

Health Care Law

Mid-Atlantic Ethics Committee Newsletter

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Mid-Atlantic Ethics Committee
Newsletter, Fall 2007

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MID-ATLANTIC ETHICS COMMITTEE

NEWSLETTER

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

Fall 2007

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

*Diane E. Hoffmann, JD, MS
Editor*

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ART, EMOTIONS & ETHICS

At MHECN's July 26 conference, *Ethics Committees in Action*, art therapist Julia Andersen guided attendees through an experiential session to explore how they, as ethics committee members/ethics consultants, might enhance their own self-awareness and emotional health through art therapy techniques. Some attendees had difficulty recognizing the relevance of this activity to the work of ethics committees. This surprised me. Many ethics consultations or cases discussed at ethics committee meetings involve emotionally charged issues such as withholding or withdrawing life support from patients. Are those involved in these case discussions with patients or family members not affected by the barrage of emotions they stir up? If they are affected, how do they process these emotions? One attendee wrote on the conference evaluation form: "I didn't respond to the art. But I realized my feelings are dictated by medicine." Indeed, many health care professionals (HCPs) are trained to strive for emotional objectivity in their encounters with patients or family members. Does this serve HCPs well? Does it serve patients/families well?

In her book, *From Detached Concern to Empathy: Humanizing Medical Practice*, philosopher and psychiatrist Jodi Halpern challenges the practice of teaching "detached concern" to medical students and physicians. Instead, she advocates nurturing empathy such that the clinician can emotionally connect with

the patient/family while not losing sight of his or her role as healer in the process. She argues that connecting emotionally with patients makes physicians more effective healers. Eric Cassell (2002) concurs, stating, "it is impossible to banish emotions from medicine, because both physicians and patients are people, and emotions are as much a part of people as thought." He continues, "[t]he emotions that patients arouse within physicians are also evaluative and tell physicians much about the patients, about themselves, and about their relationship." Unfortunately, the current training and culture of medicine (which pervades other health care disciplines as well) encourages HCPs to deny their patients' and their own emotional responses, and to internalize feelings in unhealthy ways.

Is the same predisposition toward detached concern operative among ethics committee members? We can assume so, since ethics committees operate in health care facilities strongly influenced by the culture of medicine. So one might then ask, is emotional detachment effective in resolving ethical conflicts? From a humanistic perspective, one could appeal to common sense and compassion to support a more emotionally connected response between ethics consultants and patients/families. But for the skeptics, an appeal to science might help. Evidence is mounting that emotions are more at play in the processes of thinking and reasoning than was formerly believed.

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REGIONAL NEWS

MARYLAND HEALTH CARE ETHICS COMMITTEE NETWORK (MHECN)

The Maryland Health Care Ethics Committee Network (MHECN) is partnering with WVNEC to plan a one-day conference on May 14, 2008, entitled, "More is Not Always Better: Seeking Value in End-of-Life Care." MHECN members will receive a 20% discount on registration fees for this conference, which will take place in Morgantown, VA. MHECN is also planning a conference in February of 2008 on health care reform and related issues. Look for more information in our e-mail announcements and our website, at www.law.umaryland.edu/mhecn, or contact us at MHECN@law.umaryland.edu.

MONTGOMERY COUNTY END-OF-LIFE COALITION

The end-of-life coalition in Montgomery County is taking part in the inaugural National Healthcare Decisions Day on April 16, 2008. On this day, throughout the country, healthcare providers, chaplains, attorneys, and others will participate

in a massive effort to highlight the importance of advance healthcare decision-making. To facilitate this process, initiative organizers will provide clear, concise, and consistent information and tools for the public to execute written advance directives (healthcare powers of attorney and/or living wills) in accordance with their applicable state laws. To access resources or organize your own community to participate in National Healthcare Decisions Day, visit www.nationalhealthcaredecisionsday.org.

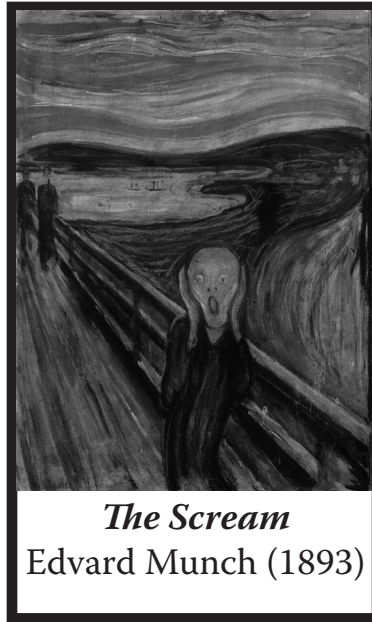
WEST VIRGINIA NETWORK OF ETHICS COMMITTEES (WVNEC)

The West Virginia Network of Ethics Committees (WVNEC) is sponsoring a series of lunchtime audio conferences early in 2008 (see Calendar). WVNEC hopes this innovative initiative will make bioethics education more accessible. Registration, fees, CE information, and dial-in instructions are available at <http://www.wvethics.org/>. Note that pre-registration is required. Contact cjamison@hsc.wvu.edu for more information.

