

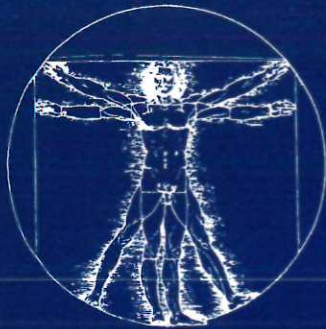
Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 1992*

Mid-Atlantic Ethics Committee
Newsletter, Fall 1992

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MID-ATLANTIC ETHICS COMMITTEE

N E W S L E T T E R

A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
Published by the Institutional Ethics Committee Resource Network
Law & Health Care Program
School of Law, University of Maryland at Baltimore

Fall 1992

Educating Ethics Committees

Inside this issue:

Network News	2
State News	3
Maryland Legislation	3
Case Law	3
Education Section	
Decisions Near The End of Life	3
Using Literature to Educate	4
Educating Committee Members About Process: The Use of Mediation	5
Case Presentation	6
Case Comments:	
Psychiatrist/Bioethicist	7
Attorney	8
Ethical Issues in the Care of the Elderly	9
Calendar of Events	11

It is taken as a given that ethics committees must be adequately educated - when they first begin and on some continuing basis thereafter. The first seems much easier than the latter. Without much else to do, a newly-formed ethics committee appropriately can devote a majority of its time to studying key concepts in moral reasoning and reviewing a variety of practice cases. But once under way, even the most diligent committee can lose sight of its educational needs under the increasing load of policy development and case review. Here are a couple of tricks of the trade expanded from a discussion at a recent D.C. Bioethics Network meeting.

- distribute one or two key articles with each mailing to committee members;
- sponsor educational sessions (Grand Rounds, Brown Bag Lunches, etc.) on various units of the hospital/nursing home and invite committee members to lead or participate;
- develop a centralized library for committee members;
- send a representative to meetings of The Society for Health and Human Values (703)556-9222; The Society for Bioethics Consultation (216)444-8720; The American Society for Law and Medicine (617)262-4990; or The Kennedy Institute of Ethics (202)687-6771. Membership in one of these

About this newsletter

This issue of the Mid-Atlantic Ethics Committee Newsletter focuses on education — education of ethics committee members and of institutional staff. Education is one of the most important functions that ethics committees can perform. Most committees, in my experience, spend some time at the outset educating themselves about the relevant laws and ethical issues that they are likely to confront. But, as time marches on, education efforts seem to fall by the wayside. This issue of the newsletter gives you some ideas about how you can keep educating your committee as well as ideas for in-house educational programs and resources. Several creative approaches such as using literature to educate ethics committee members about ethics and human values and the use of mediation in case consultation are described. Please let us know if your committee has other suggestions or ideas on education that might be of interest to others.

Diane E. Hoffmann, Editor

organizations gets you on the mailing list for information about new literature and important conferences. Rotate attendance at the conferences and have the person who attended the conference report back to the committee.

- devote part (even 15 minutes) of each meeting (or some number of meetings a year) to the review of one or

Cont. on page 2

Maryland Legislation

Efforts to achieve a broad based consensus on a package of proposed legislation on Advance Directives and Health Care Decisionmaking continue as representatives of the Maryland Office of the Attorney General and the Judicial Conference of Maryland fine tune their draft bill. The most recent version of the bill, made available for public review this week, most notably deletes the earlier provisions which restricted a physician from withholding or withdrawing life sustaining treatment at the direction of a surrogate or health care agent if the patient were known to be pregnant. The restriction would still hold, however, if the patient had executed a living will. Also modified is the definition of futility.

The proposed legislation which addresses life sustaining treatment decisions made by a competent patient, under a living will or durable power of attorney for health care, by a surrogate, a guardian or a judge, will be the subject of a day long conference co-sponsored by the Maryland Office of the Attorney General and the Law & Health Care Program at the University of Maryland School of Law, on November 18th at the School of Law. At the conference, Jack Schwartz, Chief Counsel for Opinions and Advice of the Maryland Office of the Attorney General, will provide an overview of the proposed legislation and panels of legislators, judges, health care providers and patient and family representatives will give their perspectives on the proposed bill. In addition, David Smith, Director of Legal Services for Choice in Dying will speak on how the proposed legislation compares to other state legislation in this area. For more information about the conference call 410/706-3378.

Case Law

On October 5th, the case of *Mack v. Mack*, regarding termination of life support for Ronald Mack, a 31-year-old man who has been in a persistent vegetative state for nine years was argued before the Maryland Court of Appeals--Maryland's highest court. An opinion should be forthcoming in the next several months.

