

Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 2011*

Mid-Atlantic Ethics Committee
Newsletter, Fall 2011-Winter 2012

This paper is posted at DigitalCommons@UM Carey Law.
<http://digitalcommons.law.umaryland.edu/maecnewsletter/21>



MID-ATLANTIC ETHICS COMMITTEE

NEWSLETTER

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

Fall 2011/Winter 2012

Inside this issue . . .

Involving Greater Participation of an Ethics Committee: The Online Consultation Forum.....	1
BioethX Launching New Consult Management Service	4
Compliance Toolbox Wiki Now Available.....	4
Medically Ineffective Treatment Under Maryland Law: Update On MHECN's Efforts To Address Concerns	5
Case Presentation	6
MHECN Program Coordinator Anita Tarzian Receives Award.....	9
Maryland MOLST Update	10
Calendar of Events	10

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. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

Diane E. Hoffmann, JD, MS
Editor

INVOLVING GREATER PARTICIPATION OF AN ETHICS COMMITTEE: THE ONLINE CONSULTATION FORUM

As Director of Ethics for Shore Health System, I have the privilege – and the challenge – of leading an active Patient Care Advisory Committee comprised of talented and busy professionals who are called upon to consult on ethics issues that arise in the delivery of health care for a regional medical system that covers a four-county area. The members of the committee include eight physicians, eight nurses, a social worker, two case managers, a chaplain, and two community members along with the medical librarian, a member of the administration, as well as me as the Director of Ethics for the health-care system.

Committee members are involved in two areas of the committee's mission: writing policy and promoting ethics education system-wide. The members also lend their expertise when requests for consultation on general topics are submitted to our monthly committee meetings. We have addressed issues such as elective Caesarian-sections, mandatory flu vaccinations and requests for non-traditional practices, just to name a few.

The Patient Care Advisory Committee members are less available to participate in clinical bedside consultations. Even with an on-call procedure in place, I am often unable to round up members of the committee for an in-person meeting when the committee's assistance is required for

urgent consultations on patient cases.

On average, the Shore Health System Patient Care Advisory Committee responds to 140 requests a year. I am the only member of the committee for whom ethics consultation is a full-time job. All of the other committee members have volunteered to participate on the committee and each of them has other duties, especially the clinical members. They often find that they are unable to leave their full-time jobs to consult on an issue referred to the committee, especially when being involved may require traveling 20 to 30 miles to get to one of our facilities.

The Patient Care Advisory Committee does participate in retrospective review of case consultations that have been provided. This approach has several drawbacks. Retrospective reviews do not have the vitality of real time discussions that occur as a case itself unfolds. I also find that reviewing a case after the fact is less effective as a teaching tool than learning by doing. Mentoring and learning must be connected to practice.

I yearned for a way to capture real time involvement of as many of our committee members as I could in our busy and complex organization, which includes two acute care hospitals, a freestanding emergency center, an acute rehabilitation unit and several outpatient units.

Cont. on page 2

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

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

Contributing Editors:

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

Brian H. Childs, PhD
Director, Ethics & Organizational
Development, Shore Health Systems

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

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

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

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

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

Comments to:
MHECN@law.umaryland.edu

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

Online Consultation Forum
Cont. from page 1

By luck - or perhaps providence - I chanced upon an article by David Ramsey, Mary Lou Schmidt, and Lisa Anderson-Shaw (2010) in the Journal of Nursing Administration's (JONA's) Healthcare Law, Ethics, and Regulation, "Online ethics discussion forum facilitates medical center clinical case reviews." The authors described their development and use of a web-based discussion board with secure access by their ethics committee members. The Intranet-based forum was used to facilitate real time discussion of open and active ethics consultations within the University of Illinois at Chicago Medical Center. They described how the forum is encrypted and secure and how it has been in operation for ten years. I immediately thought that this forum was exactly what the Shore Health System Patient Care Advisory Committee was looking for to encour-

age and broaden the members' participation in case consultations.

I sent the reference to this article to the Shore Health System office of Corporate Communications, whose staff manages the Intranet. I asked our web experts to read the article and let me know if they could develop a platform on which we might create our own consultation forum. They told me that this could be done. I then shared the article with our Patient Care Advisory Committee and we discussed it at the next meeting. The committee responded with enthusiasm and encouraged me to make it happen.

I had a number of discussions with my Corporate Communications colleagues and the Internet design team of a local company that supports Shore Health System's websites and Intranet.

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

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

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support. Current affiliate members include the Johns Hopkins Berman Institute of Bioethics.

In just a couple of months, they designed a forum for me to review.

I enlisted the help of two other members of our Patient Care Advisory Committee. We went through a testing and refining period that resulted in a product presented to the committee, which includes our Corporate Compliance Officer. The group approved the forum and we are now using it for our ethics consultation system-wide.