Even if one tries, emotions cannot be checked at the door when working through ethical problems with patients, families, and staff members.

So, where does art therapy fit in this discussion? Freedberg and Gallese (2007) describe how mirror neurons “hard wire” us to empathically connect pre-rationally in response to viewing another’s expressed emotions, whether in person or as depicted in art. For example, viewing Edvard Munch’s *The Scream* activates the same areas of the brain in the viewer as in an individual experiencing agony like that expressed by the main character. Viewing someone else being caressed likewise produces a brain response in us that would mirror the response of the person being caressed. HCPs (and likewise, ethics committee members) are exposed to a range of emotions expressed by patients and families, including the agony and sorrow of dying persons and bereaved loved ones. We are biologically predisposed to respond empathically, whether we want to or not. Trying to block one’s emotional responses as a self-protective mechanism is a losing proposition, since the empathic response happens pre-consciously. HCPs who try to do this are likely to exhibit flawed or quite dysfunctional empathic behaviors toward patients/families. I’m reminded of a nurse who encountered me sobbing after I’d learned some particularly sad news as a patient in her clinic. We were alone together in an exam room. She didn’t think to hand me a Kleenex or offer comfort, and actually pondered aloud whether she should have bunion surgery for her painful foot.

A more effective approach would be to develop what Salovey and Sluyter (1997) describe as emotional intelligence, just as we develop other types of professional expertise. An ethics consultant with this



orientation would connect emotionally with the patient/family and staff at the onset of an ethics consult, and would maintain this connection while working through the more cognitive aspects of an ethical analysis. The consultant might even cry and laugh with the patient and family, but would be clear about her role and well-practiced in strategies to maintain her own emotional health.

How does one learn to nurture empathy and hone emotional intelligence? Medical humanities programs are leading the way in these efforts at some institutions. Rabow and McPhee (2001)

describe how personal narratives and poetry are used in “Doctoring to Heal” discussion groups among physicians to promote emotional well-being. Work in narrative ethics is another resource. Wikstrom (2001) describes how viewing art was used to complement theoretical knowledge in teaching nursing care. Or, as Julia Andersen demonstrated, you might explore art therapy and its role in nurturing emotional intelligence.

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WHAT'S SO SPECIAL ABOUT ETHICS COMMITTEES?

This article is adapted from a talk presented at the MHECN conference, "Ethics Committees in Action," held at the Bon Secours Spiritual Center in Marriottsville, MD, on Thursday, June 26, 2007.

Ethics committees are special. Be they ethics committees in hospitals, nursing homes, home health care agencies, or ethics committees in other kinds of health-focused organizations, ethics committees may just be the most important committee in a health-care organization. Healthcare ethics committees (HECs) are special because of what they are, what they were created to do, and what they have become. They are even more special, however, because of what they can and should be.

HECs were created (in the main) to keep end-of-life cases out of the courts. They have evolved into places within healthcare organizations where complex ethical issues are brought and discussed. Some committees, particularly those in Maryland, do more than discuss ethically complex cases; they make recommendations that carry varying degrees of weight, both ethical and legal, for patient outcome and institutional functioning (DeRenzo et al, 2001). HECs are also places of ethics education and policy development and review.

But, now it is time to move ethics committees to the next level (Wolf et. al., 2005). To be all that HECs can and should be, they need to reconceptualize their personae within their institutions. HECs need to see themselves as the organization's primary ethics change agent.

HECS HAVE ALWAYS BEEN SPECIAL: A LITTLE HISTORY

In Catholic hospitals since the 1950's, ethics committees were introduced into secular hospitals in the mid-1970's, legally formalized by the judgment in the Karen Ann Quinlin case. From the beginning, hospital ethics committees have been special. From early on, ethics

committees have been recognized as hospital committees like no others. As Jonsen stated, "...unlike the standard hospital committees, such as the pathology committee ... [t]he ethics committee had no well-defined task to perform; they were ordered to think about ethics, probably the vaguest and most controversial of topics" (Jonsen, 1998, p. 363).

The early HECs were created with a two-fold intent: first, to help patients, surrogates and clinicians prevent disagreements about how to care for seriously ill and/or dying patients from spilling over into the courts, and second, as places to talk about how best to accomplish this increasingly difficult task.

THE EVOLUTION OF HECS: WHERE WE ARE NOW

Today, many ethics committees are important hospital and healthcare organization committees. Unfortunately, many are not.

