The 14th Congressional District's
Student Advisory Board

Health and Medical Ethics

2004 Annual report

Saturday, May 15, 2004

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Introduction
Preeti Piplani, Student Advisory Board Chair

Over the past academic year, the members of the Student Advisory Board have explored modern medical ethics. As non-voting constituents, we are appreciative of this chance to share with Congresswoman Eshoo our perspective on pressing issues pertaining to healthcare. It has been a valuable opportunity to voice the concerns and views of her youth constituency.

Within the overarching topic of healthcare, there are countless potential avenues of research. In light of the upcoming presidential election, members of the board feel that it is necessary to tackle the increasingly important ethical issues within the topic of general health.

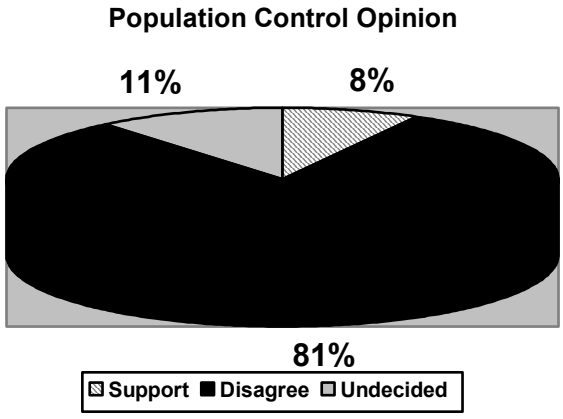
Research advances and new technology have contributed to significant medical gains, but they have also raised pressing ethical questions. In this report, the Student Advisory Board has researched eight topics in an attempt to gain insight into these issues. Specifically, our research has focused on stem cell research, genetic research, medicinal marijuana, euthanasia, abortion, AIDS, patients' rights, minors' rights and a survey of our peers' opinions.

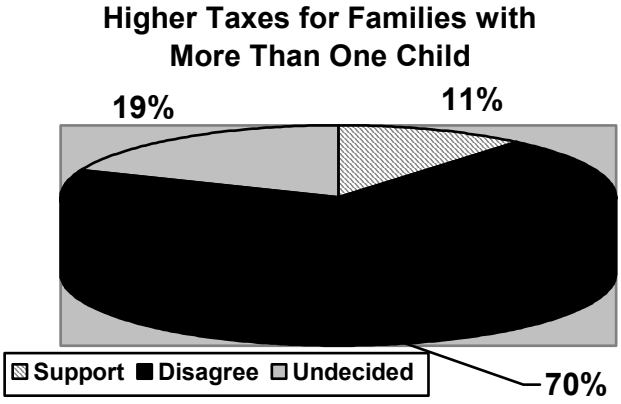
Survey Group
Meredith LaSala
Chris Curd
Aaron Wyse

Introduction

Our group was in charge of organizing a survey and handing it out to some high schools within the 14th Congressional District. First we acquired the questions from each of the individual groups of the Board. We then narrowed the questions down to the best inquiries that could provide strong statistical backing to represent the information being presented. This proved to be a difficult task at some times to get all of the groups deadlines of questions in on time, and check the questions with the others several times for their approval. We interviewed a total of one hundred and thirty-six students with all of our surveys, so we will able to reach quite a few students in our time constraints. We will now address some of the conclusions that we arrived at in each of the different subjects, based on our research.

Population Control

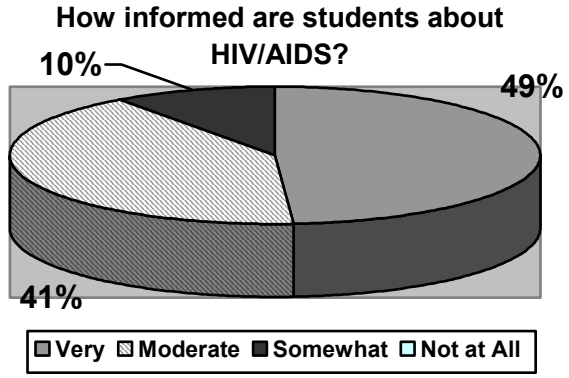


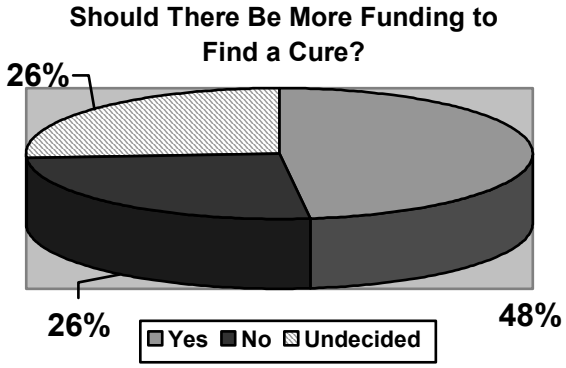


We discovered that an overwhelming percentage of students were opposed to population control. In addition, we also discovered that almost three-fourths of the

students interview believed that it was unjust to enact financial measures designed to penalize those families who had more than one child to support, as in the policy in China.

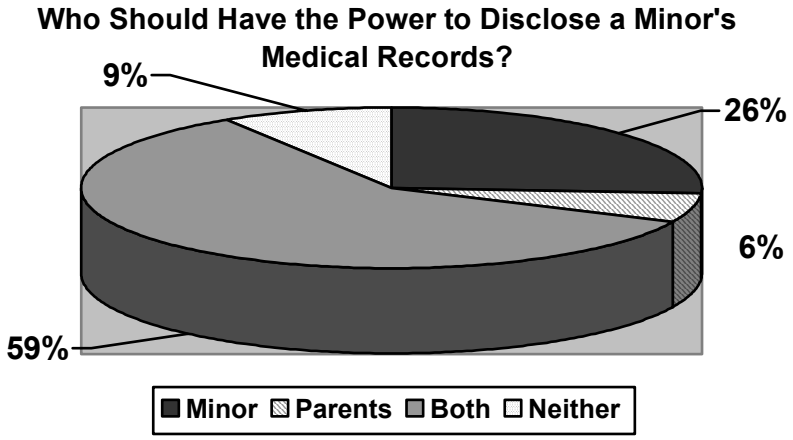
HIV/AIDS





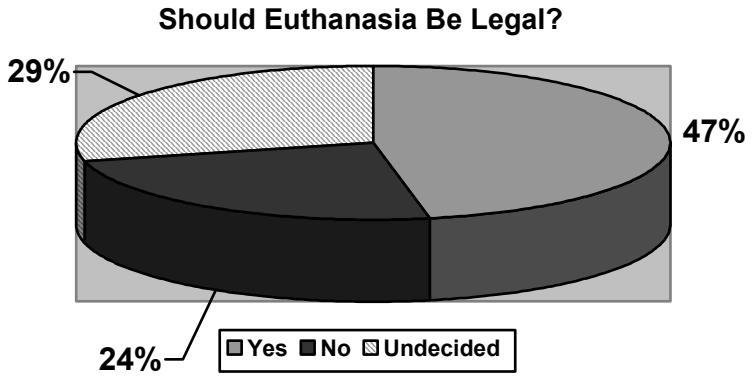
Most students believed that they were at least "moderately" informed about HIV/AIDS effects and consequences. Not one student indicated that they knew nothing about AIDS. Furthermore, almost half of all the students interviewed believed that AIDS was such a serious epidemic that the government should provide more funds to find a cure.

Minors' Rights



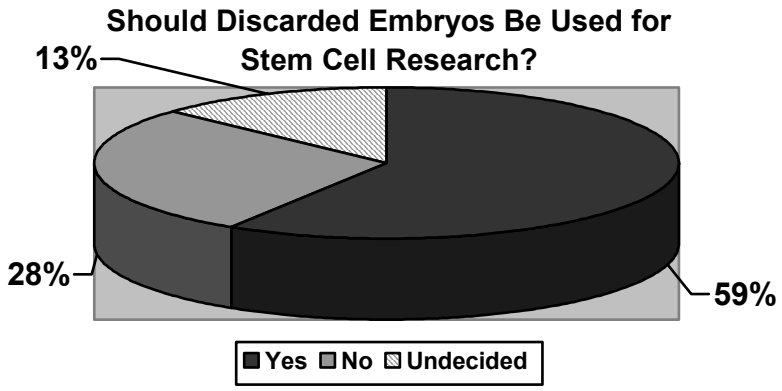
We were not surprised when we discovered that most students wanted some control over their medical records. It is interesting to note however that only about a quarter of students want total control, while a little over half want to share control with their parents. We found this to be interesting, because it indicated to us that students still believed that their parents should be involved in their medical affairs. Conversely, we also discovered that a huge proportion of students believed that minors did not need a parent's consent to an abortion.

Assisted Suicide (Euthanasia)



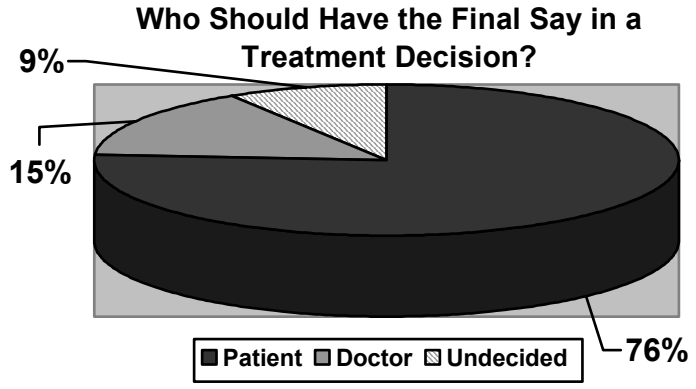
Our research indicated that about half of all students believed that euthanasia should be legalized, with approximately a quarter dissenting and a quarter undecided. However, when asked that if someone they knew chose to be euthanized, over half of all students said they would be opposed. This indicated that students were tolerant of the legalization of euthanasia, however, if one of their friends or family members decided to kill themselves, they would be opposed. This contrast was one of the most interesting dilemmas we ran across throughout our research.

