook what an exciting and challenging time it is to be in the field of bioethics.

Part of the challenge we currently face is the burgeoning developments that continue to occur in medical science. These developments awe us at their therapeutic potential; but also humble us with the potential to be employed in ways that are unforeseen.

Another part of the challenge lies in the continuous change we experience in the demographics we serve. These demographics may constitute changes in the socio-economic dynamics of our communities, the ethnic composition of those communities, or shifts in populations.

While we may not face these specific issues now, it behooves us to consider the practical implications of both of these issues and apply them to our own current realities...

In this issue, we will examine two areas that relate to both of these challenges: the development and employment of induced pluripotent stem cells in medical research and the role or place of Islamic religious leaders within complex ethical consultations. Due to the realities in the community that your organizations serve, you may find these articles highly relevant or not. You may live or work in an area where both of these issues are rarely, if ever, encountered. However, the discussion of these issues is far from “academic”. The growing diversity of all of our communities – whether the diversity is religious, ethnic, or other – is something that all of us face. And the medical technologies that may derive, and are being derived, from stem cells are no longer “science fiction” but are becoming dawning realities. While we may not face these specific issues now, it behooves us to consider the practical implications of both of these issues and apply them to our own current realities: recognizing that those “current” realities will quickly become “past”. While we look at these “trees”, hopefully we will gain a greater sense of the forest within which we journey.

Welcome to the new *BIO Quarterly*!

...the Board has heard the feedback from many of our members and has undertaken a thorough review and redesign of the publication.

As those of you who have received *BIO Quarterly* in the past will hopefully note, we have a new look and feel to the publication. Over the past few years, the Board has heard the feedback from many of our members and has undertaken a thorough review and redesign of the publication.

First, we have a new editor. Corey Perry, MDiv, JD, will now be serving as the editor for *BIO Quarterly*, picking up the work that Matt Stolick, PhD, had carried for the past several years. Corey is the Corporate Director of Clinical Ethics for OhioHealth and a member of the Board of Trustees for BENO and is eager to hear from all of you about these changes.

Second, we have moved to a new design and layout for the publication. Working with MA Marketing Communication, we have developed a design that looks more like a magazine or commercial publication. While we appreciate that many scholars may not feel the need to move away from the “tried and true” journal format, we believe that our members will actually find it easier to read and consume the publication with this format.

Third, we have changed the paper that is used to print the publication. While this may seem a “small” change, it allows us the opportunity to save printing and mailing costs, which is then turned back into additional design elements, such as adding some color to the publication. We were also trying to create a commercial or magazine “feel” with the paper.

Fourth, you are going to see substantive content changes from past publications. Some elements that we’ve had in past issues – such as bioethical issues in the news – will remain, though in a much smaller format. Some elements – such as the President’s Address – will only appear a limited number of times each year. Many other elements, however, will be wholly new to the publication.

An example of these new elements is the schedule of rotating content that will be presented in each issue. We plan to focus on specific topics in each issue. We hope that this will provide you with some content that is relevant to your work each time you receive *BIO Quarterly*. The proposed rotation of content for each issue is as follows:

Fall Issue

President’s Address
Genetics/Stem Cell Issues
Diversity Issues (Cultural, religious, etc.)
Introduction of new board members

Winter Issue

Case Consultation Issues
Pediatrics
Global Ethics

Spring Issue

Research Issues
End-of-Life Issues
Legal Issues & Developments

Summer Issue

Public Health Issues
Emerging Technology/
Human Enhancement Issues
Ethics Education &
Development
Conference “Feedback”
and Report



In addition to the rotating content, each issue will also include the following information: The Editor’s Desk; Ethics in the News/Legislative Updates; Member Recognition; Upcoming educational conferences. Many of these elements are self-explanatory. However, we want to use “Member Recognition” to not just recognize those people who have recently joined the organization, but those who have enjoyed publication or awards in the past quarter. If you, or someone you know who is in the organization but may be too humble to recognize himself or herself, have been published, have spoken at a recent conference, or received some award for your work, we want to hear about it and celebrate this accomplishment with you.

