WEBVTT

1
00:00:16.890 --> 00:00:17.940
12522580318: This is Maria Klay

2
00:00:20.160 --> 00:00:22.650
Neuroethics Canada: Morning everybody in Vancouver.

3
00:00:40.290 --> 00:00:40.530
Neuroethics Canada: Morning.

4
00:00:42.030 --> 00:00:42.600
Neuroethics Canada: Vancouver.

5
00:00:43.530 --> 00:00:44.100
Everyone

6
00:00:49.500 --> 00:00:50.340
Rabbi Claudio Kogan: Morning everybody

7
00:01:06.090 --> 00:01:06.750
Paul Wolpe: Hey, Kathy.

8
00:01:14.400 --> 00:01:23.070
Paul Wolpe: This meeting doesn't really have a set agenda. It's just an opportunity for people to check in and talk about what's going on and talk about coven

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00:01:25.620 --> 00:01:34.050
Paul Wolpe: Activities in general and some of the academic work. People are doing collaboratively, or even by themselves. So

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00:01:38.490 --> 00:01:44.100
Paul Wolpe: This was just scheduled as a sort of Community conversation amongst

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00:01:46.050 --> 00:01:51.540
Paul Wolpe: Bioethics leaders who are interested in just checking in. So that's where we are and

12
00:01:55.710 --> 00:02:00.480

Paul Wolpe: Anybody wants to start the conversation. Go ahead. We couldn't give some updates on on

13
00:02:01.920 --> 00:02:03.180
Paul Wolpe: Michael, what did you want to say.

14
00:02:03.570 --> 00:02:13.800
Michael Green: What just to kick it off because I just got off a phone call with legal counsel our institution. I just wanted to see if people are

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00:02:15.750 --> 00:02:24.300
Michael Green: Also having similar experiences which is you know we like everywhere else, you know, the ethics folks we've assembled a

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00:02:24.900 --> 00:02:39.390
Michael Green: Task Force of bioethics people to develop guidelines for the institution. And we've been working, you know, overdrive to really address all the kinds of issues that we see on the list serves and things that we talked about and

17
00:02:40.770 --> 00:02:52.170
Michael Green: And recently have been quite frustrated by you know the guy sort of how what happens with the guidelines that we develop and how

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00:02:53.310 --> 00:02:55.710
Michael Green: You know institution sort of

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00:02:56.910 --> 00:03:08.310
Michael Green: Makes you so the the recommendations and things get sort of filter through leadership and then through legal counsel and legal counsel you know lawyer rises it and

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00:03:09.090 --> 00:03:20.070
Michael Green: Oftentimes disregards what we say, or contradicts what we say and you know it's much like the conversations about an ethics committees about the relationship between ethics and legal and

21
00:03:20.370 --> 00:03:31.920
Michael Green: And it sort of plays out. And so I just had a, you know, very good working relationship with our legal counsel. I like them personally there they're nice good people who, you know, who just have different

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00:03:33.330 --> 00:03:33.810
Michael Green: Kinds of

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00:03:33.990 --> 00:03:43.440
Michael Green: Priorities and yeah and interests and and and what I'm struggling with I'm sort of directing the task force for the institution.

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00:03:43.860 --> 00:03:48.360
Michael Green: And what I'm struggling with is that the other people on the task force are

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00:03:48.840 --> 00:03:58.620
Michael Green: Getting you know they're getting frustrated because they're like, we're working, we're doing all this work. And then, you know, our work goes into a black hole and then legal gets a hold of it ignores it

26
00:03:59.070 --> 00:04:15.270
Michael Green: And then they come up with different policies and so I guess I'm wondering how other are other people experiencing similar things. And what what their approaches to deal with the relationship between ethics and legal and ethical hospital leadership and things like that.

27
00:04:18.630 --> 00:04:21.300
Paul Wolpe: Anyone else want to chime in on that.

28
00:04:22.170 --> 00:04:24.900
18324720858: Sure. This is telling me Anderson and

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00:04:26.130 --> 00:04:37.680
18324720858: We actually included our head healthcare lawyer in unless of our discussion. So it kind of ironed out those difficulties before we sent it on to lead to the other leadership.

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00:04:38.670 --> 00:04:43.140
18324720858: Which I think made a big difference. But we also know that were there were distinction saying

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00:04:43.410 --> 00:04:52.860
18324720858: This is the ethical guidance and then if they had something they want to say next. And here's the legal guidance and we submitted them as separate document that's what you do. And that allows the

32
00:04:54.030 --> 00:05:02.190

18324720858: President of the institution and the leaders that he had selected to say which one they were going to follow. So I just think that's a little bit different. Yeah.

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00:05:05.310 --> 00:05:05.670
Kathleen Powderly: Yeah.

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00:05:09.330 --> 00:05:09.630
Kathleen Powderly: Hello.

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00:05:10.260 --> 00:05:23.850
Kathleen Powderly: Yeah, in, you know, in New York. Obviously, the New York State Task Force guidelines have been used by a lot of folks. I think in and outside of New York as guidelines for developing guidelines, because they were so much work when it's them and they're

36
00:05:24.210 --> 00:05:26.760
12522580318: They're very good but you know

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00:05:26.820 --> 00:05:33.420
Kathleen Powderly: Our problem is that, you know, there's so much of the, the media discussion has been around.

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00:05:33.450 --> 00:05:35.190
12522580318: ventilators, and fortunately

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00:05:35.580 --> 00:05:43.020
Kathleen Powderly: With a lot of thin layers coming in. We actually haven't gotten to the point of triage and ventilators, but at the bedside. There are

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00:05:43.110 --> 00:05:44.880
12522580318: All kinds of other decisions.

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00:05:45.630 --> 00:05:49.500
Kathleen Powderly: Mostly around things like DNR that are being made differently by

42
00:05:49.500 --> 00:05:50.250
12522580318: The clinicians

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00:05:50.340 --> 00:05:51.540
Kathleen Powderly: Bedside than they were.

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00:05:51.570 --> 00:05:55.230
Kathleen Powderly: Before this, but we have a total lack of

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00:05:56.640 --> 00:05:59.940
Kathleen Powderly: Acknowledgement of that really at the upper levels and

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00:06:00.540 --> 00:06:02.220
Kathleen Powderly: I worked with our, our

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00:06:02.760 --> 00:06:21.060
Kathleen Powderly: With management person who's a very user savvy lawyer and are critical care people and palliative care and folks like that to develop guidelines for the institution, based on the test for Scotland's but because the governor has never who I think it's been awesome through most of this

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00:06:22.710 --> 00:06:32.100
Kathleen Powderly: Has not it's not you know codified those it's legal. We've got we were actually people were actually told do not work on guidelines. We don't need them.

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00:06:33.120 --> 00:06:38.610
Kathleen Powderly: We worked on them anyway. And we sent them forward because we know that there are decisions being made differently at the bedside.

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00:06:39.600 --> 00:06:56.370
Kathleen Powderly: But I share Michaels, you know, kind of frustration and concern because anybody who's talking to the clinicians at the bedside, especially, you know, we obviously have more of an issue in New York goes that that there are things that are causing moral anguish at the bedside.

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00:07:04.770 --> 00:07:05.490
Paul Wolpe: Anyone else

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00:07:07.050 --> 00:07:09.090
hannah lipman: From. Oh, sorry. Go ahead. Christie.

53
00:07:11.040 --> 00:07:13.470
Christine Mitchell: This is Christine Mitchell. I think it's a pretty

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00:07:14.520 --> 00:07:20.580

Christine Mitchell: Common experience that even though the public health crisis standards of

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00:07:20.580 --> 00:07:21.150
Christine Mitchell: Care.

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00:07:21.390 --> 00:07:38.460
Christine Mitchell: Have not been politically authorized by the governors in various states or the Department of Public Health, which is they're triggering mechanism, the content of them has been quite influential in the institutions that are doing their best to try and

57
00:07:38.460 --> 00:07:40.410
12522580318: prepare in advance and

58
00:07:40.770 --> 00:07:47.820
Christine Mitchell: Meeting regularly with their frontline critical care staff in particular I think around the kinds of

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00:07:49.260 --> 00:07:57.930
Christine Mitchell: Factors that should not lead to exclusion. So one of the things that we did in Massachusetts is try and be very clear about

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00:07:59.040 --> 00:08:12.210
Christine Mitchell: Categories that should not be used as exclusion criteria for receiving critical care even so in our own state. We've got a lot of public pushback about the failure to have a public comment period.

61
00:08:13.470 --> 00:08:26.610
Christine Mitchell: And not including vulnerable populations in the crafting of the guidelines, some very legitimate concerns among the public about how these guidelines have been created.

62
00:08:28.320 --> 00:08:29.970
Christine Mitchell: But I think they are.

