

Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 2012*

Mid-Atlantic Ethics Committee
Newsletter, Fall 2012

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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 Francis King Carey
School of Law and the Maryland Health Care Ethics Committee Network

Fall 2012

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The *Mid-Atlantic Ethics Committee Newsletter* is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland Francis King Carey 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

CODE OF ETHICS & QUALITY ATTESTATION FOR ETHICS CONSULTANTS

In 1998, the American Society for Bioethics and Humanities (ASBH) published the first edition of the Core Competencies for Health Care Ethics Consultation. The Task Force for Standards on Bioethics Consultation recommended that the Core Competencies be used as voluntary guidelines, and discouraged movement toward “professionalizing” ethics consultants (for example, through individual certification and program accreditation). However, the field of ethics consultation continues to evolve, with several post-graduate programs and clinical fellowships available to educate and train ethics consultants. In 2011, ASBH published the second edition of the Core Competencies, in which the movement toward professionalizing the field of health care ethics (HCE) consultation was recognized, rather than discouraged. A small but growing number of HCE consultants have advocated for moving their field forward by developing a Code of Ethics, certification of ethics consultants, and accreditation of programs that train ethics consultants.

ASBH has responded. Its Clinical Ethics Consultation Affairs (CECA) Standing Committee is developing a Code of Ethics for Health Care Ethics Consultants (see Box). ASBH is currently collaborating with Eric Kodish, a physician and ethics consultant at the Cleveland Clinic, who was recently awarded a grant from the Josiah Macy, Jr. Foundation to support a project entitled, “Toward Consen-

sus: Quality Attestation for Clinical Ethics Consultants.” ASBH’s position is that all individuals who do HCE consultation should be held accountable to the standards outlined in the Core Competencies. However, only individuals functioning at an advanced level—particularly those doing solo HCE consultations—would pursue the “Quality Attestation,” which would be a step toward a more formal certification process in the future.

Members of the Core Competencies Update Task Force (which authored the second edition of the Core Competencies) recognize that most individuals doing HCE consultation do not consider themselves to be professional HCE consultants. However, the Task Force believes that running an effective ethics consultation service typically requires having access to at least one individual with advanced-level HCE consultation competency. Toward that end, efforts toward professionalizing HCE consultants will hopefully not displace health care providers who wish to remain involved in ethics activities at their institutions, but instead, will ensure that there are enough expert HCE consultants to help run ethics programs at health care organizations throughout the country. The goal is that this should make it easier, not harder, for those who want to stay involved in HCE consultation activities at their institutions to do so without feeling overburdened. But this will

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**The Mid-Atlantic Ethics
Committee Newsletter**
is published three times per year by
the **Maryland Health Care Ethics
Committee Network**
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Code of Ethics
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only happen if health care administrators and corporate leaders realize the value of having an ethics consultant with recognized expertise in charge of their health care organization's ethics program. Below is the Draft Code of Ethics for Health Care Ethics Consultants prepared by the ASBH Clinical Ethics Consultation Affairs Standing Committee.

**Draft Code of Ethics for Health
Care Ethics Consultants**

Preface: This statement sets out the core ethical responsibilities of anyone engaged in health care ethics (HCE) consultation. HCE consultation is 'a set of services provided by an individual or group in response to questions from patients, families, surrogates, health care professionals, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care' (ASBH CC TF, 2011). The goals of HCE consultation include identifying, clarifying and analyzing the ethical issues that underlie the consultation request. HCE consultation seeks to facilitate agreement among involved parties about ethically justifiable options. HCE consultation addresses the ethical concerns of persons involved in health care decision making and medical research, including patients, families, and providers, and those who set guidelines and create policies.

In addition to their role as HCE

consultants, some individuals are also members of other professions and may be accountable to different codes of ethics. While engaging in HCE consultation, individuals should adhere to this statement of responsibilities.

Professional Responsibilities

Be competent: HCE consultants should practice in a manner consistent with recognized standards of excellence.

Avoid conflicts of interest: HCE consultants have an obligation to properly manage conflicts of interest, i.e., situations in which the professional judgment of a HCE consultant may appear to be affected or compromised by a personal or financial interest, especially in a way that might adversely affect recommendations regarding patient care. If it is not possible to avoid a conflict of interest through recusal or referral, HCE consultants have an obligation to be transparent and make full disclosure to all the involved parties of the nature of the conflict, maintain their independence, remain unbiased, and to exercise good professional judgment.

