

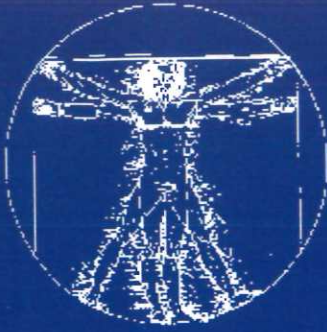
Health Care Law

Mid-Atlantic Ethics Committee Newsletter

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Mid-Atlantic Ethics Committee
Newsletter, Fall-Winter 1999

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MID-ATLANTIC ETHICS COMMITTEE

N E W S L E T T E R

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

Fall-Winter 1999

A QUESTION OF COMPETENCE?

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In 1996-97, a Task Force of the American Association for Bioethics and Humanities (ASBH) began to discuss the question of what ethics committee members should know in order to perform ethics consultations. Results of their work, a set of standards entitled *Core Competencies for Ethics Consultation*, were published in 1998. The Standards raised the question: What do ethics committee members actually know about performing ethics consults and do their skills and knowledge match those set forth by the Standards? In January of 1998, the Maryland Healthcare Ethics Committee Network, in conjunction with the University of Maryland School of Law, undertook an investigation of ethics committees in Maryland to address this question. Diane E. Hoffmann, JD, MS, Associate Dean of the School of Law, was the Principal Investigator and was assisted in this project by J. Anne O'Neil, Ph.D., R.N., Project Coordinator, John Song, M.D., and Anita J. Tarzian, Ph.D., R.N., research associates. The project was funded by a small planning grant from the Greenwall Foundation.

The purposes of the study were to (1) assess the composition of ethics committees and how the ethics consultation process takes place, (2) assess the educational background of those conducting consults, and (3) determine if

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

those performing consults possessed or thought they possessed the necessary skills to participate in the consultation process as articulated by the Task Force Standards.

The study was conducted in two phases. The first phase was directed to the chairpersons of ethics committees in Maryland. It requested demographic information about the participating hospital, the structure and make-up of the ethics committee, and support provided by the hospital administration.

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Diane E. Hoffmann, J.D., M.S., Editor
Evan G. DeRenzo, Ph.D., Co-Editor
Nancy Zibron, M.A., Layout Editor

Contributing Editors:

Louis Breschi, M.D., Member, Ethics Committee, Franklin Square Hospital

John Fletcher, Ph.D., Director, Center for Biomedical Ethics, University of Virginia

Jacqueline J. Glover, Ph.D., Associate Director, Center for Health, Ethics and Law, Robert C. Byrd Health Sciences Center of West Virginia University

Edmund G. Howe, M.D., J.D., Director of Programs in Medical Ethics, Uniformed Services University of the Health Sciences

Sanford Leikin, M.D., Adjunct Medical Officer, Office of Protection of Human Subjects, National Institutes of Health

Joan Lewis, Coordinator, Washington Metropolitan Bioethics Network, D.C. Hospital Association

Steven Lipson, M.D., Medical Director, Hebrew Home

Franklin Miller, Ph.D., Bioethicist, Member, NIH Clinical Center Bioethics Committee

Jack Schwartz, J.D., Chief Counsel, Division of Advice & Opinions, Maryland Office of the Attorney General

Ian Shank, M.D., Member, Fairfax Hospital and Reston Hospital Center Ethics Committees

Henry Silverman, M.D., Chair, Ethics Committee, University of Maryland Medical System

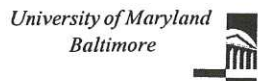
Peter Terry, M.D., Member, Johns Hopkins Hospital and Francis Scott Key Medical Center Ethics Committees

Jan Vinicky, Ph.D., Bioethicist, Washington Hospital Center
Margot White, J.D.