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00:08:31.410 --> 00:08:40.320
Christine Mitchell: By those who are trying to be responsible already influential in care decisions. And I think that's a positive thing.

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00:08:44.850 --> 00:08:45.240
Mark Aulisio: Maria

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00:08:45.990 --> 00:08:56.910
12522580318: And I would do that because we're very early on, had a fairly broad Task Force looking at the policy and so because we were not in and David

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00:08:57.960 --> 00:09:06.840
12522580318: And could take a more leisurely approach. We use a lot of that time and then subsequent time through a broader vetting process to begin educating

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00:09:07.170 --> 00:09:14.370
12522580318: People about kind of the underlying ethical principles that guide the decision making process.

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00:09:14.850 --> 00:09:22.350
12522580318: And it's been a very interesting conversation. And we have the hospital attorney as a member right from the beginning.

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00:09:22.740 --> 00:09:35.250
12522580318: And so it's been a really good given take. We also have members on our task force to serve on the North Carolina task force. So there's been a lot of crossover in terms of communication and sharing of ideas.

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00:09:38.430 --> 00:09:46.680
18324720858: So hello again I think bedside. It's been interesting because we've listened to some of the leadership or trying to make sure the beds or update, whatever.

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00:09:47.250 --> 00:09:54.690
18324720858: When they've said to us, this person still here. You guys haven't been successful, to get them discharged because they won't do what the doctor say and so

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00:09:56.070 --> 00:10:03.000
18324720858: A couple of notes for the show leaders who said we weren't legal to go to the bedside and we've been successful at Ephesus and that's not appropriate.

73
00:10:03.300 --> 00:10:10.830
18324720858: Because once you bring in the attorney to direct them out the door, then you've turned it into a legal matter. Don't add that to all these layers of other things.

74
00:10:12.180 --> 00:10:23.970
18324720858: But they're feeling the frustration and trying to look for, you know, what you do when the patient still will not agree with the doctors about whatever it is usually about his church so

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00:10:25.320 --> 00:10:36.360
18324720858: It's been an interesting debate, in a way, but also having to stand our ground as episodes and saying that still not the best way, and sometimes read become the voice of reason about very

76
00:10:38.160 --> 00:10:48.570
18324720858: energized and compassionate, as well as passion discussions about how to solve the problem to get the flow to be the way that they want, which is the challenge.

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00:10:50.760 --> 00:10:54.270
hannah lipman: It is Hannah Lippmann in New Jersey. The view from here.

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00:10:54.270 --> 00:10:57.270
hannah lipman: Is a wish that we had had the

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00:10:57.270 --> 00:11:08.940
hannah lipman: Time to educate people on the ethical underpinnings of the different choices that are available. We got inundated so fast and our command center has been up and running. Now for a month that

80
00:11:10.710 --> 00:11:22.350
hannah lipman: You know, it was sort of like the time between trying to get people's on board to plan and the needing to have the plan in place was very, very short and people's bandwidth for

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00:11:23.220 --> 00:11:34.530
hannah lipman: An exploration of ethical issues is is narrow people's bandwidth for anything except taking care of patients is very narrow obviously the state of New Jersey convened an advisory committee to put out its own

82
00:11:34.530 --> 00:11:35.580
hannah lipman: Guidelines and I

83
00:11:35.670 --> 00:11:37.230
hannah lipman: I expect those in the next

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00:11:37.260 --> 00:11:43.710
hannah lipman: Day. I think the final version is done. I'm not on that advisory committee, but I think it'll be out

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00:11:44.520 --> 00:11:55.230
hannah lipman: In terms of collaborating with our lawyers. It's been that we've collaborated from from the beginning. So we haven't had that same what as what same issue is what was described, but

86
00:11:55.800 --> 00:12:04.680
hannah lipman: Because the the Pittsburgh protocol was published in JAMA in a very abbreviated version with reference to ethical underpinnings

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00:12:05.040 --> 00:12:16.680
hannah lipman: And in a very usable way it's become almost normative. So I think a lot of people, and I don't know what the state of New Jersey will do, but a lot of people I've spoken to around the state, even before the

88
00:12:16.980 --> 00:12:22.950
hannah lipman: Advisory Committee was convened were very attracted by the Pittsburgh guidelines and then

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00:12:23.670 --> 00:12:37.830
hannah lipman: It sort of skips to the implementation and then trying to really understand how we need to modify or some of the ethical nuance and even logistical nuance has been a challenge because it feels like that's a package that people could

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00:12:38.220 --> 00:12:41.040
hannah lipman: Use but there's lots of things to still be worked out.

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00:12:42.180 --> 00:12:43.710
hannah lipman: From that short document.

92
00:12:46.680 --> 00:12:48.090
Mark Aulisio: So here and

93
00:12:49.470 --> 00:12:50.280
Mark Aulisio: In Cleveland.

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00:12:51.360 --> 00:12:55.980
Mark Aulisio: We've worked with the four or four affiliated institutions.

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00:12:57.450 --> 00:13:08.460

Mark Aulisio: And also a couple of other hospitals in the region to try to come to substantive agreement about what these, you know,

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00:13:08.490 --> 00:13:11.370
Mark Aulisio: As Mr protocols will embody

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00:13:13.020 --> 00:13:18.660
Mark Aulisio: And one of the interesting things with respect to legal is our working group at Metro health

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00:13:20.160 --> 00:13:30.270
Mark Aulisio: We have legal involved right from the get go, but we have found that legal counsel at different institutions don't always share the same view.

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00:13:31.260 --> 00:13:46.830
Mark Aulisio: Not surprisingly, really have some especially things like you know with throwing ventilator support in a tree as situation whether you need explicit consent from a, from a surrogate or a patient or whether you can move forward.

100
00:13:48.030 --> 00:13:54.810
Mark Aulisio: The i think you know state guidance has a chance to iron that out because there's a risk averse concern.

101
00:13:56.490 --> 00:14:02.730
Mark Aulisio: The other thing I don't know if any of you have seen this, but our bigger issues been folks.

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00:14:02.820 --> 00:14:04.980
Mark Aulisio: Higher institutional level.

103
00:14:06.060 --> 00:14:19.260
Mark Aulisio: Being nervous about some aspect of the policy getting out even though the agree with the policy and being construed in a way that portrays the institution in bad light.

104
00:14:19.800 --> 00:14:30.240
Mark Aulisio: And there's been a lot of I think kind of wishful thinking, or maybe maybe it'll turn out to be true because Ohio's flattening the curve pretty successfully from the looks of it.

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00:14:31.350 --> 00:14:40.050

Mark Aulisio: About Oh, we're not going to really need this, so keep it, it won't be official will make it official if we need it.

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00:14:40.440 --> 00:14:53.460
Mark Aulisio: But, but here we are. This is where things stand, so we have a near final draft that will be approved by the institution. If and when the powers that be. Think it's needed, but not until then.

107
00:15:01.680 --> 00:15:07.140
John Carney: Have a question related to using the IHS me data as a way to engage

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00:15:08.100 --> 00:15:24.030
John Carney: On worst case scenario versus the projections for the state because they are moving. We've been emphasizing that the the for our region. All of those assumptions in terms of being able to bend the curve are related to the continuing

109
00:15:25.350 --> 00:15:32.280
John Carney: Requirement that the stay at home requirements go through the end of May, which I think is

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00:15:33.300 --> 00:15:51.840
John Carney: presumptive right now. So we've been pushing that as a measure of making sure that hospital personnel understand that that preparing for the worst case scenario is vitally important in terms of protecting for against the resurgence or spiking of

111
00:15:52.860 --> 00:15:53.640
John Carney: The incidents.

112
00:16:02.160 --> 00:16:02.850
Audiey Kao: I would say

113
00:16:05.190 --> 00:16:06.720
Paul Wolpe: That, odd, odd, you go first.

114
00:16:07.140 --> 00:16:14.220
Audiey Kao: Yeah, I would just, I would just add that, given the descriptions of what's going on to the various regional levels that the

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00:16:15.690 --> 00:16:18.750
Audiey Kao: American College of Chest Physicians

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00:16:19.830 --> 00:16:22.110
Audiey Kao: I think will be publishing their

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00:16:23.430 --> 00:16:25.950
Audiey Kao: Guidelines in chest

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00:16:27.750 --> 00:16:45.030
Audiey Kao: Pretty soon and I believe that these guidelines, while they're Cuoco not national if you're from a relevant society will also be endorsed by other critical care organizations like critical care nurses and Critical Care Medicine and so on so forth. So

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00:16:46.710 --> 00:16:54.450
Audiey Kao: Whether or not there is Coco National Guideline I just would like people to know that something like that will be coming out in the chest journal

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00:16:54.960 --> 00:17:07.860
Audiey Kao: I think the next week or so and then my question is that in reviewing any other protocols, whether they're published or and drop. Many of them use the sofa school or sofa like score.