The forum works easily. I identified the people who have approved access to the system. They each have a password that they use to log on to the home page of the forum. For security reasons, users must enter their user name and password each time they enter the forum; they cannot sign in once and stay logged in indefinitely.

Once a user enters the home page, a number of actual forums appear. It is possible to have any number of active forums on the opening page. Currently we have four forums:

- open cases for the calendar year
- closed cases for the calendar year
- a journal club
- a policy forum for posting and discussing administrative policies directly involving the Patient Care Advisory Committee, such as DNAR, MOLST and organ transplantation

The Open Case forum contains all cases that are active and in process. The cases are identified by date and time of request, location of the patient, and a brief description of the nature of the request (e.g., end of life, code status, surrogate conflict).

When the case portal is opened, the first thing that the committee member sees is a fairly detailed description of the case. A template is used, which includes the date and time of

the request; basic patient identifying information; location; urgency as defined by the requestor and consultant; persons involved in the care of the patient; how the requestor conceives of the issues at hand; the presence of an advance directive and a summary of its contents; code status; family involvement; background and medical history; the ethics issues as perceived by the consultant; involvement of the patient or surrogates; actions taken; follow-up and outcomes; date of closing the case; time spent on the case, including documentation; reflections for improvement; and the consultant's identification.

When a new case is posted in the forum, members of the committee receive an email alerting them that a new case is open and awaiting feedback. Once notified, the committee members may read the information on the template and then post comments, questions and suggestions in a string that appears just below the opening case information. Each comment that is made in response to the case is posted with a time stamp and generates an email that is sent to the committee members, informing them that comments have been posted to the currently active case at hand. This feature encourages more involvement and, since it is our experience that a majority of cases remain open for at least a day and on average three days, comments can be posted at any time. The consultant can also be involved in the conversation, answering questions, clarifying points of information and adding to the original case study as events may dictate.

When the case is resolved and closed, a note is posted by me as the forum administrator in the forum informing the committee of the case's outcome and closing. The case is then

moved to the closed case forum for the calendar year.

Shore Health System uses an electronic medical record system and the consultant dictates a summary of the consultation in the patient's medical record. The forum description and conversation is not placed in the medical record and remains as a resource for the committee. All consultations are generated electronically as well and are sent to my office as the Director of Ethics for the system.

The ethics forum does not replace in-person consultation and live discussions. However, having this tool expands the participation of committee members who may be unable to attend a meeting as the case unfolds.

Another very important feature of the forum that we modeled after the University of Illinois at Chicago Medical Center is the ability to search the forum for information that might be important to the committee. We can see trends in the types of cases for which consultations are needed by grouping the cases by medical issue, urgency, patient area within the system, and by the identity and role of the requestor. Because our policy allows anyone to call for an ethics consultation - nurses, doctors, case managers, patients and their family members - we anticipate that this search function will be very useful as we use this tool over time.

I already see many benefits of having this ethics forum in place. The forum has made it possible for us to streamline committee meetings since every member has access to the case material, which makes it possible to move through the retrospective review of cases in a more economical fashion.

The forum also

- facilitates learning

Cont. on page 4

Online Consultation Forum

Cont. from page 3

- encourages greater collaboration in case consultations among all members of the committee
- allows us to share information published in the literature via attachments
- provides a discussion board for members to participate in a journal club
- gives us access to information that will be of value for an analysis of our work in general

Brian H. Childs, Ph.D.

Director of Ethics

Shore Health System

University of Maryland Medical

System

Easton, Maryland

REFERENCES

Ramsey, DJ, Schmidt, ML, Anderson-Shaw, L (2010). Online ethics discussion forum facilitates medical center clinical case reviews. *Journal of Nursing Administration's (JONA's) Healthcare Law, Ethics, and Regulation*, 12(1), 15-20.

BioethX LAUNCHING NEW CONSULT MANAGEMENT SERVICE

BioethX™, a Maryland-based company, is launching the first commercial Web-based system to assist healthcare ethics consultants in their management of ethics consultations. All that is needed is a computer with a standard web browser and an Internet connection. The system maintains a roster of all individuals who are authorized and eligible to become involved in ethics consultations. Shared access among designated consultants to a common repository of information streamlines communications and allows the inclusion of consultants, no matter where they are. The system supports notifications via email to ensure timely response and coordination of activities by advising consultants of referrals, reminders and planned activities.

A key feature of the system is its ability to help manage ethics consultations by cueing users to follow

an established workflow process for orderly execution of activities that typically lead to well-managed ethics consults. This guidance can be particularly useful for less experienced consultants, but for more experienced consultants or in fast-paced environments, a streamlined process supports efficient provision of concise consult information.