The Maryland Health Care Ethics Committee Network

Law & Health Care Program
University of Maryland School of Law
515 West Lombard Street
Baltimore, MD 21201
410-706-7191 or 410-706-7239

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NETWORK NEWS

Maryland Health Care Ethics Committee Network (MHECN)

MHECN has been quite active during the past few months. Throughout the summer a small committee began work on and completed a final draft of by-laws for the organization. The by-laws specify that an executive board elected by the membership will govern the Network. At the annual meeting on November 18th the by-laws were accepted and the first executive board was elected (see page 5). This First Annual Meeting was a celebration of the growth and expansion of MHECN from the former Baltimore Area Ethics Network. After the short business meeting dinner was served and a panel discussion held on the implications of the Wright vs. Hopkins case (see accompanying article on page 4).

Membership in the Network continues to grow. At the time of the annual meeting there were 44 members. Of these 23 were institutional members and 21 individual members. Since then two more hospitals and three individuals have joined.

The Policy Sub-Committee had its first meeting November 23rd. It was decided to survey the Network membership on their thoughts as to what the focus of the committee should be. Network staff plan to mail the survey to the membership in January.

The board will meet in January 2000 to elect officers and begin planning for the Network's move into the 21st century.

Metropolitan Washington Bioethics Network (MWBN)

Recent events of the Network included a meeting on October 19, 1999 that addressed the question "Who is my Neighbor? An Exploration of our Moral Responsibilities to meet the Health Care Needs of the Poor". Meetings scheduled for the winter of 2000 include a case study presented by the Genetics

Consortium and a program on the "Ethical Issues of Privacy and Electronic Data Systems" (see calendar for further information).

The Network is part of the D.C. Partnership to Improve End-of-Life Care. The Partnership recently completed a planning project to develop ways to improve end of life care in the District funded by the Robert Wood Johnson Foundation. In August, at the conclusion of the eight month planning period, the Partnership submitted an implementation grant application to Robert Wood Johnson to focus on the following areas:

(1) professional education (multi-disciplinary professionals, Baccalaureate Nursing Programs, practicing and resident physicians, Certified Nursing Assistants and Home Health Aides);

(2) public education (with an emphasis on clergy and school counselors as key messengers);

(3) public policy (with a focus on passage of the Emergency Medical Services-Do Not Resuscitate legislation in D.C. to match similar legislation in Maryland and Virginia, as well as several Medicaid issues);

(4) research (two efforts: one on resident physicians having end-of-life conversations with patients; the other on adding hospice and symptom management professionals to multi-disciplinary rounds in hospitals to measure various types of improvement)

The Foundation made a site visit to D.C. in November. The Partnership should hear about continued funding early next year.

Virginia Healthcare Ethics Network (VHEN)

The Network and The Center for Biomedical Ethics and Darden Graduate School of Business at the University of Virginia sponsored the program "Healthcare Organization Ethics" on November 18th and 19th, 1999.

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A Question of Competence?

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For those chairs whose committees conducted ethics consultations, the survey also requested information related to the number of consults performed, the types of healthcare providers and others engaged in consults, and the process used for performing consults. Forty of 67 hospitals in Maryland returned their questionnaire, yielding a 61% response rate. Thirty-six chairpersons whose committees provided ethics consultation services completed the second part of the questionnaire. Of these thirty-six, thirty-one committees participated in the second phase of the investigation.

The second phase was sent to members of ethics committees identified by committee chairs as performing ethics consults. A questionnaire was developed to elicit respondents' self-perceptions of their knowledge and skills for participating in the consultation process, their knowledge of Maryland healthcare law, hospital policies relevant to ethics consults, and their answers to several multiple choice questions regarding health care ethics in Maryland. Questionnaires were sent to over 400 committee members, and 192 members returned questionnaires, resulting in a response rate of 41%.

Results

Fewer than one-third of the committees had a formally trained philosopher or bioethicist in their membership. Most committees (69%) had some criteria for who could perform consults. However, 42% of those only required membership on the committee. A large majority of chairs (86%) said their committee provided some type of education for members performing consults, but for most this consisted only of readings in bioethics. Only five committees (13.9%) provided a formal orientation and only three (8.3%) provided any type of apprenticeship. Interestingly, 89.5% of the chairs indicated that the hospital administration provided sufficient support for the ethics committee to carry out its work. However, only 10% reported having any type of budget. Of

the 59% who said they had a paid staff person, that person consisted of a secretary for which the ethics committee was only a small part of his or her responsibilities.