121
00:17:08.760 --> 00:17:28.770
Audiey Kao: And I know that the National Academy of Medicine published something late last month, and specifically said that sofa like scores should not be used. So I'm not sure how people are handling that type of inconsistency, given what I interpreted in Nam.

122
00:17:29.790 --> 00:17:32.190
Audiey Kao: Emergency report to have said.

123
00:17:35.160 --> 00:17:36.660
Matthew Wynia: This is Matt, I think the

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00:17:37.800 --> 00:17:50.910
Matthew Wynia: The Academy's concern is not that they not use self a period, but that sofa, not be used alone. And there are a number of sort of concerns with sofa that are

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00:17:52.500 --> 00:18:00.990
Matthew Wynia: Based on partly the fact that it hasn't really been validated in coven but also it hasn't really been validated for viral a RDS period.

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00:18:01.530 --> 00:18:12.090
Matthew Wynia: And it didn't perform particularly well in the pan flu epidemic in 2009 so there are reasons to believe it might not be great.

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00:18:12.600 --> 00:18:25.860
Matthew Wynia: On the other hand, early data from China did suggest that it was predictive maybe not as predictive as D dimer. For example, but still predictive so it's not that you can't use it. It's just, you need to be

128
00:18:26.100 --> 00:18:27.030
Matthew Wynia: A LITTLE CONCERNED.

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00:18:27.420 --> 00:18:34.320
Matthew Wynia: And I just one quick anecdote part of sofa is are you on norepinephrine or W to me.

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00:18:34.920 --> 00:18:37.170
18324720858: Well those, you know, are not

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00:18:38.940 --> 00:18:45.570
Matthew Wynia: The way sofa is built right now doesn't reflect contemporary standards for use of web and norepinephrine.

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00:18:45.990 --> 00:18:55.770
Matthew Wynia: And in particular, at least in Italy, there were people putting folks on low doses of norepinephrine very early in their course because they were trying to stay out of the room.

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00:18:56.550 --> 00:19:00.510
Matthew Wynia: And if you're trying to stay out of the room and you're worried about someone becoming hypertensive

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00:19:01.500 --> 00:19:17.400
Matthew Wynia: On a tiny dumpster norepinephrine at the outset, so that you don't have to go in there and do their hypotension episode. Yeah. And so that's going to give you it for an artificially elevated sofa, or because someone gets four points for being on norepinephrine.

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00:19:19.050 --> 00:19:28.710
Matthew Wynia: So that's the concern is that a sofa score is, you know, okay, but you can't look at it without knowing more about the clinical circumstance.

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00:19:30.300 --> 00:19:42.540

hannah lipman: And Pittsburgh guidelines refer to something called a laps to score. Does anybody have any experience with that or anybody's committees, looking at using that instead. No, none of my people have used it.

137
00:19:49.980 --> 00:20:00.000
Nneka Sederstrom: It's Nika know we haven't used that. But what we did add besides our sofa as we added a scale for co-morbidities

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00:20:01.320 --> 00:20:06.720
Nneka Sederstrom: Relevant co-morbidities which was something that was a lot of conversation of, what does it mean to be irrelevant comorbidity

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00:20:07.980 --> 00:20:16.080
Nneka Sederstrom: And then the other thing that we add was duration of need for things like the event and and sort of last but not least,

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00:20:16.590 --> 00:20:24.450
Nneka Sederstrom: There's a age as it relates to clinical prognostication, but not in of itself. So those were additions to kind of

141
00:20:25.260 --> 00:20:35.100
Nneka Sederstrom: augment the sofa concern. And we did some modeling of running through current coven patients in our AC us as well as all our ICU.

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00:20:35.550 --> 00:20:47.880
Nneka Sederstrom: Other ICU patients and see whether the modeling would put them in the proposed category of priority as we expected that it should. And so far.

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00:20:48.510 --> 00:20:58.050
Nneka Sederstrom: The model show that that would make sense if we did the protocol, the way it was the people who should have the event are getting the event and those who should not have an event will not be getting event.

144
00:21:01.110 --> 00:21:03.960
hannah lipman: Are you willing to share your list of co-morbidities and

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00:21:04.020 --> 00:21:08.760
hannah lipman: How you accounted for age or is that or the accounting for ages. Just kind of a sense

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00:21:09.060 --> 00:21:09.540

Of

147
00:21:10.650 --> 00:21:12.570
hannah lipman: You know, clinical judgment for each person.

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00:21:13.230 --> 00:21:19.800
Nneka Sederstrom: Yeah, I'm willing to share and in the in the age really is just a accounted specifically when

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00:21:21.300 --> 00:21:27.450
Nneka Sederstrom: In the sense of like a tiebreaker. So one of the things that are at our state level that got really hung up on Minnesota, of course, has

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00:21:27.840 --> 00:21:36.510
Nneka Sederstrom: A lot of elderly population here and I told my parents have like something in the water. Has everybody live until 90 and 100 around this area.

151
00:21:37.440 --> 00:21:44.310
Nneka Sederstrom: So they were really concerned that they would justifiably so have like an eight year old with the same priority score. It's like a 30 year old.

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00:21:44.700 --> 00:21:56.340
Nneka Sederstrom: And then they would just go into a lottery process of some sort of randomization and that was really distressing to try and figure out how to to deal with that. So the thought was that if

153
00:21:56.790 --> 00:22:08.910
Nneka Sederstrom: If it came down to that age in of itself would not work. But if they looked at the overall picture does age, change the clinical outcome because that eight year old no longer

154
00:22:09.330 --> 00:22:22.350
Nneka Sederstrom: Is just like a healthy eight year old. It's an eight year old with co-morbidities and being on event for more than three days would mean that they got a higher score by adding age as a prognosticator and then that's when it would be considered

155
00:22:24.450 --> 00:22:35.550
Matthew Wynia: So there is a validated tool, the Charleston comorbidity index, which is being adapted to this to address the concerns of age discrimination and disabilities communities.

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00:22:35.910 --> 00:22:54.570

Matthew Wynia: And I can send you what Colorado has done to adapt the CCI so we have a modified CCI which we've validated against one year mortality sorry in hospital mortality for patients with with respiratory failure requiring ventilation.

157
00:22:55.380 --> 00:22:56.370
Nneka Sederstrom: Yeah, we added

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00:22:56.670 --> 00:23:02.970
Nneka Sederstrom: We added the CCI and the thumb of the palliative care index as well. I mean, it was kind of

159
00:23:03.030 --> 00:23:03.900
cut and pasted

160
00:23:05.100 --> 00:23:10.050
Nneka Sederstrom: Yeah, the people. Yes. And then, of course, because we're Pete's we added he lied and

161
00:23:11.670 --> 00:23:23.100
Nneka Sederstrom: FSS for functional statuses. And so it's, there's a bunch of stuff to try and, you know, mash together as many validated tools as we can to try and standardized process. That makes sense.

162
00:23:28.080 --> 00:23:39.030
Paul Wolpe: I don't know how many of you are on the chat function, but you should be looking at it. If you're not the chat button at the bottom. Barbara just offered to gather together these

163
00:23:39.090 --> 00:23:41.400
Paul Wolpe: Documents. People are asking for or standards.

164
00:23:41.790 --> 00:23:51.720
Paul Wolpe: You're going to share and send them out to everybody. So if you have something like that you're willing to share, please send it into Barbara and she'll put it together and send it out to everybody.

165
00:23:55.710 --> 00:23:59.550
Amy McGuire: This is Amy. This is a slightly different topic, but I just wanted to mention before

166
00:24:00.420 --> 00:24:08.820

Amy McGuire: Before while we're on the call that based on our last call. There was a very large group of 40 of us that got together and wrote a paper.

167
00:24:09.510 --> 00:24:18.000
Amy McGuire: outlining some of the ethical issues that we discussed on the last call and other ethical issues that have come up that was submitted to a job today for a special issue that they're

168
00:24:18.930 --> 00:24:28.590
Amy McGuire: Going to be publishing this month. They said they're going to be turning it around within 48 to 72 hours and they're looking for open pure commentaries. So I'm going to send they've

169
00:24:29.250 --> 00:24:33.990
Amy McGuire: given me permission to send the entire draft of the paper confidentially out to the entire ab PD.

170
00:24:34.410 --> 00:24:48.270
Amy McGuire: If you are any of your colleagues or students or trainees or whatever are interested in writing open peer commentaries, you can contact Bella at a job and let her know what you're interested in writing about. So just wanted to make that announcement.