Decisions Near the End of Life: An Educational Program for Health Care Providers

A number of area hospitals are considering implementing an interdisciplinary continuing education program on medical ethics for hospital staff called "Decisions Near The End Of Life". This "Decisions" program, developed jointly by the Education Development Center, Inc. and The Hastings Center, is focused on the difficult decisions faced by patients, families, and clinicians regarding the use of life-sustaining technology. The program is targeted to all professionals involved in the care of critically and terminally ill patients: physicians, nurses, social workers, respiratory therapists, clergy, attorneys, and administrators. The overall goal of the Decisions program is to improve decisionmaking regarding the use of life-sustaining treatments. To achieve this goal, the program is designed to:

- enhance communication between health care providers and patients and their families and among providers caring for the same patient.
- demonstrate appropriate roles and responsibilities for health care professionals fostering teamwork and conflict resolution.
- improve providers' understanding of medical ethical principles and enhance their ability to integrate that understanding into clinical practice.
- improve providers' understanding of the laws concerning withdrawal of life-sustaining treatments and instill a sense that decisions should not be influenced by an inappropriate fear of legal liability.

The "Decisions" program consists of two parts: an assessment phase followed by a multi-level educational

process.

In the assessment phase, members of the hospital staff complete a questionnaire that:

- examines beliefs, attitudes and self-reported practices regarding the use of life-sustaining treatments,
- determines knowledge about medical ethics, recently promulgated national ethics guidelines, and legal standards,
- identifies perceived impediments to good decisions regarding forgoing of life-sustaining treatments, and
- assesses satisfaction with the involvement of patients and families in decisions about the use of life-sustaining treatments.

The multi-level educational program begins with grand-rounds type sessions that discuss the results of the questionnaire and explore selected medical-legal concerns. Subsequently, interdisciplinary small group seminars are held, where participants discuss specific cases highlighting typical ethical dilemmas that occur in clinical practice.

The University of Maryland Medical Center began implementation of the program last year. The "Decisions" questionnaire was distributed to the University of Maryland hospital staff in December of 1991 and over 300 responses were collected.

The following list is a sample of the responses from the more than 70 items on the questionnaire:

1. More than 50% of the hospital staff felt that "fear of legal action" was a potential impediment to making good decisions about the care provided to patients who are critically and terminally ill. Other factors considered as significant obstacles in the decisionmaking process included: staff shortages/time constraints, communication difficulties with patients and their families, communication difficulties among staff, lack of adequate hospice services, and lack of knowledge of medical ethics.

2. Approximately 60% of the staff thought that cardiopulmonary resuscita-

Cont. on page 4

EDUCATION

"The Promise" is a poem by contemporary poet Sharon Olds; it first appeared in *The New Yorker* in 1990. It is offered to medical and nursing students in a basic clinical ethics class on issues in death and dying as an ethically complex case, that is, a case in which ethical principles conflict or compete with one another and for which prevailing clinical guidelines and societal rules seem inadequate. The case involves avowing one's willingness to carry out a mercy killing for reasons of love, compassion, and personal loyalty.

The poem summarizes a dialogue between a man and a woman, probably husband and wife, in which each has solemnly promised to kill the other in the event of an incapacitating, hopeless illness. The fact that this "case" is in poetic form allows us to know and to experience first-hand its emotional intensity and complexity. A conventional case presentation of this same situation would not afford such immediate access to the emotional dimension of the debate over mercy killing, to the inner world of one considering mercy killing, or to the personal dimension where commitments grounded in love, spirituality, passion, and blood often take precedence over the reasoned rules of community.

The poem presents a situation in which several ethical principles conflict and in which legal and social obligations pale beside the individual's perceived moral and emotional duties to self and spouse. The claim to self-determination and the vow of each lover to honor the selfhood of the other (the ethical principle of respect for persons) drives the dialogue and empowers the poem. Personal autonomy and the autonomy of the couple as a unit seem here both elemental parts of the natural order of things, just as their bodies belong to nature ("we are part soil already"), and transcendental phenomena, beyond the natural and social orders. Their relationship, and their

promise, assumes significance of an almost religious nature, although the spirituality here is grounded very much in the secular realm. Because the right to self-determination is extended here even unto death, it runs headlong into the community's legal, social, religious, and professional codes which forbid killing. This conflict points up a key difficulty in clinical ethics today: the patient's right to self-determination, which includes the right to refuse treatment, is not absolute; it does not in practice extend to the free choice of death even in lieu of prolonged suffering and loss of dignity. The rights of the individual patient at this juncture conflict with prevailing laws, accepted social mores, and codes of ethics in medicine (including the Hippocratic oath) that seek to protect persons from harm (the principle of nonmaleficence). In addition, in the context of medical care today, the physician's efforts to do good for the patient (the ethical principle of beneficence) can and sometimes do inflict harm (e.g., pain and suffering of the physical, emotional, and spiritual sorts), while efforts to avoid doing the ultimate harm (i.e., causing the patient's death) may cause other harms (e.g., prolonging suffering, denying the patient dignity, violating the patient's autonomy).