Automation of the documentation process is an advantage over paper-based methods employed by most organizations today. It supports efficient capture and centralized storage of key information and online sharing of that information among involved consultants. This can greatly improve the individual productivity of ethics consultants. Simultaneous online access to shared resources improves collaboration among staff members, greatly reducing coordination and communications overhead activities

and enabling the inclusion of additional participants in a consult for added expertise and peer validation. Comprehensive reports can be easily generated on consulting activities across an entire facility.

This system provides a secure portal for information-sharing among ethics consultants, generates an ethics consultation summary to put in a patient's health record (for case consultations), or to provide to those who requested a consult, and allows for tracking consultation performance and outcomes. All network transmissions are protected by the same HTTP/SSL encryption widely used and accepted today for other healthcare applications, e-commerce, and online banking systems. The service is fully HIPAA-compliant.

For more information, visit www.bioethx.net, or contact Ben Martindale at bmartindale@bioethx.net.

COMPLIANCE TOOLBOX WIKI NOW AVAILABLE

Are you interested in Healthcare Compliance and Ethics? Then you will want to visit the Compliance Toolbox wiki at <http://compliance-toolbox.wikispaces.com>. Martha Ann Knutson, JD, CHC, developed this wiki after discovering the absence of organized online content on this subject. She also realized that many individuals doing compliance and ethics in healthcare settings remain isolated in single or slimly staffed departments where they may not have someone to ask "what do you think?" or "have you seen ..."? So, there is a discussion section in the Toolbox where you can post a question if the wiki doesn't have an answer to your question. There is also a function for getting notifications when something is added to the site or to a particular page so that you don't have to spend time checking back. This is a non-commercial venture that Ms. Knutson (a former MHECN education committee member) has developed as her own initiative. Membership is free. Whether you become a member of the wiki or not, send any feedback on the concept or any ideas you might have to improve it to maknutson@gmail.com.

MEDICALLY INEFFECTIVE TREATMENT UNDER MARYLAND LAW: UPDATE ON MHECN'S EFFORTS TO ADDRESS CONCERNS

Maryland's Health Care Decisions Act (HCDA) allows two physicians to certify that a treatment is "medically ineffective" (sometimes called "futile") if it will not "prevent or reduce the deterioration of the health of an individual," or prevent "the impending death of an individual," to a reasonable degree of medical certainty. Such treatment may then be withheld or withdrawn after certain procedural steps are followed. In 2009, MHECN surveyed Maryland adult intensive care unit (ICU) physicians, risk managers, and hospital attorneys to identify their awareness, understanding, and interpretation of Maryland's HCDA. On November 30, 2010, MHECN held a symposium to address concerns about differing interpretations of the law that present a barrier to withholding or withdrawing medical treatments considered medically ineffective. Last September, MHECN sponsored a round table discussion with Maryland hospital attorneys and risk managers to consider possible solutions to ensure more uniformity in implementing the law as regards withholding and withdrawing medically ineffective treatment.

ETHICAL JUSTIFICATION FOR MEDICAL FUTILITY LEGISLATION

Empowering clinicians to withhold or withdraw medical treatment deemed ineffective may be justified based on concerns that the treatment may harm the patient (i.e., a "best interest" ethical standard), that the treatment may not be what a patient who previously had decision-making ability would now want (i.e., a "substituted judgment" ethical standard), or that providing the treatment may constitute poor stewardship of limited health care resources (i.e., a "justice" ethical standard). Laws regulating

medical futility decisions are directed toward supporting good medical practice that is fair and consistent across institutions.

ARGUMENTS IN FAVOR OF MEDICAL FUTILITY LEGISLATION

Proponents of medical futility laws and policies argue that surrogate decision-makers are unnecessarily burdened by "false choices" to stop treatments that are only prolonging their loved one's death and not providing a benefit. They consider requests to "do everything" for a dying loved one as an expected reaction of grief that should be met with appropriate palliative interventions, and that succumbing to aggressive end-of-life interventions to appease bereaved family members at times amounts to "expensive grief therapy." Moreover, health care staff experience moral distress when they provide life support interventions that they perceive cause more burden than benefit to dying patients, and that diminish the dignity of the dying process. Lastly, using ICU technology on patients who cannot benefit from it deprives others who may benefit, and demonstrates poor resource allocation.

ARGUMENTS OPPOSED TO MEDICAL FUTILITY LEGISLATION

Opponents of such laws argue that less adversarial and more humane and compassionate approaches are available to help dying patients and family members than futility legislation. With good communication, these requests to continue medically ineffective/non-beneficial treatment are rare; as such, a hard line approach is unwarranted. Futility stand-offs may be the result of clinicians' poor palliative care and end-of-life communication skills, and futility laws

do not provide incentives to physicians to avoid such stand-offs. Also, clinicians should take responsibility for determining and implementing the medical standard of care and not rely on legislation that provides them with legal immunity.