The institutionally important ones have become safe havens for complex moral discussions about the delivery of health care in the institution and beyond. Their members have become seen as wise counselors around the institution to whom others can go for advice. Some or all of the members are actively involved in the committee's consultation service, providing hands-on assistance in real time to clinicians, patients and surrogates, and other healthcare organization professionals. These highly functioning committees are a rich source of ethics education for their own committee members and others around their institution. Such committees work collaboratively with other hospital committees and departments in developing and/or refining existing policies, systems and educational activities that have moral heft within their institutions. Such committees also reach out to collaborate with other hospitals and healthcare organizations to extend their reach beyond their own hospital walls.

Some HECs have risen to this level. Some have not. Those that have

not, i.e., HECs that are moribund and perceived by others within the institution as useless, unconstructive or obstructionist, are worse than merely ineffective. They degrade the respect that others in the institution have for the importance of moral debate and introspection about the profound moral complexities that organizationally-provided healthcare pose. Rather than being merely neutral or invisible, such committees reduce the prospects that the healthcare organization will ever achieve excellence in its healthcare delivery.

HECS' TRUE POTENTIAL: BECOMING A CHANGE AGENT FOR EXCELLENCE IN HEALTHCARE DELIVERY

Mastering the Basics

To become all that an HEC can and should be requires that the committee members commit themselves to aspiring to internal processes that meet a level of excellence in healthcare ethics competence. Although the American Society for Bioethics and Humanities' Core Competencies (ASBH, 1998) proposes the modest goal that just one person on the committee need possess the various skills and knowledge called for, meeting such minimal standards will not be enough. Rather, there needs to be a commitment on the part of all members to master all competencies. Of course, each member will be starting at a different baseline and some of us are better at some things than others; that is immaterial. What seems to be the critical piece is that there is a will, on everyone's part, for continuous self-improvement related to the core competencies.

Flattening the Medical Power Hierarchy

Invariably, whenever someone mentions the flattening of the traditional medical power hierarchy, the comment is followed by a gasp and then total silence. But it is clear to those of us

who have been doing this work since the early days that if a healthcare organization is going to make progress in becoming a healthcare organization of excellence, for purposes of moral discourse, it is necessary to flatten the traditional medical power hierarchy. Please note the qualifier in the preceding sentence, i.e. “for purposes of moral discourse...” The medical power hierarchy has developed for good reason. It is structured on the basis of specialized knowledge and ethical and legal responsibilities. For example, an attending physician bears the ultimate responsibility for the medical care of the hospitalized patient assigned to him or her. This is because he or she has the requisite skills and knowledge to treat the patient and to oversee other caregivers involved in that patient's care. Moreover, the attending physician is personally responsible if minimum medical standards are not upheld (i.e., he or she could face legal or regulatory sanctions). Given these stakes, it is understandable that an attending physician garners the most power in the medical hierarchy. In the context of having a discussion about the ethical aspects of the care of a patient, however, the attending physician's medical expertise is only one of many factors to consider in determining an ethically justifiable course of action. Regarding high level moral discourse, all interested parties have equal moral standing when it comes to discussions of what is ethically optimal.

What is not so simple or procedurally straightforward is how to manage the process within an HEC to make that happen. Rather, learning to do this, especially for the most senior physicians and the most junior residents, nurses and social workers (the polar ends of the medical power hierarchy), is hard and complex. This would be true if doing so were in a vacuum. It never is. Just before the HEC meets, the traditional medical power hierarchy is in control. Once the meeting's halo effect has evaporated and day-to-day practices are at the fore, the traditional medical power hierarchy is back in control.

When attempting to figure out the technical aspects of complex medical care for an individual patient, traditional medical power

hierarchies—where respectfully played out—are appropriate. When open and vigorous moral discourse is needed, the exercise of traditional medical power hierarchies gets in the way and needs to be flattened.

Learning this dance, i.e., to take the steps in and out of the force field of these traditional ways of interacting in the medical setting, is very, very hard indeed. It takes great skill and ego strength, especially on the part of those who must temporarily cede power and for those who must regularly give it back, to learn to perform these complicated dance steps. But that is what is required for excellence in process in an ethics committee. Without learning this skill, the HEC can never become all it can and should be. It will never move to the level of ethics change agent within the organization.

HEC as Change Agent

Wikipedia, as good a source for this point as any, defines a change agent as, “someone who intentionally or indirectly causes or accelerates social, cultural, or behavioral change...”, An agent who is constantly adapting to new practices is often motivated to find better ways to do things” (*accessed August 31, 2007*). The definition is appropriate for defining excellence in HEC performance because, according to the Institute of Medicine's report, *Crossing the Quality Chasm* (2001), change is the hallmark of excellence in 21st. century healthcare delivery. Not only do our healthcare organizations need to change from where we are today, but excellence calls for an organizational flexibility that is embedded into the practice patterns of the organization. No longer is computer-like linearity the model of choice. Rather, excellence requires that organizational practices take on the non-linearity of human cognitive function. HECs will be best thought of as neurons of ethical practice, education and modeling that grow a thick web of dendrites into and throughout the healthcare organization.