We recognize that this is a sudden and dramatic departure from what you have been accustomed to, but we felt that if we were going to begin to make some changes, we should make all the changes we thought we would need for the foreseeable future at one time.

However, we also recognize – and hope, quite honestly – that you have feedback on these changes. Perhaps we aren’t including a topic or issue that

you think is important or relevant. Perhaps we aren’t devoting enough space and content to specific issues that you believe they should receive. Perhaps, even, you like the change. Whatever your feedback would be, we want to hear it.

To that end, there is now a dedicated email address that all communication to and about *BIO Quarterly* can be directed: bioquarterly@gmail.com. If you have any feedback on the current changes, proposed changes, or contributions to the publication, please direct all communication to this email account.

We hope that you enjoy your “new” *BIO Quarterly*. As always, our goal is to provide our membership with the most timely and relevant information on issues related to bioethics that we can. We want to do this in a way that also highlights the benefits that membership in the organization provides. If there is any way that we can continue to refine this product to make it more relevant to your work, please let us know as we are going through this transition and we will make every effort to continue to improve and develop this publication to meet those needs.

Member Recognition

BENO welcomes the following new members and thanks them for joining the Network and contributing to the work of the organization.

Elizabeth B. Morrow, LISW, Chardon, OH

Dolores N. Hemrich, RN, BSN, North Olmsted, OH

Sally Paumier, RN, MA, PC, Canton, OH

Bonnie Ploeger, RN, BSN, MPM, Batesville, IN

Jennifer Yoder, LSW, Millersburg OH.

Also, several members of BENO presented at the 13th Annual Meeting of the American Society for Bioethics & Humanities (ASBH). BENO members presenting at this meeting included:

Mark Aulisio, PhD, Case Western Reserve University/MetroHealth Medical Center; *Mental Illness: Transforming the Definition of “End-Stage” and “Terminal” Illness.*

Corey Perry, MDiv, JD, OhioHealth; *Ethics Consultation Liability: Has It Transformed Since the Task Force’s 2004 Report?*

Kathryn Weise, MD, MA, Cleveland Clinic; *Ethical Issues Surrounding Palliative Surgical Procedures in the Terminally Ill Patient.*

In addition to those who presented, two members of **BENO** were recognized with a special ASBH President’s Citation for their contribution to the work of the Clinical Ethics Consultation Affairs (CECA) Committee. These members were:

Martin Smith, STD, Cleveland Clinic

Jack Gallagher, PhD, Catholic Health Care Partners

We applaud the work of our colleagues in continuing to advance the work and scholarship on bioethics locally and abroad and hope that you will join us in congratulating them on their work and recognition.

● Patient-specific Stem Cells and Therapies: Will Induced Pluripotent Stem (iPS) Cells Offer a Solution?

By Corey D. Perry, M.Div., J.D.

In 2009, in *Nature*, Dr. Andras Nagy at Mount Sinai Hospital, Toronto, ON, announced that he and fellow researchers had developed a method for creating stem cells that was unique and promised the ability to create patient-specific stem cells that could be used for various regenerative therapies.¹ This method was able to induce stem cells from other recovered adult cells, such as skin cells, hence the name induced pluripotent stem (iPS) cells. While stem cells had been developed from adult cells in the past, all of those methods employed viruses that damaged the DNA of those cells. Nagy’s approach used non-viral vectors to induce the cells into a pluripotent state, allowing the cells to retain their specific DNA profile, enhancing their ability to be used in patient-specific regenerative therapies.

Up until that point in time, stem cells were typically developed in one of three ways: through the recovery of embryonic stem (ES) cells that were recovered from 4- to 5-day old blastocysts; extracting umbilical cord blood, from which stem cells would be recovered; or extracting bone marrow from adult patients, from which stem cells could be derived.² However, the development of iPS cells may well signal the advent of a new age in stem cell research and the development of viable stem cell therapies.

What is the “big deal”?