171
00:24:49.920 --> 00:24:58.860
Neuroethics Canada: So following that neurology today had a feature piece on featuring Paul wolpe and Jason liberal

172
00:24:59.550 --> 00:25:05.790
Neuroethics Canada: And some comment from me about this forthcoming paper and some of the ethics initiatives that are being led by

173
00:25:06.570 --> 00:25:17.310
Neuroethics Canada: By our association. I tried to send that link around I'm having some trouble with the listserv. But I'll try to get that fixed today and get that link and article sent around to everybody. It really

174
00:25:17.880 --> 00:25:24.150
Neuroethics Canada: speaks very highly of this group and the effort that Paul and Amy have been leading towards that special issue.

175
00:25:37.110 --> 00:25:51.840
Christine Mitchell: Our people in other states, getting a lot of responses from disability groups. That's one of the areas that we've gotten a lot of input from in our state and so

176
00:25:52.230 --> 00:26:05.910
Christine Mitchell: I'm actually going to have to leave this call right at 12 sharp because we're reconvening our statewide committee to address some of the concerns that have come up here around

177
00:26:07.020 --> 00:26:09.540
Christine Mitchell: disability advocates and

178
00:26:09.960 --> 00:26:13.140
Christine Mitchell: Massachusetts BPH crisis standards of care.

179
00:26:15.780 --> 00:26:17.490
Denise M Dudzinski: It's part of the reason there's nothing more

180
00:26:17.490 --> 00:26:18.720
19146211770: Transparency

181
00:26:18.900 --> 00:26:21.630
Robert Klitzman: Instead of institutions developing guidelines.

182
00:26:21.660 --> 00:26:23.910
Robert Klitzman: Or because of the concerns about that which

183
00:26:24.240 --> 00:26:25.770
Robert Klitzman: Itself is certain that there's

184
00:26:26.160 --> 00:26:26.490
Not

185
00:26:29.010 --> 00:26:30.120
Robert Klitzman: A lot of documentary

186
00:26:30.420 --> 00:26:31.770
Robert Klitzman: being worked on and

187
00:26:32.100 --> 00:26:33.360
Denise M Dudzinski: Not for distributed

188
00:26:33.420 --> 00:26:35.760
Robert Klitzman: Data, which I think is unfortunate in several ways.

189
00:26:45.390 --> 00:26:45.870
12522580318: Log

190
00:26:47.010 --> 00:26:48.120
12522580318: Files forum.

191
00:26:49.440 --> 00:26:54.960
19146211770: Right, good resource for seeing the debate being played out as we're as we're speaking

192
00:26:56.550 --> 00:26:57.840
12522580318: And Christina.

193
00:26:58.590 --> 00:26:59.970
John Carney: Dr. Carla currents from Katie

194
00:27:00.660 --> 00:27:03.630
John Carney: Is a historian emphasis is put together a list of the

195
00:27:03.840 --> 00:27:20.460
John Carney: Disability Rights groups, mainly because I think the hospital system has already been there's been a suit filed against them for discrimination for disability. So anyway, I'll, I'll get that list to you if you don't already have it. It's, it's, there's about six or eight

196
00:27:21.030 --> 00:27:22.380
12522580318: Different References

197
00:27:22.980 --> 00:27:25.470
Paul Wolpe: John. Can you send that to Barbara so that

198
00:27:26.280 --> 00:27:31.860
John Carney: Sure, yeah, it's, we're still cultivate it's, it's, we got a clean it up because it's some of them are dukes and stuff like that. But I know

199
00:27:35.820 --> 00:27:36.210
19146211770: I know that

200
00:27:36.270 --> 00:27:45.270
Paul Wolpe: I mean, I've been done doing I've done a number of media and it's a question every time I just did CNN Espanol

201
00:27:46.830 --> 00:27:48.390
Paul Wolpe: Or really concerned about it.

202
00:27:48.390 --> 00:27:50.160
Paul Wolpe: So, you know,

203
00:27:50.340 --> 00:27:52.110
19146211770: It certainly is is

204
00:27:52.170 --> 00:27:53.070
Paul Wolpe: penetrated the

205
00:27:53.190 --> 00:27:55.890
Paul Wolpe: Consciousness of public that issue.

206
00:27:56.970 --> 00:27:58.590
John Carney: So her work included

207
00:28:00.000 --> 00:28:09.750
John Carney: You know publications have 17 different languages for disability or excuse me for risk factors associated with language barriers. I'm not including that on our list because

208
00:28:09.870 --> 00:28:12.870
John Carney: We were just looking at disability rights groups. Do you want all of that.

209
00:28:13.020 --> 00:28:14.040
John Carney: And I can just send it to

210
00:28:14.040 --> 00:28:14.670
19146211770: Pollen and

211
00:28:14.940 --> 00:28:16.470
John Carney: You guys can clean it up. However, you

212
00:28:16.740 --> 00:28:17.670
Paul Wolpe: Sure do that.

213
00:28:18.330 --> 00:28:18.510
Yeah.

214
00:28:22.200 --> 00:28:23.010
Robert Klitzman: Well house I'm

215
00:28:23.040 --> 00:28:24.600
Robert Klitzman: Wondering what people think in terms of

216
00:28:24.600 --> 00:28:27.840
Robert Klitzman: How that should best be addressed in other words of the one hand, we've been talking

217
00:28:27.840 --> 00:28:29.910
19146211770: About so scores that should

218
00:28:30.360 --> 00:28:32.910
19146211770: prevent discrimination.

219
00:28:33.000 --> 00:28:34.830
Robert Klitzman: But what might help my

220
00:28:35.160 --> 00:28:37.140
Robert Klitzman: Best look on the road or what should be

221
00:28:37.140 --> 00:28:38.940
19146211770: Said to disability groups.

222
00:28:38.940 --> 00:28:40.710
19146211770: That makes sense, given the

223
00:28:40.710 --> 00:28:43.980
Robert Klitzman: ambiguities of the scoring systems that we've just

224
00:28:43.980 --> 00:28:47.310
holly tabor: Talked about about I think part of what has to happen is there.

225
00:28:47.400 --> 00:28:51.330
holly tabor: Has to be an explicit non discrimination statement at the beginning of

226
00:28:51.330 --> 00:28:51.810
19146211770: Each of his

227
00:28:51.840 --> 00:28:55.410
holly tabor: Policies, which most of the I believe in the

228
00:28:55.950 --> 00:28:59.820
holly tabor: Analysis that Amy referred to that I was a part of only seven

229
00:28:59.850 --> 00:29:00.540
Of the

230
00:29:01.980 --> 00:29:08.250
holly tabor: I think it was seven of the 30 some policies had any statement about disability. And I also think that

231
00:29:08.790 --> 00:29:11.280
holly tabor: There's concerns about both explicit and

232
00:29:11.310 --> 00:29:15.660
holly tabor: Implicit bias and discrimination against people with disabilities, when you look at a lot of

233
00:29:16.560 --> 00:29:17.220
holly tabor: Policies and

234
00:29:17.430 --> 00:29:19.290
holly tabor: Publish. Some of them explicitly

235
00:29:19.530 --> 00:29:20.700
19146211770: And the DR EDF.

236

00:29:20.970 --> 00:29:24.060
holly tabor: Guidance. He had copied and pasted the chats talk about this, but

237
00:29:24.060 --> 00:29:24.570
holly tabor: Some of it.

238
00:29:25.170 --> 00:29:28.740
holly tabor: Is explicit in that it says, as I believe the Alabama and

239
00:29:28.770 --> 00:29:32.850
holly tabor: Tennessee ones did suggesting that that certain people with disabilities to

240
00:29:32.850 --> 00:29:34.200
holly tabor: be excluded from access to

241
00:29:34.200 --> 00:29:39.480
holly tabor: ventilators, on the basis of really nothing to do with prognosis short term or long term.

242
00:29:39.690 --> 00:29:40.380
19146211770: And then some of it is

243
00:29:40.440 --> 00:29:41.940
holly tabor: Implicit and some of that.

244
00:29:42.630 --> 00:29:44.070
holly tabor: May not be sofa scores.

245
00:29:44.070 --> 00:29:46.500
holly tabor: But other kinds of quality other kinds

246
00:29:46.560 --> 00:29:48.120
criteria that are used.

247
00:29:51.810 --> 00:29:53.070
holly tabor: Quality of life.

248
00:29:53.280 --> 00:29:54.930
19146211770: implicitly or explicitly

249
00:29:55.200 --> 00:29:56.640
holly tabor: And I also think the involvement.

250
00:29:56.670 --> 00:29:58.830
holly tabor: Of people in the disability community embedding these

251
00:29:58.860 --> 00:30:01.560
holly tabor: Policies and complete transparency is really important.