Experience teaches that to have excellence in healthcare delivery, organizations must be morally safe environments, i.e. places where everyone feels safe enough to speak up, to question, to disagree without fear of

retaliation. To create and sustain such environments requires a critical mass of people throughout the healthcare organization—not only those on the HEC, who are committed to providing care based on explicit consideration of the combination of sound science and sound ethical judgment. A single HEC is never going to be large enough to include enough members to carry the weight of that kind of load. For HECs to be all they can be, there will need to be persons in all the nooks and crannies of the institution, high and low, who are connected to the energy of the neuronal HEC. As this critical mass of overtly ethics-interested hospital personnel grows, the whole organization will gain strength from the ethics committee's dendritic educational activities. In addition, the committee will need wise counselors, members skilled in dancing in and out of entrenched hierarchical relationships, and processes that will stimulate increased respect for the committee. Only through dendrite-like outreach will those throughout the institution, who carry on the daily work of the organization, be sufficiently energized themselves to take on the burden produced by the effort required—the moral courage—to speak up when things need a little more discussion and a little more moral consideration; when the situation calls for just a little more moral discourse.

CONCLUSION: GETTING THERE FROM HERE

HECs are very special places, indeed. Where ever along the continuum towards excellence your committee is, there's always going to be room for improvement. Some concrete ways to move forward on this path include:

- Ensuring that members of your ethics committee have adequate training and support.
- Securing a spot for the HEC at the new employee/new clinician orientations. Have the HEC chairperson and members take turns fulfilling this responsibility. Speak for just a few minutes on the purposes of the HEC, how to access it, and who the members are. Emphasize that employees/clinicians can seek out the HEC members in their own domains as wise counselors as well

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as individuals to whom they can formally take concerns or questions. Provide a handout listing the names of all the HEC members with each member's title, department, phone, and pager numbers.

•If you are at a teaching facility, having the HEC members share responsibilities for providing the ethics talks required by the Accreditation Counsel for Graduate Medical Education (AC-GME).

•Getting HEC members to serve on as many other committees and review bodies as possible throughout the organization in order to increase HEC visibility and build HEC dendrites.

When all these activities have been put into place and are humming along, when the HEC learns the dance of moving in and out of the traditional medical power hierarchies, and the dance is regularly modeled throughout the organization by those high and low, the HEC will have become a true change agent moving the whole organization towards sustainable excellence; forward movement on which our patients depend.

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PHILOSOPHER'S CORNER – MEDICAL FUTILITY

In the very first sentence of *Principia Ethica*, G.E. Moore observes that “in ethics, as in all other philosophical studies, the difficulties and disagreements of which history is full, are mainly due to a very simple cause: namely to the attempt to answer questions, without first discovering precisely what question it is you desire to answer” (Moore, 1903). Nowhere in contemporary bioethics is this better illustrated than in debates surrounding medical futility.

Since conceptual issues can have enormous practical normative consequences, it is not surprising that the proper role of the term “medical futility” has been the subject of a huge dispute. Definitions have been proposed and exhaustively debated for nearly twenty years. What that debate has shown is that the term is a mere (purportedly neutral scientific) cloak under which various normative judgments have been smuggled. Since health professionals have been unable to reach consensus about the propriety of those underlying normative judgments, many now recommend avoiding use of the term altogether.

That may be too drastic a step. Since the term has been, and continues to be, used in all the relevant medical, philosophical, and legal literature, we ought to bow to convention. As discussed below, we should not use the term “medically futile” to describe a *treatment*. But, we can still use the term to describe a particular type of dispute. That type of dispute is typically an end-of-life dispute in which a health care provider seeks to stop life-sustaining medical treatment (such as assisted ventilation, artificial nutrition and hydration, renal dialysis, surgical procedures, blood transfusions) that the patient or surrogate wants continued.

In the classic right to die situation illustrated by Quinlan, Cruzan, and Schiavo, the patient or her surrogate wants to limit life-sustaining medical treatment (LSMT) but the health

care providers resist. In contrast, in a futility situation, the roles are reversed: the healthcare provider wants to limit LSMT and the patient or her surrogate resists. It is the health care provider who judges LSMT to be of no benefit. It is the health care provider who wants to stop the train when the patient or surrogate says “keep going” (Lee, 2005).