Stem cells have been a part of the bioethical conversation since their discovery in the early 1980’s. It was in the late 1990’s, however, that human ES cells were able to be recovered and the debate became hotly contested. In order to recover ES cells, it is necessary to have a fertilized embryo develop to a blastocyst, which occurs at approximately four to five days after fertilization, when the embryo comprises 50-150 cells. It is at this point that the inner cell mass can be recovered, which yields pluripotent stem cells. However, this process results in the destruction of the host blastocyst, which causes significant ethical concerns for many.

The term “pluripotent” means that a cell has the ability to develop into any of the three embryological germ layers that allow for the differentiation of the roughly 220 human cell types.³ These three layers are the endoderm, mesoderm, and ectoderm. Pluripotency varies from multipotency in that multipotency only allows for the development of specialized cell types.⁴ Further, pluripotency differs from totipotency, which is the ability to create an entire adult animal by producing embryonic and extra-embryonic tissue, as well as complete gestational development.⁵

However, as previously noted, the ability to recover stem cells from fertilized embryos created an enormous ethical concern for many. The thought that oocytes might be recovered and fertilized “merely” for the purpose of developing blastocysts, from which cells could be recovered for the purpose of cultivating stem cells, was met with widespread criticism. In 1995, Congress passed the Dickey Amendment, which stated:

None of the funds made available by Public Law 104-91 may be used for—

- (1) the creation of a human embryo or embryos for research purposes; or
- (2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death

greater than that allowed for research on fetuses in utero under 45 CFR 46.208(a)(2) and 42 U.S.C. 289g(b). For purposes of this section, the phrase “human embryo or embryos” shall include any organism, not protected as a human subject under 45 CFR 46 as of the date of enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes.⁵

This law continued to be reauthorized by every Congress since 1995 in almost exact wording. Further, additional federal funding limits were established by the Bush Administration in 2001.⁷ These limits allowed for federal funding on ES cell lines that were already in existence, but no federal funding would be extended to research that involved the creation or use of new ES cell lines. The Bush funding restrictions were eased by executive order when Obama took office, but that order was enjoined by a federal trial judge in August 2010. However, in April 2011, a federal appeals court overturned that trial court’s decision, clearing the way for additional federal funding of this research.

However, as a result of these funding limitations, it has been challenging for researchers to explore multiple regenerative therapies. While the science has held the promise of addressing many conditions and has earned the support of innumerable public figures – from actors, such as Michael J. Fox, to politicians, such as Sen. Orrin Hatch – the ability to conduct such research and begin to unlock those potentials has been hampered.

IPS cells, however, offer a new hope to these researchers. While some researchers have held out hope for other approaches to the funding dilemma – including somatic cell nuclear transfer (SCNT), which places a somatic cell nucleus into an enucleated oocyte, thereby creating a cloned zygote – such approaches are still not possible⁸ and would likely still run afoul of the funding limitations imposed by Congress.⁹

Coupled with the potential funding limitations of SCNT, though, there is also a very practical limitation: there are only a finite number of oocytes available for such potential research. In order to achieve patient-specific therapies, a number of oocytes would need to be consumed for each patient requiring the therapy. The oocytes would need to have the somatic material placed within them and be allowed to develop to the point at which the inner cell mass could be recovered, rendering the stem cells necessary to develop the therapy. If SCNT were used for a large number of conditions, such as Parkinson’s, diabetes, and Huntington’s disease, the number of available oocytes would quickly be exhausted. While it is conceivable that additional oocytes could be recovered from recruited, willing subjects, the numbers that would be required, and the expense of recovering the oocytes, would be so immense that it would render the process impractical.

IPS cells, on the other hand, do not involve any embryonic material. As a result, all of the potential ethical concerns that have been voiced about ES cells could be effectively nullified. Further, given that the cells are developed from the fibroblasts of the subject for whom the therapy is intended, there is, conceivably, an unlimited potential for source material.

Are there still ethical concerns?

While iPS cells appear to hold immense promise and seem to avoid some of the pitfalls of ES cell research, iPS cell research is not without its own concerns. First and foremost are concerns regarding the expense of such research and the potential expense of such patient-specific therapy. The research that has been conducted with regard to iPS cells, thus far, has advanced

rapidly. However, further developments and large-scale research potentials will require extensive expense.