Avoid conflicts of obligation: HCE consultants should identify, disclose, strive to avoid and manage within ethically appropriate means those conflicting obligations that arise when they perform multiple roles within an organization. Consultants may need

Be a part of the process! Provide your thoughts and comments to drafters of the Code at a special workshop at the ASBH Annual Meeting on Friday, October 19, 1-2:30 PM, at the Hyatt Regency on Capital Hill in Washington D.C. The ASBH Annual Meeting "Representing Bioethics" offers pre-conference sessions, concurrent and plenary sessions from October 18-21. It alternates cities so take advantage of its proximity and consider attending this year! See <http://www.asbh.org> to view the full program.

to recuse themselves when conflicts of obligation cannot be appropriately managed.

Protect confidentiality: HCE consultants should recognize when information is personal, respecting and protecting privacy with confidentiality, and only sharing such information with discretion in accordance with standards of ethics, law, and organizational policy.

Promote integrity: HCE consultants should cultivate attitudes and attributes that support reflective practice and promote personal and professional integrity.

Make responsible public statements: When addressing the lay public about HCE issues, HCE consultants should speak responsibly.

Contribute to the field: HCE consultants should participate in the

advancement of the field through contributions to practice, education, administration, knowledge, and/or skill development.

Promote just health care: HCE consultants should collaborate with other professionals and lay persons to promote a more equitable health care system.

MHECN CO-SPONSORS COMMUNICATIONS CONFERENCE WITH CARROLL HOSPITAL CENTER

On June 13, 2012, MHECN collaborated with Carroll Hospital Center to hold a workshop entitled, “Navigating Communication Landmines in Ethics Consultation.” The workshop was co-developed by Lucia Wocial, Ph.D., R.N., Nurse Ethicist with The Fairbanks Center for Medical Ethics (FCME) at Indiana University Health and Sandra Petronio, Ph.D., Professor in the Department of Communication Studies, senior affiliate faculty with FCME, and Core Faculty of the Indiana University Center for Bioethics.

Dr. Wocial presented at the workshop, incorporating concepts adapted from the work of Drs. Ann Cook and Helena Hoas, who direct the National Rural Bioethics Project at the University of Montana (<http://www.umt.edu/bioethics/>). Cook and Hoas discovered that health care providers in rural settings were not troubled as much by “ethical problems” and dilemmas often featured by academic bioethicists. Rather, they were troubled by conflicts arising when health care providers from different disciplines disagreed with each other when trying to make health care decisions. Wocial adapted a script from the National Rural Bioethics Project’s Reader’s Theater, in which characters play out a scene demonstrating various communication landmines.

The workshop focused on the following ethics consultation skills identified in the Core Competencies for Health Care Ethics Consultation (ASBH, 2011):

- Listen well, communicate interest, respect, support and empathy to involved parties.
- Enable the involved parties to communicate effectively and be heard by other parties.
- Recognize and attend to various relational barriers to communication.

Anyone who has done ethics consultation knows that communication breakdown is at the root of many, if not most, ethics consultation requests. This likely stems from a definitional feature of communication that Dr. Wocial underscored in her introductory presentation: communication is the response you get from the message you send regardless of your intent. Dr. Wocial reviewed the following five core communications competencies:

- Communicative Adaptability: Remaining composed during communication interactions and responding appropriately through confirmatory statements based on others’ perceptions and

understanding of the situation (e.g., “You did the right thing by asking for help.”).

- Conversational Involvement: Being responsive, perceptive, and attentive to what others in the encounter are communicating, without minimizing what they feel is important, while paying attention to meta-messages (e.g., “I can see you’re angry that your blood had to be redrawn.”).
- Conversational Management: Taking appropriate turns when speaking and avoiding unnecessary interruptions, asking meaningful questions, and being attentive to non-verbal messages (e.g., “You say that you’re not angry but you seem upset to me. Are you upset? ... Can you tell me more about that?”).
- Empathy: Listening attentively and reacting to the person’s emotional state, offering tissues if the person is crying, not changing the topic merely to reduce emotional intensity, showing warmth and caring via verbal and non-verbal messages (e.g., “Oh my, you’ve been

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Conference

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through so much this last month. I'm so sorry.”).