HCDA MAIN CONCERNS

The main concerns expressed about the HCDA relates to the following provision:

"A health care provider that intends not to comply with an instruction of a health care agent or a surrogate shall:

(1) Inform the person giving the instruction that:

(i) The health care provider declines to carry out the instruction;

(ii) The person may request a transfer to another health care provider; and

(iii) The health care provider will make every reasonable effort to transfer the patient to another health care provider;

(2) Assist in the transfer; and

(3) Pending the transfer, comply with an instruction of a competent individual, or of a health care agent or surrogate for an individual who is incapable of making an informed decision, if a failure to comply with the instruction would likely result in the death of the individual."

First: Legal counsel and risk managers at some institutions feel it is unclear whether a guardian needs to be appointed to withhold or withdraw medically ineffective treatment for a patient who has no identifiable surrogate.

Second: Many are concerned that

Cont. on page 9

CASE PRESENTATION

One of the regular features of this 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. We may also change facts to protect confidentiality. Cases and comments should be sent to MHECN@law.umaryland.edu, or MHECN, Law & Health Care Program, University of Maryland Francis King Carey School of Law, 500 W. Baltimore St., Baltimore, MD 21201.

The following case study and responses are reprinted with permission from the Handbook for Nursing Home Ethics Committees, edited by Diane Hoffmann, Philip Boyle, and Steve Levenson, and published by the American Association of Homes and Service for the Aging in 1995.

CASE STUDY FROM A NURSING HOME

Mr. Smith, a retired truck driver, was a seventy-three-year-old widower and former World War II prisoner of war. He had been living in a nursing home for two weeks. Upon admission, it was noted that he had several enlarged lymph nodes in his neck. A history was taken, and the nursing home physician found that approximately four years ago Mr. Smith had been treated for laryngeal cancer with radiation therapy. The physician immediately requested an oncology consult. The oncologist made the decision that Mr. Smith could remain in the nursing home for the workup. A CAT (computerized axial tomography) scan revealed a mass in and around the left vocal cord, and a biopsy confirmed the recurrence of the cancer. The oncologist presented Mr. Smith with a choice of surgery or chemotherapy. Before Mr. Smith could make a decision, a woman named Mrs. Adams presented herself. She announced that she was a long-time friend of the resident's family and that she was, in fact, the resident's health care proxy, according to a signed durable power of attorney for health care, with full decision making

powers regarding all of the resident's medical treatment. This news raised the question of the resident's capacity in the progress notes for the first time. A psychiatric consult revealed that the resident had the capacity to make health care decisions. However, the durable power of attorney document indicated that it went into effect immediately—not upon the resident's incapacity.

The oncologist was not sure how to proceed. He stated that initially Mr. Smith seemed to prefer the chemotherapy, but when Mrs. Adams refused to consent to chemotherapy he seemed "noncommittal" about his treatment in the sense that he "agreed to anything." The oncologist indicated that "without the consent of the medical power of attorney," he would not feel comfortable giving chemotherapy, even though it was indicated.

Mrs. Adams called the facility's social worker out of concern about the home's efforts to obtain Mr. Smith's consent for the chemotherapy. She stated that she knew the resident did not want chemotherapy, since he had told her after his earlier radiation therapy that he did not want "any more treatments." She said that the resident was illiterate and had no experience in making important decisions for himself. Before her death, his wife had made all financial and other decisions for the couple. The wife had made it clear that Mrs. Adams should assume and continue these same functions for Mr. Smith. Mrs. Adams also revealed that she worked for a private oncologist and knew all about chemotherapy

and that she could not in good conscience consent to such treatment for Mr. Smith. She would, however, be willing to consent to the surgery.

How should the nursing home handle this case?

NOTE: *Below, the commentators on this case use different terms to describe the role of Mrs. Adams—agent, proxy, and surrogate. Some state statutes use very specific language to describe a legally appointed agent—for example, New York calls them "health care agents" and Florida calls them "surrogates." New York state calls the document by which an agent is appointed the health care proxy. New York state defines a "surrogate" as a person not legally appointed by the resident to make health care decisions. Even when similar terms are used or two different terms seem to be functional equivalents, it is imperative that an ethics committee understand what power a state's law gives to the term. For example, a "surrogate" in one state may be able to make any and all decisions, whereas in another state a law might limit the kinds of decisions a surrogate can make—for example, only decisions that will not end in the death of the person on whose behalf he or she speaks.*

COMMENTS FROM A HEALTH LAW PROFESSOR

The significant question in this case is whether Mr. Smith has the capacity to make his own health care decisions. If so, he has the right to make his own treatment decisions in spite of having a duly appointed health care agent. There is nothing in the case which in-

icates that he lacks decision-making capacity. Surely, the inability to read is not a prerequisite for the ability to make medical decisions. Yet, this case presents a troubling and confusing scenario for many health care providers. The confusion comes from having a legal document—a durable power of attorney for health care—that clearly states that the named agent (Mrs. Adams) has the authority to make health care decisions for the principal (Mr. Smith).