These expenses can only be “recovered” through commercial applications. Typically, therapeutic advances involve the development of a device or drug that can be provided to thousands – if not millions or billions – of patients. The cost of research into those developments, therefore, is borne by all those who are supplied such medications or devices and the cost to any one individual is small in relation to the expense of the research. However, in any patient-specific therapy, the development of the treatment is, by very definition, limited to only the person receiving the treatment.

While iPS cells appear to hold immense promise and seem to avoid some of the pitfalls of ES cell research, iPS cell research is not without its own concerns.

While it could be argued that the research that is being done is research into the most effective and efficient ways to convert any patient’s fibroblasts into pluripotent stem cells, thereby creating processes that would allow for the expeditious creation of any therapy, it is naïve to believe that this can be accomplished without immense research and expense. Further, once the stem cells are actually created, it remains to be determined by what mechanism those stem cells could be introduced into a patient, given their condition, to achieve the maximum effect. At this point, therefore, the creation of ethically acceptable stem cells only clears the first hurdle in a much longer stream of research that will be necessary to develop patient-specific therapies. All of the potential streams of patient-specific therapies would entail their own expenses, as well, only compounding the cost of such research.

Induced pluripotent stem cells seem to avoid many of the obstacles that have, thus far, foiled extensive stem cell research. To that end, their development and the refinement of their creation is an exciting breakthrough. However, their development, and the research that is likely to spring from their development, is not without its own risks, of which the most obvious are the expenses that will flow from such research. While it may be tempting to heed the siren’s song of possibly curing conditions that have, thus far, resisted our best efforts, we must recognize that to do so may hazard financial costs on patients and societies that become unbearable. It will require wise stewardship of such resources and a will to resist throwing resources at such efforts indiscriminately, merely pursuing the dream of a cure, or we face the potential of winning the battle but losing the war.

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1] <http://www.lunenfeld.ca/researchers/nagy>
2] Stem Cell Basics: Introduction . In *Stem Cell Information* [World Wide Web site]. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services, 2009.
3] Zacharias D, Nelson T, Mueller, P, Hook C. The Science and Ethics of Induced Pluripotency: What Will Become of Embryonic Stem Cells? *Mayo Clinic Proceedings*. July 2011; 86(7):634-640.
4] Ibid.
5] Ibid.
6] Sec. 128, *Thomas H.R.2880*. The Library of Congress.
7] Condic M, Rao M. Alternative Sources of Pluripotent Stem Cells: Ethical and Scientific Issues Revisited. *Stem Cells and Development*. 2010; 19 (8):1121-1129.
8] Note, however, that it was reported on Oct. 5, 2011, that researchers at The New York Stem Cell Foundation had successfully completed the first such transfer in a human cell. See *Ethics in the News* for more information.
9] Zacharias, et. al.

● “Neighborly Needs”: Issues Regarding Muslim Chaplains and Imams as Part of Interdisciplinary Bioethical Decision Making in Health Care Settings

By Jimmy Jones, D.Min., and Matiniah Yahya, M.Ed.

Chapter (Sura) 107 of the Quran, the Muslim sacred text in the very popular A. Yusuf Ali English interpretation ends with a reference to “neighborly needs” (Al-Ma’un 107:7). Classical and modern exegetes of this chapter interpret this particular text as emphasizing the importance of being a good neighbor as one of the core values of the religion of Islam.

It is in this provision of “neighborly needs” context that we begin our discussion of issues regarding Imams and Muslim Chaplains as part of interdisciplinary bioethical decision making. We start here because, by definition, bioethical decision making usually takes place outside of the sacred or communal space of the Muslim American community. However, the health care facility or hospital in question is usually located so close to the Muslim community’s worship or living space, they can be classified as “neighbors.” Theologically speaking, in Islam, neighbors are due certain rights and responsibilities from Muslims.