A significant finding from Phase I was the lack of educational opportunities provided to ethics committee members who perform ethics consults and a general lack of institutional support for ethics committees, despite chairs' perceptions of adequate institutional support. The Standards state that "[h]ealth care institutions must be responsible to those who utilize ethics consultation services by providing support for ethics consultants in their institution."¹ This support is shown by "a clear process by which ethics consultants are educated, trained and appointed."² This requires supporting continuing education as well as providing access to basic bioethics course work and other resources. The Standards also mention adequate time and compensation for attendance at non-remunerated activities that benefit the consultation service. These results of the first phase of the study indicate that, in Maryland, the current level of institutional support for ethics committees do not match the ASBH Task Force recommendations. Yet, chairs are satisfied with the level of institutional support. These results raise questions—are the Task Force standards set too high, or are the chairs' expectations of institutional support too low?

The second phase of the study assessed the educational background and perceived ethics consultation knowledge and skills of ethics committee members who perform consults. Most striking of the results was that 62% of respondents had received no formal education in bioethics. Moreover, in 1997, nearly one-third of the 62% had not received any ethics education in the form of in-services or out-of-hospital ethics consult training. Interestingly, respondents with no ethics education rated their consult skills relatively high, although respondents with an ethics-related graduate degree³ rated their consult skills higher, on average, than those with no ethics education. Those with an ethics-related graduate degree performed more

consults in 1997 than those without (9.0 vs. 2.7, respectively), and had higher perceptions of their ethics consult skills than those who had not performed consults in 1997. In addition, those who performed one or more ethics consults in 1997 attended more hours of in-service or out-of-hospital ethics education in 1997 than those who performed no consults in 1997. The encouraging findings in the second phase of the study were that those with more ethics education were also those members who perform more ethics consultations. The discouraging finding was that individuals with such education remain in the minority.

All those who participated in this study will receive a summary report of the findings. If you did not participate but would like a copy, please call the Project Coordinator, Anne O'Neil at 410-7064457 or e-mail her at aoneil@law.umaryland.edu.

¹*Core Competencies for Health Care Ethics Consultation: The Report of the American Society for Bioethics and Humanities, 1998. Report may be obtained from the American Society for Bioethics and Humanities, 4700 W. Lake Avenue, Glenview, IL 60025-1485.*

²*Core Competencies, p. 30*

³*This was a self-report measure. Respondents who indicated they had a "degree in a discipline relevant to ethics" interpreted this as including clinical psychology, divinity, human development, nursing, public health, social work, sociology, theology, law, philosophy, and medicine. Some mentioned having taken coursework in bioethics as part of these programs.*

NETWORK TELECONFERENCE

Last fall Diane Hoffmann and Anne O'Neil from the Maryland Healthcare Ethics Committee Network participated in a teleconference with twelve other parties involved in ethics committee networks in Canada and the United States. Maryland, Florida and Vermont represented networks from the United States. Manitoba, Southern Ontario, and Alberta represented Canada. The Provincial Health Ethics Network of Alberta initiated the meeting in order to provide a format for ethics networks in North America to learn more about each other and to share information.

As the discussion developed it became evident that ethics networks come in all shapes and sizes. Funding amongst the group came from the government (Alberta), hospital associations (Florida), donations (Vermont), grants (Maryland, Vermont), and membership (Manitoba, Maryland, Vermont). One Network had no discernible funding (Southern Ontario). The focus of each network varied, but mainly centered around some type of educational endeavor. For some, that meant providing education for their members. Others focused on health care providers and still others on the community-at-large. Publications of the networks varied from educational booklets, to monthly bulletins, calendars of up-coming events, and newsletters such as the Mid-Atlantic Ethics Committee Newsletter.