Legally, a person may execute a durable power of attorney for health care that takes effect prior to the principal's incapacity. In Maryland, for example, the model statutory form provides the principal with the option of having the agency take effect upon the principal's incapacity or when the principal signs the document. Some individuals—in particular, those who are elderly and infirm—want their spouse or child to make health care decisions for them, even though they have the capacity to make health care decisions. They trust these individuals to make the right decision for them. They may be too sick or too weak to concentrate on the issues, perhaps due to certain sedating drugs or because they are uncomfortable or in pain.

The appointment often works smoothly. However, health care providers are appropriately troubled when the agent instructs them to do something that is inconsistent with the expressed wishes of the principal. As a legal matter in those cases, the wishes of the principal take precedent. This is so for two reasons. First, a principal can always revoke the appointment of the agent. Every state's durable power of attorney for health care statute has a provision for revocation. In many cases, the revocation can be accomplished simply by an oral statement from the principal. Other jurisdictions require destruction of the original document or execution of another document. While this alone is sufficient reason for health care providers to listen to the principal rather than his

agent, there is also a second reason. Most state statutes governing health care agents provide that these agents must make a decision that is consistent with the resident's known wishes. The agent is not to make a decision that is at odds with the resident's expressed wishes.

In this particular case, there is a third reason to be skeptical of Mrs. Adams's role. It is not totally clear whether the original durable power of attorney is valid, for it is questionable whether Mr. Smith actually understood what he was signing and whether he agreed to it. Mrs. Adams states at one point that Mr. Smith's wife had made it clear before her death that Mrs. Adams should continue to make the same type of important decisions for Mr. Smith as Mrs. Smith had. There is no indication that these were Mr. Smith's wishes, and the fact that he cannot read raises questions about his full understanding of the document he signed.

While this case is rather straightforward as a matter of law, as a practical matter it is still problematic. Mr. Smith appears somewhat intimidated by Mrs. Adams and seems to defer to her. As a result, even if the agency is revoked, Mr. Smith may still be influenced by Mrs. Adams. Some effort needs to be made to speak with Mr. Smith alone and explain to him his right to make his own health care decisions. This alone may not be sufficient to get him to make an independent decision, especially if he feels in any way dependent on Mrs. Adams for further care. Therefore, someone from the facility also needs to talk to Mrs. Adams and explain to her the limits of her authority and the rights of Mr. Smith to make his own decisions. She may feel as though she is protecting Mr. Smith from the "medical establishment," given her experience working for an oncologist, and she may feel that the oncologist in this case is not being fully honest with Mr. Smith. As a result, it might be helpful if someone who is not from the medical staff, such as the facility administrator or clergy,

speaks to Mrs. Adams.

The personal dynamics in this case appear more troublesome than the actual legal or ethical problem. We are not privy to the historical or current relationship between Mr. Smith and Mrs. Adams. This information is essential to understanding how Mr. Smith views his choices in this case. A social worker or someone trained in counseling skills may be helpful in getting Mr. Smith to describe his relationship with Mrs. Adams and why he appears intimidated by her. If such information can be obtained, steps might be taken to alleviate Mr. Smith's concerns. If not, the nursing home must continue to confer with Mr. Smith and follow his instructions—even allowing him to defer to Mrs. Adams if he fully understands the implications of that choice.

*Diane E. Hoffmann, JD, MS
Director, Law & Health Care Program
& Professor of Law
University of Maryland
Francis King Carey School of Law*

COMMENTS FROM A RELIGIOUS STUDIES PROFESSOR

This case underscores the importance of identifying surrogates or proxies and involving them in care planning as soon as possible. The sudden appearance of Mrs. Adams turns Mr. Smith passive, halts his planned chemotherapy treatment, and presents the nursing home with some questionable explanations to sift through. Mrs. Adams's rationale for refusing chemotherapy is not only inconsistent in itself, but at variance with Mr. Smith's own preference. In short, Mr. Smith's personal values and his best interests may well be jeopardized by Mrs. Adams's decision making. The nursing home is dealing with a potentially undependable proxy.

Mrs. Adams's primary obligation is to make treatment decisions reflecting Mr. Smith's own preferences. In

Cont. on page 8

Case Presentation

Cont. from page 7

the absence of stated preferences, her decisions should be guided by Mr. Smith's basic values and beliefs. Moreover, Mr. Smith still has decision-making capacity. (Despite what Mrs. Adams implies, his illiteracy does not constitute decisional incapacity.) Mrs. Adams can elicit Mr. Smith's actual preferences for treatment. There is, however, no indication that she does so. She has played no active role in Mr. Smith's admission to the nursing home or in the subsequent decisions to proceed with a diagnostic work-up and biopsy. Her lack of contact with Mr. Adams is made more troubling by the revelation that she was named proxy not by Mr. Smith himself, but by his now deceased wife. On the whole, Mrs. Adams does not seem to have the kind of ongoing contact with Mr. Smith that would make her a well-informed proxy.