- **Respect and Expectations:** Paying attention to those involved in the communication encounter and respecting different points of view. Looking for the meta-communication issues to identify the way individuals involved are framing the issues and taking them into account.

Workshop attendees then reviewed specific “communication landmines” that can derail an effective ethics consultation (as well as other communication encounters). These include “negative messaging” that makes people involved feel unimportant, disrespected, undervalued, or insignificant. For example, implicit or explicit statements may dismiss or discount another person’s credibility or point of view. Other examples of “negative messaging” include defensive behaviors (e.g., being judgmental, controlling, unemotional, or inflexible), relational barriers (e.g., jumping to conclusions, being hostile), and listening barriers (e.g., avoiding difficult topics, being closed-minded, bored, inattentive, or insincere).

The ethics consultant should obviously avoid displaying these negative messages, but more commonly, should recognize them and respond when others involved in an ethics consultation exhibit negative messaging during the consultation process. Strategies involve disarming these communication landmines by counteracting the negative messaging with “confirming” messaging. For example, say during an ethics consultation group meeting, the patient’s adult daughter says, “My brother (Joe) doesn’t care about my mom. He never comes to see her.” The ethics consultant could disarm such a remark through a confirming message,

such as, “Joe is here with us now. Let’s hear what he has to say.”

Disarming defensive behaviors during ethics consultation can be challenging, as these often arise from underlying emotional turmoil of the individuals involved. It’s important to be astutely aware of your own bodily responses, as strong emotions cause physiologic changes that affect one’s vocal tone, posture, facial expressions, hand gestures, etc. The aim here is for “bounded emotionality” - that is, acknowledging emotions that come up, expressing them constructively (e.g., “You seem sad” ... “I feel frustrated when you ...”), and at the same time, exercising control over them. Disarming relational and listening barriers involves various strategies to gain trust and connect with individuals in the communication encounter.

Most health care professionals have received some education or training on effective communication strategies. Yet, there are too few opportunities to hone these skills, particularly as they relate to ethics consultation. At the workshop, volunteer actors read through two scripted scenes based on a case study involving a 72 year old hospitalized woman at the center of an ethics consultation: one involving one-on-one conversations between the ethics consultant and various involved



(from l to r:) Anita Tarzian, PhD, RN, MHECN Program Coordinator; chaplain Angela Boggs, Manager of the Spiritual Care Department at CHC; Diane Hoffmann, MHECN Executive Director and Professor of Law at the University of Maryland School of Law; Lucia Wocial, PhD, RN, nurse ethicist at Indiana University Health Charles Warren Fairbanks Center for Medical Ethics; and Kevin Smothers, M.D., F.A.C.E.P., Senior Vice President of Medical Affairs and Chief Medical and Quality Officer at CHC.

parties, and another involving a group meeting with involved parties. The involved parties included: the patient’s primary physician, ER physician, primary nurse, social worker, chaplain, adult daughter, and adult son. Workshop attendees tried to spot the landmines and took turns trying to disarm them with the strategies Dr. Wocial presented. Attendees were enthusiastic about this interactive method of practicing advanced communication skills.

If you are interested in using the workshop case study and script for a training session at your facility, contact Anita Tarzian at (410) 706-1126, atarzian@law.umaryland.edu.

DHMH RESPONDS TO MOLST FEEDBACK

Maryland Medical Orders for Life Sustaining Treatment (MOLST) is a portable and enduring form for orders about cardiopulmonary resuscitation and other life-sustaining treatments. MOLST regulations were proposed in the September 23, 2011 Maryland Register, with the public comment period ending October 24, 2011. The Department of Health and Mental Hygiene (DHMH) summarized the comments they received in the August 10, 2012 issue of the Maryland Register. These comments and responses are excerpted from The Maryland Register, 39(16), August 10, 2012, 1087-89.

Comment: Several comments emphasized the value of patient decision making in health care and urged DHMH to issue regulations to implement MOLST.

Response: DHMH is proposing these regulations to implement MOLST and support patient autonomy in key health care decisions. Because DHMH highly values the input of affected organizations and individuals, the Department accepted public comment on the initial proposal. DHMH is accepting public comments on this proposal as well.