Comparatively speaking, the basic discussions that might arise regarding the Imam and Muslim chaplain as part of bioethical decision making include three salient issues: perspective, authority and role. Hopefully, a due consideration of each may provide both Muslims and non-Muslims with a better idea of how Imams and Muslim Chaplains can best assist in dealing with complex, contentious bioethical consultations. When we address the issue of “perspective”, we find marked differences in the approach of the Imam and Muslim Chaplain. Basically, the Imam’s perspective tends to emphasize the communal, whereas the Chaplain’s focus tends to be institutional. In asserting this, we are by no means implying that Imams do not care about health care institutions or that Chaplains do not care about Muslim communities. The point is that, as they carry out their particular functions as Imam and Muslim Chaplain, one needs to be aware that these different perspectives influence how they approach difficult issues.

On the second issue, that of “authority” or the right to do something, there is also a fundamental difference inherent in the particular approaches of Imams and Muslim Chaplains. In general, in the Muslim community the Imam is seen as more authoritative than a Chaplain. Since the word “Chaplain” came out of a Christian religious context, some Muslims even reject the use of the term when referring to Muslim leadership. Generally speaking, it is assumed that, unless the Chaplain is also an Imam, “chaplaincy” has less authority. Therefore, his or her pronouncements are less authoritative than that of the Imam. Consequently, health care professionals often defer to him (the Imam) even when it is clear that he does not understand all of the medical and institutional issues involved.

Finally, when comparing the “role” of the Imam with that of the Muslim Chaplain we see a basic difference as well. In carrying out their respective roles, the Chaplain (who often has clinical pastoral training) tends to focus on short term supportive personal relationship with patients and their families of different

faiths as needed. On the other hand, Imams are often trained (sometimes overseas) to focus on the rights and obligations of Islamic religious adherents. Consequently, in bioethical consults, they may approach matters entirely differently. Again, this does not mean that Imams do not care about or attend to short term supportive relationships or that Chaplains are not knowledgeable or concerned about Islamic law. It is just that in their respective roles they have different emphases. Optimally, depending on the nature of the bioethical consultation, you may need elements from both the Imam’s and Muslim Chaplain’s perspectives, authority and roles. In addition, there may be situations where one or the other is clearly the more appropriate interdisciplinary team member.

From the perspective of health care institutions, it is useful to know the answers to the following critical questions about their affiliated Imams and Muslim Chaplains:

Imams

- ① To what extent is he aware of the complex, contentious clinical issues that a health care facility faces on a regular continuous basis? If he “doesn’t have a clue,” then he is likely to provide input that might be totally inappropriate for the health care context in the US.
- ② To what extent does he trust the health care facility to tend to the needs of Muslims in a competent non-biased way? If he believes that all non-Muslim institutions are hostile towards Muslims then this will undoubtedly be reflected in the kind of advice that he offers.
- ③ To what extent does he work effectively with people of other faith traditions and women? The lack of these orientations would likely make such a person a difficult person to work with on an interdisciplinary team.

The bottom line here is that health care facilities need to know about the attitudes and training of its affiliated Imams and Muslim Chaplains.

Chaplains

- ① To what extent is he or she “connected” to local Islamic communities? We have seen cases wherein people have become chaplains simply because they were available and wanted to be one. With no “connection” to the local community, it is difficult for a chaplain to bring the important communal perspectives to bear on bioethical consults.
- ② To what extent is he or she familiar with the classical issues in Islamic law regarding contentious issues such as cloning, abortion and end of life decisions? A lack of knowledge in this area often leaves the health care facility open to the charge of being totally insensitive to the needs and norms of the local Muslim community.
- ③ To what extent does he or she work effectively with people of other faith traditions and across genders? The lack of these orientations would likely make such a person a difficult person to work with on an interdisciplinary team.

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“Neighborhood Needs” *continued...*

The bottom line here is that health care facilities need to know about the attitudes and training of its affiliated Imams and Muslim Chaplains. Ideally this task should be facilitated by robust Muslim-run local and national endorsement processes for persons who facilitate Islamic services in health care institutions. As of the writing of this article, we are aware of only one such local effort (the newly formed Muslim Endorsement Council of CT) and none on the national level. Hopefully, the broader Muslim American community will make implementing such processes a higher priority. In doing so, they will likely be more effective in providing “neighborly needs”.