Sharon Old's poem is an exploration and statement of one couple's response to this dilemma in our society. It is precisely because of these fundamental conflicts of principles and their impact on medical (and legal) practices that this man and woman have felt the need to make this pact. The sanctity of their promise is evident from the tone of the poem: the loving obligation they have to one another is proving to be a higher calling than the ethics of either medicine, society, or law.

It is probably safe to say that the motivations and emotions of some family members contemplating — or carrying out — a mercy killing are not unlike those conveyed in this poem. In

giving voice to this intense experience, the poem becomes not only a testament to a particular couple's love for one another but a test for each of us generally, against which we may measure our loves, our loyalties, our own inner laws and those of our community.

submitted by
Marcia Day Finney, Special
Assistant to the Vice-President for
Health Sciences, University of Virginia

Educating Committee Members About Process: The Use of Mediation

In addition to educating themselves about substantive issues in ethics and law, committee members should spend some time educating themselves about alternative processes for case consultation. A number of ethics committee members did this in June when they participated in an interactive video conference on the use of mediation to resolve ethical disputes in the health care institution. The teleconference, sponsored by The Center for Health Law and Ethics and the Center for the Study and Resolution of Disputes, University of New Mexico, School of Law, described the concept of mediation and how it might be a useful adjunct to the arsenal of process options ethics committees utilize in case consultation. Mediation may, in fact, already be used by some ethics committees but in theory it differs significantly from the "paradigm" process used by most ethics committees. Most committees seem to use a process in which *members* hear the problem from the perspective of each of the parties involved in the case and then *members* meet and make a recommendation. In mediation, the

Cont. on page 6

EDUCATION

She was convincing in her arguments that the care and future of her 12 year old daughter were not of concern to her since she had a brother and sister-in-law who were both willing and capable of caring for the daughter and of raising her with the same value perspective that both Mrs. C and her husband would have provided.

The decision about surgery became more critical as the days passed. The director of the burn unit estimated that if Mrs. C did not have surgery within the next 48-72 hours she would die. Despite ongoing discussions with both the health care team as well as with her family, Mrs. C remained adamant about her decision to refuse surgery.

While her family is understanding of the reasoning process that led to her refusal, it is their contention that Mrs. C should not be making this decision.

Case Discussion: Comments From A Psychiatrist/Bioethicist

Should Mrs. C.'s refusal of surgery be overridden? The critical consideration in answering this question is whether Mrs. C.'s emotions have been so strongly affected by her husband's death and her present condition that they have altered her understanding of what she truly wants. This determination is particularly problematic because her reasoning would remain intact and even be utilized to support her altered beliefs.¹ Yet, if this has occurred, intervening over and against Mrs. C.'s objection may not only be justifiable on the ground of beneficent paternalism but obligatory to restore her autonomy.

Legally, the decision will depend on whether Mrs. C. is judged competent. This decision depends, in turn, on the standard used to determine competency, what features are given most weight when making this determination, and whether, as in this case, one

psychiatrist's conclusions regarding both these questions are taken as the final word when determining the patient's outcome.

The appropriate legal standard for determining competency often is unclear.² Ethically, the argument is strong that in a case such as this, a high threshold, which takes into account the effects of patients' feelings is most appropriate.³⁻⁸ Under such a standard, we would not find a person to have decisionmaking capacity if, for example, the person was overcome by grief. In such a case, it would be important to wait to make the decision, if possible, until the person was better able to deal with their grief. Burn victim, Dax Cowart, sensitized us to the importance of respecting each patient's autonomy, but this respect is not necessarily due immediately. Rather, it should gain rapid and increasing priority over time, as patients have greater time to reflect on the issue.

Since psychiatrists, knowingly or unknowingly, can impose their personal bias when both selecting a competency standard and determining competency, in controversial cases such as this one, they should consider seeking a second psychiatric opinion, ideally from a colleague whose bias tends to differ from their own. Since this judgment inherently has ethical as well as clinical components, it also should be subjected to ethics committee review for a still more balanced, broad-based perspective.

