

Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 2019*

Mid-Atlantic Ethics Committee
Newsletter, Winter 2019

This paper is posted at DigitalCommons@UM Carey Law.
<https://digitalcommons.law.umaryland.edu/maecnewsletter/77>



MID-ATLANTIC ETHICS COMMITTEE

NEWSLETTER

A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
Published by the Law & Health Care Program, University of Maryland Francis King Carey
School of Law and the Maryland Health Care Ethics Committee Network

Winter 2019

Inside this issue . . .

Maryland Courts Hear Medically Ineffective Treatment Cases.....	1
Court Intervention & Cultural Sensitivity.....	8
The Ethics of Medical Repatriation.....	12
Anita Tarzian Named Hastings Center Fellow.....	5
Calendar of Events	16

MARYLAND COURTS HEAR MEDICALLY INEFFECTIVE TREATMENT CASES



Over the past 14 months, two Maryland Circuit Courts have adjudicated cases involving the medically ineffective treatment provisions of the Maryland Health Care Decisions Act (HCDA). In each case, the provisions were relied on by a health care provider to terminate a patient’s life-sustaining treatment. This article is based on the court papers filed in those cases, as well as conversations about the legal process with one or more attorneys involved in each case. Neither the health care providers from the medical institutions nor the attorneys disclosed any protected health information due to the restrictions imposed by Maryland law and HIPAA.

Case #1

On Friday, December 1, 2017, an attorney representing Harjeet Malhi, the father of Gurpreet Singh Malhi, a 32-year-old male patient in a persistent vegetative state and on a ventilator at Anne Arundel Medical Center (AAMC), filed a motion for a temporary restraining order (TRO) in the Circuit Court to prevent AAMC from disconnecting Gurpreet from the ventilator (Case No. C-02-CV-17-003473).

Gurpreet, an Indian national temporarily residing in the United States, was admitted to the emergency department at AAMC on t

The *Mid-Atlantic Ethics Committee Newsletter* is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland Francis King Carey School of Law’s Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

Diane E. Hoffmann, JD, MS - Editor

**The Mid-Atlantic Ethics
Committee Newsletter**
is published three times per year by
the Maryland Health Care Ethics
Committee Network
Law & Health Care Program
University of Maryland
Francis King Carey School of Law
500 West Baltimore Street
Baltimore, MD 21201
410-706-7191

Diane E. Hoffmann, JD, MS, Editor
Anita J. Tarzian, PhD, RN,
Co-Editor

Contributing Editors:

Joseph A. Carrese, MD, MPH
Professor of Medicine
Johns Hopkins University

Brian H. Childs, PhD
Community Professor of Bioethics,
Mercer University School of Medicine,
Savannah, GA

Evan DeRenzo, PhD
Ethics Consultant
Center for Ethics
Washington Hospital Center

Edmund G. Howe, MD, JD
Professor of Psychiatry, U.S.U.H.S.
Department of Psychiatry

Laurie Lyckholm, MD
Assistant Professor of Internal
Medicine and Professor of
Bioethics and Humanities,
Virginia Commonwealth
School of Medicine

Jack Schwartz, JD
Adjunct Faculty
University of Maryland
Francis King Carey School of Law

Henry Silverman, MD, MA
Professor of Medicine
University of Maryland

Comments to:
MHECN@law.umaryland.edu

**The information in this newsletter
is not intended to provide legal
advice or opinion and should not be
acted upon without consulting an
attorney.**

October 25, 2017 with a diagnosis of acute pancreatitis. Four days later, he suffered a cardiac arrest, went into a coma, subsequently diagnosed as a persistent vegetative state, and was placed on a ventilator. Approximately three and a half weeks later, based on the hospital's policy on "unbeneficial treatment," his treating physicians told his local family members that they were going to remove Gurpreet from the ventilator and discontinue other life-sustaining measures. The family members objected to the hospital's plans.

Gurpreet's father, Harjeet, who spoke only Punjabi, traveled to Baltimore from India as soon as he could (Nov. 30) to see his son and meet with his physicians. Once he arrived, he also expressed his disagreement with the decision to remove Gurpreet from the ventilator and halt other medical treatment and implored the hospital and the treating physicians to wait until he had time to pursue other treatment options.

Concerned that the hospital would move forward with the plan to remove life-sustaining treatment (LST), on Dec. 1, Gurpreet's father filed the motion for the TRO. The motion referred to provisions of the HCDA that allow a family member to make health care decisions for patients lacking decision-making capacity. The motion further stated that, according to the statute, if

a health care provider intends not to comply with the wishes of a surrogate, at the request of the surrogate to transfer care to another facility, the provider will ' . . . make every reasonable effort to transfer the patient to another health care provider; . . . assist in the transfer; and . . . comply with the instruction of the surrogate . . . if a failure to comply with the instruction would likely result in the death of the individual.

On Dec. 5, the court granted the TRO and directed AAMC to forgo removing Gurpreet from the LST until a full adversarial hearing could be held. Subsequent to the granting of the TRO, Mr. Malhi filed an amended petition to temporarily and permanently enjoin the hospital from withdrawing LST from Gurpreet and to order AAMC to meaningfully assist the family in the transfer of care.

The hearing, which included testimony from several family members, the treating doctor, and the hospital bioethicist, was held on Friday, Dec. 15th. At the hearing, Mr. Malhi's attorney explained that her client was requesting a preliminary injunction to prevent the hospital from taking Gurpreet off of LST and so that arrangements could be made to transport him to a hospital in India. The family had made efforts to transfer Gurpreet to several other hospitals in Maryland but none were willing to accept him in his current condition. The judge expressed concern about the cost of transport to India for a patient requiring ventilator support and asked whether there was any source of funding for the transfer, i.e., third party private or government insurance or other source. Because of the patient's immigration status there was no public source of payment and

the patient's family had not yet approached the Embassy of India to see if it might offer assistance.

Witnesses called by Mr. Malhi's attorney included two relatives of the patient (a cousin and his uncle's brother-in-law), in addition to Gurpreet's father. Through their testimony, it was brought to the attention of the court that the hospital had issued a "no escalation of care" order that was not in accordance with the family's wishes. Subsequent to the order, they contacted other Maryland hospitals to see if they would accept Gurpreet. Initially, one hospital's intake coordinator agreed to accept Gurpreet and place him on its wait list for care. After this, AAMC lifted the "no escalation" order and began to treat Gurpreet with antibiotics and blood transfusions as he had a blood infection that had not been treated because of the order. The day after this treatment, the family members observed that some of his vital signs and lab numbers had improved and that he looked much better. They believed that with continued treatment he would have a chance to live. Gurpreet's father also testified that he had spoken to a physician in India who told him that he could get Gurpreet admitted to any one of a number of hospitals in New Delhi.