Stem Cell Research



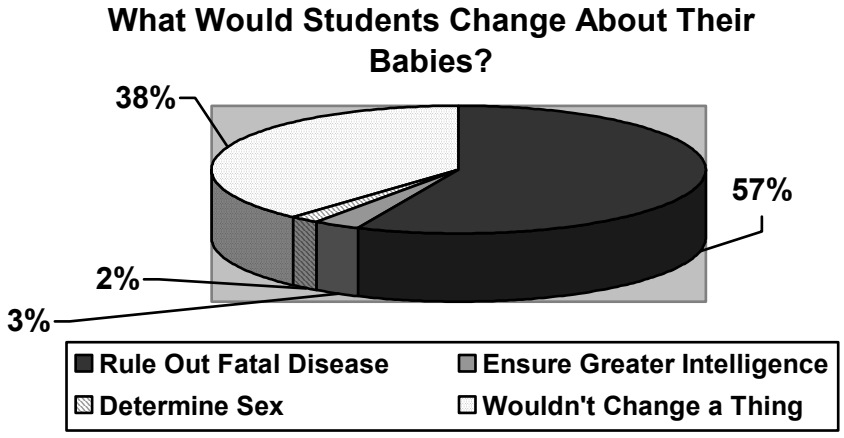
Many students believed that there could be serious negative effects from stem cell research; however, over half of all students supported the use of discarded embryos to be used to further stem cell research. Furthermore, students believed that stem cell research did not involve religion, as fifty percent of students indicated that if they opposed stem cell research, it was not due to their religious beliefs. There was a lot of non-response in this section, most likely due to its lack of public attention and knowledge about the issues. Therefore, students were not as informed as we originally assumed.

Patient's Rights



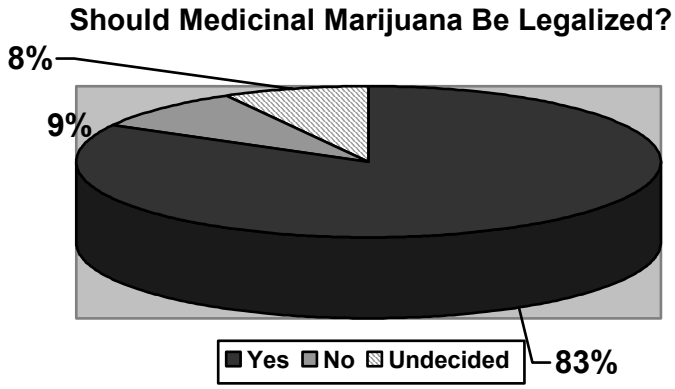
We discovered that an overwhelming number of students believed that the patient should have the final say in medical treatment decisions, preferring to trust themselves over the medically trained doctors. We found this somewhat surprising, as we believed that most of the students would trust in the doctor's medical expertise to prescribe the right treatment. Obviously, the doctor-patient relationship is not as strong as it used to be. We also discovered that over half of all students believed that the government and private providers should manage healthcare, but exclusive management power should be given to neither. Students felt that equal management would provide them with the best service.

Genetic Research



Over half of all the students interviewed would not change anything about their baby, even if they had the opportunity, due to either religious or moral reasons. Those that would change something about their baby opted to rule out fatal disease instead of insuring greater intelligence or determining the sex or physical traits. In addition, the majority of students felt that parents with genetically linked diseases should be required by law to test their children for those same diseases. Clearly, students were alarmed by diseases infecting their children and wanted to take whatever measures were necessary to combat them.

Medicinal Marijuana



The majority of students almost unanimously were supportive of distributing marijuana for medicinal purposes to those who were suffering from a variety of diseases. In terms of our research, this was the most forceful response among all the questions asked. For those that were opposed, the majority opposed the use of medicinal marijuana because they feared that it had the potential for abuse. Ironically, not one student opposed the use of marijuana because of its lack of medicinal value. Apparently, students feel that it will obviously alleviate the suffering of patients, but it may lead to other dangers.

Conclusion

The medical field is constantly evolving and improving. With this evolution, controversial issues will arise. The survey group has come to the conclusion that the consensuses among high school students that we surveyed suggest the medical field should proceed with caution and thoroughly study the ethics that surround their work and findings. Ultimately, our generation will be faced with finding answers to medical ethics questions that we face today

Genetic Research

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Genetic engineering is defined as the direct manipulation of genes for practical purposes. The following will describe the advantages and disadvantages of genetic engineering and research as well as the ethical issues that arise as a result.

Advantages of Genetic Research and Engineering

During a time of great scientific advancement in the many fields of genetics, the question of whether the advantages of genetic research outweigh its disadvantages is a question which potentially prevents or hinders further research. The advantages, however, of genetic research are manifold, and they, with the right regulations, may lead to innovations beyond our current imaginations. Among these innovations are the ability to compile a criminal database based on DNA.

Currently, all fifty states have passed laws requiring convicts to provide the government with a sample of their DNA whether it is blood, hair, or another form. The collected DNA is analyzed at thirteen different points and placed in a digital database. Later, when crimes are committed, the DNA information is checked against DNA that is collected at the crime scene. If the DNA does not match any of the 210,000 members of this database, it is called a cold hit. There have only been around 600 cold hits to date. Currently, there is no single gene identified with crime, but there are potential groupings of genes which may be a sign of violent or criminal behavior. These groupings, however, are very complex to disentangle, therefore making the process of finding these groupings extremely difficult.

Genetic research may also be used to test for and research certain genes and their influence in causing genetic defects. These genes would first have to be discovered by genotyping, and later, they could be manipulated in order to have their effects determined. When the effect of the gene is determined, it may be altered or removed. Current genetic diseases that can be tested with the aid of genetic research include Alzheimer's disease, inherited breast cancer, Cystic fibrosis, Fragile X syndrome, and Huntington's disease

The altering or removing of genes in order to delete a genetic disease is an extremely difficult process. This process can only take place during the embryonic stage of a child’s existence. If not done at that time, the gene must somehow be altered individually. Altering genes individually would mean going through fifty billion cells, taking the gene out of each one. With further research, the removal of the genes at later stages may become quicker and more efficient.

Disadvantages of Genetic Research and Engineering

One problem with genetic research is the fact that if all the gene's that cause diversity and disease are found and then corrected, there will be no diversity in the world. America prides itself on diversity and by getting rid of certain diseases and certain types of skin or eye color there would be no diversity left. Scientists have recently made it possible to expecting parents to choose the sex of their baby. This also leads to the possibility that parents will be able to choose characteristics for their unborn children such as eye color or hair color.

Another issue that would result from genetic engineering would be further division of society by incomes. Because a majority of procedures are extremely expensive only a person of moderate to wealthy income would be able to afford the procedure.

A concern with genetic engineering and research is the protection of doctors who would administer these procedures. Important questions are posed such as: Who would be responsible if something went wrong? The parents or the doctors? Knowing the risks involved, the parents chose to have the procedure done, but are they responsible if something were to happen or are the parents able to sue the doctors for malpractice.

With genetic research comes the issue of privacy. Once genetic research is perfected it is probable that any person's DNA may be decoded and understood. If insurance companies receive genetic information and discover that a person is going to get cancer at the age of 40, the company may make one of two negative decisions. Companies may (1) not want to insure the person or (2) raise insurance rates due to the fact that it is known their client is going to have a disease. A second aspect of the privacy issue is the fact that companies may decline to hire someone who is sick or will be known to become sick while working for the company.

Ethical Concerns of Genetic Engineering

Fairness and Privacy

Fairness in the use of genetic information is a major ethical concern of the public. The primary public concerns are that (1) insurers might use genetic information to deny, limit, or cancel insurance policies or (2) employers might use genetic information against existing workers or to screen potential employees. Because DNA samples can be held indefinitely, there is the added threat that samples will be used for purposes other than those for which they were gathered. Included in this concern is the issue of privacy and confidentiality: should individuals be required to release their genetic information to their insurance companies, employers, or even the government upon receiving test results?

Coverage and Regulation

In most cases, an individual will have to contact his or her insurance provider to see if genetic tests, which cost between $200 and $3000, are covered. Usually insurance companies do not cover genetic tests, those that do will have access to the results. With the high price of genetic testing comes the question of what role the government should play in assisting individuals who can not afford testing. Furthermore, there are no regulations in place in the United States for evaluating the accuracy and reliability of genetic testing. Most genetic tests developed by laboratories are categorized as services, which the Food and Drug Administration does not regulate. This lack of government oversight is a troublesome in light of the fact that a handful of companies have started marketing test kits directly to the public. There is a fear that individuals who purchase such kits will not seek out genetic counseling to help them interpret results and make the best possible decisions regarding their personal welfare.

Clinical

Even if individuals visit health clinics, there is no guarantee that genetic tests will be reliable or even properly evaluated. Effective methods for spreading information collected from various medical researchers and publications need to be utilized. There is an obligation to educate doctors and other health service providers, patients, and the general public in genetic capabilities, scientific limitations and social risks.

Gene Therapy

Gene therapy is a technique for correcting defective genes responsible for disease development. Though the Food and Drug Administration has not yet approved any human gene therapy product for sale, the new technology will likely hit the markets in the near future. With the onset of this technology comes an important question: Who has the power to decide which disorders or disabilities require gene therapy? Are disabilities diseases that need to be prevented? Also, to what extent is society prepared to alter the imperfections of future generations? Where is the line between medical treatment and enhancement? For example, should parents be allowed to insert genes into their children that make them more athletic?

Recommendations

Insurance Discrimination

- Insurance providers should be prohibited from using genetic information or an individual's request for genetic services to deny or limit any coverage or establish eligibility, continuation, enrollment, or contribution requirements.

- Insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services.

- Insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information. Insurance providers and other holders of genetic information should be prohibited from releasing genetic information without the individual's prior written authorization. Written authorization should be required for each disclosure and include to whom the disclosure would be made.

Workplace Discrimination

- Employers should not require or request that employees or potential employees take a genetic test or provide genetic information as a condition of employment or benefits.

- Employers should not use genetic information to discriminate against, limit, segregate, or classify employees in a way that would deprive them of employment opportunities.

- Employers should not obtain or disclose genetic information about employees or potential employees under most circumstances.

Role of Government

- Set up a federally funded program to expand the education of doctors, patients, and the public on genetic capabilities, scientific limitations and social risks of genetic engineering.

- Encourage the Food and Drug Administration to strictly regulate both genetic test kits as well as any human gene therapy product.

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Straughan, Robert. "Ethics, morality and animal biotechnology". Biotechnology and Biological Sciences Research Council, 2000. 24 Feb 2004 <http://bioresearch.ac.uk/browse/mesh /detail/C001738 7L001738 7.html>.

Examines the ethical, moral and social issues surrounding relatively recent developments that involve the genetic modification of animals, and cloning by nuclear transfer.

Hunt, Robert and John Arras. Ethical Issues on Modern Medicine. Palo Alto: Mayfield Publishing, 1977.
Takes a look at the ethical issues in biological engineering, focusing on positive and negative eugenics.

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Stem Cell Research

Mark Stefanski
Hannah Tsui
Christie Richards
Alia Salim

Introduction and Scientific Background

Stem cell research is, at its core, a scientific practice that has only recently been thrust into the political arena. Without a doubt, a scientific foundation rests beneath all debate and legislation that grows out of this issue. Therefore, an understanding of the science behind stem cell research is not merely a helpful reference but more of a prerequisite for legislating it.