Were I consulted either as a psychiatrist or an ethics committee member, I would be inclined to recommend surgery. We are not given the family's reasons for the surgery. They are potentially important, however, and thus, the physicians should inquire about them. Yet, even without this information, there are substantial bases for deciding to go ahead with the surgery. Mrs. C. has undergone two most recent, overwhelming events. Either, alone, could eradicate her desire to survive. In addition, her possible suicidality implies that previously she may have been depressed. Her

accepting treatment prior to the surgery also suggests significant ambivalence. Still more compelling, her daughter would lose not one, but both parents. The daughter's loss, therefore, would be exponentially, rather than doubly increased.

The foregoing arguments could be excepted on the basis of Mrs. C.'s religious belief, but, unlike a Jehovah's Witness patient needing life-saving blood, it is unclear that Mrs. C. would have held the same view prior to the explosion. Moreover, unlike a Jehovah's Witness patient who accepts blood and therefore risks loss of eternal life, it is unclear whether Mrs. C.'s acceptance of the surgery would violate her religious beliefs and so wholly affect her spiritual life. Religious beliefs, like autonomy, deserve great respect, but they do not always warrant absolute priority. As Albert R. Jonsen stated in arguing for giving blood to an adult Jehovah's Witness patient: "The good casuist . . . [] . . . comes to cases with a sincere commitment to broad moral imperatives, such as the respect for autonomy and, at the same time, a sensitivity to those conditions that might qualify that commitment in the name of some other equally moral purpose."⁹

A final concern is one which some might consider feminist. It asks the extent, if any, to which Mrs. C.'s decision reflects a demeaning social-cultural context. Could it, for example, be related to the notorious practice of women throwing themselves on their husbands' funeral pyres? I would explore this possibility with her family. If it were related, some might accept this as a cultural difference and ignore it. Others might consider the practice heinous and, in response, attempt to maximize her dignity by honoring her request. I would find it heinous also, but would oppose her request to avoid implicitly supporting this practice.

The case involves two further issues too important to overlook. First, on what basis did Mrs. C.'s husband's

Cont. on page 8

ETHICAL ISSUES IN THE CARE OF THE ELDERLY

Conference on Advance Directives: Legality v. Liability

On August 27, 1992, the Health Facilities Association of Maryland (HFAM) held a conference for nursing home administrators and members of patient care advisory committees on some of the tensions that exist between nursing home practices and the federal Patient Self Determination Act and state advance directive laws. Key speakers included Jack Schwartz, Chief Counsel for Opinions and Advice of the Maryland Office of the Attorney General, Patricia McMullen, Assistant Professor, University of Maryland School of Nursing; Diane Hoffmann, Associate Professor, University of Maryland School of Law; Thomas Finucane, Associate Medical Director, Johns Hopkins Geriatric Center; and Gene Heisler, Deputy Director, Long Term Care, Office of Licensing and Certification Programs, Maryland Department of Health and Mental Hygiene. One of the motivations for the conference was a series of hypothetical problems that were discussed at several workshops conducted by HFAM around the state on the establishment and operation of patient care advisory committees. The problems dealt with issues surrounding the performance of CPR and the execution of DNR orders. As a result of the conference, Jack Schwartz, sent a letter to Gene Heisler making the following points about the law with respect to DNR orders:

1. Typically, institutional policies require that CPR be attempted on any patient who is discovered to have suffered a cardiac arrest unless an order not to resuscitate has been entered on the patient's chart. (The Office of Licensing and Certification has stated that nursing homes may not have a policy that CPR will not be performed as a matter of course or that limits admissions to patients who do not wish CPR to be performed.)

2. Every effort should be made to

make an individualized determination of a patient's wishes regarding CPR in advance of an arrest. If the patient is incapacitated, the patient's physician should discuss the issue with the patient's authorized surrogate. During this discussion the physician should obtain consent for either the performance of CPR or an order not to resuscitate.

3. The ability of a family member to consent to the withholding of CPR, i.e., a DNR order, is limited to those cases where the patient is in a "terminal condition". In some cases, a patient may not be terminal prior to arrest but after an arrest, is very likely to die within a matter of days or at most a few weeks. In those cases, the patient would be considered terminal at the moment of arrest and consent may be obtained from family members for a DNR order prior to the patient's arrest.