Comment: Several comments recommended providing time for training and preparation prior to implementation of the MOLST regulation.

Response: DHMH agrees with this comment. The final MOLST regulation will provide time for training and preparation.

Comment: Several comments expressed concern that under certain circumstances, the MOLST is inappropriate and could affect the trust between the provider and the patient. Specifically, comments recommended that MOLST should not be required for patients whose primary diagnosis is

related to pregnancy, children under age 18 with non-life threatening conditions, and patients with a primary psychiatric diagnosis.

Response: The proposed regulations exempt these three populations from the requirement that their physicians fill out a MOLST form. Physicians caring for these patients may elect to fill out a MOLST form, depending on the circumstances and the voluntary participation of the patient. In addition, the training for MOLST includes education for health care providers about discussing life-sustaining treatment decisions with a patient or authorized decision maker.

Comment: A comment noted that the completion of a MOLST form should always be based on voluntary participation from the patient or the patient's authorized decision maker.

Response: DHMH agrees with the comment. The proposed MOLST form already includes the following language:

"Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary. If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given."

Comment: Several comments expressed concern about the language on the form related to medical effectiveness and the Health Care Decisions Act. This legal path is rare in Maryland and must be substantiated with appropriate documentation.

Response: DHMH recognizes that medical ineffectiveness is a rarely

used path in Maryland. Based on the comments, the proposed regulation rewords the language related to the Health Care Decisions Act and makes reference to the requirement for appropriate documentation in the medical record. The proposal, however, does not drop all mention of the Health Care Decisions Act from the MOLST form, on the grounds that (1) Existing EMS forms provide an option to document an order based on this path, and MOLST should be consistent with current practice and (2) the MOLST legislation anticipates that the MOLST form can serve as a single pathway for orders regarding life-sustaining treatments.

Comment: A comment stated that to be consistent with the Health General Article, the MOLST regulation should state consistently that a health care facility shall, "On request of the patient, offer any physician or nurse practitioner selected by the patients the opportunity to participate in updating or completing the form."

Response: DHMH agrees. The proposed regulation states:

E. When initially completing a MOLST form or updating an existing MOLST form, a health care facility shall:

(1) Offer the patient or authorized decision maker the opportunity to participate in completing or updating the MOLST form, and on request of the patient, offer any physician or nurse practitioner selected by the patient the opportunity to participate in updating or completing the MOLST form.

In addition to the above changes, the proposed regulation corrects the website address, clarifies a statement related to maintenance of the

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MOLST

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MOLST form in the patient's active medical record, deletes the phrase "Blank order forms shall not be signed," as it is standard not to sign blank order forms, and makes several clarifications under the section "certification for the basis of these orders."

Comments sent to Michele A. Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, were accepted through September 10, 2012. A public hearing has not been scheduled.

This issue of the Maryland Register is available at <http://www.dsd.state.md.us/MDRegister/3916.pdf>.

For updates on the MOLST form and to download the form itself, visit <http://marylandmolst.org/>

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.

CASE STUDY INVOLVING A POSSIBLY PREGNANT DONOR

A 27 year old woman involved in a motor vehicle accident is declared dead by neurologic criteria. She had indicated on her driver's license that she wished to be an organ donor, and her parents have agreed (she is unmarried). As the transplant surgeon proceeds with the surgery to procure her organs, he suspects from the size and feel of her uterus that she may be pregnant. He asks staff to check whether a pregnancy test was done in the emergency department or intensive care unit; there is no record of a pregnancy test in her medical records. He asks a nurse to do a pregnancy test. The nurse wonders whether consent to test for pregnancy is required. They decide to call the ethics consultant on call to ask whether they need to get consent to do a pregnancy test.

COMMENTARY FROM A TRANSPLANT ETHICIST, TRANSPLANT SURGEON, AND ORGAN PROCUREMENT ORGANIZATION MEDICAL DIRECTOR

In this case, we have a 27 year-old female, who has been declared dead by neurologic criteria (i.e., "brain dead"). She has previously authorized donation of her organs by so designating on her driver's license. This is a document of gift under the Maryland Revised Uniform Anatomical Gift Act (SB756, 2011), and although, as stated, her parents have agreed, the decedent's authorization is sufficient and binding in and of itself (see <http://mlis.state.md.us/2011rs/billfile/sb0756.htm>).