To begin, the definition of a stem cell is an undifferentiated cell that has the ability to develop into any specialized cell (Johnson). In other words, a cell is considered a stem cell if it does not have a predetermined fate. A stem cell, for example, can develop into parts of the body as diverse as the epidermis, the epithelial lining of the respiratory system, and the skeletal system.

Stem cells are classified as totipotent or pluripotent. A totipotent stem cell has the capacity to start the development of a human independently (Duffy). A pluripotent stem cell, on the other hand, can develop into any type of tissue but is too advanced in development to give rise to a human like a totipotent stem cell (Duffy). Despite their differences, both types of stem cells are useful to scientists in the field, and both have the highly practical tendency to regenerate extensively in a laboratory setting (Fischbach and Spiegel).

The means of obtaining stem cells are varied, spanning both the ethical spectrum and the life cycle. Researchers harvest pluripotent embryonic stem cells from the morula, the structure that follows the zygote in development and exists with fewer than 128 cells until four days after fertilization (The Visible Embryo). The often equally useful totipotent stem cells can be harvested up to six days after fertilization from a structure called the blastocyst (The Visible Embryo). For this reason, one-week embryos created by in-vitro fertilization or left over from abortions and miscarriages are prime sources of stem cells (Johnson). Though miscarried embryos appear to be the most ethical source here, even earning the support of President George W. Bush at one point, they are too often marred by genetic defects.

Stem cell lines, researchers' current source of choice for stem cells, are subject to speculation over their number and quality. The National Institutes of Health Registry once listed 78 stem cell lines though now only lists nine (Johnson). President George W. Bush capped the number of stem cell lines open to federal funding in the country by executive order in his August, 2001 address (Johnson).

The potential applications of stem cell research are far-reaching. Stem cells may aid in the study of diseases and genetic defects by revealing how fetal development goes astray and leads to deformities in humans. They have already been transplanted to repair bodily damage via nuclear transplantation technology, which has the explicit support of 40 Nobel Laureates. Stem cells may serve as cures for, among other conditions, Huntington's, Alzheimer's, cardiovascular diseases, type 1 diabetes, burns, osteoarthritis, and baldness (Duffy). The very doctors studying stem cells could aid their own research

by using stem cells to test the toxicity of medicines, possibly making animal and human testing phases obsolete (Fischbach and Spiegel).

So far, developments in stem cell research have only begun to creep towards their full potential. Nevertheless, these initial steps in recent years have begun to hint at the power of this technology. For example, researchers have successfully experimented with parthenogenesis, which induces cell division chemically (Johnson). Such a process will be instrumental in any effort to produce stem cells on a truly massive scale. Scientists have harvested stem cells from cattle and mice, possibly opening the door to non-human stem cell sources that will likely be more acceptable to the public (Johnson). In addition, Advance Cell Technologies has used nuclear transplantation technology to make "heart patches" – parts of the heart – and miniature kidneys, both of which were compatible with the human immune system (Lanza and West).

It is important to include in this discussion the debate over adult stem cells, which, though often seen as the solution to the ethical firestorm, are dubious in their scientific value. These adult stem cells assume the structure and physiological role of a type of cell that is in short supply, usually following an injury (Fischbach and Spiegel). However, stem cells are widely thought to be present in a more fundamental and useful variety in embryos. That is, there might not be *adult* stem cells that can develop into *any* specialized cell type, making them different from the truly versatile embryonic stem cells (Fischbach and Spiegel). For example, adult stem cells may *only* develop into epidermis but not the lining of the liver. Furthermore, they are often present in small numbers, which is compounded by the fact that they cannot reproduce as extensively as embryonic stem cells (Fischbach and Spiegel).

Technical difficulties, in addition to legislation and public pressure, are obstacles to the realization of the hopes of stem cell researchers. Tissue rejection problems occur when stem cells are derived from other individuals, and stem cell division must last long enough to produce a sufficient number of stem cells (Johnson). Even worse, determining and influencing the exact type of cell a stem cell will develop into is difficult to achieve (Fischbach and Spiegel).

Stem Cell Legislation

The diversity of public opinion about this controversial and sensitive topic manifests itself in heated Congressional debates, many pieces of legislation, and passionate lobbying on behalf of interest groups.

The Clinton administration's *Dickey Amendment* restricted Health and Human Services funding for cloning and stem cell research and prohibited the creation of embryos for scientific purposes (National Institutes of Health). State legislation includes Gray Davis's *Involving Embryos and Prohibition of Human Cloning 2002 Bill*, which permitted research on stem cells from any source and directly contradicted the federal limits on stem cell research established by the Bush administration in 2001. On the other hand, in both Michigan and Virginia, all forms of cloning research were banned.

President Bush's August 2001 address defined the status quo of stem cell research. The address initiated the National Institute of Health (NIH) Stem Cell Registry**,** a collection of 78 stem cell lines derived prior to August 9, 2001, for use in federally-funded research and accessible to the public and scientists via the registry's website (NewsMax Wires). The lines were mainly composed of destroyed embryos lacking developmental potential. Criteria for embryos on the line included the informed consent

of donors, embryo creation only for reproductive purposes, and embryos in excess of clinical need. Federal funding of research using the existing stem cell lines was permitted (Press Secretary of the White House). The recent dearth and unsuitability of the lines, which has caused a shortage in available stem cells, has caused controversies in the scientific and general communities.

This address also prohibited the destruction of additional human embryos and poured $250 million of federal funds into stem cell research from other sources, such as the umbilical cord blood, placenta, and adult and animal tissues (Naral Pro-Choice America). In addition, the *President's Council on Bioethics* was established to monitor stem cell research and recommend guidelines and regulations. Chaired by Dr. Leon Kass, it consists of leading scientists, doctors, ethicists, lawyers, and theologians. On February 13, 2002, the council voted unanimously against reproductive cloning, or human-being cloning, but could not agree on therapeutic cloning, or cloning embryos to generate specific tissues or organs.

Another key piece of national legislation was the *Human Cloning Prohibition Act of 2003*, through which the cloning ban's effects reached stem cell research. Currently, the FDA's *Center for Biologics Evaluation and Research* issues guidance for new stem cell policies based on the latest research.

Arguments in Favor

In the United States alone: Approximately 4.5 million people are afflicted with Alzheimer's disease (Alzheimer's Association); an additional 18.2 million suffer from diabetes; 1.5 million have Parkinson's disease (Centers for Disease Control and Prevention); and an estimated 250,000 are living debilitated by severe spinal injuries (Centers for Disease Control and Prevention). As diverse as these ailments are, those affected by them all share a common hope that medical advances may one day be able to improve or even cure their conditions. Encouragingly, scientists have made impressive strides toward developing cures for these and many other afflictions through the study of stem cells. However, the current administration's unethical and hostile stance on stem cell research is blocking further progress toward these goals.

President George W. Bush has endorsed a policy that severely interferes with the medical community's ongoing quest to save and better the lives of the American people. As Jeffery D. Rothstein, Professor of Neuroscience and Neurology and Johns Hopkins University stated,

> The political environment only acts to stagnate this vital medical research. Without appropriate funds and availability of scientific access to a wide range of stem cells, this research will move at an agonizingly slow rate and patients will continue to die (Stem Cell Help).

Stem cell technology has already led to the development of life-saving medical practices, such as bone marrow transplants for leukemia sufferers and advanced skin grafting methods for burn victims (Stem Cell Research Foundation). The value of this research has thus been proven, and its future potential appears almost boundless. Until the field has been thoroughly explored, it is impossible to predict to what extent stem cells can be used to save lives. Therefore, the government has a responsibility to the millions of citizens suffering from what may prove to be curable diseases to allow scientists to

pursue their studies in stem cell technology unfettered by politically motivated restrictions.

Those who argue that it is enough to allow the use of adult stem cells (as opposed to embryonic stem cells) are as guilty of obstructing medical progress as those who seek to disallow the research entirely. While adult stem cells do hold promise, scientists agree that embryonic stem cells have significantly more potential to cure disease—they are more likely to be free from genetic defects and "can grow and differentiate into any of the body's cells and tissues and thus into different organs" (Coalition for the Advancement of Medical Research). Many such embryonic stem cells that could be used in research would in any case otherwise go to waste—leftover embryos from the in-vitro fertilization process are frequently discarded or frozen indefinitely (Stem Cell Research Foundation). If the option exists between allowing human embryos to perish altogether and using them in potentially life-saving research, the government should clearly encourage the latter choice.

Far from placing restrictions on stem cell research, the government should do everything possible to further its advancement through public funding. Government funding adds to the quality and professionalism of scientific research, and, most importantly, ensures that any medical developments yielded from the studies are harnessed for the greatest possible public good (Goldstein). In the interest of protecting human life by curing disease, the government must develop a policy more favorable toward the science of stem cell research. Withholding support, both material and political, from this promising scientific field is both highly illogical and morally questionable.

Arguments Against

The source of stem cells is often what is most detestable about this field of research. Stem cells can come from pluripotent or totipotent embryos, aborted fetuses, miscarried embryos, embryos created by in vitro fertilization, the umbilical cord, and adult bone marrow (Johnson). The greatest controversy however occurs when stem cells come from pluripotent or totipotent embryos, aborted fetuses, or miscarried embryos. People usually are against the use of stem cells if they come from these sources mainly because they are against abortion. When one uses the embryos for stem cells one must kill the embryo first – the embryo is living once it is conceived. This is plausible to believe because the embryo has all of the potential DNA to become a human so it is just an early stage of life (Hinman). Since it is a stage of life though, it should be respected and given the same rights as any fully formed person (Hinman). If you were to kill the embryo to use it for stem cell research you would be murdering the person. This is the same case with aborted fetuses. In addition, killing embryos and fetuses for stem cell research is immoral because it is killing a person for the benefit of another person and the embryo is just as important as the fully formed person. The end does not justify the means, so therefore we should not use embryos and aborted fetuses for the purpose of stem cell research. The arguments against using miscarried embryos, which dies naturally, is clear: These embryos may have genetic defects that could be transferred on to the stem cell recipient (Johnson). The worry of using adult sources is that if they are not taken from the person who would be receiving them, then further health risks could

be caused if the body were to reject the cells (Johnson). These are the most controversial issues surrounding stem cell research.

Aside from these arguments, if stem cells are taken from the umbilical cord, the adult who will be receiving them, embryos created by in vitro fertilization, or by nuclear transplantation technology, most are supportive of stem cell research (Hinman). It is a promising science and, if handled responsibly by taking the cells from less controversial sources, people are supportive of the research.