The provider and surrogate disagree because they have different goals. The patient's goals might include cure, amelioration of disability, palliation of symptoms, reversal of disease process, or prolongation of life. The provider, on the other hand, might, under the circumstances, judge these goals to be either unachievable or inappropriate. Much of the debate over medical futility concerns the validity of the provider's grounds for refusing the surrogate's request for LSMT.

Refusing a surrogate's request on grounds of achievability seems more defensible because the provider starts with the patient's own goals. The provider merely determines either that those goals are not possibly achievable (physiological futility), or that they are not probably achievable (quantitative futility).

Physiologically futile interventions will not produce an effect that measurably affects the patient. Like chemotherapy for an ulcer, they have a zero percent chance of being effective. With physiological futility, the provider does not make any assessment that the effect is not likely enough, not large enough, or not worthwhile. Health care providers can readily ascertain physiological futility based solely upon their clinical knowledge. There is no normative disagreement. The basis for refusing treatment is an empirical one: the treatment simply will not work.

But this objectivity comes at a steep price. Physiological futility has a very limited applicability. It is often difficult to be certain that there is a 100% probability that a given intervention will have zero effect. Most decisions on

withholding and withdrawing treatment are based on probabilities as opposed to certainties. Since technology permits many “effects” such as keeping a heart beating, true physiological futility rarely applies when considering withholding or withdrawing LSMT.

Since physiological futility covers so few cases, some have proposed employing the broader concept of quantitative futility, which refers to treatments that are “virtually” unachievable. Unlike physiologically futile treatments, quantitatively futile treatments might work. But based on clinical studies and scoring systems, they most probably will not work.

Quantitative futility suffers from two serious problems. While it seemingly possesses the precision of mathematics, unlike physiological futility, a quantitative standard is value-laden and cannot be determined by reference to science alone. First, where should we set the threshold percentage for quantitative futility? The most prominent proponent of quantitative futility, Lawrence Schneiderman, argues that “a treatment should be regarded as medically futile if it has not worked in the last 100 cases” (Schneiderman & Jecker, 1995). But some believe that a provider must offer even a chance of “1 in a million.” Setting the threshold of probability is a value judgment about which there is considerable variability. Second, even if we were able to settle upon a threshold percentage, how do we ascertain when that threshold standard is obtained with respect to a particular patient? Measures from clinical studies are very imprecise when applied to a particular patient with “individualized symptoms, medical history, character traits and other variables” (*Arato v. Avadon*, 1993).

While physiological futility and quantitative futility question only the achievability of the patient’s goals, qualitative futility questions the worthwhileness of the patient’s goals themselves. The focus is on the benefits rather than on the effects of LSMT. There are several versions of qualitative futility.

The most compelling version of

qualitative futility holds that LSMT is medically inappropriate where the prospective benefits of treatment are outweighed by their associated burdens. For example, in the recent Emilio Gonzales case in Texas, providers refused to provide LSMT for Emilio because it would only “serve to prolong his suffering without the possibility of cure.” Providers felt that “the burdens associated with his current care plan outweigh[ed] any benefit Emilio [might have been] receiving” (*Gonzales v. Seton Family of Hospitals*, 2007).

Another version of qualitative futility weighs the prospective benefits against the health care resources used to provide the treatment. When looking just to hard resources like ICU beds, this version of qualitative futility does not differ much from triage. However, a more robust version of resource-focused qualitative futility looks to the rational allocation of soft resources like health care dollars. This is widely condemned on the grounds that rationing should be developed through public policy and not at the bedside.

A third version of qualitative futility provides that regardless of burdens or resources, the expected outcome of the requested treatment is of no value because the patient can derive little or no benefit from continued LSMT. The most notable example involves the patient who is permanently unconscious. No value judgment is required to conclude that such a patient cannot experience or appreciate anything that society or life has to offer. Suggestions to expand this version of qualitative futility have been very heavily criticized, because, in application, it is subject to all sorts of biases, especially against the disabled.

While the various definitions of medical inappropriateness have been exhaustively debated over the past twenty years, only physiological futility is supported by a consensus in the medical, legal, and bioethical communities. Yet, physiological futility is inapplicable in the vast majority of futility disputes involving a patient for whom LSMT can produce some effect. Therefore, the relevant question

is whether the expected effect is a benefit to the patient and whether it is worthwhile. But about this there is no consensus.

Many have despaired of reducing the circumstances under which a provider may refuse requested LSMT to a definition or algorithm. Instead, they concede that medical futility (or its cousin, medical inappropriateness) can be identified only like beauty or pornography. It is in the eye of the beholder. We know it when we see it (Pope, 2007). Thus, the focus in recent years has been not on the definition of “medical futility,” but rather on the process for resolving futility disputes (AMA Council, 1999). While provider discretion is inescapable, it is not unfettered. The challenge for the next decade is to develop a mechanism that properly balances provider discretion and independent accountability.