252
00:30:03.300 --> 00:30:03.960
19146211770: The other thing.

253
00:30:03.990 --> 00:30:05.520
Matthew Wynia: That there was a nice piece in the

254
00:30:05.610 --> 00:30:07.680
Matthew Wynia: Pacing center today.

255
00:30:08.940 --> 00:30:20.070
Matthew Wynia: By RA naman that talks about how, for example, the sofa score really needs to be amended to address some of these issues. So if you have a chronic

256
00:30:21.090 --> 00:30:23.880
Matthew Wynia: Disability that prevents you from speaking normally

257
00:30:24.450 --> 00:30:29.910
Matthew Wynia: That's going to give you a poor score on your Glasgow Coma Scale, which is going to feed into the selfish.

258
00:30:30.090 --> 00:30:40.860
Matthew Wynia: Or and shouldn't right because it has nothing to do with your long term survival prospects, or even your short term survival prospects, but right now the way the sofa score is developed

259
00:30:42.060 --> 00:30:43.590
Matthew Wynia: Someone with a speech impediment.

260

00:30:44.160 --> 00:30:45.000
Matthew Wynia: Gets a ding

261
00:30:45.630 --> 00:30:47.310
holly tabor: Yeah, I agree. And I see

262
00:30:48.000 --> 00:30:50.070
holly tabor: Are a Neiman has done a lot of work good work on this.

263
00:30:50.070 --> 00:30:51.330
holly tabor: So his just just just

264
00:30:51.330 --> 00:30:54.510
holly tabor: Tremendous and I'm forgetting the one that was

265
00:30:54.510 --> 00:30:55.920
19146211770: A feminist

266
00:30:55.950 --> 00:30:56.940
Matthew Wynia: Priority external I

267
00:30:57.810 --> 00:30:58.830
holly tabor: Get her name, she's done

268
00:30:58.830 --> 00:31:00.900
holly tabor: Some amazing work on this and

269
00:31:00.990 --> 00:31:01.650
Matthew Wynia: So in the

270
00:31:01.920 --> 00:31:06.240
Matthew Wynia: In the same way that you know doing modified versions of CCI to make

271
00:31:06.330 --> 00:31:07.500
19146211770: adjustments for

272
00:31:07.800 --> 00:31:08.670
Matthew Wynia: Things that really ought to

273
00:31:08.730 --> 00:31:13.890
Matthew Wynia: Be adjusted. I think we are, we should be doing the same with the sofa score.

274
00:31:16.800 --> 00:31:24.510
Robert Klitzman: I think that's, I think that's important because I I agree totally obviously guidelines should state explicitly that

275
00:31:25.320 --> 00:31:35.820
Robert Klitzman: Discrimination won't occur, and I should just put that in some new york guidelines that some of us have been drafting. But I'm wondering if that's sufficient. I think this next level, as Matt is just saying is important.

276
00:31:37.320 --> 00:31:38.460
19146211770: If you're

277
00:31:38.760 --> 00:31:45.780
Christine Mitchell: right about that. Especially, I mean we are guidelines were very clear from, you know, the front page about

278
00:31:47.400 --> 00:31:49.590
Christine Mitchell: Not taking certain kinds of

279
00:31:50.730 --> 00:32:02.910
Christine Mitchell: things into account, you know, like gender and race and ethnicity and disability and so forth. But when it comes right down to it, we do actually know and see that some of these

280
00:32:03.300 --> 00:32:12.870
Christine Mitchell: disparities in health care actually affects survivability and when survivability is part of the criterion for allocating critical care resources.

281
00:32:13.350 --> 00:32:25.380
Christine Mitchell: It's hard to protect the most vulnerable groups. I mean, we, I don't want to say we're talking out of both sides of our mouth, but since we're in a confidential group here, I just want to drill down a minute about this issue of how we both

282
00:32:27.870 --> 00:32:41.220
Christine Mitchell: Avoid on justified discrimination and also do responsible clinical evaluations about not only need but survivability. It's a really tough issue.

283
00:32:42.810 --> 00:32:52.020
Robert Klitzman: I also think we haven't talked about race and ethnicity, but the reports have higher rates of problems among African Americans, partly because of

284
00:32:52.380 --> 00:33:04.950
Robert Klitzman: More co morbidity part because of less X. I mean, I think these are huge issues that also set factor into, you know, operational ization of sofa scores or other scores, etc. Yeah.

285
00:33:06.360 --> 00:33:11.850
hannah lipman: The way that those scores are being modified i think is, is very important. And it's taken a

286
00:33:12.420 --> 00:33:28.500
hannah lipman: Tremendous amount of time and conversation where I am to come to that. So, and, you know, I just thank you again, especially Matt for sharing the way that you've modified Charlson and and sofa, so that we could all at least do it in the same way.

287
00:33:29.880 --> 00:33:32.250
hannah lipman: Because that will help. I think with some of the

288
00:33:33.660 --> 00:33:39.690
hannah lipman: Challenges and and also legal concerns. So, if I can say this is the way it's being done. That would be very helpful.

289
00:33:40.530 --> 00:33:49.140
Matthew Wynia: Yeah. The other thing I'm sensitive to Christine's point. By the way, about being out of both sides of our mouth. I think we have to be honest about this.

290
00:33:49.590 --> 00:34:01.560
Matthew Wynia: And recognize that, you know, just say we promise we won't discriminate. But we're going to use a modified Charlson we're going to use sofa and we know that all of those end up in the end.

291
00:34:02.220 --> 00:34:09.630
Matthew Wynia: You know, affecting people who are already disadvantaged in our communities because they have underlying co-morbidities

292
00:34:10.830 --> 00:34:21.270
Matthew Wynia: That affect their survival that we have to acknowledge that and not and not pretend like just because we said we promise not to diss discriminate against anyone

293
00:34:22.410 --> 00:34:29.160
Matthew Wynia: That we can then ignore the fact that the tools were using will in will actually have a disparate impact.

294
00:34:29.400 --> 00:34:40.830
Paul Wolpe: And you can't because the articles coming out from the disability rights groups are very explicit about the implicit bias of those scores. So we would just look like we weren't even

295
00:34:41.280 --> 00:34:42.690
Matthew Wynia: Address right

296
00:34:43.170 --> 00:34:46.320
Matthew Wynia: Look completely untrustworthy or stupid. Yeah.

297
00:34:46.740 --> 00:34:58.830
Armand Antommaria: Matt, can I ask how you're modifying the GCS do you get an automatic two points on best verbal response is it based on, you know, a care providers.

298
00:35:00.630 --> 00:35:08.400
Armand Antommaria: Relative assessment of what the underlying scale is attempting to measure. And what do you down terms of

299
00:35:09.750 --> 00:35:16.410
Armand Antommaria: Visitation in terms of individuals with disabilities, particularly if somebody shows up on accompanied

300
00:35:17.940 --> 00:35:22.650
Armand Antommaria: In order to have enough history to know if they might not have they might be nonverbal

301
00:35:24.090 --> 00:35:32.640
Matthew Wynia: Yeah, those are great questions and I don't have all of the details yet because we're still working on this, and thankfully we haven't had to implement it at all.

302
00:35:33.600 --> 00:35:42.750
Matthew Wynia: But we are starting to do the scoring on everyone who's admitted to the hospital. So we're getting a chance to get some

303

00:35:43.440 --> 00:35:53.940
Matthew Wynia: You know, some experience with this. And the bottom line on the GCS is that you is that you do give a score, even if it's non testable.

304
00:35:54.780 --> 00:36:09.420
Matthew Wynia: You try and give a score that is based on other things, right. So if they can't verbalize or or move you look at you know if they're paralyzed. You look at their mouth and their tongue.

305
00:36:10.380 --> 00:36:19.380
Matthew Wynia: Motor capacity that kind of stuff. There is actually guidance on this on the GCS website there's, you know, Glasgow Coma scale.org

306
00:36:20.250 --> 00:36:31.380
Matthew Wynia: Has guidance on how to address this and people with long term disabilities, it's not great, in terms of being really detailed. So that's what we're trying to figure out is, you know,

307
00:36:32.670 --> 00:36:40.920
Matthew Wynia: What does this actually mean in terms of implementation on the visitation that is right now happening on a case by case basis.

308
00:36:42.870 --> 00:36:48.450
Matthew Wynia: So that, so we have a no visitors policy. What we're, what we're allowing for exceptions.

309
00:36:52.530 --> 00:37:03.000
Ken Goodman: I heard it put this way, this is kind of Miami, but if you live in a country with a with a discriminatory and dysfunctional healthcare system you're unlikely to correct that during a mass casualty of that.