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Patients' Rights

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The topic of patient's rights is extremely broad, but for the purposes of our exploration, our committee focused on the positive advances brought by the passage of HIPAA, the balance between patient's rights and the costs of malpractice lawsuits, the debate over the Patient's Bill of Rights, and the state of patients' relationships with their healthcare providers.

I. Health Insurance Portability and Accountability Act

Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in August 1996 in order to amend the Internal Revenue Service Code of 1986. This act, a landmark in the patient's fight for privacy and control of the medical records, gives patients increased control over their private health information (PHI), defined as any identifying characteristic or condition used in the health care field. Under HIPPA, patients must receive a written statement of the organization's privacy practices at each visit and be informed of any disclosure of PHI to an outside party. Patients may also ask for revisions to their records, "access, inspect, and copy their records" (Graul), and control the use of their PHI.

HIPAA also calls upon the Department of Health and Human Services (DHHS) to pass and enforce new rules to standardize the formats of many health care transactions, to create "unique health identifiers", and to create higher security standards for the transmission of PHI. In response, the DHHS made three rules. The Privacy Rule was published in December 2000 and requires the "appropriate technical and physical interception of PHI" (Graul) when regarding physical or mental health or when created by or received by a health care provider. The rule includes written, verbal, electronic, and photographic information and was made effective in April 2003. The Security Rule was published February 2003 and standardizes protocol for protecting patient information, especially using electronic signatures, to ensure that all patients enjoy the same level of security. The DHHS also published the Electronic Transaction and Code Sets (TCS) Rule to standardize the formats of many transactions. While this rule, effective October 2002, does not directly affect patients, it ensures that the health system will be coordinated so as to provide the best possible service.

The DHHS also implemented strict civil and criminal consequences for violating the rules, ensuring that the new regulations were taken seriously. Violations of the TCS, Security, or Privacy Rules results in civil fines reaching $25,000 per year for each violated standard. Violating the Privacy Rule intentionally for "commercial or malicious purposes" results in criminal penalties of one to ten years in prison and $50,000 to $250,000 in fines (Graul).

The entire health service community has been affected by HIPAA. Even the Palo Alto Fire Department Explorers, 14-18 year olds trained in emergency medicine and

basic fire operations, had to revise their entire system of documenting patient care and draft a written notification of their procedures for patients. Measures to ensure compliance are often costly and inconvenient for all organizations, but the benefits of the act are well worth the effort.

II. Malpractice lawsuits and patients' rights

The issue of medical malpractice reform is becoming an increasingly heated debate. Skyrocketing insurance prices have forced many in the medical field to change practices or close doors permanently. Many Americans are left with few options for medical care, and cases of mothers crossing into border-states for prenatal care are not unheard of. These factors have pushed medical malpractice to the foreground of the debate over patient's rights; Congress is forced to confront the issue of whether there should be a cap on non-economic injuries for victims of medical malpractice, or if there is another solution. Either way, the country is in dire need of a response from Congress.

California was one of the first states to address the issue, which its Medical Injury Compensation Reform Act of 1975 (MICRA). Essentially, what the act did was place a $250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries. A non-economic injury is an injury that does not result in a tangible bill; examples include loss of fertility, severe disfigurement, and the death of a child or senior citizen. Furthermore, it established both a statute of limitations on which malpractice victims can seek retribution, as well as a sliding scale for attorneys' fees that limited the amount of money lawyers can collect from their customers.

Thirteen years after this legislation was placed into law, an initiative which liberal lawmakers felt better addressed the ballooning insurance prices was placed on the ballot. In a statewide referendum, California voters passed Proposition 103 in 1988. It rolled back insurance rates 20% for all property and casualty insurers—including medical malpractice insurers—and froze those rates for a period of one year. The proposition went on to create the office of Insurance Commissioner as an elected position. This person was given the authority to approve rate changes of insurance companies. The proposition went on to allow consumers to challenge rates and forced insurance companies to refund billions of dollars to policyholders for inflammatory rates. The proposition had deep-seated impacts; within three years of its passage, total medical malpractice premiums had dropped by 20.2%. Furthermore, whereas malpractice premiums had generally tracked the nationwide average in the period of 1975-88 (under the jurisdiction of MICRA), insurance premiums dropped dramatically following Proposition 103 and avoided the bucking national trends.

On the national scene, most recently Congress saw the Help, Efficient, Accessible, Low Cost, Timely Healthcare Act of 2003 (HR 5) in March of 2003. The bill's sponsor, Rep. James C. Greenwood (R-PA), claimed that the bill did essentially the same things as California's MICRA. It established a $250,000 cap and established a sliding-scale for attorney's fees as well. Although both bills put the cap on damages at $250,000, MICRA was over 25 years ago. And in 1975 dollars, $250,000 would be around $900,000 today. The bill passed the US House of Representatives; the Senate has yet to pick up on it.

While Republicans point to California's relatively stable medical field as a sign of the effectiveness of MICRA—and caps on non-economic injuries—careful analysis of the data trends shows that real results were felt as a result of Proposition 103 instead. If Congress wants to fully address the issue of ballooning insurance premiums, they need not look further than insurance providers.

III. The Patient's Bill of Rights

Our Patient's Rights group investigated the Patient's Bill of Rights and the differing versions in the House and Senate-passed bills. Both bills had similar purposes of guaranteeing access to needed health care professionals, requiring continuity of care protections, and providing a fair and effective appeals process to address health plan grievances.

In the *McCain-Edwards-Kennedy Bill* of the Senate, patients were given the following rights: to have their medical decisions made by a doctor, see a medical specialist, go to the closest emergency room, designate a pediatrician as a primary care doctor for their children, keep the same doctor throughout their medical treatment, obtain the prescription drugs their doctors prescribe, access a fair and independent appeals process if the care is denied, and hold their health plan accountable for harm done. This version is preferable to the version passed in the House, as it sets a minimum of rights that the states can build upon, rather than setting a maximum. It also holds HMOs accountable to a greater extent than does the House version. The House version also offers unfair advantages to the insurance companies. Also, the Democrats' bill in the Senate covers over 150 million Americans; while the Republicans' House Bill would only cover the 48 million Americans currently in employee-funded health plans.

The AFL-CIO is also working to make their own Patients Bill of Rights that guarantees consumers the right to seek an external review when they disagree with a decision of their health plan, to hold health care plans accountable when patients are harmed, to protect health care workers from employer retaliations when they raise concerns about patient care, and to ensure that consumers have access to emergency care, prescription drugs, and opportunities to participate in clinical trials.

The Patients Bill of Rights is a valuable piece of legislation that can be beneficial to many generations, and the Senate Bill provides a means for the best bill to be passed.

IV. Patient-Doctor relationships

Patient-doctor relationships are very important in today's medical world. A good patient-doctor bond is often built on trust and experience. But the most vital part of the entire relationship is communication. Both the physician and the patient need to communicate their agendas in the beginning stage of the consultation process. Agreeing on the right treatment plan for the physician's needs, but more importantly the patient's, is vitally important. Patients should never feel obligated to do anything that they feel uncomfortable with and should, regardless of the situation, request a second opinion from another physician.

A physician's job throughout the treatment process is to meet with the patient initially, assess the status of patient, and improve that status after the chosen treatment plan is executed. A good physician needs to be an active listener and should encourage the patient to tell his story of the problem. A physician must also be empathetic and demonstrate an understanding of the patient's pain and distress while maintaining an

objective and observant stance. They must also be able to educate the patient when dealing with important and complex parts of procedures or other medically related concerns. This education involves a dialogue where the physician elicits the patient's thoughts, feelings, and beliefs and then provides new information consistent with the patient's needs and interests. And lastly the physician should be able to confidently reassure the patient and legitimize his concerns or worries without offering false information.

The patient, on the other hand, must initially provide the right information. This includes all health records as well as any other important medical information (allergies, date of last surgery, etc). It is also important that a patient asks questions because ultimately the patient is responsible for consenting to undergo the form of treatment that his doctor has discussed with him. It is important that the patient has a voice in the selection of the health plan or procedure that best suits him. Open communication about the proposed treatment is vital, and it is imperative that the patient tells his physician if they think for any reason they cannot commit to the proposed plan of treatment. Patients are also responsible for the financial responsibilities and lifestyle changes they may encounter because of the treatment.

It is important to always maintain a positive, healthy, and close relationship with your physician at all times. A good relationship will benefit both parties and will help in the future with any other medical problems or needs.

In conclusion, after our months of research, the members of this committee developed an understanding of the status of patient's rights in California and the United States. HIPAA is an excellent example of Congress' commitment to the patient's right to privacy and the optimal level of service, especially with the clear penalties for violating the DHHS rules. However, when delving into the issues of malpractice and patient's rights, the Patient's Bill of Rights, and patient-doctor relationships, we see room for improvement. Congress should focus on the role played by insurance companies in malpractice lawsuits when trying to regulate the costs of malpractice lawsuits. California actually sets a great example with Proposition 103 and this successful legislation should not be disregarded when drafting new laws. As for the Patient's Bill of Rights, we find the Senate version to be very thorough and certainly superior to the House version of the Bill. The responsibilities of both doctors and patients must be emphasized and taken seriously in order to provide the best possible treatment and experience for the patient. We are very encouraged and optimistic about the progress made in the issues of patient's rights and are confident that these modifications are well on their way.

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Minors' Rights

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Liesl Pollock
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As our world continues to become more technologically advanced, ethics in the medical fields are continually questioned, by citizens and their governments. It is imperative that ethics are continually observed, and that minors be able to continue receiving care. In order to thoroughly explore the issues behind minor's rights in relation to medical ethics, the "Minors' Rights" sub-committee has divided the topic into two major sectors:, access, and confidentiality. We have thoroughly explored both pro and con arguments for access and confidentiality. Through our research we have come to conclusions and one final recommendation for Congresswoman Eshoo as to our position on minors rights in relation to medical ethics.

Pro Argument- Access and Confidentiality:

Confidentiality is a right to which all minors are entitled. Thirty-one states have passed laws that require minors to notify their parents or legal guardian if they seek an abortion, alternate reproductive services, substance abuse treatment for venereal disease and alcohol abuse, parental care and contraception. Eleven of these states enforce the law.

There are several reasons why these laws are ineffective and sometimes even dangerous. 1) The laws are overly optimistic. They try to reinforce a good parent/child relationship; unfortunately they do not do so. 2) Texas has the third highest rate of subsequent births. (25%). Texas also has had the second lowest decline in teen birth rates (-18%). Pregnant teens are less likely to utilize the services available if they are required to notify their parents than if they had the freedom to exercise their right to confidentiality and access.