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CASE PRESENTATION

One of the regular features of the Newsletter is the presentation of a case considered by an ethics committee and an analysis of the ethical issues involved. Readers are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information about patients and others in the case should only be provided with the permission of the patient. Unless otherwise indicated, our policy is not to identify the submitter or institution. Cases and comments should be sent to MHECN@law.umaryland.edu, or MHECN, the Law & Health Care Program, University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201.

CASE STUDY – VERBAL ABUSE IN THE EMERGENCY DEPARTMENT

A family came to the Emergency Department (ED) with their 8 year-old daughter stating that she had a rash under her arm that needed to be seen. The nurse triaged the patient to the hospital's "Express Care" unit due to the non-urgent nature of her symptoms. Express Care is run by two nurses, a physician, a technician, and a secretary from 9:00 AM to 9:00 PM seven days a week. The girl was escorted by her mother and the mother's partner, who referred to himself as the patient's stepfather. The patient and her family were placed in one of the six rooms in Express Care. Upon seeing the physician assigned to care for the patient, the stepfather began to protest loudly, stating that there was "no

way that physician is coming near my daughter!" He slammed his fist on the counter, demanding to be seen by another physician, and stood very close to staff members, causing them to feel very uncomfortable and threatened. All three members of this family come monthly for minor complaints. Similar verbally abusive and threatening behavior is repeated during each visit.

The staff informed the family that the current doctor was the only one on duty in Express Care and if they wished to see another physician they would need to be seen in the ED. The family agreed to go to the ED. However, there was already a two to three hour wait for non-urgent patients in the ED. In the interest of the patient, the ED physician went to Express Care to see the patient, discharging the family within thirty minutes. When the staff went in to clean the room they noted that someone had written explicit, derogatory language directed toward the Express Care physician and staff on the dry erase board.

The staff felt betrayed because they had tried hard to make things right for the family, only to be humiliated by them. They had mixed feelings of anger, sadness, and non support. They also felt powerless, as there were no limits set or repercussions for the stepfather's behavior. After notifying security to file a report about the incident, an ED staff member consulted the ethics committee.

RESPONSE FROM AN ETHICS CONSULTANT

In a nutshell, clinical ethics involves identifying how to maximize good and minimize harm while respecting individual rights and treating people fairly. The hospital's Express Care unit is a good example of an attempt by the organization to achieve these goals by limiting overuse of the emergency department (ED) for non-urgent care

needs. In this case, we are presented with a family member who manipulates the triage system and verbally abuses staff in order to gain control over how his stepdaughter is treated. Considering merely the clinical outcomes of the case, one could argue that the ethical goals of maximizing good, minimizing harm, and respecting individual rights were achieved for this patient and family, as the patient was promptly treated and the stepfather's demand that the Express Care physician not be involved was met. However, the ethical duty of fairness was compromised, since the ED physician diverted attention from emergency care patients in order to treat this patient. Furthermore, the stepfather's verbal abuse and threats are harmful to the health care staff and to fellow patients being seen at the ED and Express Care unit.

The Bureau of Labor Statistics (BLS) reported that in 2000, 48% of all non-fatal injuries from occupational assaults and violent acts occurred in health care settings. Verbal abuse and threats constitute a workplace hazard that is commonly underreported and on the rise in health care facilities, EDs in particular. An Occupational Safety and Health Administration report sites some reasons for this increase, including long waits in EDs or clinics, increasing presence of drug or alcohol abusers, low staffing levels, and lack of staff trained in managing hostile patients or family members (OSHA, 2004). OSHA's report on workplace violence is a helpful resource for assessing whether a hospital has adequate policies and safeguards in place to address workplace violence across the board. Examples of such measures include:

- Creating and disseminating a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats and related actions. Ensuring that managers, supervisors, coworkers, clients, patients and visitors know about this policy.

- Ensuring that no employee who reports or experiences workplace violence faces reprisals.

- Encouraging employees to promptly report incidents and suggest ways to reduce or eliminate risks. Requiring records of incidents to assess risk and measure progress.

- Outlining a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.

- Affirming management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client. (OSHA, 2004, pp. 8-9)

Processing the staff's emotional response to the stepfather's abusive behavior is also a necessary component of adequately addressing workplace violence—as much as ensuring that staff are protected from future abusive encounters with the patient's stepfather. The staff had mixed feelings of humiliation, anger, sadness, and did not feel supported. They felt powerless, as there were no limits set or repercussions for the stepfather's behavior. Those responding to the ethics consult should address these emotional responses. This will likely involve assessing the organization's commitment to eradicate workplace violence through policies and processes as described above.