As organ recovery begins, "the surgeon suspects from the size and feel of the uterus that she might be pregnant." No pregnancy test has yet been performed, and when the surgeon asks

that one be done, a nurse questions whether consent needs to be obtained for this, and an emergent ethics consult is requested. The question initially posed to the clinical ethicist is whether consent is required to perform a pregnancy test on this donor, but to answer this question, we need much more background information regarding authorization (note that I do not use the word "consent") for donation, and also about the outcomes of pregnancies in brain dead individuals. Thus, if it were known that no brain dead individual had ever been artificially maintained (not "kept alive!") long enough to deliver a live infant, then the question of pregnancy becomes moot. It is entirely possible that this knowledge base is not within the experience of a single individual, and so even if the ethics consult in such an emergency may be responded to by a single person, (s)he may need to reach out to others with the expertise necessary to provide the

factual base required for meaningful recommendations.

The question in this particular case is unusual in the sense that it is posed when the donor is already in the operating room, and, presumably, during the initial exploration of the abdominal cavity, which is routinely performed to exclude unsuspected medical problems that might preclude organ recovery, such as an undiagnosed malignancy. This suggests that, if pregnant, the donor is relatively early in her pregnancy, as the uterus typically is large enough to be felt on examination after twelve weeks, and reaches the level of the umbilicus by 20 weeks. There is variability across the country regarding routine pregnancy testing of organ donors, and many organ procurement organizations (OPO) only obtain such testing in unusual circumstances, or to rule out particular malignancies. Obviously, it would have been preferable for many reasons, not least of which is the ability for a less rushed ethics consultation, to have determined whether the donor was pregnant or not prior to the start of the donor operation. Brain dead individuals have been artificially supported for as long as 3.5 months to permit live birth of an infant, and pregnancies have resulted in live births from brain-dead individuals as early as 16 weeks of gestation, so the question here is not irrelevant (Esmailzadeh, 2010). Although organ recovery has begun, no irretrievable steps take place in the procedure until the very end, so, should the donor turn out to be pregnant, and should the decision be made to attempt to support the pregnancy, it would be possible to close the incisions and return the donor to the ICU. This would only be possible in the case of a heart-beating, brain dead organ donor. In the setting of DCD donation (donation after circulatory death), no incision is made until after the cardiopulmonary death of the donor (and a suitable 2-5 minute waiting period thereafter), and by the time the surgeon felt the uterus, the fetus

would no longer be viable. Similarly, in the instance of a brain-dead donor, if the question of pregnancy was raised after cross-clamp and perfusion of the donor, there would be no option of “rescuing” the fetus.

Authorization for organ donation includes all testing necessary to determine if the subject would be a suitable donor, and, thus, no separate consent for a pregnancy test would be necessary. More important, however, is the question of what one would do with the results of such testing, and what the ethics consultant would recommend. Obviously, a negative pregnancy test would resolve the issue, but one should not order the test hoping for such a result until thinking through the course should the opposite result be obtained. Assuming a positive test, and assuming a pregnancy could possibly be carried until the fetus was viable, a number of important questions face the ethicist. A non-exhaustive list of such questions might include:

1. Did the patient know she was pregnant?
2. If so, had she made a decision regarding her desired outcome of the pregnancy?
3. If the patient had planned to keep the pregnancy, would she make the same decision knowing she would not survive to raise the child?
4. We know she is unmarried, but is the putative father in the picture? Does he have an opinion, and does he have any rights?
5. If the parents and the father disagree, who prevails?
6. If the decision is made to try to maintain the pregnancy, does that preclude subsequent organ donation? (not necessarily)

There is rarely an issue in pausing the process of organ recovery in a brain dead donor for a few hours, except in the case of a hemodynamically unstable donor, in which case the issue of maintaining the pregnancy

would be out of the question anyway. As soon as the surgeon raises the question, a halt should be called to the procedure until the ethics consult can be performed. Ideally, the ethicist should respond to the operating room, but a phone consultation would also be possible. The OPO medical director and administrator on-call should be notified by the organ recovery team, and should participate in the discussion. The clinical ethicist should also gather whatever experts are needed to help answer the medical questions, whether these be members of the hospital ethics committee, should such expertise reside there, or others (e.g., maternal-fetal medicine) as necessary. The ethicist must determine who is/are the legal agents for the donor, and who will make the ultimate decision regarding the disposition of the pregnancy, should that turn out to be the issue. Hospital counsel should also be notified.