Most teens that decide to keep their pregnancy a secret from their parents usually do so for a legitimate reason. Requiring teens to notify their parents of use of contraception, abortions and other services puts them in danger of physical and sexual abuse.. There are legal ways of obtaining an abortion or other reproductive services with out the concern of a minor's parent. The most common is the Judicial Bypass. Yet, this method is extremely complicated, time consuming, and expensive. If this method is chose, it quit possibly may lead to altercations between guardians and children, and may cause more controversy. It is also necessary for the minor to explain possibly embarrassing details of their sexual activity to a judge. This is a long and expensive process that is extremely difficult to go through, especially if the financial state of the minor is precarious. Forcing the teen to wait to have an abortion also puts her at a higher risk for possible complications.

It is true that the health of minors is often put in the hands of their parents. Parents ultimately decide the medical fate of their children. Because there is much moral

stigma around issues related to sexual activity, parents are not always ready to make the correct choice for their child. A teenager is much more capable to make that personal decision and might not have the same views or feelings as their parents. In order to have an effective system it is imperative that minors have the right to access reproductive services, and the right to confidentiality.

Con Argument- Access and Confidentiality:

Minors, defined as those under the age of eighteen, lack the maturity and awareness to knowledgeably make decisions that deal with abortion or other serious health issue. They generally do not have a comprehensive study of the consequences that result from the practice because of lack of education and experience. Instead, minors seek the practice rashly in order to pursue their current interest—avoidance of being discovered as pregnant. Though certain minors may seem to understand, their parents' experiences invariably surpass theirs. Because of this and the general interest of parents to protect their children, the States must seek parental consent in allowing minors to have access to abortion procedures in order to ensure the best interests of the minors.

The foremost concern with minors in dealing with such practices is their safety. It has been shown that many who seek abortions do so "as a form of birth control rather than preventing health risks."[1] Studies of the rates of illegal abortions when parental consent is required are inconclusive for the following reasons, as stated in Deborah Haas-Wilson's article in the *Journal of Human Resources*:

1. "State abortion policies are continuously changing and previous empirical analyses of the impact of abortion restrictions cover only a short period time, in most cases one year.
2. Many states have enacted parental involvement restrictions, but never enforced those restrictions or enforced them for only a short period of time. Previous research does not distinguish between enforced and un enforced restrictions.
3. The published research does not take into account un measurable taste factors, such as anti- or pro-abortion sentiment, and thus suffers from omitted-variable bias"[2]

Thus, many contradictory statistics have been found. Regardless of the statistics, parents generally offer the best counsel to their children since they have an involved interest in the welfare of the children Some argue that physicians have a better ability to treat and inform minors, which ensures the minors' privacy. However, the U.S. Supreme Court

[1] Charles A. Barbour, and William F. Shughart II, "Legal institutions and abortion rates in Mississippi," *The Cato Journal*, v18 i1 (1998): p 119, 7 March 2004 <http://0-web7.infotrac.galegroup.com.scpl.ci.santa-clara.ca.us/itw/infomark/341/201/44011540w7/purl=rc1_ITOF_0_A54134560&dyn=30!xrn_4_0_A54134560&bkm_30_4_11?sw_aep=scci_main>.

[2] Deborah Haas-Wilson, "The impact of state abortion restrictions on minors' demands for abortions," *Journal of Human Resources*, v31 n1 (1996): p140, 7 March 2004 <http://0-web7.infotrac.galegroup.com.scpl.ci.santa-clara.ca.us/itw/infomark/341/201/44011540w7/purl=rc1_ITOF_0_A18331030&dyn=30!xrn_11_0_A18331030&bkm_30_4_11?sw_aep=scci_main>.

has stated, "[i]t is cardinal with us that the custody, care and nurture of the child reside first in the parents."[3] Minors may not understand the reality of the consequences of abortion despite having been told by the physician. Therefore, in order to prevent minors from rashly choosing to have an abortion and thus endangering of their lives, parental consent in dealing with such a measure must be enforced. Such enforcement will also prevent cases in which a minor has been taken to have abortion by the adult who impregnated her so that he could not be committed of statutory rape by the minors' parents.

It may be argued that not all parents seek to protect the welfare of their children. There have been cases where minors have sought abortions without their parents' knowledge because of fear of punishment. However, these minors are protected under the law. In such cases, a judicial bypass can be sought: "The US Supreme Court has consistently required state laws which mandate parental notification prior to an abortion performed on a minor to provide for the waiver of that notice in exceptional circumstances. This waiver is made at the discretion, usually, of a Superior Court judge and is based upon the substantiated claims of the minor that she is emancipated or abandoned, that she is subject to abuse or maltreatment by her parents, or some other concern for her welfare."[4]

This leads to the question of how such a policy is to be implemented. All minors should be protected from the dangerous practice of abortion, thus each state should not be able to arbitrarily decide what is safe for the minors living in it since every minor faces the same risks. The United States federal government must protect every minor.

In conclusion, the Student Advisory Board of 2003/2004 feels that it is imperative for minors to have both access to necessary medical procedures, and to be guaranteed confidentiality. As minors representing the fourteenth congressional district, it is important that our confidentiality be kept in order to prevent avoidable altercations with guardians. As new technology emerges, and medical procedures become increasingly safe and easy to obtain, it is important that minors have control over their own bodies, and records that pertain to them. We thank Congresswoman Eshoo for her continued support for minors, and for being our voice in Congress.

[3] "Mandatory Parental Consent to Abortion," (JAMA. 1993; 269; 82-86) © 1992-1993.

[4] *Integrated Medical Curriculum*, 2003, Gold Standard Multimedia, 7 March 2004 <www.imc.gsm.com/demos/dddemo/consult/bypass.htm>.

Abortion

Abortion Background: Nikki Perlman

For centuries women had no rights to abort a fetus or unborn child, even if a woman had serious health issues related to the birth of that child. However, in the 1960's with the birth of the women's rights movements, and in 1973 with *Roe v. Wade*, a woman's right to have an abortion and choose the fate of her child, as well as the fate of herself, was ruled constitutional. Over the years however, *Roe v. Wade* has been constantly challenged by anti-abortion groups who work to increase legislation limiting access and rights to abortions. Debates have continued over issues such as the necessity of parental consent and the stage of pregnancy in which abortions are legal. The most important cases came in *Danforth v. Planned Parenthood of Missouri* in which women in some states could receive abortions without the consent of a husband and *Harris v. MaCrae* in which it was ruled that the Hyde amendment, which cut almost all federal funding for abortions, was constitutional. Most recently, pro-life forces have seen the "Partial Birth Abortion Ban Act" of 2003 pass in Congress, which makes illegal intact dilation and extraction, a form of abortion where the fetus is halfway out of the womb before the abortion is preformed.

Marcella Padilla

Pro-choice means it is the woman's right to choose, "my body my choice". Whether or not a woman chooses to go through with a pregnancy is a private decision to be made by her, her family, and her doctor and the government should not intervene in the process. Regardless if her reasons to terminate the pregnancy are because of health risks emotional issues, financial issues or the fact that the pregnancy is simply undesired it is ultimately her choice. We as a country cannot impose our own moral beliefs regarding what we believe to be right and what we believe to be wrong. It is her choice. To not allow women to make their own decisions regarding their own reproductive health is a blow against women's rights and a woman's reproductive freedom.

The partial birth abortion ban or intact dilation compromises a woman's health. There are several reasons why intact dilation should be performed. For example the fetus is dead. The fetus is so malformed that it can never gain consciousness and will die shortly after birth. The fetus is alive, but continued pregnancy would grievously damage the woman's health and/or disable her. The fetus is alive, but the woman wishes to end the pregnancy for non-medical/psychological reasons. Whatever the reasons may be it is her choice. We must remember that the right to privacy is a fundamental right. The freedoms to decide whether or not to have a child and to make medical decisions that affect your health are the most important individual freedoms. This country was founded on the idea of personal freedoms and autonomy. The government must respect the individual's privacy right over these types of personal decisions.

Con Abortion- Pro Life argument

Pro-Life

The pro-life argument rests mainly on the claim that abortions are immoral and murderous. Pro-life advocates claim that abortions are not only harmful to the unborn

fetus, but also mentally damaging to the woman who opts to go through with the procedure. Their next argument rests with the fetus itself. Pro-life advocates see the unborn fetus as a child, a human being, which would make it, like any human, have the right to live. This right, according to pro-life activists, is a fundamental aspect of our society, one that is protected by law for our older citizens, and therefore should be protected by law for our unborn citizens. This argument is brought up with even more strength when discussing intact dilation or abortions where the baby is half way out of the womb before the abortion is performed. Intact dilation, banned by the "Partial birth abortion act" of 2003, gives new strength to the rights of a fetus that pro-lifers advocate. In this case, the fetus being already halfway out of the womb is a visible human and therefore is being murdered.

Hilary Englert

The Partial Birth Abortion Act of 2003 passed in the 108th Congress states that the partial birth abortion is a "gruesome and inhumane procedure that is never medically necessary and should be prohibited." In part of the bill it states that "the facts indicate that a partial -birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care," and therefore is never acceptable. Even more recent legislation in the House of Representatives (HR 3719) and in the Senate (S 2020) is the Freedom of Choice Act, introduced to the Senate by Barbara Boxer, which takes the stance that "reproductive health decisions are best made by the woman, in consultation with her medical provider or loved ones, without governmental interference." Those supporting this bill, including Senator Diane Feinstein, feel the Constitution supports the "right of every woman to weigh the personal, moral, and religious considerations involved in deciding whether to commence, prevent, continue, or terminate a pregnancy." The debate between the legality of the partial-birth abortion, or abortion at all, revolves around the question of whether or not the government has the right to regulate the choices of a woman in relation to her pregnancy.

Ellie Childress

Our stance on this issue is supporting the women's right to choose. Pregnancy and abortions are personal experiences that should not be regulated by the government. There are many different reasons why a woman may feel she should have an abortion. She may not be financially or emotionally prepared to start a family, she may have been raped, and she may need to have an abortion to remain healthy. All of these reasons are personal and private; the right to decide how someone's life should be led is not up to the government to decide, the choice should be left up to the woman whether or not she will have the child. Over the past years legal abortions have become more available, giving women more control over their own lives. This right is being threatened by pro life advocates who do not feel a woman should have the right to choose. Taking away women's right to have an abortion would be like taking a huge step backwards for America, taking away a right that gives women control over their own future.

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AIDS
Sarah Shakour
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Molly Gingras

International Legislation:

Just recently, the U.S. passed a $15 billion, five-year U.S. Emergency AIDS relief program that will help provide aide to nations struck by health problems, primarily AIDS. $350 million is ready for release to fourteen AIDS stricken nations which include: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia.