The networks participating in the teleconference had been in existence for as few as two and a half years in Alberta to over 15 years in Vermont. Diane Hoffmann started Maryland's Network in 1992. All of the networks are facing challenges similar to those in Maryland. They all saw a need to expand their educational efforts, continue the search for sustainable funding, and to reach out to distant rural areas. All agreed that networks are important because they are more likely to be grass roots initiatives and take bioethics outside the university bioeth-

ics center setting. However, at times the credibility of networks may be questioned unless they maintain close ties with those at a university bioethics center.

At the conclusion of the teleconference, all agreed that this sharing had been worthwhile. All participants hoped that they would be able to speak again and expand the group participating.

MHECN'S FIRST ANNUAL MEETING RECEIVES FOUR STAR RATING

Better than dinner and a movie, how about dinner and a fascinating panel discussion on a topic relevant to ethics committees? On November 18, MHECN held its first annual meeting, which received "two thumbs up" by those attending. Guests enjoyed a buffet dinner in Harbor Hospital's beautiful Baum room. A brief business meeting was held in which future events and projects were discussed, and ideas were solicited from members who attended. The executive board was elected, which consists of seven individuals who have a myriad of talents to help carry the goals of MHECN forward into the next millennium (see article on page 5). Bylaws were also approved.

Last but not least, a lively panel discussion took place to discuss the Wright v. Hopkins case, recently decided by the Maryland Court of Appeals. Mr. Wright's mother sued Hopkins hospital for resuscitating Mr. Wright after a post-blood transfusion reaction that caused him to go into respiratory arrest. He had previously executed an advanced directive (AD) and on prior hospitalizations had agreed to a do-not-resuscitate (DNR) order. However, there was no documented discussion of his desire not to be resuscitated during that particular hospital stay. The Maryland Court of Appeals ruled in favor of Hopkins. Rick Kidwell, managing attorney for

Johns Hopkins, explained the medical and legal facts of the case. He reviewed the many ethical issues and questions regarding ADs raised by this case in relation to the Health Care Decisions Act, as delineated by the Court of Appeals opinion. These were discussed in Mr. Kidwell's commentary in the Summer 1999 newsletter.

The Court of Appeals determined that there was insufficient evidence brought forth by the Wrights to state causes of action for negligence, wrongful death, battery, lack of informed consent, and failure to comply with Mr. Wright's AD. This obviated having to address many legal issues such as whether a health care provider may be liable for disregarding an applicable AD or DNR order. However, Mr. Kidwell believes these issues are sure to come up in the future and points to the need to educate patients and staff about ADs and DNR orders.

Brian Childs, Director of Ethics and Organizational Development of Shore Health Systems in Eastern Maryland, cautioned that ethical integrity among health care providers and the institutions they serve is not ensured merely by following legal mandates like the Patient Self-Determination Act (PSDA) or ethical principles (like the principle of respect for patient autonomy). He emphasized that the way the PSDA has been implemented does not encourage the kinds of end-of-life conversations it intended. Thus, the PSDA does not protect against physician and patient lack of clarity about end-of-life decision-making. In addition, the PSDA overloads the moral burden on the side of respect for patient autonomy, as if the physicians or institution are not moral players and actors. Allowing differing caretaker viewpoints to be trumped by patient autonomy is dangerous. Dr. Childs called for rethinking ways of solving the problem that the Wright case highlighted.

Gene Grochowski, associate professor at Johns Hopkins University School of Medicine, asked those attending to provide different reasons why an individual might not want cardiopulmonary resuscitation (CPR). Several

different reasons were offered, and he pointed out that different reasons demand different actions. An AD does not provide enough guidance in and of itself to determine when CPR should be withheld (i.e., when a "DNR" order should be written). Part of the problem with the Wright case was the confusion between an AD and a DNR order.

Additionally, there is confusion about what, exactly, DNR means. Dr. Grochowski believes that appointing a health care agent is more effective than completing a written AD, and that having continued discussions with one's health care agent and health care provider about end-of-life wishes is the best safeguard to repeating what happened to Mr. Wright.