The ethicist, in this case, realistically has only 3-4 hours to complete these tasks. Had the donor been identified as pregnant prior to beginning the donation process, one might have days to more leisurely consider the options and ramifications. The ethicist should place a preliminary note in the chart, and a more complete note could be submitted, both to the hospital chart and to the OPO via the medical director, at a subsequent time.

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REFERENCES:

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**COMMENTARY FROM A
TRANSPLANT ETHICIST IN
AUSTRALIA**

My first reaction when reading this case was, “Why wasn’t a pregnancy test performed before the surgeon opened the patient for organ procurement?” [The case states: “As the transplant surgeon proceeds with the surgery to procure her organs, he suspects from the size and feel of her uterus that she may be pregnant.”] It is unclear if the heart and lungs have been removed, and now the abdominal team is proceeding into that cavity for the liver and other organs, then noticing, “the size and feel of the uterus” being abnormal. Another possibility is that the surgeon has opened the woman’s body and done an initial manual exploration of all the organs and then notices (before removing anything) the abnormal size and feel of the uterus. The ethicist would need to ask appropriate questions to determine the staging of the procurement procedure.

Moving from those questions, I am troubled that the surgeon is already inside the patient. From an ethics perspective, the surgeon should not have ‘proceeded to surgery’ without knowing (by lab testing) if the patient was pregnant or not. The standard practice in my experience is for the organ procurement organization (OPO) to obtain this laboratory result before surgical recovery is initiated (Council of Europe, 2009; Gift of Life Donor Program, 2009; United Network for Organ Sharing, 2004). Granted, however, “standard practice” varies according to the location of practice and this commentary includes reflection on regional/national regulations (Council of Europe, 2009; UK Transplant, 2011).)] The surgeon then reviews all assay data before the donor candidate is surgically opened in the O.R.

But, as the ethicist receiving the consult request in the face of a surgeon

whose hands are inside the patient, both the surgeon and I are watching the time-clock ticking. Delays can cause irreversible organ damage putting graft utility at risk [it is unclear from the case details if cross-clamp has occurred]. Because pregnancy testing is the standard of care [in European countries], and the woman had registered her consent to donate, it can be argued that her consent for testing pertaining to donation candidacy/screening is implied. This said, no family consent for testing would be required and attempts to obtain such would unnecessarily delay proceedings.

My advice in this case would be to proceed with STAT pregnancy testing as this assay (β -HCG) is a routine element of donor screening. With regard to results... Because the donor candidate is already declared brain dead and opened in the O.R. for procurement, one has to ponder if there is a chance of fetal viability if the woman were to be closed (assuming the heart and lungs had not been removed) and continued on life-support (so as to host the fetus until term or near-term). The question should be posed and officially answered for the consult report. But even if the heart and lungs had been removed, β -HCG testing should still be performed. Why you ask?

β -HCG testing is also pertinent to matters of oncology, not just pregnancy. Specifically, this assay also can act as a tumor marker in some types of cancer, including ovarian, liver, stomach, and lung cancers. So just because this test was missed at case onset, and the woman is likely not able to bear a pregnancy to term under the current conditions, the assay may have value in that it could yield data that indicates she should not be a donor (if she has a malignancy) (Council of Europe, 2009). This is an important topic for the ethicist to include in the consult

report because it pertains to the matter of preventing harm to future patients (through preventing disease transmission).

[NOTE: if pregnancy was confirmed after her heart and lungs had been removed (one of the case stagings proposed) then there is potential legal risk for the OPO in their failure to rule out pregnancy before organ procurement was initiated. See further discussion below about brain-dead women carrying fetuses to term on life support. The ethicist should consult a medical malpractice attorney for information on fetal duties and fetal harm – is the fetus a “patient”? Is this a medical error to the deceased, a non-patient? An error to the fetus? What legal obligations are there for the OPO?]