Also at the hearing, a physician from AAMC, who was an expert in pulmonary critical care and who had been involved in Mr. Malhi's care, testified. She stated that Gurpreet was a 32 y.o. man who had unfortunately sustained a few complications from his alcohol intake including delirium tremens and severe pancreatitis. The latter led to renal and respira-

tory failure and a cardiac arrest that resulted in brain damage. She further stated that he had been in a persistent vegetative state for eight weeks and that such a diagnosis is typically made after a patient is not aware of his or her surroundings for four weeks. After three months, a diagnosis of permanent vegetative state could be made.

The physician further stated that she believed that any additional treatment of Gurpreet would be medically ineffective in that it would not prevent his death or deterioration. She told the family that she believes the role of medicine is to prolong life, not to prolong death and the most humane thing for Gurpreet would be to ensure his comfort and not to prolong his death. Mr. Malhi's attorney asked if this would include continuing to give him nutrition and hydration. The physician responded that for a patient with renal failure, continuing to give him hydration and nutrition would likely mean he would experience his last days filled with fluid and edematous, which would be very uncomfortable. Thus, in her view, it would not be appropriate to give him IV fluids.

Also, a note in the medical record by a nephrologist treating Gurpreet was read into evidence. In the note, the nephrologist stated that he believed the provision of ongoing renal replacement therapy should be regarded as futile and for this reason "continuation of kidney dialysis has created an ethical conflict for me as a provider in this case."

In closing remarks, Mr. Malhi's attorney stated that her client

believed that his son would get much better care at his home in India and would like an opportunity to find a way to get him there. She also said her client requested that, pending the transfer, the no escalation of care order be lifted to give Mr. Malhi the strength to withstand a transfer and asked for a reasonable length of time to get that done.

The attorney for AAMC stated that the legislature enacted a provision for medically ineffective treatment for exactly this type of case, i.e., when artificial care is only prolonging the dying process. He referred to the four legal requirements for granting a Preliminary Injunction (PI) (*see* Box, p.4) and stated that "the legislature has given us a clear indication of what the public interest is by enacting this provision. There is harm on both sides of the table. The patient is being harmed by continuing a painful dying process, the providers are being harmed by giving morally and ethically inappropriate care and watching the patient suffer when the law allows for discontinuing care." Finally, he addressed the plaintiff's chance of success on the merits, and concluded that there was virtually no evidence that the plaintiffs would be successful in finding a hospital willing to accept transfer of the patient, that no hospitals they had contacted in the U.S. had agreed to take the patient and even if a hospital in India would agree to accept him, the transfer to India would be cost prohibitive.

After the hearing, the court granted a time-limited PI prohibiting the hospital from removing Gurpreet from the ventilator or discon-

Patients ask Courts for TRO and Preliminary Injunction

In both the Malhi and Kwon cases, the patients asked the courts for a temporary restraining order, often referred to as a TRO, and a Preliminary Injunction. Both are forms of injunction but a temporary restraining order is typically issued in circumstances where immediate action is needed, specifically, where there is not time for a court hearing on the issue because the requester will suffer “immediate, substantial and irreparable injury” unless the order is issued. Courts often issue TROs based on affidavits from a person whose interests are about to be harmed. In Maryland, such injunctions may not remain in effect more than ten days for a resident and not more than 35 days for a non-resident. A preliminary injunction, in contrast, is issued only after there has been an opportunity for a full adversarial hearing on the issue. In both cases, the party seeking the injunction must prove each of the following four factors: (1) there is a high likelihood that they will prevail on the merits; 2) the harm to the plaintiff if the injunction is not granted will be greater than the harm to the defendant if it is granted; 3) the plaintiff will suffer irreparable injury unless the injunction is granted; and 4) it is in the public interest to grant the injunction. In these cases, it will virtually always be the case that without the TRO patients will suffer immediate, substantial and irreparable injury, as they will likely die without continued life-sustaining treatment.

tinuing other LST but denied the plaintiff’s request for escalation of care, finding that such additional treatment would be medically ineffective. The court ordered that the PI expire on Wednesday, December 20th, giving the family three full business days to find a hospital that would accept Gurpreet. During that time period, the hospital was required to make “every reasonable effort to transfer the patient to another health care provider.” The court stated that it could not find that the plaintiff would not be successful in finding a place to transfer his son and that it would be in the public interest to allow the patient to return to his home in India. Also, in weighing the harms of denying the request to explore transfer, the court found that while the hospital would suffer financial harms, the patient would suffer irreparable harm. In light of this, the court ordered the plaintiff to post bond in the amount of \$15,000 in three days

to cover the hospital’s expenses of maintaining the patient on LST as the Maryland rule on injunctions requires posting of a bond for the costs of damages. If the bond was not posted in the required time frame the order would expire. The court also made it clear to the parties that the chances that it would grant another extension of the PI if the plaintiff could not find another institution willing to accept the patient were “slim, if not nonexistent.” In other words, the court was providing Gurpreet’s family with one more opportunity to determine if another place of care was available. If they could not find a place within the three business days, the PI would expire and the hospital could proceed with its plan to stop all life sustaining treatment.

The family was unable to find another provider who would accept the patient in the allotted time frame. Therefore, the family did not proceed with its claim for in-

junction relief and the hospital ultimately removed the patient from the ventilator and other life support.

Case #2

Less than a month after the Malhi case was decided by the Anne Arundel County Circuit Court, a second case involving medically ineffective treatment was filed in Baltimore City Circuit Court (Case No. 24-C-18-000189). The complaint was filed by Haeyoung Lee on January 12, 2018, on behalf of her husband, Hyok Won Kwon, a patient at Johns Hopkins Medical Center (JHMC). In August 2017, Kwon was diagnosed with head and neck squamous cell carcinoma. He presented with a tumor that progressed from August to January from a lump below his right neck the “size of a large egg to a much larger mass that extend[ed] from the right side to the throat and the left side.” Lee, who was also

Kwon's agent under his durable power of attorney for health care, alleged that JHMC had refused to give curative treatment to her husband because of an erroneous assumption about his condition, specifically that because he had asymptomatic tuberculosis he could not receive chemotherapy. She filed the complaint for "medical emergency injunctive relief" because on the evening of January 9, 2018 she was notified that JHMC personnel were planning to disconnect her husband the following morning from the ventilator without the family's consent and against her husband's wishes. Lee called 911 and sought the assistance of the police, who directed her to call the courthouse where she was able to obtain temporary relief – an administrative judge, by verbal order, on the morning of January 10th, required that JHMC keep Mr. Kwon on the ventilator until his family was able to initiate court proceedings on his behalf.

On Friday, January 12th, the court held an initial hearing on the case. Ms. Lee (acting pro se) and one of her daughters testified along with Mr. Kwon's attending physician and the co-chair of the Hopkins Ethics Committee, who had consulted on Mr. Kwon's case.