310
00:37:03.450 --> 00:37:12.210
Ken Goodman: The best you can do is be transparent. You can acknowledge you're doing your sorry best and that and that in the extreme of someone even said

311
00:37:12.810 --> 00:37:28.050
Ken Goodman: Ada definition of disability might make it someone with coven 19 has a disability that he that we can that it's good getting this Goldilocks right is going to be a real challenge. And then leading into the biases of individual clinicians surely worse than no guidelines at all.

312
00:37:34.500 --> 00:37:42.780

Audiey Kao: Can I have another topic, I think, given the fact that matches said that, given the now it's work in Colorado. They haven't yet.

313
00:37:43.530 --> 00:37:57.780
Audiey Kao: Needed to implement it, which I think is the place we all want to be as it relates to this topic, but if I could just to kind of the cocoa phase to sort of speak issues and have people been thinking about

314
00:37:59.010 --> 00:38:17.550
Audiey Kao: The intersection of public health interventions and big data digital epidemiology obviously those are the things that will affect everybody and not just people currently in the hospital. So I'm not sure people have been starting to think about that.

315
00:38:18.630 --> 00:38:27.390
Audiey Kao: We are doing a little bit of thinking about that here at the AMA because obviously that's like couple steps down from the current situation. So any thoughts on that be helpful.

316
00:38:29.730 --> 00:38:35.490
Ken Goodman: The informatics community is mindful of the kind of surveillance that we've it's been argued needs to be done.

317
00:38:36.630 --> 00:38:48.120
Ken Goodman: And the two arguments are don't don't make it worse than it already is. On the other hand, we've already suspended aspects of my don't know HIPAA EMTALA and for that matter of the US Constitution.

318
00:38:48.990 --> 00:38:56.520
Ken Goodman: If you live in a country where people trusted those people doing surveillance, which I think I'm balanced, they tend to

319
00:38:56.910 --> 00:39:06.060
Ken Goodman: Then, then it would be permissible to use some of the surveillance and machine learning strategies that are available to for contact tracing and that sort of thing.

320
00:39:06.840 --> 00:39:19.080
Ken Goodman: Needs to be temporary needs to be time limited it needs to be done by trusted agents, but it's possible to get it right, although I'm not sure that is a as much of a comfortable provides much of a couple of

321
00:39:31.080 --> 00:39:41.430

Paul Wolpe: There's a lot of discussion about all of this and Israel, the future of privacy Forum, which is a group of privacy professionals internationally is had a couple of seminars on this.

322
00:39:42.360 --> 00:39:54.510
Paul Wolpe: One about general corporate data sharing and the time like this. And another one about mobile apps and data sharing. I think those are available on the future privacy forum site but

323
00:39:56.040 --> 00:40:07.020
Paul Wolpe: There's been a very robust about this discussion about using mobile apps in Israel. And, you know, mobile apps haven't been as big here in terms of

324
00:40:07.560 --> 00:40:18.930
Paul Wolpe: This question, but I think that that audience right i mean i think there's going to be a big post initial crisis question about how we use the data.

325
00:40:20.460 --> 00:40:23.310
Paul Wolpe: And the secondary wave surveillance data.

326
00:40:24.750 --> 00:40:27.180
Paul Wolpe: And I'm not sure that we're having it robustly enough

327
00:40:32.790 --> 00:40:36.870
Michael Green: I'd read that Google and Apple we're teaming up together to develop

328
00:40:37.980 --> 00:40:39.030
Michael Green: Platforms

329
00:40:40.110 --> 00:40:46.230
Michael Green: That work on all the cell phones using that would identify

330
00:40:47.640 --> 00:40:49.800
Michael Green: Based on proximity who

331
00:40:51.750 --> 00:40:59.640
Michael Green: If you've come in contact with somebody or close proximity to somebody who was coven positive anonymously and

332
00:41:01.890 --> 00:41:08.160

Michael Green: I mean, it's so it's an interesting surveillance technique, it raises all kinds of privacy issues and trust issues about

333
00:41:11.100 --> 00:41:19.290
Michael Green: Who would you want to have access to that information, but from a public health perspective, if it actually worked. And it was universally applied, you could actually

334
00:41:20.340 --> 00:41:28.740
Michael Green: Do a great deal to help make decisions about who safe to go back to the workforce and who isn't safe to go back to the workforce.

335
00:41:30.690 --> 00:41:35.160
Michael Green: But there's, there's a lot of what ifs. I think that would have to be ironed out

336
00:41:36.930 --> 00:41:44.520
John Carney: Michael. We talked about that this morning and staff meeting because you know if we should do something on the ethics issues around that. And one of our nativist young

337
00:41:45.900 --> 00:41:56.130
John Carney: At the CES just said, there really isn't anything in there that Google and Apple haven't already been doing all along. It's just that now they're cooperating together to do it.

338
00:41:56.610 --> 00:42:12.270
John Carney: So he was he was much less concerned about the public, the need to go ahead and do that and declare it as something that we're going to do publicly now rather than behind closed doors. So I'm, I'm, I was very struck by that comment because I thought, I'm

339
00:42:12.540 --> 00:42:14.550
John Carney: Like, and I really don't know all that stuff that

340
00:42:14.730 --> 00:42:19.080
John Carney: You know, I guess I'm just swimming and ignorance. So it was an interesting discussion this morning.

341
00:42:21.300 --> 00:42:37.920
Robert Klitzman: Question, what they do with the data. Did they contact individuals that contact health departments and say person X has not been socially isolating and distancing themselves and therefore in a state where it's police are involved with that could lead to different outcomes.

342
00:42:39.600 --> 00:42:48.420

12522580318: This is Maria and one of the concerns in North Carolina is the number of undocumented workers recount and the

343
00:42:49.740 --> 00:42:58.560
12522580318: Just trust that that community has any kind of information like this. And so there has been lots of discussion among the

344
00:42:59.670 --> 00:43:05.910
12522580318: Latino and other populations about how to not participate

345
00:43:14.910 --> 00:43:20.070
Ken Goodman: Imagine if you could with big data and machine learning, reduce discrimination against minorities.

346
00:43:24.840 --> 00:43:29.820
holly tabor: Well, that would imply that the machine learning would be based on data that wouldn't intentionally discriminate right

347
00:43:30.660 --> 00:43:43.500
Ken Goodman: And it implies a lot but but at the end of the day, once every hour that we have is imperfect, to some extent, but if the more data you have, the less biased. That is, assuming it's more comprehensive

348
00:43:43.740 --> 00:43:55.470
Ken Goodman: And if there were a chance to be able to say we're trying to make it as objective as possible, taking into account histories of bias, they're baked into the algorithms Caribbean opportunity actually to use the population.

349
00:43:55.860 --> 00:44:02.250
holly tabor: I think there's a lot of data that a lot of those machine learning and AI algorithms do in fact have implicit bias baked into them.

350
00:44:12.090 --> 00:44:22.410
Neuroethics Canada: That's especially the case for mental health disorders on, particularly the psychotic disorder schizophrenia, bipolar, the AI algorithms are very biased.

351
00:44:24.600 --> 00:44:28.950
Ken Goodman: One could argue, not that I know that I'm doing that now that there's a chance to improve

352

00:44:30.030 --> 00:44:36.810
Ken Goodman: That the argument that the biases in the algorithm always risks proving too much, namely that you're never going to make them better.

353
00:44:37.290 --> 00:44:45.510
Ken Goodman: Whereas if you intentionally tried to build data sets that were inclusive, then you might and prince will be able to reduce the kind of bias that was inherent

354
00:44:53.400 --> 00:44:58.110
Audiey Kao: To this topic beyond a list of other topics that we want to

355
00:44:59.850 --> 00:45:05.640
Audiey Kao: Focus our expertise and energy in terms of scholarship. I'm just seeing that up, that's a possibility.

356
00:45:10.650 --> 00:45:16.320
Robert Klitzman: as need be great to think about another paper or some other projects that group might do here is, Bob.

357
00:45:19.980 --> 00:45:32.370
19146211770: This is Millie. I'm very interested in this, too. I would love to hear just a few more comments on what people anticipate the applications to be I I certainly understand

358
00:45:33.270 --> 00:45:40.470
19146211770: The opportunity for digital surveillance by. I mean, we're already. I think there's already something in development to

359
00:45:41.340 --> 00:45:52.980
19146211770: identify whether you've been near somebody who was coven 19 positives. But are there. What other applications can people describe it would be nice to begin to have a taxonomy, the range.

360
00:45:54.540 --> 00:45:56.070
19146211770: Of mobile apps where

361
00:45:57.390 --> 00:45:59.790
19146211770: Surveillance and data sharing questions are going to arise.