Responding to the O.R. the ethicist should write a preliminary consult note in the OPO donor chart; but if not feasible, the guidance can be called to the O.R. telephonically. A full consult report should be given to the surgeon who requested the consult asap. This surgeon is also likely employed by the OPO and thus it would be prudent for the medical director of the OPO to also receive a copy of the report. (Note: as a matter of collegiality, the medical director should also be notified of the consult request, though they are already likely aware of the matter per their own procedural rules). It is important for the OPO medical director to receive a copy of the ethics consult report because this individual needs to be aware of procedural missteps so that case review and corrective action is undertaken on an organizational level. Additionally, as an aid to the surgeon and OPO, the ethicist should include bioethics and regulatory references as appropriate. These can be a great teaching tool, as well as a source of integrity for advice given in the report.

As an aside, if organ procurement

had not already been started; that is, the woman was still on life support and her body had not been surgically opened, the case might take a different turn. β -HCG testing would still be performed as standard procedure for donor screening (again, depending on regional practice variations), and positive results would then be reviewed with the patient's surrogate to explore the woman's values about pregnancy and motherhood. Did the woman know she was pregnant? Perhaps

she did but her family or unmarried partner did not know. Did the woman desire to continue her pregnancy? Perhaps she was still deciding about this matter? Perhaps she decided to terminate the pregnancy but had not yet done so. Perhaps she would have wanted to carry the child to term? If the latter, and there is family willing to raise and support the child, continuing the mother on life-support with the intent to deliver the child could be posed (the ethicist should not exclude

the possibility that though unmarried, the woman might have been in a long-term relationship with a man or a woman and not married to her partner). The psychosocial issues would need deep exploration and the assistance of a social worker would be of great aid to the ethics consultation. According to Esmaeilzadeh et al. (2010), "The important question is from which gestational age onward should the pregnancy be supported? At present, it seems that there is no

WHAT, AND WHERE, TO DOCUMENT?

In the second edition of the Core Competencies for Health Care Ethics Consultation (ASBH CC TF, 2011), "emerging process standards" were added to identify best practices for ethics consultation. The Task Force that updated the Core Competencies recognized that ethics consultants may respond to a range of requests, but a request involving an active patient is given special status due to the more direct potential to help or harm stakeholders based on the consultant's involvement. For ethics consultations involving an active patient, the attending physician and patient (or family) should be notified about the consultation, and the consultation should be documented in the patient's medical record, in addition to the ethics consultation service's internal records.

Dubler and colleagues (2009, p. 26) wrote: "A formal note in the medical record, such as a typed note in the chart, is the standard method care providers use to communicate about all aspects of the patient's care." Should the ethics consultation featured in this case study be documented in the patient's medical record? Should the patient's family be notified about the consultation? One might argue that because the patient is dead, there should be no family notification of the consultation nor documentation in the medical record. Recommendations at this point do not affect health care decisions for this patient, so some would argue they don't belong in the patient's chart. Instead, an analysis of the case should be given to the involved staff (both at the hospital and the Organ Procurement Organization).

In addition, the ethics consultant(s) should follow up on the policy issue of whether pregnancy testing should be established as a standard procedure pre-organ procurement if not already done in the clinical setting. This case clearly has implications beyond the question posed to the consultant: "Can we test the patient for pregnancy without consent?"

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Case Presentation
Cont. from page 9

clear lower limit to the gestational age which would restrict the physician's efforts to support the brain-dead mother and her fetus." There is still the potential for the mother's organ/tissue donation to occur after childbirth.

If the results are not pregnancy, but rather cancer, one could argue that the next of kin should be told of those results if there is the potential for that type of cancer to be genetic (i.e., other family members might also need to be tested).

As always, there is an ethical duty to recognize that scope of practice issues apply. Due to the complexity and time sensitivity of this case, it should be handled by a professional medical ethicist rather than a hospital ethics committee (the latter group will likely not be prepared to handle it unless

it is staffed with an on-call medical ethicist).

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CALENDAR OF EVENTS

OCTOBER

1

The Role of Patient Satisfaction: What Does it Mean for Health Care? The New York Academy of Medicine, 1216 Fifth Avenue at 103rd Street, New York, NY. For more information, visit <http://www.nyam.org/events/2012/2012-10-01.html>.