This long-range plan is to provide treatment to two million HIV-infected as well as prevent seven million new HIV infections. This plan is also to provide care to ten million affected by AIDS, notable children.

These fourteen countries, two in the Caribbean and twelve in Africa, account for more than 50 percent of the world's AIDS infections. Five billion dollars will go to provide continuing support approximately 100 nations where the United States currently has built HIV/AIDS programs. And one billion will go support another committee that Secretary Tommy Thompson chairs, Global Funds to Fight AIDS, Tuberculosis and Malaria.

The United States intent has been to move quickly to bring relief to these devastated countries struck by AIDS. These areas were chosen because they were paralyzed by the high devastation due to AIDS. The programs specific recipients already have programs built in place that can continue and have the capacity to rapidly scale up operations so that the U.S. can bring immediate help.

Within this framework, hopefully the U.S. will strive to coordinate and collaborate efforts to respond to local needs that will vary from different countries and also hopefully implement their strategies within these programs.

Women and International AIDS

Every country around the world has problems with AIDS and HIV. Half the world population affected are women. The United Nations has said that 26.6 million adult and children have AIDS in Sub-Saharan Africa. Women in other countries, such as Africa, need as much medical resources as they can receive. In Kenya, about 27% of women do not receive any formal education (Reproductive Rights). Poverty is also a key factor that leads many women to becoming commercial sex workers (Women of World). Without having any knowledge of what to do when being molested, the number of rapes gradually increases. Kenya alone has a strong violence problem, for there were around 454 rapes reported.

President Bush has set three pillars in his African Policy, but have any of them truly been enhanced? In the principles of bilateral engagement, the President's plan proposed an economic reform. Promote health and education (Washington Government). Why is still more than half of Africa not educated and the disease is spreading rapidly. Americans have to live up to our word and help these countries. President Bush announced in his 2003 State of the Union Address, the Emergency Plan For AIDS Relief (PEPFAR). To help the people of Africa...I ask the Congress to commit $15 billion over the next five years...to turn the tide against AIDS in...Africa. The money is to be spread out in different categories. The White House has already purposed that with this funding, we would be able to prevent 7 million new infections by performing regress testing. This plan would also treat 2 million people who are already infected with AIDS. The PEPFAR treatment will be focused on 15 countries, and 12 of them are sub-Saharan African countries.

American foreign policy should focus more on those people who are already affected by the disease than trying to find new types of infections. Sure, we will have more knowledge about it, but what good does that do us? We still don't have a cure for AIDS. In President Bush's act, he also stated that the price of ARV drugs has dropped increasingly, from $12,000 to $300 per year. But only 50,000 people of the 29.4 million people who are affected by Aids in Africa are receiving the treatment. The US should find other means of ways to help this country by giving them help. The act does say that there will be doctors in hospitals with the highest degree in their training, but how will the women in Africa be able to see these doctors if they can't afford them.

One of the countries that President Bush seeks to help in the fight against Aids is Kenya. In 1993, the Kenya National Aids Control Program estimated that 841,700 people were infected with HIV. About 75% of those people got HIV through heterosexual intercourse. Because of the rapid growth, Kenya has imposed laws regarding HIV/Aids. Some of the rules within these laws seem reasonable, while others are isolating people who are infected. For example, if a person who is suffering from [Aids] willfully exposes themselves in public without proper precautions, or enters any public conveyance without previously notifying the owner, or driver of their condition, that person is guilty of an offense and is liable to a fine or imprisonment (Women of World.) How can a country put up such a rule like that? They are basically telling these poor people that whenever being with others, you have to share with these strangers that you are infected with Aids. That takes away the freedom that President Bush imposed in one of his three pillars.

It has been said by the United Nations Development Fund for Women that young women who are the ages of 15-24 are twice are likely to tested positive for HIV than their male partners. Women may be seen vulnerable to HIV, and they are unable to protect themselves for they do not have the information or confidence to do so. In Africa, the diagnosis for Aids is considered as a death sentence and it is that reason that many women do not seek treatment. A doctor in South Africa has said, we have no medicines, many hospitals tell people, you've got AIDS but we can't help you, go home and die (Whitehouse.gov). So then how are these people suppose to get help if their own country sees them as bad people? Action should be then to make the leaders aware that if they continue with this type of ways and attitude, that they will not have a country to run anymore because all their people would be dead.

Federally Funded Sex Education and HIV/AIDS:

The Institute of Medicine noted in 2001that "investing hundreds of millions of dollars of federal and state funds…in abstinence-only programs with no evidence of effectiveness constitutes poor fiscal and health policy." Abstinence-only education programs are based on the idea that they can stop teenagers from having sex entirely, but there is no evidence to support this. Rather, these programs simply delay sexual activity while increasing students' risk of pregnancy and sexually transmitted diseases because of their failure in, and indeed prohibition of, educating the students about safe and effective contraceptives.

To wit, the results of a study by Northern Kentucky University showed that 61% of college students who had pledged to remain abstinent until marriage broke that pledge, and also that those students were less likely to have used condoms when they did have sex that students who didn't take the pledge. A similar study by Columbia University showed that students who had been through virginity pledge programs were 30% less likely to use contraceptives when having sex.

A study by John B. Jemmott, published in the *Journal of American Medical Association* found that both safe sex programs and abstinence-only programs were successful in delaying sexual activity in the short term, the safe sex programs were actually more effective in the long term in reducing unprotected sexual intercourse and frequency of sexual intercourse. The study drew this conclusion: "Our finding that the safer-sex intervention curbed unprotected sexual intercourse, whereas the abstinence intervention did not, suggests that if the goal is reduction of unprotected sexual intercourse, the safer-sex strategy may hold the most promise, particularly with those adolescents who are already sexually experience." So abstinence-only education programs neither prevent students from having sex before marriage nor reduce the incidence of unprotected sex.

Numerous federal public health organizations, including the National Institutes of Health and the U.S. Centers for Disease Control and Prevention advise proper condom instruction for adolescents in order to reduce risk of STDs , including HIV/AIDS.

Moreover, abstinence-only programs directly impede access to information about HIV/AIDS and contraceptives. Charmaine Heimes, a master teacher in Laredo, Texas, told Human Rights Watch this in 2002: "We don't talk about HIV/AIDS prevention except to say 'remain abstinent until marriage and once married, be monogamous with your spouse.' We don't talk about contraception or condoms because that would be crossing the line that the state or federal guidelines have set. We don't mention the word "condoms" at all. If a student brings it up, he's directed to speak with other people, like his parents or a counselor."

One typical federally funded abstinence-only program is the McLennan County Collaborative Abstinence Program (McCap). Watch summarized the thoughts of McLennan County teacher Sally Flemming: "She noted that she cannot say, 'use a condom to prevent HIV' or 'if you use condoms, your chances are better of avoiding disease,' and cannot tell her students that they 'need to use something to prevents HIV and STDs.'" Teachers under the McCAP program are also instructed to teach that condoms don't work either for pregnancy prevention or for STD prevention, and teachers recalled trying to avoid saying that condoms are better than nothing.

That's no the least of it, either. Federal abstinence-only movements not only give support to abstinence-only programs, they also crowd out legitimate safe sex programs. For example, the Office of Inspector General of the U.S. Department of Health and Human services (DHHS) has been auditing federally funded HIV/AIDS prevention programs since 2001, often concluding that safe sex programs are supposedly "obscene" or that they encourage sexual activity.

In order to legitimately work to prevent HIV/AIDS and other serious STDs, the federal government must take steps to fund programs that provide adequate information about contraceptives and HIV/AIDS prevention.

Domestic AIDS legislation

In contrast to the massive federal budget allocation for fighting the AIDS epidemic internationally, the congress and the Bush Administration has left many AIDS patients in the United States fighting for access to good doctors and drugs. Currently, the Centers for Disease Control and Prevention (CDC) estimate that 900,000 U.S. residents are living with HIV infection, of whom more than 200,000 are unaware if their infection. When researching domestic legislation on AIDS funding allocated toward medication and patient care was difficult to find because there is not a lot of federal legislation on the topic, the one exception being the Ryan White CARE Act and from this the In August of 1990, Congress signed the Ryan White CARE Act and in doing so created a system of services that has greatly improved the quality and availability of health care services for people living with and affected by HIV and AIDS

Title I of the act provides grants in metropolitan areas where the epidemic has hit hardest. Services made available by Title I include outpatient health care, case management, home health and hospice care, housing, nutrition services and transportation. Title II provides funding to states and is used for such services as testing, education, and prevention, home and community based health care, medications through the AIDS Drug Assistance Program, also known as ADAP, local consortia that assess the needs of the HIV population and assist in implementation of services to meet those needs, and direct health support services. Title III provides for early intervention out-patient care for all persons living with HIV. Programs funded by Title IV, provide family centered care for children, women and families. The majority of people serviced by Title IV are poor, minorities, and have limited access to housing and transportation.

Named for Ryan White, the HIV positive teenager from Indiana who made headlines with his brave fight against ignorance and prejudice, the CARE Act funds a variety of health and social programs across the country, but the programs from this act are not receiving adequate funding to meet the need of HIV/AIDS infected patients in the United States. In almost half of the states, worthy applicants to the programs the act provides, especially the ADAP, have been put on lists, and told to wait while their T-cells slowly dwindle do to program budget restraints. Locally, on March 19th , House Minority Leader Nancy Pelosi (D-Calif.) has sent a letter to Health and Human Services Secretary Tommy Thompson calling for a "full explanation" of a $4 million reduction in San Francisco's Ryan White CARE Act funding, the *San Francisco Chronicle* reports. The city's grant amount for fiscal year 2004 is 12% less than the amount the city received in fiscal year 2003.

AIDS Drug Assistance Program from title II of the act, , provides life-saving medication to nearly 100,000 Americans living with HIV/AIDS each month, is not receiving enough funding from congress. The program needed a $215 million increase to keep pace with the growing demand, yet it only received a $35 million increase for fiscal year 2004. Without additional funding, approximately half of the programs in the country will start the new fiscal year with their doors closed to new clients. Americans living with HIV will once again start dying from preventable diseases in large numbers. Federal funding has shortchanged this program for years, resulting in people with HIV being placed on waiting lists to receive life-saving drugs. *To solve this problem, the ADAP budget must be substantially raised to $1 billion for 2005.*

We applaud Congress and Bush administration for their contribution to the global fight against AIDS with allocating $15 billion to Africa and the Caribbean, but what about the thousands of AIDS related deaths here at home that could have been extended and some prevented? We propose that the 108th congress allocate more funds to the ADAP and the other programs instituted by the Ryan White Care act of 1990 to continue to fight against the AIDS epidemic at home.