Anna Moretti, nurse practitioner at Montgomery Hospice and formerly an attorney working with Choice in Dying, presented a more personal perspective on the impact of the Wright decision for patients and families. Drawing from her own experiences with family members who were hospitalized, she underscored that mistakes happen in hospitals. What happened to Mr. Wright was a significant mistake, and focusing on the details of his AD does not change this fact. She believes the Court made the wrong decision about the Wright case, which unfortunately will send the wrong message to health care professionals about their obligations to patients. It is the responsibility of all health care professionals to make sure that what happened to Mr. Wright does not happen again. This requires continued education and increased communication among patients, family members, and health care professionals.

Perhaps this is one area where all the panelists agreed: patients, family members, and health care professionals are confused about the function and importance of ADs, the connection between ADs and DNR orders, and where responsibilities lie in communicating values and preferences about end-of-life wishes.

Definitely a "two thumbs up" discussion.

MHECN'S NEWLY ELECTED EXECUTIVE BOARD

MHECN enters 2000 with the following newly-elected executive board members. Elections for officers will take place in January, 2000.

Shahid Aziz, MD

Dr. Aziz is a pediatrician and received his MD from the King Edward Medical College in Lahore, Pakistan. Two years later he came to Baltimore, contributing to both pediatric practice and ethical practice in Maryland. Since 1992 he has served as Vice President of Medical Affairs at Harbor Hospital in Baltimore. He has also served as Chair of the ethics committee at Harbor since 1992. Previous to his position at Harbor he was Assistant Chairperson of the Department of Pediatrics at St. Agnes Hospital. He has contributed immeasurably to MHECN, most notably as Chair of the education sub-committee.

Brian H. Childs, PhD

Dr. Childs is currently the Director of the office of Ethics and Organizational Development at Shore Health Systems in Easton, Maryland. He has a diverse background both educationally and professionally. He is a PhD cum laude graduate of Princeton Theological Seminary where he also obtained a Masters degrees in philosophy and the New Testament. In addition to his position at Shore Health, he is a Professor for Seaton Hall University's on-line program, a consulting supervisor at Prime Employee Assistance Program in Baltimore, and a family therapist in private practice. Dr. Childs moved to the Eastern Shore from Atlanta, Georgia in 1998, where he was Assistant clinical professor of community health at Emory University School of Medicine from 1985 through 1998. During that tenure he served as Chair of the National Commission for Biomedical Ethics from 1996-98 and was Director of Medical Ethics at the Georgia Baptist Health Care System. He brings to the board a broad expertise in organizational theory, ethics, and religion.

Eugene C. Grochowski, PhD, MD, FACP

Dr. Grochowski is an Associate Professor of Medicine at Johns Hopkins University School of Medicine and at The Bioethics Institute of The Johns Hopkins University. He is a nephrologist and medical ethicist and practices at Johns Hopkins Bayview Medical Center in Baltimore. Dr. Grochowski received both his M.D. and Ph.D. at Northwestern University in Chicago. He did his residency and fellowship training at the Mayo Clinic in Rochester, Minnesota. In 1992, he took a year off from his private practice to do a fellowship in Clinical Medical Ethics at the University of Chicago.

Dr. Grochowski has been involved in medical ethics since he became the charter chairperson of the hospital ethics committee at Bronson Hospital in Kalamazoo, Michigan in the early 1980s. He has taught ethics to undergraduates, medical students, residents, fellows, nurses and practicing physicians, and continues to teach ethics at Hopkins. He is currently a member of the ethics committee at Franklin Square Hospital and at Johns Hopkins Bayview Medical Center.