Moreover, her explanation for refusing chemotherapy is disturbingly inconsistent. She bases the refusal on Mr. Smith's statement, four years earlier, that he did not want "any more treatments." Yet she indicates that she would consent to surgery—certainly a "treatment," perhaps even more drastic than chemotherapy. She further clouds her refusal by saying she has worked for an oncologist and knows "all about" chemotherapy. Her announced certitude here suggests that she will not seek medical advice for Mr. Smith, much less weigh it seriously. In sum, her failure to elicit Mr. Smith's present wishes, her dismissal of his decision-making ability, and her absolutist stand about oncology all suggest a poorly informed, potentially coercive proxy.

On the other hand, proxies need not be "perfectly" rational, expertly informed, medically "obedient" decision makers, any more than the residents they represent. Biased, information-resistant, potentially coercive proxies can function validly—up to a point.

Determining that point is, of course, a critical task for care providers. The rights and powers of proxies are not absolute. The obligations of care providers to respect residents' preferences and to pursue their best interests should not be abrogated by a dubious proxy. And Mrs. Adams is perilously close to being dubious.

The oncologist's reactions too are morally questionable. His temporizing suggests legalistic paralysis more than moral caution. If the oncologist is inhibited by Mrs. Adams's refusal of consent, the nursing home should not be. The home should engage Mr. Smith in further conversation to clarify the reasons behind his initial choice of chemotherapy and his later vagueness when Mrs. Adams vetoes the treatment. The nursing home should also make sure that Mr. Smith recognizes his rights to determine his own care and to reject or accept Mrs. Adams's surrogacy. Certainly, the home's administrators should ask how he wants them to proceed when Mrs. Adams makes decisions that run counter to his own preferences.

Full and open communication with Mrs. Adams would also be essential. It would provide the nursing home with an opportunity to voice its concern that she has overridden Mr. Smith's stated preference and that her explanations for this are troubling. Discussion of this sort might stir some second thoughts in Mrs. Adams and might give the nursing home a better understanding of her style of surrogacy. If no deeper mutual understanding results, the home should be ready to take whatever formal action might be necessary to challenge Mrs. Adams's decision in this particular instance and perhaps to challenge the appropriateness of her being a proxy altogether.

In dealing with this case, the nursing home's staff will be helped immensely if the facility has clear policies and procedures for dealing with conflicts

that arise around surrogate/proxy decision making. The home's ethics committee should have a clear role in making and reviewing such policy and in carrying out the education that would make it effective. In particular, an ethics committee looking at this case retrospectively might want to examine its facility's admissions process, especially in light of the Patient Self-Determination Act (PSDA).

A minimalist response to the PSDA requires only the formality of a question about the existence of an advance directive. A full-fledged response, however, would call for an in-depth exchange about the content of the directive and the identity of any surrogates named (Johnson, 1991). Such an exchange might have uncovered Mrs. Adams's proxy status (and its potential problems) at a much earlier point. The committee might also feel the need for educational work with staff members on questions relating to advance directives. Mr. Smith has executed an "immediate" durable power of attorney and not the more common "springing" durable power of attorney (which would go into effect only in the event of his decisional incapacity) (New York State Task Force, 1987). It would be especially crucial for nursing home staff to know about this type of agency since it is active even when a resident has decision-making capacity. For that reason it can seriously complicate the decision-making process—as this case amply indicates.

Bart Collopy, PhD

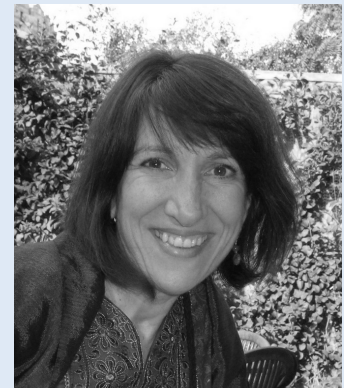
REFERENCES

- Johnson, S. (1991). "PSDA in the Nursing Home," in "Practicing the PSDA," special supplement, *Hastings Center Report*, 21(5), 53-S4.
- New York State Task Force on Life and the Law (1987), *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent*, pp. 95-100; see p. 41.

MHECN PROGRAM COORDINATOR ANITA TARZIAN RECEIVES AWARD

On October 15, 2011, MHECN's Program Coordinator Anita J. Tarzian, PhD, RN was awarded The Distinguished Service Award from the American Society for Bioethics and Humanities (ASBH). Dr. Tarzian's service to ASBH over the years has included serving as a Board Member at Large (2002-2004), as Board Secretary (2004-2008), and currently, as Chair of the Clinical Ethics Consultation Affairs (CECA) Standing Committee. CECA recently published a report with recommendations to the ASBH Board regarding whether and how to certify ethics consultants and accredit programs that train them. It also advises the Board on issues related to health care ethics and standards for ethics consultation. In addition, ASBH recognized Dr. Tarzian's service as Chair of the Core Competencies Update Task Force, which produced the second edition of the report, *Core Competencies for Health Care Ethics Consultation* (published by ASBH in 2011).