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Population Growth and Immigration in the United States

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Laura Vollmer

Population control and its related problems – migration, fertility, and environmental effects are very difficult to pinpoint or easily solve. At this point it is unclear just how many people the earth can sustain, but it is clear that population control will become an issue as the birth rates of developing nations rise. In order to slow global population growth, drastic measures, similar to the policies of China or India, would need to be taken. It is clear that the United States will likely serve as a leader on this international issue. On a domestic level, the United States must consider how to balance immigration and birth rates in order to maintin the quality of living for all Americans. At this time, the United States experiences one birth every nine seconds, one death every twelve, and gains one international migrant every twenty-five seconds, resulting in a net gain of one person every thirteen seconds.[5] The easiest and most feasible way to regulate population growth in the United States is to regulate immigrants.

The volume of legal migration has fluctuated since the 1930s. Immigration has accounted for an increasing portion of population growth as American women began having fewer children. Many foreigners also enter the country illegally each year. The exact number of persons migrating illegally to the United States is unknown, but estimates range from 100,000 to 500,000 per year. Today one-third of the U.S. population growth is from net migration. In 1998, 660,477 immigrants were admitted legally to the United States. The U.S. Census Bureau projects that the U.S. population will reach 403,687,000 by 2050. Of this projected growth, 36 percent may result from immigration, with 46,691,756 new immigrants being added in the next 50 years.[6]

As more and more immigrants enter the U.S. each year, both legally and otherwise, the effects on the quality and availability of health care are significant. The problems most often encountered by foreign persons seeking medical aid are a language barrier, lack of insurance, and, for illegal aliens, a fear of deportation if health services are regularly sought. Many in the U.S. Congress have tried to ameliorate the situation with little success, mainly because the immigrant population of the U.S. has no strong lobby or much bearing on voting. The problem is too important to be ignored due to political reasons, and action must be taken to bring quality health care to those citizens and non-citizens who are in need.

Non-white Hispanic immigrants currently represent the most significant ethnic group entering the United States. Last year, the foreign-born Hispanic population rose to

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[5] US PopClock Prediction, Maintained by Laura K Yax, <http://www.census.gov/cgi-bin/popclock>

[6] "Effect of Migration on Population Growth" http://www.prb.org/Content/NavigationMenu/PRB/Educators/Human_Population/Migration2/Migration1.htm

nearly 17 million[7], with millions more estimated to have entered the United States illegally. A significant percent of these people have little or no command of the English language, the primary language that health care is conducted in. Because they lack the ability to effectively communicate with their doctors, practitioners, and insurance companies, the non-white Hispanic population often goes without proper health care. While bilingual forms have allowed some to get care on a hospital by hospital basis, a national initiative to hire more bilingual health care workers would create a more effective environment for treating marginalized ethnic groups. In addition, government subsidies to medical and nursing schools could be award for educating students in a foreign language as well as in English. Because not all health care workers actually deal with patients directly, training a small percentage of doctors and nurses could solve the problem and allow more foreign-born patients to receive the proper health care.

Illegal aliens are often some of the poorest inhabitants of the United States, but are often the most in need. When it comes to health insurance, aliens are rarely insured, leaving the bill to be paid entirely on their own. Often what occurs in these situations is that the bill goes unpaid, and the hospital, county or state is forced to pay for the care. Another scenario is that the bill will be passed to insurance companies, forcing higher premiums for their paying customers. Federal funding to states with large illegal immigrant population specifically earmarked for immigrant-specific, affordable health insurance would keep costs to the consumers as low as possible while ensuring proper care for all. A discount could be offered on this state-sponsored insurance if the recipients took steps to become naturalized, so as to treat both the symptoms and the disease of costly health care.

A third problem arising with a large immigrant population is the fear of deportation overriding the need for health care. Illegal residents often ignore regular health evaluations because of government threats to track, register, and deport them. Though a vast majority of physicians do not agree with this practice[8], arguing that treatment should come before politics, many government leaders are proposing limiting the access to care[9] unless illegal residents are registered or deported. This raises many issues about the rights of illegal immigrants, but more importantly, leaves a gap in health services leaving millions more vulnerable to disease, injury, and death. A federal law outlining the medical rights of illegal immigrants, while allowing for a system to register their residing in the United States would take a middle road allowing for better health care and more accurate statistics on immigrant populations to better serve their needs.

These health issues are some of the most pressing of our time, because they concern a growing population that is losing its ability to stay healthy. Outbreaks of diseases, like AIDS or Hepatitis are bound to occur in these groups unless steps are taken to allow more preventative care and health education. It is impossible to ignore these

[7] U.S. Census Bureau, Current Population Survey, March 2002, Ethnic and Hispanic Statistics Branch, Population Division.
[8] http://www.acep.org/1,33421,0.html, American College of Emergency Physicians.
[9] http://phoenix.bizjournals.com/phoenix/stories/2003/07/14/daily52.html, Business Journal of Phoenix.œ

millions of people for political reasons and steps must be taken to ensure that they can live and contribute to our country while remaining healthy.

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Euthanasia

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Euthanasia means, essentially refers to, "the act or practice of ending the life of an individual suffering from a terminal illness or an incurable condition, as by lethal injection or the suspension of extraordinary medical treatment." (*www.dictionary.com)* The controversy over the morality of Euthanasia is dated back to the ancient Greeks. Because of the increase in death rate due to degenerative diseases, such as heart diseases and multiple sclerosis, this issue is highly debated over today. Despite its inadequacies, Euthanasia should be legalized specifically under strict regulations.

Different Forms of Assisted Suicide and Euthanasia

There are two types of assisted suicide and euthanasia: passive and active.

• **Passive** euthanasia is to bring along death by removing outside resources and support. Examples of passive euthanasia include removing life support machines and/or medications, starvation, and dehydration. A "do not resuscitate order" (a request to not use extraordinary means to revive or maintain life) is a form of passive assisted suicide.

• **Active** assisted suicide and euthanasia is to bring upon death by using outside resources and means. Examples are lethal injection and overdoses of medication.

The History of Euthanasia:

Euthanasia has been accepted in different forms by a range of groups in society and history. It dates back to the ancient Greeks and Romans; during these eras, limited forms of Euthanasia were considered acceptable; for example in Sparta, when infants were born with severe birth defects. Furthermore, voluntary Euthanasia was an approved custom for the elderly. However, as Christianity began flourishing in the west, it became improper. The ethical and moral aspects were questioned. As a result, the practice of Euthanasia was avoided. The issue reappeared in the 1930s. The first organizations arose promoting Euthanasia, however, had little impact on society. Eventually in the 70s, these associations started gaining influence internationally.

International and Federal Timeline:

1906 – Ohio introduces the first Euthanasia bill but is unsuccessful.
1935 – The world's first Euthanasia society is founded in London.
1967 – In Florida, Dr. Walter W. Sackett presents the first freedom to die bill. It brings about controversy, but is declined.
1969 – Idaho writes a bill attempting to pass Euthanasia, but it fails.
1973 – In the Netherlands, Dr. Gertruida Postma gave her dying mother a lethal injection. This issue was brought to court; she received a light sentence.
1975 – In New Jersey, Karen Ann Quinlan's parents disconnect the respirator. This initiated the movements, and New Jersey achieves success.
1975 – Dutch Voluntary Euthanasia Society was formed and launched its

Members' Aid Service to counsel the dying.

1979-80 – World Federation of the Right-To-Die Society is formed in Oxford. It was comprised of twenty-seven groups from eighteen different countries.

1984 – Netherlands Supreme Court legalizes voluntary Euthanasia under specific circumstances.

1987 – The California State Bar passes Resolution 3-4-87 and approves of only the slightest physician aid in dying.

1990 – Dr. Jack Kevorkian assists Janet Adkin's death. She suffered from Alzheimer's disease. Michigan legislature then tries to prevent him from assisting any other suicides.

1991 – The voters of Washington reject the ballot initiative 119. This resolution attempted to legalize Euthanasia.

1992 – Californian voters decline Proposition 161, which also tried to legalize Euthanasia.

1994 – Oregon passes Measure 16, which sanctions terminally ill patients, with legitimate authorities, to end one's life in a humane way.

1997 – The people of Oregon pass Measure 51, which permits Euthanasia.

International Standpoints:

Belgium: The law permits solely Euthanasia – not assisted suicide. They differ in that assisted suicide is ultimately performed by the person him or herself. A doctor, family member, or a person who has medical power of attorney is the one to carry out Euthanasia.

Switzerland: There are three Right-To-Die organizations that help terminally ill patients bring about an end to their lives. They insist on the medical certifications of the illnesses before proceeding. Lethal injections are banned here, and Euthanasia can only be committed with the intake of oral drugs in a drink or tablet form, or through a stomach tube. The person must be mentally capable at the time, and also an adult when requesting Euthanasia.

Germany: Euthanasia is illegal.

France: There is no specific law regarding assisted suicide or Euthanasia.

Holland: There are special laws for those between the ages of twelve and eighteen. There must be a third party involved in it, however, the person must also submit their consent.

"No foreigners are permitted to enter the country for the purpose and act of Euthanasia, however."

PROS:

Research has only buttressed the ethical benefits to Euthanasia. Provided is a list of pros for Euthanasia regarding the different aspects of it.

Firstly, this will reduce the patients' suffering and pain. When it has already been determined that the patient only has limited days, why should he or she still suffer and spend his or her last days in a helpless state? The expected counterargument is that it detracts from the true value of life; however, won't the patient only have better memories and a more positive outlook on life if he or she has only experienced the best? A

patient's last days should not be spent in pain. The patient can correspondingly die with dignity, rather than being reduced to a state of helplessness.

Furthermore, the right to die should be a fundamental freedom of each person. The constitution does not prohibit a person from committing suicide. Coinciding with this, is there truly a difference between suicide in a humane manner rather than a gruesome or painful one that may prove to be ineffective and even more detrimental? This is not something America would and should want to constitute. (Messerli, Joe. Should an incurably-ill patient be able to commit physician-assisted suicide?)

Health care and insurance costs will not rob the patients' penniless. Medical and insurance bills have inflated throughout the years. These bills are comprised of x-rays, lab tests, drugs, hospital overheads, medical staffs – where the prices are ranging from almost fifty to one hundred thousands dollars a year. If the patients wish to bestow their money upon their children or grandchildren, why should they be denied that over a life they, themselves, do not wish to live?