Matiniah Yahya, M.Ed.,

is a full time Chaplaincy Resident at Yale-New Haven Hospital (New Haven CT) who is an educator with a wide range of teaching and training experiences in the US and the Middle East over the past three decades. A volunteer hospital and prison chaplain for more than 10 years, she began ACPE-certified Clinical Pastoral Education (CPE) training in October, 2010. Chaplain Yahya has been the Program director of the Al-Azhar University (Cairo, Egypt) Summer Arabic Intensive for Americans for the past seven years and is currently on the boards of the Association of Muslim Chaplains and the Muslim Endorsement Council of Connecticut.

Jimmy (James) Jones, D.Min., is Chair and Associate Professor of World Religions at Manhattanville College (Purchase, NY). Prof. Jones is also a visiting Professor at the Graduate School of Islamic and Social Sciences. A volunteer prison chaplain with the CT Department of Corrections since 1980, he has also served as a community-based mentor with the Yale New Haven Hospital Clinical Pastoral Education (CPE) program. Prof Jones chairs the Board of Masjid Al-Islam (New Haven CT); is President of the Islamic Seminary Foundation and has been the unpaid project director for the National Islamic Endorsement project for the last five years. Dr. Jones holds a Master of Arts in Religion from Yale Divinity School and a Doctor of Ministry degree from Hartford Seminary.

● The Role and Function of the Muslim Chaplain

By Hasan Shanawani, M.D., M.P.H.

While in training as an ICU medicine fellow, I was routinely called upon to provide “religious services” to Muslim patients at our large University Hospital and tertiary referral medical center. I was in training at Duke University Hospital, a university that started as a seminary in the Methodist heartland of America. We had a small Muslim community in Durham County, NC, and didn’t have the depth of resources to support a full-time Muslim Chaplain at the hospital. Faculty, staff, trainees, and students filled in, answering calls from pastoral care whenever “a Muslim Chaplain” was needed.

...the concept of religion itself as a profession...is still foreign to our community...

For years, the Muslim community in America has taken what I like to call a “Sunday School volunteer” approach to meeting the spiritual and religious needs of our community. Mosques and communities do hire full-time staff, almost exclusively from overseas, to serve as *Imam*, or Muslim religious leader, to meet the immediate religious needs of small communities. And the religious needs of American Muslims are increasingly becoming sub-specialized, as religious schools, preparers of religiously sanctioned (“halal”) food, and religiously allowable forms of business and finance spawn full-time “Islamic” businesses and professions. However, this is still in its infancy when compared to more established faith communities. And the concept of religion itself *as a profession*, and the pastoral care needs of the community as a non-denominational duty that might be filled by a professionally trained person who is not an Imam, is still foreign to our community; currently, the duties fulfilled by a chaplain are being served on a part-time basis by volunteer amateur chaplains, often with little more than an elementary education in faith tradition, and none in pastoral care.

The result of these unqualified “amateur chaplains,” regrettably, is what those trained in pastoral care might expect: countless stories of well-meaning and enthusiastic but untrained volunteers and Imams coming to hospitals, with a deficit of understanding of the varied pastoral care needs of patients. At best, they routinely fail to meet the needs of the patients whom they serve. At worst, patients occasionally suffer more, as the encounter intended to relieve the spiritual suffering, existential uncertainty, and general anxiety of a patient often devolves into a Sunday-school lesson, not meeting the very real needs of the patient.

To be sure, the institution of clinical pastoral care and chaplaincy is itself a new institution. According to the Association of Clinical Pastoral Education (ACPE), the first formal chaplaincy residency program is itself less than 100 years old, and was born in the United States. And the US is itself a crucible for so many new ideas, such as emerging concepts of mental health and the field of bioethics, with the rest of the world following. It shouldn’t be surprising that faith communities without a strong presence in the US might find themselves struggling to interface with the field of pastoral care—and vice versa, as professional concepts borne out of a Western Judeo-Christian culture turn out a “square peg” in the “round hole” that is other faith traditions.

This last point bears emphasis, as hospitals continue to ask Muslim physicians to fill the role of chaplains, with the hospital, physicians and patients neither realizing the shortcomings of such an approach nor the potential negative impact such an approach has on all stakeholders.