At the hearing, the attending physician explained that the hospital staff were encountering increasing difficulty attaching the endotracheal tube coming out of Mr. Kwon's windpipe to the tube that connects it to the ventilator. The e-tube had been in place much longer than is typical. An e-tube is usually only in place for a few hours, days or possibly a couple of weeks. In this

case, it had been in place for over 100 days. The tube was inserted originally because Mr. Kwon's tumor was putting pressure on his airway, making it difficult for him to breathe. Although a tracheostomy is usually performed after about two weeks to ventilate the lungs rather than keeping the endotracheal tube in place, in his case, Mr. Kwon's family did not consent to that procedure at the time. The attending further explained that the patient was no longer a candidate for a tracheostomy; the ENT surgeon said it was no longer feasible as his tumor had grown, despite radiation therapy. The attending also explained that he did not believe further treatment would be medically effective and that the hospital staff should focus on keeping Mr. Kwon comfortable. He also stated that no other physicians at Hopkins who had seen Mr. Kwon, including ENT surgeons and oncologists, believed further therapy would be medically effective. The oncologists said they would not give him

chemotherapy because he was so weak. The treating physicians had documented that further treatment would be medically ineffective.

The attending further testified that the disagreement with the family developed two days earlier when the connection between Mr. Kwon's e-tube and the tube connected to the ventilator kept coming apart. Staff was having a difficult time keeping the tubes connected because the end of the e-tube was friable and slit and there was a leak where the tubes were connected. Due to moisture in the area where the tubes connected, tape was ineffective and thus not a viable long-term solution. The physician also said that it was probably not feasible to replace the e-tube; it might result in losing the airway altogether. If the airway closed up, it would not be possible to insert another tube. Furthermore, Mr. Kwon might experience considerable pain if his physicians removed the e-tube as there could be adhesions



Furthermore, Mr. Kwon might experience considerable pain if his physicians removed the e-tube as there could be adhesions between the lining of his windpipe and the tube. The physician also indicated that Mr. Kwon's condition met the statutory definition of an "end-stage condition."

In response to questions from the judge and the hospital attorney, the physician distinguished between the types of care that would qualify as comfort care versus an escalation of care. He stated that he believed that comfort care would not include vasopressors, antibiotics, or other care to treat new complications and that initiating CPR or increasing the settings of the ventilator would be an escalation of care. However, he did not believe that maintaining the ventilation would be an escalation.

The co-chair of the hospital's ethics committee also testified. He explained the role of the ethics committee and explained the impact of continued treatment of Mr. Kwon as requested by the family. He said that the treating staff felt moral distress at, among other things, the threat to the dignity of the patient by continuing ineffective treatment. The co-chair also said that members of the ethics committee had met with the family in December as well as the week of the hearing and learned more about the family's perspective. The family felt that any form of life is meaningful and wanted life-sustaining treatment to be continued for as long as possible. They also continued to hold out hope that Mr. Kwon's cancer could be treated once his TB was under control.

Mr. Kwon's daughter also testified that the family found meaning with every day they had with their father. She said he was not awake all the time but would interact with them when he was awake. She said that only a week before the hearing, he had become emotional, tearing up as they told him stories. Such interactions made it difficult for the family to accept the hospital's decision to stop the ventilator support.

After this hearing, the Court issued a TRO requiring JHMC to continue ventilator therapy for Mr. Kwon, "to the extent possible." It also found that Mr. Kwon was "suffering from an end-stage condition" and that "escalation of his treatment would be medically ineffective within the meaning of Md. Code, Sec. 5-601(o) of the Health-General Article." The Order was to stay in effect for no longer than ten days during which time any party could apply for modification or dissolution of the Order on two days' notice. The Court also scheduled a second hearing for the morning of Tuesday, January 16th, to allow the Court to hear from several individuals who were unable to come to the initial hearing.

At the second hearing, additional members of Mr. Kwon's family were present, including his daughter, brother, and brother-in-law. An internist and pulmonary medicine fellow who had been involved in Mr. Kwon's care also testified on behalf of Johns Hopkins. They reported that Mr. Kwon's condition had changed over the weekend; one of his pupils was not reactive, which could indicate deep sedation, metabolic disturbance or very severe brain dam-

age. Much of what was explored at this hearing was the feasibility of transferring Mr. Kwon to another hospital, specifically whether it was a realistic possibility and how far the plaintiff and her family had gone in exploring it.

At the end of the hearing, the judge asked whether the hospital would be agreeable to transferring the patient if the family were to find a hospital that would accept the patient within the next 24 – 48 hours. The attorney for the hospital responded that at no point had the hospital indicated that it would stand in the way of transfer; the issue was how much Hopkins was required to do pending the transfer and how long they would have to continue to provide care if transfer was not imminent.

In response to an assertion by the plaintiff that the statute requires a hospital to provide LST pending transfer if failure to do so would result in the death of the patient, the judge asked, but "for how long?" The plaintiff's attorney responded that the statute does not provide a limit. The judge then posed the following hypothetical case: "suppose that you explored with Alexandria [Hospital] and they said no and then you said to [Hopkins], we are exploring with Prince George's Medical Center and they said no two days later, and then you said we are exploring with Fairfax Hospital and they said no two days later, and then you said we are exploring with Richmond Hospital and they said no. . . On that reading of the statute, you could prolong the requirement of medically ineffective care indefinitely."

The judge later stated that he rejected the notion that section 6-613 of the statute "means that the moment at which a patient or his family articulates the possibility of a transfer that necessarily means the provider has to provide exactly what the family requests until that transfer is accomplished." Rather, it must be interpreted as meaning that LST is to be continued if efforts made to transfer are reasonable and the possibility of transfer is feasible. "My construction of the statute is that in these particular circumstances, . . . the plaintiff has failed to show that Hopkins Hospital has an obligation to undertake every treatment modality that the family requests while there is pending some possibility of transferring him to another hospital because the plaintiff has not provided evidence that there is a reasonable likelihood that the transfer will occur or that it is imminent."

After the second hearing, the court issued a "modified limited temporary restraining order" and denied the plaintiff's request for a preliminary injunction because the plaintiff had not been able to show that she would likely succeed on the merits of her claim that Johns Hopkins is required to render treatment to Mr. Kwon above what it was currently providing. The Court issued the modified TRO to ensure that Hopkins continued to provide the level of care that it was currently providing, including ventilator therapy, while Mr. Kwon's family pursued a possible transfer of Mr. Kwon to another hospital. However, the court stated that it recognized that the ventilator therapy was being provided "only through extraordinary mea-

asures to cope with the deteriorating breathing tube" and that the hospital was "required to use its best efforts to continue the therapy, but only as long as . . . feasible to do so." Best efforts, the court went on to say, "means reasonable efforts in the circumstances and does not include requiring a nurse or technician manually to hold together the connection of the ventilator to the breathing tube."