Euthanasia will only be an option to patients who do not suffer from any mental illnesses and wish to die. They themselves will have agreed to it and, ideally, no pressure from outside sources should be applied. Therefore, if such actions are passed, the doctors' and nurses' times will be freed up, and they can aid the savable and those who want to live. In addition, vital organs can be used and preserved for others who need them and can be saved.

Emotionally, the anguish the family members feel while watching the loved one suffer would incontrovertibly be mitigated. Preparing for one's demise rather than watching the pain and turmoil involved with death is an option preferred by many.

CONS:

Patients' rights: It has been argued that if assisted suicide were legalized patients with both physical and mental disabilities, would fall victim as a result of the laws. Disability groups against assisted suicide such as *Not Dead Yet* argues that the disabled would wrongfully receive euthanasia treatments out of pity, misunderstanding and uselessness in society. *Not Dead Yet* argues that disabled people already receive less adequate medical care due to these attitudes. There is also an argument that people suffering from mental disabilities and illnesses such as depression may not be capable of making reasonable decisions when given the option of assisted suicide.

Assisted suicide would go against the Hippocratic oath of doctors that states they are not to "play G-d" (Lasagna, Louis . Nova Online. Mar. 2001. Apr. 2004 <http://www.pbs.org/wgbh/nova/doct ors/oath_modern.html>). Also, a doctor's personal feelings could get in the way of giving accurate advice, especially if the doctor had a strong emotional attachment to the patient.

Insurance companies are charged the most for treatments given to patients in the last two to three weeks of life. According to *Costs and Patterns of Care at the end of life,* 27% of

the entire Medicare budget goes to 5-6% of benefactors in their last year of life. A chance to be saved from this "pointless spending" may motivate the companies to put undo pressure for assisted suicide on families, doctors and patients.

Many religions oppose assisted suicide and euthanasia because they believe G-d created life and should have the power to take it away. According to Religioustolerance.org, leaders of religions and churches such as Islam, Lutheran, Orthodox Christianity, Orthodox Judaism and Roman Catholicism, have spoken out against assisted suicide. Another reason many religions are against assisted suicide is because it leaves no chance for miracles.

Interesting Facts about Euthanasia:

- Women are more interested in undergoing Euthanasia than men are.
- As health care rises for the aged and disabled, Euthanasia is becoming a solution to contain health costs.
- Teens do not have the highest suicide rate, in fact, senior citizens do. (Messerli, Joe. Should an incurably-ill patient be able to commit physician-assisted suicide?)
  Relatives are more in favor of Euthanasia than patients.
- "Euthanasia is problem solving, by killing."
- A sick person's desire for suicide is transient.
- 93 to 94% of people who committed suicide suffered from an identifiable mental disorder.
- A study performed by the American Journal of Psychiatry showed that less than 25% of people with terminal illnesses wished to die – all of those had clinically diagnosable depression
- 47% of people who committed suicide were schizophrenic.

    - When a person tries to commit suicide, they usually do not do so again for another five years.

After research and discussions, as a group, we unanimously agree with Euthanasia. This report was written with the intent to inform and potentially get you to support Euthanasia, too.

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Medicinal Marijuana
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I. Legislative and Judicial History

Marijuana has a number of demonstrated medicinal uses, especially in the treatment of AIDS, glaucoma, cancer, multiple sclerosis, and epilepsy, and in as a tool to "relieve nausea, increase appetite, reduce intraocular pressure, reduce muscle spasms, and relieve chronic pain" ("Medicinal Marijuana"). In addition, the "National Academy of Sciences' Institute of Medicine (IOM) concluded that 'there are some limited circumstances in which we recommend smoking marijuana for medical uses' as the result of research funded by the White House drug policy office" ("Medicinal Marijuana").

The history of medicinal marijuana in the United States reaches back to the early part of the twentieth century. Although "until 1937, marijuana…was legal in the United States for all purposes…federal law [presently] allows only seven…Americans to use marijuana as a medicine" ("Medicinal Marijuana").

Before "1937, at least 27 medicines containing marijuana were legally available in the United States" by outfits like "Squibb (now Bristol-Myers Squibb) and Eli Lilly." The monumental act that first impugned the reputation of marijuana as a legitimate medicine was the Marijuana Tax Act of 1937 which "federally prohibited marijuana," which passed over the objections of the American Medical Association and its president, Dr. William C. Woodward. Nearly half a century later, access to marijuana was further inhibited by the Controlled Substances Act of 1970, which grouped marijuana in Schedule I, signifying that there was "a great potential for abuse, no accepted medicinal value, and danger associated with using it" ("Medicinal Marijuana"). This federal action both prohibited doctors from prescribing marijuana and curtailed federally funded research about marijuana's medicinal value. In 1972, administrative judge Francis L. Young ruled that marijuana be placed in Schedule II in order to permit research; his decision was overturned by the D.E.A. and the D.E.A.'s right to do so was upheld by a ruling the U.S. Court of Appeals, D.C. Circuit.

In 1975, the court victory of Robert Randall, a glaucoma patient arrested for growing his own marijuana, led to the creation of the Investigational New Drug compassionate access program, which allowed "some patients to receive marijuana from the government" ("Medicinal Marijuana"). The program was abolished in 1992, however, and in 1999 its closure was reaffirmed.

Supreme Court decisions have proved detrimental to the use of medicinal marijuana. For instance, in "*United States v. Oakland Cannabis Buyers' Cooperative*, [a case in which the government sued said cooperative, which had been approved by California voters], the Supreme Court ruled 8-0 against the manufacturing and distribution of marijuana for medical purposes." When the Court ruled on May 14, 2003, that "marijuana distributors and manufacturers do not have a medical necessity defense under the U.S. Controlled Substances Act" Justice Clarence Thomas wrote, "'It is clear from the text of the act that Congress has made a determination that marijuana has no medical benefits worthy of an exception'" ("Distribution of medicinal marijuana").

The American public has been consistently supportive of legalizing marijuana for medicinal uses, as demonstrated by the multitude of scientific polls conducted on the subject. A 1999 Institute of Medicine publication "public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally reported 60-70 percent of respondents in favor of allowing medical uses of marijuana" while "a study by the Harvard School of Public Health…published on March 18, 1998, in the *Journal of the American Medical Association*…analyzed the results of 47 national drug policy surveys [and] reports that more than 60% of the public support the 'legalized use of marijuana for medical purposes'" ("Appendix D").

Ultimately, the future of medicinal marijuana will be determined by the U.S. Congress, "although state legislatures have the authority to exempt patients from state prosecution for marijuana possession/cultivation and exempt doctors who recommend marijuana from prosecution" ("Medicinal Marijuana"). This is because of Congress' oversight authority over the DEA and the federal government's current prohibition of marijuana. Recent legislation in the House has attempted and generally failed to make headway in the fight to legalize marijuana. H.AMDT.297, an amendment to the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 2004 that was voted upon on July 23, 2003, would have "prevented the Justice Department from spending money to raid cannabis clubs in states that allow medicinal marijuana"; it failed by the wide margin of 152-273, suggesting that legislators are out of touch with the interests of their constituencies. H.R. 2233, the States' Rights to Medicinal Marijuana Act, which was introduced by Democratic Congressman Barney Frank of Massachusetts on May 22, 2003, is currently awaiting action in the Subcommittee on Health. This Act would transfer marijuana to Schedule II and allow states to form their own policies regarding marijuana, provided they do not legalize it for purposes other than medicinal ones (http://thomas.loc.gov).

II. Opponents and supporters of legalization:

There are very few organized activist groups who protest the legalization of marijuana. Many opponents cite reasons such as marijuana is a gateway drug and legalization will result in increased crime, youth usage, and more health problems for their position against legalizing marijuana (The Science of...). Other arguments against marijuana stem from ideology that other "approved drugs can meet the needs of patients" and do so without harming human organs ("Medicinal Use...").

Most support for the legalization of medicinal marijuana can be traced to a fundamental belief in its healing abilities. Supporters agree that marijuana successfully helps to reduce pain caused by a variety of chronic diseases ("Medicinal Use..."). Additionally, proponents believe that by legalizing marijuana for medicinal purposes there will be a reduction in crime for those who are caught in possession of marijuana. Furthermore, proponents source numerous credible studies that justify the benefits of marijuana to suffering patients. However, most opposition can be traced to the fundamental ethical debate of whether marijuana has medicinal value and if the benefits of legalization outweigh the potential for misuse.

While the issue of legalizing marijuana might appear to be initially a partisan decision, support for medicinal marijuana stretches far beyond political lines. Democrats,

Republicans and independents have rallied together to help further the fight for legalization. Historical support for legalizing medicinal marijuana has showed an unlikely bipartisan support from former Representative McKinney (R-Connecticut) and now from current Representatives Barney Frank (D-Massachusetts). However, there is still a growing increase in bipartisan support. In fact, in May 2003, Maryland Governor Robert Ehrlich (R) became the first Republican governor to sign a medicinal marijuana bill ("About the Marijuana..."). Similarly, various independent political parties have rallied to support legalizing marijuana. Among such groups is the Libertarian Party, a firm supporter of legalizing marijuana ("Should we...") The Libertarian platform calls for an end to prosecuting medicinal marijuana patients and repealing laws that prohibit the sale and consumption of marijuana ("A New...). Elected officials who support legalization include prominent Democrats and Republicans such as Representatives Barney Frank (D-Massachusetts), Gary Ackerman (D-New York), Tom Campbell (D-California), former Representative Martin Hoke (R-OH) and many others (thomas.loc.gov and "Members of…"). Financial support for legalization can also be found in activist groups such as the Marijuana Policy Project which spends approximately $9 million dollars in lobbying, publicity and projects supporting marijuana policy reform ("About the Marijuana...")

III. Student Recommendation

Legalization of marijuana for medicinal purposes marks a step forward for medicine. In continuous nonpartisan studies the medical benefits of marijuana have proven unmatched for several debilitating diseases. Although the possibility for misuse exists, the risks are no different than those compared to various other federally approved drugs on the market. Congress must continue the fight to legalize marijuana on a national level by enacting legislation to ensure the health of millions of Americans who can be helped with medicinal marijuana.

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Conclusion
Preeti Piplani, Chair

The 2003-04 Student Advisory Board's research marks only the beginning of the search for answers to the ongoing medical ethics debate. In upcoming years, the American people will address the ethical issues presented in our research both at the polls and in their own lives. This learning experience has challenged each member both morally and intellectually. In the process of writing this paper and formulating our recommendations, we, too, have been forced to examine our own beliefs. This emerging topic will have continued relevance in our lives as we become voting citizens. As a result of this research, we will be better qualified to make decisions that affect the rights of every American.

Once again, we would like to thank Congresswoman Eshoo for this opportunity of research and recommendation.

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