What little we know about the endeavors of Muslim physicians acting as amateur part-time chaplains is not encouraging[1]. My work at Duke ultimately led to an informal faculty appointment at the Duke Divinity School, where I was invited to speak to chaplains-in-training. More importantly to me, it exposed me to the world of pastoral care, and made me “know what I don’t know,” and understand that pastoral care service was out of my scope of practice. I’m not sure that doctors in general understand what chaplains do, and I’m certain, based on anecdotal experience and formal surveys, that Muslim physicians generally don’t.

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...those of us who understand the role of chaplains (especially chaplains themselves) have an obligation to reach out to minority religious communities throughout the US, and invite them to the chaplaincy profession as a way to meet the spiritual and religious needs of people in the US.

To this end, I believe those of us who understand the role of chaplains (especially chaplains themselves) have an obligation to reach out to minority religious communities throughout the US and invite them to the chaplaincy profession as a way to meet the spiritual and religious needs of people in the US. Put simply, people need to understand what chaplains do. It may not work for all people or all faith communities. These communities, I'm quite sure, have something to teach us. At the very least, it will allow for a better interaction between people, faith communities, and the "public space" that continues to evolve a relationship with people of faith here in America. At best, it will lead to a better meeting of the needs of the patients, prisoners, uniformed service members and others served by our faith professionals. Muslims are just beginning to "get it," as more Muslims enter chaplaincy as a career.

I. Padela, A.I., et al., *The perceived role of Islam in immigrant Muslim medical practice within the USA: an exploratory qualitative study*. J Med Ethics, 2008. 34(5): p. 365-9.

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Hasan Shanawani, M.D., M.P.H., is an Assistant Professor in the Division of Pulmonary and Critical Care Medicine at Wayne State University School of Medicine in Detroit, MI. He is a research fellow for the Institute for Social Policy and Understanding (ISPU), an independent non-profit research organization studying US domestic policy issues. He advises the Association of Muslim Health Professionals (AMHP) and the Islamic Medical Association of North America (IMANA) on issues of professionalism, bioethics, and patient needs. He serves on the ethics committees of the Detroit VA Hospital and Harper University Hospital and was appointed to the ethics committee of the Michigan State Medical Society.

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LEGISLATIVE Updates

● Ethics in the News

It was announced, in early October, that Dieter Egli, PhD, a senior research fellow, and Scott Noggle, PhD, at The New York Stem Cell Foundation (a private research group working to advance stem cell research) and a team of scientists had successfully transplanted nuclei of adult stem cells into unfertilized donor oocytes. This process, known as somatic cell nuclear transfer, is the same technique that allowed scientists to clone a sheep in Scotland in 1996. The announcement, which was made in *Nature*, was heralded as a major advancement in the development of patient specific stem cells. However, as noted by many commentators, this step is far from the ideal development of these cells. This technique left the new cells with three sets of chromosomes, which would render it impossible to clone a human. However, this is considered a significant step forward in this particular method of creating patient-specific stem cells.



For more information, visit:

<http://nyscf.org/news/nyscf-press-releases/item/1094-scientists-at-new-york-stem-cell-foundation-columbia-u-make-advance-in-development-of-patient-specific-stem-cells>

<http://www.npr.org/2011/10/05/141073036/researchers-advance-cloning-of-human-embryos>



On July 20, 2011, Gov. Kasich signed a bill into law that will limit when pregnancies may be terminated after 20 weeks gestation. The law (which became effective Oct. 20, 2011) establishes a presumption of fetal viability at 20 weeks gestation and makes it unlawful to terminate a pregnancy after that point unless 1) the mother's life or health is at risk ("health" being defined as only physical health) or 2) the fetus is not viable. The law sets forth six steps that a physician performing a termination after 20 weeks gestation would need to take to be able to avail him/herself of the affirmative defense provided in the law.

If the physician did not satisfy these elements, the State Medical Board is required to revoke his/her license to practice in the State of Ohio and he or she may face a fourth-degree felony prosecution and potential civil liability.