The Court stated that, "with the single exception of adjustments in the ventilator controls, [the] Defendant ha[d] appropriately assessed Mr. Kwon's condition and the fact that escalation of his care would not be medically effective within the meaning of Md. Code, Sec. 5-601(o) of the Health-General Article." The Court further found that Mr. Kwon had an "end-stage condition" and that JHMC was not "required to render care that it has determined . . . to be medically ineffective in light of that condition."

Finally, the Court ordered that JHMC cooperate with Mr. Kwon's family to transfer Mr. Kwon if a hospital agreed to accept him as a patient, that the order would remain in effect for no longer than ten days from the date of initial issuance (Jan. 12th) and that it could be extended for another ten days for "cause shown."

Ultimately, the family was unable to find another facility that would accept the patient and he died at Hopkins Hospital.

Both this case and the prior case indicate a willingness on the part of the Maryland courts (at least at the trial court level) to give

credence to clinical evaluations of medically ineffective treatment and to allow a hospital to terminate such treatment, despite patient or family objections, if after a reasonable period of time no other hospital will accept the patient. Such reasonable period of time, at least in these two cases, appears to be approximately ten days.

*Diane Hoffmann, JD, MS
Jacob A. France Professor of Health Law
Director, Law & Health Care Program
University of Maryland School of Law*

Court Intervention & Cultural Sensitivity

Most ethics experts agree that courts are the least-favorable place to resolve conflicts about end-of-life (EOL) treatment. State statutes, such as Maryland's Health Care Decisions Act (HCDA) and similar legislation in California, Texas, and New York, offer an alternative to the courts by defining a process for resolving disputes about withholding or withdrawing medical interventions that have been deemed medically ineffective or inappropriate. In this issue of the Newsletter, we review the first two Maryland cases where judges affirmed the provisions in the HCDA that allowed withdrawing life support over surrogates' objections. Here, I offer some reflections on what role culture may have played and clinicians' duties to respect differing cultural beliefs and practices in the context of medically ineffective or ethically inappropriate interventions at the end of life.

Mr. Malhi was from India, temporarily living in the United States (U.S.). His father (who traveled from India upon hearing of the plans to withdraw his son's life support) only spoke Punjabi. This is very little to go on to speculate about the core beliefs, practices, and values that guided medical decision-making for him. Mr. Malhi could well have ascribed to non-mainstream beliefs and practices. However, with nothing else to go on, we can try to extrapolate from statistics: about 80% of Indians practice Hinduism, with a smaller percentage identifying as



Muslim, Christian, or Sikh. If Mr. Malhi were Hindu, the concept of “karma” may be meaningful (i.e., that past actions affect our present life circumstances and our current actions affect our future circumstances). It's not uncommon for Hindus to consult numerologists to inform important decisions, such as naming a child, marrying, or even withdrawing life support (see https://www.hinduwebsite.com/hinduism/h_numerology.asp). Family harmony is valued, as well as respecting social order. Given that Mr. Malhi had been unable to communicate his values and preferences prior to becoming comatose, decision-making would fall to a surrogate. Assuming Mr. Malhi lacked a spouse or domestic partner, according to the HCDA, his father is considered a legally authorized surrogate (on par with Mr. Malhi's mother). There are several challenges here in providing “culturally sensitive” care to Mr. Malhi and his family:

1. **DISTANCE:** While Mr. Malhi had some family members locally available, his surrogate—his father—was thousands of miles away, requiring communication presumably through a phone or online Punjabi medical interpreter. This complicates the process by which trust is established between the surrogate and clinical team.
2. **CROSS-CULTURAL COMMUNICATION:** While use of certified medical interpreters is the gold standard for communicating with patients or family members who don't speak English, there are known cultural differences that contribute to gaps in understanding among stakeholders. A “cultural broker” can help bridge these gaps, but effective cultural brokers are not readily available.

3. **REAL OR PERCEIVED BIAS:** We don't know whether Mr. Malhi was in the U.S. legally, but the court makes clear that he didn't have health insurance to cover his ongoing hospitalization or his travel back to India. While these factors should not affect decisions about whether life support is medically ineffective, surrogates may perceive that such decisions are influenced by the patient's citizenship, race, or health insurance status, which can thwart the trust-building process necessary to ground effective communications.
4. **TIMELINE:** The physicians' decision to withdraw life support occurred relatively quickly after the patient's admission to the ICU (about one month). According to the summary, the ventilator was deemed medically ineffective after the patient was determined to be in a persistent* vegetative state (PVS). However, patients in PVS can remain stable on life support for much longer than one month. What justifies moving more quickly to withdraw life support rather than giving the family more time? In Mr. Malhi's case, multi-organ failure precluded ICU discharge and presumably made his death imminent. Competition for ICU beds is an unavoidable consideration. Indeed, fair resource allocation and institutional stewardship are in tension with motivations to accommodate family members' emotional, spiritual, religious, and/or cultural needs and values. How much time allotted to loved ones at a dying patient's bedside is considered an acceptable accommodation?

Let's assume that all efforts were made to inform the family of his condition, but despite the staff's and ethics consultants' best efforts, the father, acting as the legally authorized surrogate, requested continued interventions deemed medically ineffective or inappropriate (e.g., renal dialysis, ventilatory support, blood products, antibiotics, and cardiopulmonary resuscitation efforts). One justification for moving forward to withhold/withdraw life support using the HCDA provisions in such a case is that doing so constitutes a form of "culturally sensitive" medical paternalism. That is, in some cultures, surrogates demonstrate their love and fidelity by asserting that "everything be done" for the patient. In some countries, this demand is not interpreted literally by medical providers, as it often is here in the U.S.. Furthermore, the expanded options for "doing everything" in U.S. critical care and trauma units complicates bridging this cultural gap. Having the medical team make a clear recommendation to stop interventions that are merely prolonging Mr. Malhi's impending death may ease the family's burden in feeling complicit in contributing to his death (see Box on page 11).

Mr. Malhi objected to the hospital withdrawing his son's ventilator. Perhaps this was because he viewed the act of ventilator withdrawal as causing his son's death. While it's generally agreed that there is no ethical distinction between withholding or withdrawing life support (i.e., the underlying illness or injury causes the death, not the ventilator withdrawal), it *feels* different to those involved. Moreover, some individuals recognize a moral distinction between stopping versus starting life support (e.g., Orthodox Jews). When ICU clinicians institute "do not escalate treatment" orders for dying patients, they are acknowledging and accommodating this perspective. Whether this is a reasonable accommodation is an open question, given the burdens of ICU-level care to the patient, the competition for ICU beds, and incurred hospital costs (both monetary and non-monetary). Yet, in Mr. Malhi's case, the family objected to the no escalation of treatment order as well—that is, they believed the antibiotics and blood transfusions Mr. Malhi had received helped him and should be continued, that they were not just "prolonging his dying." So, Mr. Malhi's family objected both to withdrawing *and* withholding interventions because they perceived a benefit in prolonging life whereas the medical team believed the burdens and costs of the interventions would not justify the potential minimal extension of Mr. Malhi's life.