While limits on the stepfather's behavior need to be set, attempts should be made to determine whether any of his behavioral outbursts were motivated by valid reasons. Research has shown that communication styles vary by gender and culture, and may be at play in communication encounters being perceived as antagonistic or verbally abusive. For example, Ribeau, Baldwin and Hecht (1994, p. 144) found that

African Americans “often talk with one another in a way that ‘whites would consider antagonistic or brutal.’ For this reason, many African Americans code switch, or change their communication style and language, when they interact with European Americans.” Considering the cultural and class diversity among both patients and health care staff in U.S. hospitals, the ethics consult team might consider whether communication differences based on culture, gender, or class are at play in the conflict between the stepfather and the Express Care physician.

Johnson and colleagues (1996) describe abuse as along a continuum of “noncompliant” behaviors, ranging from behaviors that harm only the patient, to disruption of services for other patients, to verbal threats, to physical abuse. They offer the following suggestions for dealing with abusive behaviors:

1. Learn the patient's story and seek to understand his or her perspective.
2. Identify the patient's goals for treatment.
3. Share control and responsibility for treatment with the patient.
 - a. Educate the patient so he or she can make informed decisions.
 - b. Involve the patient in the treatment as much as possible.
 - c. Negotiate a behavioral contract with the patient.
4. Consult a psychiatrist or psychologist for assistance in patient management or determination of decision-making capacity.
5. Be patient and persistent.
6. Do not tolerate verbal abuse (see Box on p. 10).
7. Contact law enforcement officials when physical abuse is threatened or occurs.
8. As a last resort, consider transfer to another facility or discharge (assuming the patient does not have an emergency medical condition that must first be stabilized).

9. Consult with legal counsel before proceeding with plans for discharge and do not discharge without advance notice and disclosure of future treatment options. (Johnson, *et al.*, 1996, p. 78)

The ethics committee should also consider establishing a behavioral contract that spells out which behaviors are expected and which are not allowed (from both parties), as well as the consequences if the contract is broken. Unfortunately, some patients or family members will not be psychologically equipped to honor such a contract, and must face the consequences. Health care providers have the right to a violence-free workplace, and patients/family member' obligations toward this end should not be dismissed as “part of the job.”

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RESPONSE FROM AN EMERGENCY DEPARTMENT MANAGER

As an Emergency Department Manager, I can see when confronted with such a difficult situation that staff are frustrated that an abusive parent is delaying care of their child by acting inappropriately. I think what bothers them the most is that as inappropriate as the patient's stepfather was, he got what he wanted and was seen faster. It appears that our patients are not only more informed due to the readily accessible healthcare information on the Internet and TV, but they have also learned what gets them seen faster in the ED. We have seen people throw themselves on the floor, yell and scream as well as threaten to sue in order to be seen faster. So why does the squeaky wheel get the attention? For one, we may be worried that there is something terribly wrong with the patient, which our initial assessment missed. I would like to say this is purely motivated by wanting the best for the patient, but the practice of "defensive medicine" is a practical reality in the ED environment. Sometimes, however, we simply want to get the disruptive patient or family member out of a public place like a waiting room so they do not make others there think we would ignore someone in such distress.

In my opinion, we need to explain to those who are impeding the work that we, as emergency healthcare providers, are trying to give that not only do they have rights but that staff members also have rights. The ED staff has the right to work in a healthy, successful, non violent, non abusive environment. Patients and family members should understand that we as a hospital will take whatever actions necessary to preserve everyone's rights.

For this particular case, it seems as though the stepfather had an issue with the physician on duty in the ExpressCare area. Whether or not this is a reasonable complaint needs to be addressed. This could involve speaking to the stepfather and the Express Care physician

(separately) to determine the nature of the stepfather's grievance and whether the animosity harbored by the stepfather toward the physician is valid (e.g., based on the physician acting unprofessionally toward the patient or stepfather in the past) or not valid (e.g., a false projection on the part of the stepfather). Regardless of whether the stepfather's anger toward the ExpressCare physician was "valid" or not, the way he expressed his anger was not acceptable. If this had been discovered while he was still present in the ED, we would have had security remove him so the daughter could still receive the medical care she needed, while protecting the ED staff from this verbally abusive individual.

If parents do not want their child seen by a particular provider, they have other options and we should present those options to them. For example, we could suggest they take their child to a different facility, such as an urgent care facility, or that they follow up with a primary health care provider. In this case, it was possible for the ED physician to see this patient without a wait. This may not always be possible, and reasons for the wait should be explained.

The question becomes at what point we draw the line and determine that the stepfather's behavior is abusive and

should not be tolerated. Patients and families need to know that regardless of what is going on with them or their loved one, no one deserves to be verbally abused, and the threat of physical abuse will warrant notification of hospital security and, if necessary, local law enforcement. Unfortunately, nurses often look the other way instead of reporting abusive behavior. This may be because of our nature (we want to give everyone the benefit of the doubt), or because we feel sorry for the patient.