For more information, visit:

http://www.legislature.state.oh.us/bills.cfm?ID=129_HB_78

The U.S. Supreme Court was petitioned to rule on the constitutionality of the "individual mandate" established by the Patient Protection and Affordable Care Act, which was held to be unconstitutional by the Eleventh Circuit Court of Appeals. Two other federal circuits – including the Sixth Circuit in Cincinnati – have held the mandate to be constitutional under the Commerce Clause. This disagreement between the federal courts, therefore, necessitates the Supreme Court's involvement and clarification. The Court will be working from the Eleventh Circuit's decision, meaning they will be deciding whether to uphold that Circuit's decision and reasoning that the mandate is unconstitutional or not. Arguments will likely occur in November and a decision from the Court can be expected by spring or summer 2012. The decision by the Court will likely play a very prominent role in the 2012 election cycle, as well.

For additional information, see here:

http://online.wsj.com/article/SB10001424052970204138204576598793856396376.html?mod=rss_Health



New **BENO** Board Members

The following three new members were elected to the Board during the last election.



Mark Auliso, Ph.D.

Dr. Auliso is Associate Professor of Bioethics in the Department of Bioethics at Case Western Reserve University, where he serves as Director of Clinical Programs and of the Ph.D. of the Program in Bioethics. He is also Director of the Center for Biomedical Ethics at MetroHealth Medical Center, where he chairs the medical ethics committee, does ethics consultation, offers regular ethics education for health professionals and students, and is a member of both the Institutional Review and Privacy boards. Dr. Auliso served as executive director of the national task force that issued the America Society of Bioethics and Humanities (ASBH) *Core Competencies for Health Care Ethics Consultation* and was co-chair of the task force that developed ASBH's *Improving Competence in Ethics Consultation: An Education Guide*.



Sally Paumier, RN, MA, LPC, CT

Ms. Paumier has been an RN in Medical and Surgical ICU's for over thirty years. For the past ten years, she has had the position of Family/Physician Liaison with the Intensivist Team at Aultman Hospital in Canton, Ohio. She is also a Licensed Professional Counselor, a graduate of Ashland Theological Seminary, and is certified in Thanatology by the Association of Death Education and Counseling. She serves as the co-chair of the Ethics Committee at Aultman.



Pedro Weisleder, M.D., Ph.D., FAAP

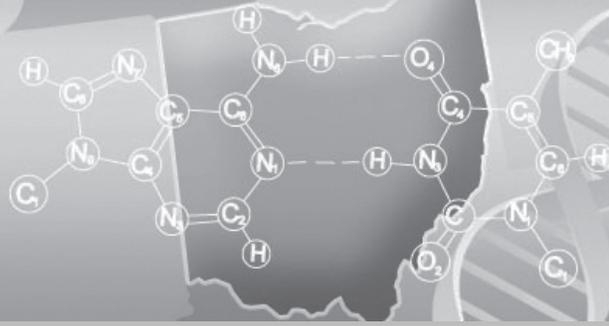
Dr. Weisleder is Associate Professor of Pediatrics and Director of the Pediatric Neurology Residency Program at Nationwide Children's Hospital (NCH) – The Ohio State University. He is a member of the Institutional Review Board and co-chair of the hospital's Ethics Committee, as well as being a member of the Hospice and Palliative Care service. Dr. Weisleder also serves on the Universal Newborn Infant Hearing Screening subcommittee of the state Bureau for Children with Medical Handicaps and is on the national Child Neurology Society's Ethics Committee.

Please join us in welcoming these three eminently qualified professionals on the Board.

We look forward to serving with them for the next three years.



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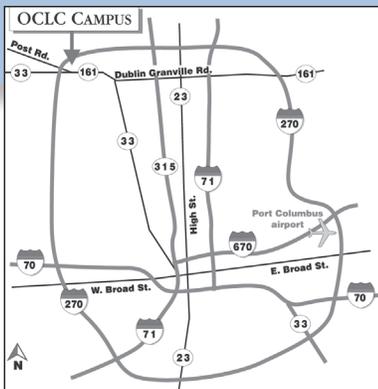
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