The case of Hyok Won Kwon presents another opportunity to explore to what extent culture played a role in a patient's trajectory of care and in ultimate court involvement. While a full exploration of Korean culture and its variations is beyond what can be presented here ("Kwon and "Lee" are common Korean last names so it is assumed that the patient was Korean), general characteristics include a strong regard for filial piety (respecting and honoring one's blood relatives and ancestors), clearly divided family roles, and family interdependence over individualism (Kim & Kelly, 2006). Koreans, especially elders, may prefer Hanbang, also known as Hanyak,

and Oriental medicine, as the preferred method of health care. This is based on balance between um (akin to yin) and yang, and balance of fire, earth, metal, water, and wood. It's not uncommon to blend these beliefs and practices with Western medical interventions. Whether such cultural beliefs were at play in the decision to forgo Mr. Kwon's tracheostomy is an open question. It's indicated that his family believed that any form of life was meaningful and they valued time spent around his bedside, which is why they requested that life-sustaining interventions be continued for as long as possible. Such beliefs are common across different cultures and religions.

What is at issue for both of these cases is what we consider a "culturally sensitive" accommodation. In the Kwon case, the decision to not escalate medical care and to stop the ventilator was influenced by physically not being able to continue mechanical ventilation (i.e., the lack of a tracheostomy and deteriorating endotracheal tube precluded maintaining the airway necessary to continue mechanical ventilation). In the Malhi case, the decision to stop the ventilator was based on an appraisal that keeping him alive for a few days (presumably a maximum of two weeks, assuming his kidneys had shut down) was of no benefit. Brown (2018) suggests that in such cases clinicians stand by their appraisal that such interventions are not *sufficiently beneficial* to justify burdens and costs, to avoid confusion that terms such as "medically futile" or "ethically inappropriate" engender.

The discussion surrounding burdens to the patient and to the staff is interesting. Descriptions of suffering inflicted on Mr. Malhi are questionable given the reported medical opinion that he was irreversibly unconscious (in which case, he would be incapable of suffering). In both cases, however, effects on staff were acknowledged (i.e., staff experienced moral distress by having to inflict interventions that appeared to cause harm or indignity to these patients). What about effects on survivors? This is the question at issue. Surely, providing culturally sensitive care doesn't mean doing whatever family members request. In considering what "doing everything" might entail to minimize future regrets of a dying patient's kin, what do we consider compassionate and fair?

Brierley, et al. (2013) found that out of 203 pediatric intensive care unit (PICU) patients for whom withdrawing life-sustaining treatment was recommended, 11 (~5%) involved protracted discussions with parents who objected, largely based on religious beliefs (e.g., sanctity of life). The authors observed that "Christian fundamentalist churches with African evangelical origins featured most frequently" (Brierley, et al., 2013, p. 574). Perhaps the same justification for mandating blood transfusions to children of Jehovah's Witnesses can justify overriding such individual's requests. Kassim and Alias (2016) and Rezaei et al. (2016) suggest alternative interpretations of vitalist religious positions.

Regarding fairness, Kapottos and Youngner (2015) point out a notable shortcoming of the Texas Advance Directive Act (TADA), a law that is similar to the HCDA but includes additional procedural mandates:

*By applying itself only to cases brought by physicians, the process incompletely takes into account the values touted in the TADA—namely, preventing harm to patients, avoiding the provision of unseemly care, and providing good stewardship of medical resources ... In order to fully preserve professional and institutional integrity as the TADA claims to do, policies should act to prevent physicians from **offering or initiating** [emphasis added] treatments that have little or no benefit to patients while inflicting significant harm. Truly fair processes would consider the entire picture. Failure to do so is at best an example of performative inconsistency. At worst it could be viewed as hypocritical or unjust because it does not treat similar cases alike. (Kapottos & Youngner, 2015, pp. 36-37)*

By relying on individual physicians to decide to withhold or withdraw treatments considered medically ineffective, instances of bias and injustice (whether actual or perceived) may thwart other efforts to establish the trust that obviates resorting to courts to settle disputes. Kapottos and Youngner single out Boston Children's Hospital as the only institution they are aware of that has effectively addressed this issue at the organizational level

(i.e., providing compassionate, culturally sensitive end-of-life care that sets consistent limits on interventions deemed medically ineffective). They suggest creating and sharing a taxonomy of cases referred to courts to enhance transparency and help guide practice. Perhaps toward that end, Mr. Kwon and Mr. Mahli have served this greater purpose by starting this process of reflection.

Anita J. Tarzian, PhD, RN
MHECN Program Coordinator

* NOTE: Recent guidelines call for a change in terminology from “permanent” or “persistent” vegetative state” to “chronic” vegetative state (Giacino et al., 2018).

REFERENCES

Brierley, J., Linthicum, J. & Petros, A. (2013). Should religious beliefs be allowed to stonewall a secular approach to withdrawing and withholding treatment in children? *J Med Ethics*, 39:573–577.

Brown, G.T. (2018). Medical futility in concept, culture, and practice. *The Journal of Clinical Ethics*, 29(2), 114-23.

Giacino, J.T., et al. (2018). Practice guideline update recommendations summary: Disorders of consciousness. *Archives of Physical Medicine and Rehabilitation*, 99, 1699-709.

Kapottos, M. & Youngner, S. (2015). The Texas advanced

directive law: Unfinished business. *The American Journal of Bioethics*, 15(8), 34–38.

Kassim, P.N.J. & Alias, F. (2016). Religious, ethical and legal considerations in end-of-life issues: Fundamental requisites for medical decision making. *J Relig Health*, 55, 119–134.

Kim, I.J. & Kelly, J.G. (2006). Developing cultural competence in working with Korean immigrant families. *Journal of Community Psychology*, 34(2), 149–165.

Rezaei et al. (2016). Conceptualization of Idle (Laghw) and its relation to medical futility. *J Med Ethics Hist Med*, 2016, 9:1.

How to Avoid Court in Medically Ineffective Treatment Cases

In many cases, if information is communicated to a surrogate in a culturally sensitive manner, the Maryland Health Care Decisions Act (HCDA) provisions need not be invoked and court involvement can be avoided. How might this be accomplished? Kon (2011) provides one such approach, which he dubbed “informed nondissent.” This would involve first conveying that the patient is dying, using known communication standards for breaking bad news (Baile et al., 2000). Then, the surrogate would be told what would and would not be done for the patient, and if the surrogate didn’t object, the team would proceed with the plan. For example, the physician might say: “We’re going to treat your [dad, husband, son...] like we would a member of our own family. We will treat him with love and respect in his final days. We’ll make sure he doesn’t suffer” (Kon, 2011, p. 22). Questions or objections (e.g., “There must be something more you can do to save him!”) should be answered directly (e.g., “I’m so sorry. It’s too late. He is too ill. All the things we use here, like shocking the heart after it stops or cleansing the kidneys when they shut down, won’t work for your [dad, husband, son ...]. They won’t prevent his death.”). The HCDA requirement to inform the surrogate that an intervention is being withheld or withdrawn because it is medically ineffective or inappropriate, and to allow the option of transfer, is only relevant if the surrogate objects to the medical recommendations.