As Program Coordinator of MHECN, an initiative of the University of Maryland School of Law, Dr. Tarzian serves as a resource for health care ethics committee members in Maryland and the mid-Atlantic region. A former surgical oncology nurse and hospice nurse, she is currently Associate Professor at the University of Maryland School of Nursing in the Department of Family and Community Health. Her professional focus has been in clinical and research ethics, including clinical ethics consultation in acute and long-term care settings, ethics education, palliative care, hospice, the influence of culture on health care decision-making, and disability rights. Dr. Tarzian received a Doctorate in nursing research (ethics track) and a Masters in Intercultural Nursing from the University of Maryland School of Nursing, a Bachelor of Science in Nursing from Rush University, and a Bachelor of Arts from Knox College.



Anita J.
Tarzian, PhD, RN

Medically Ineffective Treatment

Cont. from page 5

there is no limit to how long treatments need to be continued pending transfer, since in most situations where clinicians decide that particular interventions are medically ineffective, there is no transfer option.

PROPOSED SOLUTION

Jack Schwartz, JD, Adjunct Professor at the University of Maryland Francis King Carey School of Law and former Maryland Assistant Attorney General, has proposed a solution through rule-making through the Department of Health and Mental Hygiene (DHMH). Assuming that DHMH might be open to this approach, which is speculative at present, this option would involve elevating certain Attorney General opinion letters to regulatory status. For example, one opinion letter states that if there is no identifiable surrogate to notify regarding a decision to with-

hold or withdraw medically ineffective treatment (after reasonable efforts to locate a surrogate have been made), it is not necessary to appoint a guardian simply to have someone to notify. In addition, such regulations might clarify how long to maintain interventions deemed medically ineffective pending transfer. At the attorney/risk manager round table last September, most attendees supported this approach. Thus, efforts are underway to draft this regulatory language.

ONE PART OF A BIGGER PICTURE

Medical futility laws are most often invoked for individuals whose death is impending, where a question is raised about the ability of aggressive life-prolonging interventions to achieve a benefit for the patient. What is clear is that such individuals deserve excellent palliative care, which includes com-

fort care and psychospiritual support (the latter for both the patient and his or her loved ones). All clinicians are obligated to ensure that patients have access to excellent palliative and end-of-life care, regardless of whether the patient's dying process is prolonged through medical technology. Taking "false decisions" off the shoulders of surrogate decision-makers is good medical practice. Maryland's HCDA is intended to support that process, but it cannot replace good medical practice. Toward that end, more education is needed for health care professionals, legal guardians, attorneys, risk managers, and the public to ensure that state legislation and regulation supports best medical practice.

If you have questions about these efforts, contact MHECN Program Coordinator Anita Tarzian at atarzian@law.umaryland.edu.

MARYLAND MOLST UPDATE

DHMH's rulemaking, which is needed to complete the process of getting MOLST into final legal form, is still pending. The comment period has closed, and as of this writing DHMH continues to evaluate the comments. Meanwhile, MOLST has already come into voluntary use across the state. Many health care facilities and programs are finding that MOLST is a very useful tool for carrying out already established legal and ethical obligations. In addition, MIEMSS accepts MOLST as the equivalent of an EMS/DNR order. Therefore, although the use of MOLST is not yet legally required, its voluntary use now may be valuable in framing conversations with patients and their families about care planning and in documenting the clinical steps needed to carry out care plans. A wealth of MOLST-related information and training aids may be found on this DHMH website: <http://dhmh.md.gov/marylandmolst/>

CALENDAR OF EVENTS

FEBRUARY

8

End-of-Life Nursing Care Workshop. ELNEC-based course sponsored by the University of Maryland Medical Center's Office of Clinical Practice and Professional Development. Paca Pratt Learning Center, Room 7A, UMMC, Baltimore, MD. For more information, contact kgorman@umm.edu.

13 (1-2PM)

Embracing Cultural Diversity in Medical Practice. Sponsored by the UMMC Ethical Advisory Committee. University of Maryland Medical Center, 22 S. Greene St., Baltimore, MD, Shock Trauma Auditorium. For more information, contact Hsilverm@medicine.umaryland.edu.

16 (6-7:30PM)

The Ethics of Erasing Memories "Eternal Sunshine" Style. Speaker Matthew Liao, Ph.D., Center for Bioethics, New York University. Columbia University Morningside Campus, New York, NY. To RSVP or for more information, contact Meghan Sweeney at ms4184@columbia.edu.