362
00:46:12.450 --> 00:46:13.830
Audiey Kao: Emily. One example to

363
00:46:14.160 --> 00:46:15.540
19146211770: top my head is

364
00:46:16.020 --> 00:46:17.520
Audiey Kao: Once you surveil and you

365
00:46:17.520 --> 00:46:18.390
Audiey Kao: Know people

366
00:46:18.420 --> 00:46:19.530
Audiey Kao: Need to be either in

367
00:46:20.130 --> 00:46:21.510
Audiey Kao: Self isolation and self.

368
00:46:21.510 --> 00:46:22.770
Audiey Kao: Quarantine then

369
00:46:23.070 --> 00:46:23.910
Cell phone

370
00:46:24.990 --> 00:46:26.790
Audiey Kao: And its proximity to that person.

371
00:46:26.790 --> 00:46:29.820
Audiey Kao: Can serve as a basis for tracking and so I think

372
00:46:29.820 --> 00:46:33.900
Audiey Kao: There's currently aggregate data that states use to

373
00:46:34.260 --> 00:46:37.950
Audiey Kao: Show by now. How well certain states are

374
00:46:37.950 --> 00:46:38.760
Audiey Kao: Performing

375

00:46:38.790 --> 00:46:40.320
19146211770: In physical distancing so

376
00:46:40.320 --> 00:46:42.360
Audiey Kao: I can imagine there be an

377
00:46:42.420 --> 00:46:43.290
Audiey Kao: App that

378
00:46:43.620 --> 00:46:45.960
19146211770: Again, using geospatial

379
00:46:46.410 --> 00:46:51.570
Audiey Kao: Tracking could alert people alert authorities that

380
00:46:52.200 --> 00:46:52.560
Audiey Kao: You know,

381
00:46:52.590 --> 00:46:54.960
Audiey Kao: When you should be quarantining and self.

382
00:46:54.960 --> 00:46:59.850
Audiey Kao: Isolation, but you're not and someone so it depends on your door and says why

383
00:46:59.850 --> 00:47:00.300
Audiey Kao: Aren't you

384
00:47:00.450 --> 00:47:01.980
19146211770: Know if isolating yourself orange.

385
00:47:03.900 --> 00:47:04.560
Well, yeah.

386
00:47:05.820 --> 00:47:06.090
19146211770: Yeah.

387
00:47:07.620 --> 00:47:08.400
19146211770: The Enforcer

388
00:47:10.410 --> 00:47:10.860
19146211770: chat about

389
00:47:13.590 --> 00:47:15.090
Michael Green: Another another

390
00:47:16.230 --> 00:47:17.040
Michael Green: Use

391
00:47:18.750 --> 00:47:21.720
Michael Green: Other relying on sort of police state.

392
00:47:22.200 --> 00:47:22.650
You know,

393
00:47:23.790 --> 00:47:28.590
Michael Green: Kind of tactics on a more voluntary basis if there, if there was

394
00:47:30.120 --> 00:47:34.200
Michael Green: If there's universal testing and everybody knew whether they were

395
00:47:35.460 --> 00:47:37.590
Michael Green: Positive or not or whether they have antibodies

396
00:47:40.620 --> 00:47:41.130
Michael Green: Time that

397
00:47:42.240 --> 00:47:42.630
Michael Green: App.

398
00:47:42.840 --> 00:47:44.400
Michael Green: where the information was

399
00:47:45.060 --> 00:47:46.500
Michael Green: Available and

400

00:47:47.790 --> 00:47:53.460
Michael Green: You know, entire workplaces that are lower risk be opened up saying, if there's nobody in this

401
00:47:53.520 --> 00:47:59.070
Michael Green: Proximity, who is contagious, then you're safe to go to work and

402
00:48:01.380 --> 00:48:08.760
Michael Green: You know, would be contagious. Then, you know, you know, to avoid and and isolate because

403
00:48:10.650 --> 00:48:19.620
Michael Green: I mean, I don't know that it's practically feasible to actually implement it. But, but it could be terribly useful to work.

404
00:48:20.430 --> 00:48:21.990
Paul Wolpe: There are a lot of mobile apps that are

405
00:48:22.140 --> 00:48:23.250
Paul Wolpe: Perhaps less

406
00:48:23.550 --> 00:48:27.780
Paul Wolpe: worrisome their mobile apps where you put in your symptoms and it tells you whether you might be

407
00:48:28.380 --> 00:48:45.090
Paul Wolpe: coven you know that might be worth getting tested or you might win isolate yourself their apps that get you to, you know, show you where your nearest testing center is there, especially, there was one app. I can't remember who made it that came out for healthcare workers, especially

408
00:48:45.450 --> 00:48:47.250
Paul Wolpe: To show them where the nearest place they could get

409
00:48:47.250 --> 00:48:59.250
Paul Wolpe: Tested was there, you know, misinformation apps you know apps that tell you what the correct and validated information are you know I don't think any of those are particularly so there are a lot of apps coming out for

410
00:48:59.250 --> 00:48:59.700

19146211770: Pokemon.

411
00:49:00.150 --> 00:49:01.440
Paul Wolpe: And I don't think any of them are

412
00:49:01.440 --> 00:49:05.700
Paul Wolpe: Particularly worrisome though of course there are elements of them that could be

413
00:49:06.180 --> 00:49:08.400
19146211770: I think it's his contact at

414
00:49:08.460 --> 00:49:10.710
Paul Wolpe: Question. That's really the worry someone

415
00:49:11.880 --> 00:49:12.570
19146211770: And, you know,

416
00:49:14.220 --> 00:49:15.060
Paul Wolpe: Both

417
00:49:15.090 --> 00:49:18.090
Paul Wolpe: In terms of surveillance. But I mean, what if I just had an app.

418
00:49:18.090 --> 00:49:20.370
Paul Wolpe: That I when I walked into the CVS.

419
00:49:21.510 --> 00:49:39.450
Paul Wolpe: It had a little, you know, red dots that showed me who, who was also in the CVS has had contact with a coven patient or I get a little warning signal. I mean, it's not just government or state surveillance or even corporate surveillance there other ways this could be problematic.

420
00:49:41.160 --> 00:49:44.730
Robert Klitzman: So I'm curious just picking up on the comment, a few comments ago about

421
00:49:45.420 --> 00:49:46.800
Robert Klitzman: Areas being, quote,

422
00:49:46.830 --> 00:49:49.080

19146211770: Okay, to open up and reduce

423
00:49:49.440 --> 00:49:55.350
Robert Klitzman: A lockdown because I think this is going to be huge issue. And there's a lot of interesting and

424
00:49:55.350 --> 00:49:56.850
19146211770: Important bioethical

425
00:49:57.060 --> 00:49:58.860
Robert Klitzman: issues and concerns that come down.

426
00:49:58.860 --> 00:50:09.750
Robert Klitzman: I mean, How should political leaders be making these decisions. I mean, do they wait till they're zero cases. I mean, how low is low enough to say open the area, given the probably still be

427
00:50:09.750 --> 00:50:11.220
19146211770: Some people who may

428
00:50:11.640 --> 00:50:13.680
Robert Klitzman: Be infected or do we wait to zero. I'm just

429
00:50:13.680 --> 00:50:14.670
19146211770: curious what people think.

430
00:50:17.820 --> 00:50:25.890
Michael Green: I mean tho, those are those are the really tough political decisions that are going to have to be made because

431
00:50:26.340 --> 00:50:27.690
19146211770: You know, getting to zero.

432
00:50:28.650 --> 00:50:29.340
Would

433
00:50:31.230 --> 00:50:32.820
Michael Green: You know that the economy would

434
00:50:32.910 --> 00:50:44.490
Michael Green: Be destroyed and, you know, and so you can't wait to zero, there have to be some so risk benefit calculations and and and it's, you know, and it's the case that there's, you know, there are some

435
00:50:45.090 --> 00:50:54.870
Michael Green: regions of the country that are at much higher risk than others, and as well as industries that are higher risk than others and

436
00:50:56.040 --> 00:51:03.840
Michael Green: You know, at some point, we're not there yet. But at some point, a decision is going to need to be made that you know the risk is

437
00:51:05.580 --> 00:51:07.230
Michael Green: low enough that

438
00:51:08.250 --> 00:51:13.560
Michael Green: You know, people can go back to work. Because if nobody goes back to work and you know everything falls apart.

439
00:51:16.140 --> 00:51:30.060
Paul Wolpe: The problem is going to be the subsequent waves. I mean, how do you determine that. I mean, China is going through a second wave. Now, and you know when you have something that doesn't just trail off, but rather, you know, has a kind of roller coaster shape.

440
00:51:31.080 --> 00:51:42.270
Paul Wolpe: There is no magic moment whenever when it's okay to go back to work, but to see a political decision is going to have to be made that isn't going to depend on that kind of empirical data.