Baile, W.F., Buckman, R., Lenzi, R., Glober, G., Beale, E.A., & Kudelka, A.P. (2000). SPIKES- A six-step protocol for delivering bad news: Application to the patient with cancer. *Oncologist*, 5(4), 302-311.

Kon, A.A. (2011). Informed non-dissent: A better option than slow codes when families cannot bear to say "let her die". *Am J Bioeth*, 11(11), 22-3.

The Ethics of Medical Repatriation



The Malhi case brings to mind the issue of medical repatriation, the practice where hospitals transfer immigrant patients to their home countries for continued care. In their effort to seek continuing care for Mr. Malhi, his family sought to delay the hospital from ceasing life-sustaining treatment while they tried to arrange transport to a hospital in his native India. The Malhi case is unique in that the patient's family was requesting transfer; in many cases, the hospital initiates transfer for patients whose conditions no longer necessitate hospital-level care. As a result of their immigrant status (e.g. undocumented, visa-based, etc.), these patients often lack health insurance, the financial resources to pay out-of-pocket, eligibility for public benefit programs, or the familial support necessary to facilitate transfer to subacute care facilities or home settings.

These cases present a significant challenge for U.S. hospitals. The Emergency Medical Treatment and Active Labor Act of 1986 requires all Medicare-participating hospitals to screen and stabilize any individual who presents with an emergency medical condition. Once stabilized, however, patients may have continuing medical or care needs that would best be met in a subacute facility. Subacute facilities, however, have no legal obligation to accept such patients and hospitals face the prospect of providing unreimbursed care indefinitely. Sometimes, when other facilities decline to accept a patient like Malhi, it is an indicator that the currently provided medical interventions are medically ineffective (sometimes referred to as “non-beneficial” in that they are only prolonging the dying process). The question of how a patient's immigration

status is impacting these decisions, and what is considered “fair” to the patient and to the hospital, is complicated.

One provider relayed a story of a woman who suffered a major stroke two weeks after arriving in the U.S. on a visa. Once stabilized, her U.S.-based family members refused to accept the patient in their home and the patient's lack of eligibility for medical assistance ruled out placement in a skilled nursing facility. Ultimately, the hospital paid for the patient's care in a skilled nursing facility followed by a group home over the course of several years until family members in the native country expressed a willingness to care for the patient. The hospital then funded the patient's transport to her native country including transportation and lodging costs for a family member to accompany her on the trip. The aforementioned case cost the hospital more than \$1.5M in uncompensated care.

Hospitals across the country are facing similar cases and it is becoming increasingly common to resolve such cases through medical repatriation. A 2012 study found more than 800 instances of medical repatriations in the U.S., likely an underestimate of the practice given the lack of reporting requirements.¹ Changes to federal funding of healthcare under the Affordable Care Act have likely

contributed to greater reliance on the practice in the last four years.¹

Medical repatriation raises challenging legal and ethical questions for healthcare providers. Indeed, the practice has been met with pointed criticism from bioethicists, legal scholars and members of the media. Some have argued that such cases constitute human rights violations while others assert that only the federal government may legally “deport” individuals present in the U.S. without authorization.² There have been troubling examples cited, in some instances involving legal immigrants and U.S. citizens. In 2008, for example, the University Medical Center in Tucson sought to transfer Elliott Bustamante, an infant with U.S. citizenship born with Down syndrome and a heart condition, to Mexico over the objections of his undocumented immigrant parents.³ A few years earlier, a Florida hospital forcibly transported an undocumented immigrant back to his native Guatemala despite an ongoing legal dispute playing out in court as well as inadequate services in Guatemala to treat patients with traumatic brain injuries.⁴

In addition to the myriad legal questions, medical repatriation also implicates a number of ethical concerns regarding autonomy, informed consent, justice, beneficence, non-maleficence and trust, among others. I discuss several of these below in an effort to highlight some important considerations for hospitals as they consider medical repatriation for patients in their care.

Autonomy and Informed Consent
Respect for autonomy or an individual’s right to self-determination in the healthcare context is a core principle of biomedical ethics. While not the situation in the Malhi case, in many instances, particularly those involving undocumented patients, repatriation occurs without the informed consent of the patient or in direct opposition to the patient’s, or their family’s, stated care preferences.

Of particular concern to critics of involuntary medical repatriation is the extrajudicial nature of the process.¹ While Immigrations and Customs Enforcement may be contacted in some cases, there are many instances where hospitals are transferring immigrants to their native countries with no governmental or judicial oversight and patients are therefore unable to seek recourse if they oppose the transfer. As others have noted, medical repatriation implicates both health care and immigration law. For undocumented immigrants, return to a home country can have serious consequences for their ability to return to the U.S. (i.e., inability to return for a specified period of time ranging from three to ten years) and some have argued that clear information on those consequences needs to be communicated to the patient in order for consent to be fully informed.⁵

Beneficence and Non-maleficence
The principle of beneficence requires healthcare providers to act in the best interests of their patients while the principle of non-maleficence refers to the

provider’s duty to do no harm to the patient. In the case detailed at the beginning of this article, the patient required a level of care typically provided by a skilled nursing facility—a type of facility that is largely not present in her native country. Even in those instances where analogous facilities are present in the native country, standards of care and quality may differ markedly from those in the U.S. The principles of beneficence and non-maleficence create an obligation on the part of hospitals to fully explore care options in the patient’s home country and work with identified institutions or family caregivers to execute the transfer in a manner that minimizes risk to the patient.