MARCH

4 (6 PM)

"Am I My Genes?" Sphinxes, Chimeras, & Other Mixes of Species in Science & Art. Speaker Robert Klitzman, MD, Dept. of Psychiatry, CUMC, Guggenheim Works & Process Series. Solomon R. Guggenheim Museum, 1071 5th Ave. (at 89th St.), New York, NY. For more information, contact ms4184@columbia.edu.

13-14

Mixed Messages: Ethical Tensions in Healthcare Conversations. Sponsored by the Health Care Ethics Consortium of Georgia (HCECG) and the Emory University Center for Ethics, at the Emory University Center for Ethics, Atlanta, Georgia. For more information, visit www.hcecg.org, or call 404-727-9533.

15 (6-7:30 PM)

Speaker Oliver Sacks, MD, Low 207, Columbia University Morningside Campus, Columbia University, New York, NY. To RSVP or request more information, contact Meghan Sweeney at ms4184@columbia.edu.

16

Ethics of the Heart II: Ethics and Policy Challenges in Congenital Heart Disease. Sponsored by the Penn Cardiovascular Institute, the Cardiac Center at the Children's Hospital of Philadelphia (CHOP) and the Center for Bioethics at the University of Pennsylvania. CHOP, Philadelphia, PA. For more information, contact james.kirkpatrick@uphs.upenn.edu.

CALENDAR OF EVENTS *(cont'd)*

30-April 1

“The Significance of Neuroscience for Morality: Lessons from a Decade of Research” (Part I), and “Can Moral Behavior be Improved or Enhanced?” (Part II). Sponsored by the NYU Center for Bioethics, Duke Kenan Institute for Ethics, Yale Interdisciplinary Center for Bioethics, and the Institute for Ethics and Emerging Technologies. New York University, WSQ Campus (room TBA). For more information, contact bioethicsconference@nyu.edu or visit <http://bioethics.as.nyu.edu/object/bioethics.events.20120330.conference>

APRIL

12-13

New Technologies, New Challenges: Women and Prenatal Genetic Testing in the 21st Century. Jointly Sponsored by the Department of Bioethics at the Cleveland Clinic and the Center for Genetics Research, Ethics and Law at the Case Western Reserve Medical School. Case Western Reserve University School of Law, Cleveland, OH. For more information, visit http://www.law.case.edu/Lectures.aspx?lec_id=295, or call 216-368-1798 (toll-free 888-814-5878).

17 (12-1:15P)

Advance Care Planning: Addressing the Gaps between Knowledge and Practice. Speaker: Myra J. Christopher, Center for Practical Bioethics. Annual Shallenberger Lecture in Ethics, sponsored by the Johns Hopkins Hospital Ethics Committee and Consultation Service. For more information, contact Sharon Mears at smears@jhmi.edu, 410-955-0620.

26-27

Borders and Barriers: Mapping a Moral Path. This conference will have a Hot Topics track that will focus on high profile issues in the healthcare headlines and an Issues in Practice track that will focus on applied topics for individual and ethics committee development. Sponsored by the Colorado Healthcare Ethics Forum. Stonebrook Manor Event Center and Gardens, Thornton, Colorado. For more information, visit <http://coloradoethicsforum.org/>

MAY

1 - 3

Ethics Education in a Global Perspective. Inaugural International Conference on Education in Ethics. Organized by the International Association for Education in Ethics (IAEE) and the Center for Healthcare Ethics. Duquesne University, Pittsburgh, Pennsylvania. For more information, visit <http://www.duq.edu/healthcare-ethics/iaee/>, or e-mail iaee@duq.edu.

10-11

Reforming Ethics and Humanities Teaching in Medical Education: Fulfilling Future Accreditation Goals on Professionalism. Sponsored by the Romanell Fund for Bioethics Pedagogy at the University at Buffalo and the University of Louisville. The Brown Hotel, Louisville, KY. For more information, visit www.primemedicine.org.

15-16

Hospitals, Healthcare, and the Medical Humanities. Sponsored by Children's Hospital of Pittsburgh, 4401 Penn Avenue, Pittsburgh, PA. For more information, contact meeting Lisa Parkera (lisap@pitt.edu) or Valerie Satkskeab (vbv2@pitt.edu).

31-June 1

Third Annual Conference of the International Society of Advance Care Planning and End of Life Care. For more information, visit <http://www.acpelsociety.com/conference/>.

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

SUBSCRIPTION ORDER FORM
THE MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER

NAME _____

ORGANIZATION _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE/FAX NOS. _____

E-MAIL _____

No. of Subscriptions Requested:

_____ Individual Subscriptions
@ \$35/yr.

_____ Institutional (MHECN
non-member) Subscriptions
@ \$90/yr. (up to 20 copies)

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

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

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

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