Diane E. Hoffmann, JD, MS

Associate Dean Hoffmann started the Baltimore Area Ethics Committee Network in 1992 and has overseen the process of its development into the current MHECN. At present she is Associate Dean, Professor of Law and Acting Director of the Law and Health Care Program at the University of Maryland, School of Law. She received her law degree from Harvard Law School as well as a Master's degree in Public Health. She has researched various issues at the intersection of law, health care, ethics and public policy such as advance directives and termination of life support. She was one of the primary authors of the Maryland Health Care Decisions Act. She has also served on several hospital ethics committees, including those at the University of Maryland Medical Center, the Baltimore VA Medical Center, and the

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Board Members

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Clinical Center at NIH. In 1994-95 she took a leave from the University of Maryland's law school to serve as Acting Staff Director of the Senate Subcommittee on Aging and was responsible for all health care and aging legislation for US Senator Barbara Mikulski. She is currently PI of a study in collaboration with the American Society of Law, Medicine & Ethics on barriers to achieving adequate pain management (funded by the Donaghue Medical Research Foundation).

Martha A. Knutson, JD

Martha Ann Knutson, JD, is the first Legal Compliance Officer of Upper Chesapeake Health, Harford County, Maryland. On a daily basis, she advises doctors, nurses and other health providers in the organization's hospitals and home care agency about how to make their way through the maze of federal and state laws and regulations surrounding health care delivery today. She also chairs the UCH Ethics Committee.

Before joining Upper Chesapeake Health, Ms. Knutson spent eight years in private practice in Maryland and the District of Columbia representing health care providers. She has taught at the Washington College of Law at American University.

Jack Schwartz, JD

Jack Schwartz, JD is an Assistant Attorney General and Director of Health Policy Development in the Maryland Attorney General's Office. Mr. Schwartz is a graduate of Yale Law School and the University of Maryland Baltimore County. Prior to joining the Attorney General's Office in 1982, he held a series of senior staff positions at the Federal Trade Commission in Washington. Mr. Schwartz has taught as an adjunct professor in the law schools of the University of Maryland and the American University; has been a guest lecturer at the Kennedy Institute of Ethics at Georgetown and at the Johns Hopkins University School of Public Health; served as a senior

consultant to the National Bioethics Advisory Commission; is a bioethics consultant to, and member of, the Special Studies Institutional Review Board at the National Cancer Institute; and serves on a national advisory committee for the Robert Wood Johnson Foundation. He has written and lectured extensively on legal and policy issues in health care, particularly issues concerning care at the end of life, research involving decisionally impaired subjects, and managed care.

Robert E. Steinke, MA, MREd

Reverend Steinke comes to the Network with a very broad background. He was a Marine in Vietnam who then changed his direction to pastoral care. He is currently the Hospital Chaplain and Manager for the Department of Pastoral Care at Frederick Memorial Hospital in Frederick Maryland. In that position he serves as a standing member of the Medical Ethics Committee, Patient Rights Committee, and the Institutional Review Board. Outside of his hospital work he serves on the Clinical Advisory Committee for the Parish Nurse program sponsored by the Frederick County Health Department. He is a contributing editor to *The Palliative Care Patient and Family Counseling Manual*. He compiled *The Cultural and Spiritual Aspects of Health Care: A Handbook of Cultural & Spiritual Practices for Physicians, Nurses, Chaplains, Social Workers, and other Allied Healthcare Practitioners*. These compendiums, along with his bereavement aftercare materials, are currently being used in over 100 hospitals and healthcare institutions throughout the country.

Case Presentation

One of the regular features of the Newsletter is the presentation of a case considered by an ethics committee and how the committee resolved it. Individuals 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 of patients and others in the case should only be provided with the permission of the individual. Unless otherwise indicated, our policy is not to identify the submitter or institution. Cases and comments should be sent to: Editor, Mid-Atlantic Ethics Committee Newsletter, University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201-1786.

Case Study From A D.C. Hospital

Mr. B, a 55-year-old white male dentist with a history of diabetes, hypertension, coronary disease, previous coronary bypass surgery and congestive heart failure, was admitted for the evaluation of chest pain.

During the patient's emergency room evaluation, staff nurses and physicians observed a striking contrast: the patient described a "new" onset of chest pain which "no one had ever evaluated," yet hospital records indicated many recent admissions for the evaluation of cardiorespiratory symptoms.