Justice

In considering the practice of medical repatriation for solving conflicts about medically ineffective treatment, justice concerns are also raised. Some bioethicists claim that determining whether a treatment is medically ineffective simply boils down to a harm-benefit analysis, and that it can (and should) be considered separately from resource allocation factors. According to this view, medical repatriation should not be an option because such patients should not be transferred anywhere—instead, medically ineffective treatment should simply be withheld or withdrawn. The fact that such an approach would reduce cost burdens to the hospital is incidental. Others disagree, arguing that cost and resource allocation is inextricably linked to the ethical analysis in these cases, and that the principle of justice must be

weighed against the principles of beneficence and non-maleficence. For example, one could argue that there is no harm from continuing life support for a patient like Malhi because persons in PVS cannot suffer, and given that his family members viewed postponing his death as a benefit, this could have justified continuing life support. It is justice concerns that deem such a benefit as insufficient when weighed against the costs. The hospital has to meet the needs of all the patients it serves. Thus, the principle of justice plays a significant role in determining whether medical repatriation is ethically justified. Patients for whom continued care is medically ineffective without discharge options continue to occupy a bed, medicine, and staffing resources that may be needed by others. Hospitals bear the costs of extended periods of care for these patients. If they pursue medical repatriation, they also may shoulder the expense associated with the transfer, which often includes specialized medical transport for patients with complex conditions (e.g. ventilators). Medical repatriation raises the question of whether this is the most just use of a hospital's limited resources. And the way the question is answered may spill over to the way hospitals handle decisions about withholding or withdrawing medically ineffective treatment, and whether immigrants are unfairly disadvantaged in these decisions.

Trust

Trust plays a critical role in the healthcare enterprise. When hospitals effectively deport patients without their consent, there is an

erosion of trust in the care relationship that may result in a patient being unwilling to disclose information that is critical to decisions about treatment or reduces the likelihood that patients will seek needed care in the first place.

This failure to seek care may have significant public health consequences, particularly in cases involving infectious disease. Further, delayed care may result in the hospital providing higher-cost care than would have been needed if the patient felt comfortable seeking care earlier, as well as poorer health outcomes for the patient.



Ethical approaches to medical repatriation

In his article on the practice, bioethicist Dr. Mark Kuczweski proposed three requirements for ethical repatriation:

1. the transfer must be in the patient's best interest, independent of cost concerns;
2. the patient or surrogate must provide informed consent to the transfer; and
3. the hospital must exercise due diligence to ensure that the patient's medical needs are met upon return.⁶

While the best interest of the patient should certainly be a top priority, disregarding the cost factor entirely is rarely possible, particularly for safety net hospitals that provide a much greater proportion of uncompensated care and are already stretched financially.

Policy approaches to medical repatriation

In light of the financial constraints hospitals currently face, it is likely that the practice of medical repatriation will continue unabated. While

the best interest of the patient should be the paramount concern, hospitals should consider the development of policies and protocols to address medical repatriation and begin systematic data collection on such cases.

Data would provide a measure of accountability to ensure that policies are being implemented equitably while also informing advocacy efforts to create funding streams to support hospitals in this effort.

Given its position at the nexus of immigration law and health policy, medical repatriation is a politically sensitive but increasingly common practice. It has faced strong criticism with some alleging that medical repatriation amounts to “international patient dumping.”⁷ In the absence of meaningful legislation or regulation, however, hospitals must take responsibility for developing policies that adequately balance the various legal and ethical issues at play. Policies that clearly define decision-making protocols and informed consent processes for medical repatriation would be an important first step and would clearly demonstrate institutional commitment to conducting medical repatriation in a just and ethical manner.

References listed on page 19.

*Lauren Levy, JD, MPH
Managing Director, Law & Health Care Program*

ANITA TARZIAN NAMED HASTINGS CENTER FELLOW

Dr. Anita Tarzian has been elected a Hastings Center Fellow in recognition of her contributions to the field of bioethics. Dr. Tarzian is an associate professor at the University of Maryland School of Nursing in addition to her role as Program Coordinator for the Maryland Healthcare Ethics Committee Network.

Dr. Tarzian has worked as a research and ethics consultant since earning her doctoral degree in nursing ethics in 1998, providing guidance and consulting services in clinical ethics, research ethics, and research methods. Her scholarship, teaching, and mentorship have centered on clinical ethics (including the development of national standards for health care ethics consultation), palliative care, end-of-life care, disability rights, among other areas.

Professor Diane Hoffmann, Director of the Law & Health Care Program and founder of the Maryland Healthcare Ethics Committee Network, said of Dr. Tarzian's appointment, "This is well deserved recognition of Dr. Tarzian as a leader in the field of bioethics. In addition to her active and extensive involvement in clinical ethics consultation, she is an accomplished researcher whose work has contributed significantly to national and international discussions of some of the most challenging ethical issues in healthcare."

Founded in 1969, the Hastings Center is an internationally recognized bioethics research institution dedicated to the examination of fundamental ethical issues in health care, science and technology. Dr. Tarzian joins a community of more than 200 individuals who have been recognized for their scholarly contributions to the field of bioethics.



CALENDAR OF EVENTS

FEBRUARY

28 – March 3: 28th Annual APPE International Conference sponsored by the Association for Practical and Professional Ethics, Baltimore, MD. Visit: <https://appe-ethics.org/2019-call-for-proposals-2/>.

MARCH

21-22: Vulnerability and Presence: Sixth National Nursing Ethics Conference, Los Angeles, CA. Visit: <http://ethicsofcaring.org/>.

21-22: Deeply Rooted: Healthcare Ethics in an Era of Change, Healthcare Ethics Consortium 2019 Annual Conference, Atlanta, GA. Visit: <https://hcecg.org/event-2970721>.

28-30: Conflict Resolution and Clinical-Setting Mediation for Healthcare, sponsored by the Center for Conflict Resolution in Healthcare, Memphis, TN. Visit: www.healthcare-mediation.net.

28-30: 8th International Health Humanities Meeting, Chicago, IL. Visit: <https://healthhumanitiesconsortium.com/conferences-2/2019-chicago/>.

MARCH

29: The Ethics of Seeking and Assessing "Quality of Life," Annual Medical Ethics Conference sponsored by the University of Pittsburgh Center for Bioethics & Health Law, Pittsburgh, PA. Visit: <https://bioethics.pitt.edu/consortium-ethics-program/cep-calendar>.

APRIL

5-6: Reproductive Ethics Conference, sponsored by Alden March Bioethics Institute, The Desmond Hotel, Albany, NY. Visit: <http://www.amc.edu/Academic/bioethics/>

11-12: Pushing the Boundaries: Scientific Innovation and Biomedical Ethics, sponsored by Cincinnati Children's Hospital, Liberty Township, OH. Visit: <https://cchmc.cloud-cme.com/default.aspx?P=5&EID=26366>.

11-12: Controlling Death: Ethics, law, and the health professions, sponsored by Harvard Medical School's Center for Bioethics, Boston, MA. Visit: <http://bioethics.hms.harvard.edu/annual-bioethics-conference>.

13-15: Age and Longevity in the 21st Century: Science, Policy, and Ethics, Sponsored by the Global Bioethics Initiative, New York, NY. Visit: <http://globalbioethics.org/upcmnevents/>.