10 (2-5P)

Albert R. Jonsen Bioethics Symposium: The Journey of Bioethics: Past, Present, and Future. A Roundtable with Prominent Figures in Bioethics. The City Club, 155 Sansome Street, San Francisco, CA. For more information, visit: <http://www.cpmc.org/services/ethics/events.html>

11-12

The 10th Annual Conference on Contemporary Catholic Healthcare Ethics End of Life Care & Institutional Identity in the Catholic Tradition. Loyola University Chicago Stritch School of Medicine, Maywood, Illinois. For more information, visit: http://bioethics.lumc.edu/news_and_events/CHA_2012.html

11-12

International Neuroethics Conference, sponsored by the International Neuroethics Society. New Orleans Marriot, New Orleans, LA. For more information, visit: <http://www.neuroethicssociety.org/2012-annual-meeting>

18-21

"Representing Bioethics:" Annual Meeting of the American Society for Bioethics and Humanities. Hyatt Regency on Capitol Hill, Washington, DC. For more information, visit <http://www.asbh.org>.

24 (4-6P)

Politics of Assistive Technology: The Case of 20th Century Reading Machines. Speaker: Mara Mills, Ph.D., Assistant Professor, Media, Culture & Communication, New York University. Sponsored by Penn Center for Bioethics. 3401 Market St, Suite 321, Philadelphia, PA. For more information, visit: <http://www.bioethics.upenn.edu/Colloquium.shtml>

23-25

Brain Matters 3 “Values at the Crossroads of Neurology, Psychiatry & Psychology.” Marriott Cleveland Downtown at Key Center, Cleveland, OH. For more information, visit: <http://www.clevelandclinicmeded.com/live/courses/2012/epilepsy12/agenda.htm>

NOVEMBER

1

Reproductive Justice: The New Constitutional Battle Front. Stuart Rome Lecture at the University of Maryland King Carey School of Law. Ceremonial Moot Court Room, 500 West Baltimore Street, Baltimore, MD. For more information, visit: <http://www.law.umaryland.edu/calendar/>

2

Institutional Financial Conflicts of Interest in Research Universities. Wasserstein, Milstein Conference Rooms, Harvard Law School, Cambridge, MA. For more information, visit: <http://http://www.law.harvard.edu/programs/petrie-flom/events/conferences/fcoi/index.html>

2-5

Clinical Ethics Immersion, sponsored by the Center for Ethics at Washington Hospital Center, MedStar Washington Hospital Center, Washington, D.C. For more information, visit: whcenter.org/ethics

9

AMBI Clinical Ethics Conference. Albany Medical College, Albany, NY. For more information, visit: http://www.amc.edu/Academic/CME/Upcoming_Events.cfm

DECEMBER

13 (4-6P)

The Body Politic: The Battle Over Science in America. Penn Center for Bioethics Conversation Series featuring Jonathan Moreno, PhD (book author) and Arthur Caplan, PhD. Sponsored by Penn Center for Bioethics. 3401 Market St, Suite 321, Philadelphia, PA. For more information, visit: <http://www.bioethics.upenn.edu/Colloquium.shtml>.

JANUARY

10 (4-6P)

What do we do about low-value medical services? Speaker: Ezekiel J. Emanuel, M.D., Ph.D., University of Pennsylvania. Sponsored by Penn Center for Bioethics. 3401 Market St, Suite 321, Philadelphia, PA. For more information, visit: <http://www.bioethics.upenn.edu/Colloquium.shtml>

FEBRUARY

1

5th Annual Medicine and the Humanities and Social Sciences Conference, Sam Houston State University College of Humanities and Social Science, Huntsville, TX. For more information, visit: <http://www.shsu.edu/~hss001/conference/>

15 (4-6P)

Upcoming revolution in prenatal testing. Speaker: Vardit Ravitsky, Ph.D., Bioethics Program, University of Montreal. Sponsored by Penn Center for Bioethics. 3401 Market St, Suite 321, Philadelphia, PA. For more information, visit: <http://www.bioethics.upenn.edu/Colloquium.shtml>

*More than 200 people attended (and over 500 viewed the live webcast) of the July 27-28, 2012 conference, **The Thin Ethical Line: When Professional Boundaries and Personal Interests Collide**, sponsored by the Treuman Katz Center for Pediatric bioethics at Seattle Children's Hospital. Free webcasts are available at www.seattlechildrens.org/bioethics.*

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