In this situation, I think the stepfather should be informed that his behavior was inappropriate and will not be tolerated on future trips to the ED. Having the ethics committee do this, either in person or through a letter to the stepfather, could be helpful in making the stepfather realize that many people from different backgrounds weighed in on the matter. But I think it is time that we say that enough is enough and have a zero policy for staff abuse by patients/family members, and take action to enforce such a stance.

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RESPONDING TO VERBAL ABUSE FROM A PATIENT

1. Name the behavior. Tell the patient he/she is being verbally abusive.
2. Hold the patient accountable for his/her actions.
3. Insist that the verbal abuse stop and warn the patient of the consequences according to facility policy if it continues.
4. Do not lose your focus or your temper. Do not respond to the patient's antagonistic comments.
5. Obtain help from other staff and call security or law enforcement if necessary.

Johnson, *et al.* (1996), p. 82.

CALENDAR OF EVENTS

DECEMBER

- 10** (12:15 p.m.) Six Degrees of Dignity: Can a concept with so many meanings play a leading role in bioethics? Leslie Meltzer, JD, MSc. Sponsored by the Johns Hopkins Berman Institute of Bioethics. Hampton House, 208. For more information visit www.bioethicsinstitute.org or contact Kiran Khaira at kkhaira@jhsp.edu or 410-516-8576.

JANUARY

- 9** (12–1 p.m.) The Relationship Between the Law and Medical Ethics. AUDIO CONFERENCE. Sponsored by the West Virginia Network of Ethics Committees. To register, visit <http://www.wvethics.org>. Contact: Cindy Jamison, 1-877-209-8086.

FEBRUARY

- 5** (8 a.m.–4 p.m.) Ethical Stress: Sources and Resources. Sponsored by the Center for Ethics, Inova Health System. Presenter: Patricia O'Donnell, PhD, LICSW. IAMS Conference Center, 2990 Telestar Ct., Falls Church, VA. Contact: patricia.o'donnell@inova.org. To register, call Inova Teleservices at 703-205-8384.
- 6** (12–1 p.m.) Getting Consent for a Feeding Tube in a Failing Nursing Home Resident. AUDIO CONFERENCE. Sponsored by the West Virginia Network of Ethics Committees. To register, visit <http://www.wvethics.org>. Contact: Cindy Jamison, 1-877-209-8086.
- 13** (4:30 p.m.) Obsession: Can a Disease Have a Biography? Lennard J. Davis, Ph.D., Professor, Departments of English, Disability & Human Development, and Medical Education, University of Illinois at Chicago. Sponsored by the Center for Bioethics at the University of Pennsylvania, 3401 Market St., Suite 321, Philadelphia. RSVP to clinksca@mail.med.upenn.edu or call (215) 898-7136.

MARCH

- 4** Ethical Problems in Health Care: The Role of Consultation in Analyses and Resolution. Sponsored by the Center for Ethics, Inova Health System. Presenter: Patricia O'Donnell, PhD, LICSW. IAMS Conference Center, 2990 Telestar Ct., Falls Church, VA. Contact: patricia.o'donnell@inova.org. To register, call Inova Teleservices at 703-205-8384.
- 5** (12–1 p.m.) The Patient is Permanently Comatose: The Family Wants Everything. AUDIO CONFERENCE. Sponsored by the West Virginia Network of Ethics Committees. To register, visit <http://www.wvethics.org>. Contact: Cindy Jamison, 1-877-209-8086.
- 17** (4:30 p.m.) Title TBA, Kathryn Montgomery, Ph.D., Professor of Medical Humanities and Bioethics, Northwestern University Feinberg School of Medicine. Sponsored by the Center for Bioethics at the University of Pennsylvania, 3401 Market St., Suite 321, Philadelphia. RSVP to clinksca@mail.med.upenn.edu or call (215) 898-7136. Visit www.bioethics.upenn.edu/colloquium/ for information about title lecture.

APRIL

- 8** Professionalism: Actualizing Values in Clinical Practice and Organizational Base. Sponsored by the Center for Ethics, Inova Health System. Presenter: Patricia O'Donnell, PhD, LICSW. IAMS Conference Center, 2990 Telestar Ct., Falls Church, VA. Contact: patricia.o'donnell@inova.org. To register, call Inova Teleservices at 703-205-8384.
- 15** (4:30 p.m.) Title TBA. Paul B. Thompson, Ph.D., Professor of Philosophy, W.K. Kellogg Chair in Agricultural, Food, & Community Ethics, Michigan State University. Sponsored by the Center for Bioethics at the University of Pennsylvania, 3401 Market St., Suite 321, Philadelphia. RSVP to clinksca@mail.med.upenn.edu or call (215) 898-7136. Visit www.bioethics.upenn.edu/colloquium/ for information about title lecture.

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