CALENDAR OF EVENTS

APRIL

25-26: Patient-Centered Medicine, Annual John Collins Harvey Lecture & 6th Annual Pellegrino Symposium, Sponsored by Georgetown University's Center for Clinical Bioethics, Georgetown University Hotel and Conference Center, Washington, DC. Visit: <https://clinicalbioethics.georgetown.edu/pellegrino-seminar-and-harvey-lecture>

29 – May 3: Bioethics Intensive Course, sponsored by the Houston Methodist Hospital & The Center for Medical Ethics and Health Policy at Baylor College of Medicine, Houston, TX. Visit: bcm.edu/ethics/bioethics-intensive.

MAY

3: Communicating About Values and Valuing Communication in Healthcare, sponsored by the University of Pittsburgh Center for Bioethics & Health Law, Pittsburgh, PA. Visit: <https://bioethics.pitt.edu/consortium-ethics-program/cep-calendar>.

15-17: 7th Annual Conference of the Academy for Professionalism in Health Care, New Orleans, LA. Visit: <https://www.academy-professionalism.org/>.

22-25: The 15th Annual International Conference on Clinical Ethics & Consultation (ICCEC), Vienna, Austria. Visit: <http://iccec2019.org/>.

RECURRING EVENTS

Johns Hopkins Berman Institute of Bioethics Seminar Series & Ethics for Lunch series, either at Sheik Zayed Tower Chevy Chase Conference Center (1800 Orleans St.) Room 2117 or Feinstone Hall, E2030, Bloomberg School of Public Health (615 N. Wolfe St.) Baltimore, MD. 12N-1:15PM.

Visit: <http://www.bioethicsinstitute.org/educationtraining-2/seminar-series> & <http://www.bioethicsinstitute.org/efl>

February 25: Diane Meier, MD, FACP, Hutzler-Rives Memorial Lecture: “Ethical Principles in Action: Palliative Care and People Living with Serious Illness” (Zayed)

March 4: Dominic A. Sisti, PhD, Director, Scattergood Program for Applied Ethics in Behavioral Health Care, University of Pennsylvania (TBD)

March 11: David S. Jones, MD, PhD, “Must Innovators Study the Unintended Consequences of New Therapies? Lessons from Cardiac Therapeutics” (Zayed)

March 25: Marion Danis, MD, “Engaging the Public in Setting Health Care Priorities” (Feinstone)

April 8: Brian Carter, MD, Hutzler-Rives Memorial Lecture: “Insights from patienthood: A pediatrician and bioethicist’s reflections on pediatric palliative care” (Zayed)

April 22: Effy Vayena, PhD, “Digital Health Ethics: The Systemic Oversight Approach” (Feinstone)

May 13: Holly Fernandez Lynch, JD, MBE, “Evaluating IRB Quality and Effectiveness” (Feinstone)

Also visit <http://www.bioethicsinstitute.org/efl> to view topics for the Ethics for Lunch series every third Tuesday from 12:00 to 1:15 pm (Zayed). Co-sponsored by Johns Hopkins’ Hospital Ethics Committee & Consultation Service and Berman Institute of Bioethics. CME & lunch provided!

Continuing Education 1-hour Online Programs provided by the Medical Ethics & Health Policy department of the University of Pennsylvania: Children’s Roles in Medical Decisions, Ethics of Human Research, Neuroethics, & Tarasoff Duties. Visit: <https://www.med.upenn.edu/ethics-and-policy-online/continuing-education>.

The Maryland Healthcare Ethics Committee Network (MHECN) is a membership organization, established by the Law and Health Care Program at the University of Maryland Francis King Carey School of Law. The purpose of MHECN is to facilitate and enhance ethical reflection in all aspects of decision making in health care settings by supporting and providing informational and educational resources to ethics committees serving health care institutions in the state of Maryland. The Network attempts to achieve this goal by:

- Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution act consistently with its mission statement;
- Fostering communication and information sharing among Network members;
- Providing educational programs for ethics committee members, other healthcare providers, and members of the general public on ethical issues in health care; and
- Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland.

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support.

The Ethics of Medical Repatriation (continued from page 15)

References

1. Seton Hall University School of Law Center for Social Justice and New York Lawyers for the Public Interest. (2012) *Discharge, Deportation, and Dangerous Journeys: A Study on the Practice of Medical Repatriation*. Accessed on December 14, 2018 at: <https://law.shu.edu/ProgramsCenters/PublicIntGovServ/CSJ/upload/final-med-repat-report-2012.pdf>.
2. Stead, K. (2010) Critical Condition: Using Asylum Law to Contest Forced Medical Repatriation of Undocumented Immigrants. *Northwestern University Law Review*, 104: 307-333.
3. Deborah Sontag, *Deported in Coma, Saved Back* in U.S., N.Y. Times, Nov 9, 2008, at A1.
4. Nessel LA. (2009) The Practice of Medical Repatriation: The Privatization of Immigration Enforcement and Denial of Human Rights. *Wayne Law Review*, 55: 1725-1756.
5. Cantwell P. (2012) Relevant “Material”: Importing the Principles of Informed Consent and Unconsciousness to Analyze Consensual Medical Repatriations. *Harvard Law & Policy Review*, 10(1), 249-262. Accessed on December 14, 2018 at: http://harvardlpr.com/wp-content/uploads/2013/05/6.1_11_Cantwell.pdf.
6. Mark Kuczewski, M. (2012). Can Medical Repatriation Be Ethical? Establishing Best Practices. *The American Journal of Bioethics*, 12(9), 1-5. <https://doi.org/10.1080/15265161.2012.692433>
7. Smith, JM. (2010) Screen, Stabilize, and Ship: EMTALA, U.S. Hospitals and Undocumented Immigrants (International Patient Dumping). *Houston Journal of Health Law & Policy*, 10: 309-358.

**The Law & Health Care Program
Maryland Health Care Ethics
Committee Network
University of Maryland
Francis King Carey School of Law
500 W. Baltimore Street
Baltimore, MD 21201**

**SUBSCRIPTION ORDER FORM
THE MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER**

NAME _____

ORGANIZATION _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE/FAX NOS. _____

E-MAIL _____

No. of Subscriptions Requested:
_____ **Individual Subscriptions** @ \$35/yr. _____ **Institutional (MHECN
non-member) Subscriptions**
@ \$90/yr. (up to 20 copies)

Please make checks payable to: *The University of Maryland*
and mail to: The University of Maryland School of Law
Law & Health Care Program - MHECN
500 West Baltimore Street
Baltimore, MD 21201

For information on MHECN membership rates, contact us at
MHECN@law.umaryland.edu, or (410) 706-4457 or visit <http://www.law.umaryland.edu/mhecn>

**All correspondence
including articles, cases,
events, letters should
be sent to:**

**Diane E. Hoffmann
Editor
The Mid-Atlantic Ethics
Committee Newsletter
University of Maryland
Francis King Carey
School of Law
L&HCP
500 W. Baltimore Street
Baltimore, MD 21201
E-mail: [dhoffmann@
law.umaryland.edu](mailto:dhoffmann@law.umaryland.edu)**