4. In some cases, CPR would be medically inadvisable. In those cases, there is a very low likelihood that CPR will be successful in restoring the patient's cardiopulmonary function and even if restored, the patient will die within a few days, often having lost cognitive functioning. In these cases the law allows a physician to decline to perform CPR, unless the patient or the patient's surrogate requests that CPR be performed. In those cases, where the patient lacks decisionmaking capacity and no authorized surrogate is available, the physician may decide that CPR is not warranted.

5. If CPR would clearly be futile, i.e., would not restore the patient's cardiopulmonary function, a physician may unilaterally determine that CPR is inappropriate and may write a DNR order without the patient's or surrogate's consent.

Conference on Making Ethics Committees Work

On Thursday, November 5th, the American College of Health Care Administrators and the Virginia Association of Nonprofit Homes for the Aging will be sponsoring a half day conference entitled "Making Ethics Committees Work." The conference

will be held in Williamsburg, Virginia and will focus on how to establish an ethics committee in a nursing home, legal liability issues for ethics committee members, identifying educational resources, and analyzing cases that come to ethics committees. For more information about the conference contact Ann Finley, Administrator, Sentara Life Care Corporation, (804) 826-3100.

Conference on Ethics Committees and the Elderly

A national conference on ethics committees and the elderly is being planned by the American Society of Law and Medicine in conjunction with the University of Maryland's Law and Health Care Program and The Hastings Center for Bioethics. The conference will be held in Baltimore on March 19th - 20th, 1993. Speakers will include Christine Cassel, M.D., University of Chicago, Pritzker School of Medicine, author of several articles on nursing home ethics committees; Rosalie Kane from the Center for Health Services Research at the University of Minnesota; Ron Cranford, M.D., a neurologist and consultant on several major right to die cases; Bart Collopy, a bioethicist at Fordham University's Third Age Center; Peter Rabins, MD, a psychiatrist at Johns Hopkins Medical Center and author of *The 36 Hour Day*, and others with national reputations in this area. The purpose of the conference is to discuss experiences of hospital ethics committees and to determine what can be learned from those experiences and applied to nursing home committees given the unique characteristics of long term care facilities. In addition to two full days of lectures and panel discussions, the conference will include a "Night at the Movies" featuring films about ethical issues that confront caregivers of the elderly. For more information about the conference call 410/706-3378.

CALENDAR OF EVENTS

October

- October 17th Washington Metropolitan Bioethics Network Meeting, 9:30 - 11:30 a.m.; Marymount University. The topic is issues in nursing ethics. For more information contact Joan Lewis (202) 682-1581.
- October 26th Conference, "Finding the Right Balance," Mary Washington Hospital, Fredericksberg, VA; 8:00 a.m. - 4:30 p.m. Keynote speakers will include Chris Cruzan White (Nancy Cruzan's sister) and Margot White, JD, Assistant Professor, Law & Ethics, University of Virginia, Center for Health Sciences. For more information, contact Sherri Crosslin (703) 899-1565.
- October 28th Conference, "Pediatrics Ethics," Charleston, West Virginia. Sponsored by the West Virginia Network of Ethics Committees. Featured speaker - Dr. Norman Fost, University of Wisconsin. For more information, contact Cindy Jamison, (304) 293-7618.
- October 30 - 31st American Society of Law & Medicine, 1992 Annual Meeting, Cambridge, MA. The topic is "Health Care Professionals and Treatment at the End of Life." For more information call (617) 262- 4990.

November

- November 5th American College of Health Care Administrators and Virginia Association of Nonprofit Homes for the Aging, half day conference on Making Ethics Committees Work, 8:00 a.m. - 12:45 p.m., Williamsburg, VA, contact Ann Finley, (804) 826-3100.
- November 6th Lecture, Charleston, West Virginia. Dr. Albert Jonsen, professor of Ethics in Medicine and chairman, Department of Medical History and Ethics, University of Washington, will speak on "Fighting in the Fortress of Medicine: The Ethical Conflict Between the Personal and the Institutional." For more information, contact Cindy Jamison, (304) 293-7618.
- November 17th Washington Metropolitan Bioethics Network Meeting, 4:00 - 6:00 p.m., Hebrew Home of Greater Washington, Rockville, MD. For more information, contact Joan Lewis, (202) 682-1581.
- November 18th Conference on "The Right to Refuse Life Sustaining Medical Treatment in Maryland: Analysis of a New Legislative Proposal," University of Maryland School of Law, 8:30 a.m. - 5:00 p.m. For more information call (410) 706-3378.

December

- December 2nd Baltimore Area Ethics Committee Network Meeting, St. Agnes Hospital, 4:30 - 6:30 p.m. For more information call (410) 706-7191.