441
00:51:42.960 --> 00:51:56.730
Michael Green: But and but we you know we we as a society, and as individuals, accept a certain amount of risk in our lives. Generally, I mean seasonal flu is a risk and people die from seasonal flu. Now, you know, and

442
00:51:57.150 --> 00:52:13.590
Michael Green: And we don't shutdown society. As a result, the seasonal flu or many or any other kinds of at risk kinds of activities. And so there is a point at which we say, Yeah, you know, there is a risk, but it's low enough that we have to, you know,

443
00:52:13.800 --> 00:52:21.570
Paul Wolpe: I agree with. I'm agreeing with you. I'm saying that there will be a political decision made at some point and it will be during a dip.

444
00:52:22.230 --> 00:52:24.210
Paul Wolpe: Right. And, you know, or during a

445
00:52:25.290 --> 00:52:34.410
Paul Wolpe: Trending downward. But what's not going to happen. And what I think. And this is a this is an issue with the public misunderstanding of this

446
00:52:35.670 --> 00:52:40.350
Paul Wolpe: Pandemic people think it's going to end that you know will have a peak.

447
00:52:40.740 --> 00:52:44.430
Paul Wolpe: And you keep seeing this flatten the curve. And there's only one curve on the graphs.

448
00:52:44.700 --> 00:52:53.430
Paul Wolpe: And then people are just assuming that the curve will then trail off and it'll go away like the flu does, and they can all go back to work. And that's not what's going to happen.

449
00:52:53.940 --> 00:53:05.700
Paul Wolpe: And I think, you know, one of the big challenges we have not just us. But, I mean, we in the collective way is is getting people to understand that this isn't just a single peak.

450
00:53:06.180 --> 00:53:14.490
Paul Wolpe: And then extinction event and the exactly what you're saying. Michael a certain amount of risk is going to be part of moving forward.

451
00:53:16.050 --> 00:53:20.010
John Carney: This is the, this is the moral obligation of the are not and I

452
00:53:20.520 --> 00:53:21.150
John Carney: 100%

453
00:53:21.210 --> 00:53:21.810
John Carney: This is

454

00:53:22.470 --> 00:53:24.150
John Carney: The ability for us to judge

455
00:53:24.600 --> 00:53:35.580
John Carney: Is really not at our disposal. I mean, there are 13,000 people who died with h one and one and but 65 million people got it.

456
00:53:36.270 --> 00:53:45.360
John Carney: If we have 65 which is 20% of the population of 65 million people got this because we just went back to work and said, Well, we're just live with it.

457
00:53:45.900 --> 00:53:51.810
John Carney: That the numbers of people who die will devastating and will be overwhelmed again. So, I mean, I think.

458
00:53:52.080 --> 00:53:58.050
John Carney: That's what we're calling the moral obligation of the are not and we have an obligation, I think, to teach the public about it.

459
00:53:58.410 --> 00:54:05.220
John Carney: Yesterday morning's New York Magazine article if you've not read it by, you know, how many people will die when we go back

460
00:54:05.580 --> 00:54:19.050
John Carney: To work. I don't remember exactly, but it's five folks all of you all people who we all know with, you know, from Zynga manual that Peter Singer, it's, it's an incredibly thoughtful piece and I commend it to everybody. If you haven't seen it already.

461
00:54:19.950 --> 00:54:33.210
Armand Antommaria: Nice, good economic impact question. Can I ask if any of the members of the association are engaged in conversations within their institutions, about how equitably to share the negative

462
00:54:33.270 --> 00:54:37.530
Armand Antommaria: economic impact indoor more parochially have any

463
00:54:39.300 --> 00:54:44.310
Armand Antommaria: Views at this point about how the negative economic impact is going to affect their own centers.

464

00:54:50.610 --> 00:54:54.990
Mark Aulisio: Yeah, we've talked a little bit about that at Case Western

465
00:54:56.160 --> 00:55:01.170
Mark Aulisio: Mostly among the Council basic science chairs and also

466
00:55:02.220 --> 00:55:11.730
Mark Aulisio: Of course, at the level of the provost and the President of university and at least right now. Although the hit is really, really big.

467
00:55:13.020 --> 00:55:24.720
Mark Aulisio: The University made a decision not to go ahead with layoffs, or cuts that were even approved prior to the pandemic.

468
00:55:25.740 --> 00:55:34.050
Mark Aulisio: Because they didn't want people to be in the position of, you know, of greater vulnerability to time of pandemic.

469
00:55:35.040 --> 00:55:48.090
Mark Aulisio: Whether we can sustain that or not it's going to depend on a whole lot of things, but that was a decision that was deliberately made and the hit of courses much is significantly greater because of that.

470
00:55:50.070 --> 00:55:56.790
Mark Aulisio: There has been some talk of, well, what about voluntary salary cuts.

471
00:55:57.120 --> 00:55:58.890
12522580318: What about voluntary.

472
00:55:59.730 --> 00:56:15.000
Mark Aulisio: You know, other types of things. We're not there yet, but there is a conversation about it. And, you know, depending on how this unfolds that conversation will lead to some reality, but it is being discussed at our institution.

473
00:56:17.190 --> 00:56:24.810
Thomas D. Harter, PhD: This is Tom at Gunderson we are there in terms of having to make some of those tough decisions as well as places like Mayo Clinic.

474
00:56:26.790 --> 00:56:31.080
Thomas D. Harter, PhD: Where staffs are being impacted economically.

475
00:56:32.160 --> 00:56:40.110
Thomas D. Harter, PhD: We've already begun, and this is public information. So I'm not telling you anything that's private or that you can't find just by Googling it but

476
00:56:41.460 --> 00:56:58.440
Thomas D. Harter, PhD: We have hospital staff who have had reduced hours, some that are now being furloughed and medical staff are being asked to take our salary reductions. So we're, we're at that point. And it's meant as a way that it's all temporary and we're being told that once

477
00:56:59.820 --> 00:57:03.240
Thomas D. Harter, PhD: Elective procedures and and outpatient clinic visits.

478
00:57:10.080 --> 00:57:11.790
Thomas D. Harter, PhD: Let's begin to that.

479
00:57:12.480 --> 00:57:15.360
Thomas D. Harter, PhD: Those restrictions will be lifted and everybody is still

480
00:57:15.360 --> 00:57:17.310
Thomas D. Harter, PhD: Welcome to come back and get their full

481
00:57:17.580 --> 00:57:18.840
Thomas D. Harter, PhD: salary paid, but

482
00:57:19.800 --> 00:57:22.080
Thomas D. Harter, PhD: Whether that plays out. We'll have to see.

483
00:57:25.890 --> 00:57:33.600
Neuroethics Canada: at my institution, University of British Columbia, we received an unusual request from the Faculty of Medicine.

484
00:57:35.010 --> 00:57:48.390
Neuroethics Canada: To look at our budgets on our external grant awards, which I thought was very interesting how we were going to utilize either surpluses or allocations from those awards and redistribute them to

485
00:57:49.560 --> 00:57:56.010
Neuroethics Canada: People on in staff in in need and a waiting to see how how that plan unfolds.

486
00:58:00.240 --> 00:58:18.360
12522580318: Bria that in North Carolina. We've already had a budget year where we are operating without a budget because of legislature was not able to approve the budget and that meant that there was already reductions and university system and the academic health center father haven't been

487
00:58:19.380 --> 00:58:36.270
12522580318: Rather have been even under this pandemic further reductions. They've tried to hold the line as much as possible, but I'm not sure that it's going to continue. And that's pretty significant in the state that is currently undergoing some financial constraints.

488
00:58:38.610 --> 00:58:45.300
Paul Wolpe: So it's it's 12 o'clock now Eastern time, at least when this was scheduled to end.

489
00:58:46.650 --> 00:58:54.030
Paul Wolpe: And I want to be respectful of everyone's time. So I want to thank everybody for for coming on. We'll do this again.

490
00:58:55.500 --> 00:59:02.430
Paul Wolpe: Our next scheduled time. I don't have a ham date is. And thank you, please do send Barbara anything you want.

491
00:59:02.580 --> 00:59:03.990
Paul Wolpe: Circulated to everybody.

492
00:59:04.770 --> 00:59:07.620
Paul Wolpe: And thanks everyone for participating.

493
00:59:09.180 --> 00:59:09.720
holly tabor: Thank you.

494
00:59:10.110 --> 00:59:11.580
12522580318: Thanks. Thank you for holding this

495
00:59:11.880 --> 00:59:13.290
Neuroethics Canada: Yes, thank you very much indeed.

496
00:59:14.730 --> 00:59:15.450

Paul Wolpe: Hi everyone.

497
00:59:15.780 --> 00:59:17.160
hannah lipman: You won't get. Thank you.