A quick check with the on-call cardiology team confirmed frequent use of the hospital system. The cardiologist provisionally accepted the patient for overnight evaluation, pending transfer to the service of the patient's internist when stable.

The cardiologist explained that on many previous chest pain admissions, Mr. B had either left against medical advice or refused evaluation after presenting with dramatic symptoms.

On hospital day #8 Mr. B refused a coronary angiogram despite ongoing unexplained chest pain and an abnormal radioisotope cardiac perfusion scan. The patient's doctors believed that Mr. B had real angina but were unable to convince the patient to proceed with testing.

Importantly, Mr. B has had longstanding chronic renal insufficiency, which a nephrologist described as moderately severe and likely to require treatment with dialysis in the

near future. Based on the likelihood that invasive cardiac testing would hasten use of dialysis, the patient categorically refused angiography.

In an emotional discussion with the nephrologist, the patient asked for a new kidney doctor, explaining his "right to a specialist" who advocates alternatives to dialysis. A second nephrology consult ended in a similar discussion.

On the 10th day of admission a Bioethics consultation was requested by a kidney specialist who was asked to see the patient in consultation. After review of the chart the new nephrologist suspected that the patient was abusive in some way. The physician asks, "Must I see this patient, knowing that I will face the same unreasonable refusals to accept our help?"

A preliminary review of the chart and a brief interview with the patient revealed an impressively affable but complaining man. He implores you to help relieve his chest pain, explaining, "No one seems to know or care why I suffer so much."

Response from a Physician Ethicist

All good ethics starts with assessing the facts as accurately as possible. Thus, the first question the ethics consultant should ask is why is Mr. B responding in this way. The second question is contingent on the answer to the first one or on how one makes sense of Mr. B's behavior: What interventions, if any, could "succeed?" Only after these questions have been answered can the ethics consultant ask the relevant *ethical* questions: What should be done? And who should decide this?

The critical "diagnostic" question, which now should be raised, would appear to be why Mr. B is asking for second and third nephrologists. He, himself, provides a clue: "No one," he says, "seems to know or care why I suffer so much." But what does this mean? Clearly, to at least some extent, the nephrologists *do* know and care. This suggests that Mr. B's perception, and thus his request, is irrational.

It is at this point that several mistakes may be made. Care providers are likely to infer that such patients' irrational beliefs are wholly caused by intrapsychic factors or factors entirely having to do with these patients, themselves. Accordingly, they may conclude that aside from prescribing antipsychotic medications there is nothing they or any other care provider can do. This, most probably, was what this nephrologist was thinking when he or she said, "Must I see this patient?"

The patient's feeling that his nephrologists do not understand him may, however, be sound and express an interpersonal truth. As Eric Cassell has said in his classic analysis of suffering, "Persons are always in some relationship to other persons."¹ The nephrologists may not understand innumerable aspects of what this patient is experiencing, and, particularly, how his illnesses may be preventing him from relating in ways that he has found meaningful to others.

But what *practically*, even with this awareness, could the ethics consultant (or nephrologist) do? The first step is to look within. If the nephrologist would rather not treat this patient, it is likely that this would be conveyed to the patient by his/her attitude. If this is not the case and the nephrologist is willing to treat the patient, then, at the very least, s/he should ask the patient, "Surely, you are right. Can you help me see, then, what I am missing when you say no one cares about you?"

When patients feel as distraught and alone as Mr. B, many care providers seemingly believe that, above all else, they must set *limits*. Of course, it is the opposite that may be true. These patients often can only know that their care providers truly care if their care providers can still accept them even when they act out of control! Jay Haley, a therapist, like Cassell, known for successfully treating patients who impose such impossible demands recognizes that such patients are exquisitely sensitive to interpersonal cues and especially to rejection. Haley relates, "Should a therapist give up too easily, he will never win the difficult cases. Some people will never change

until they are sure that the therapist will not give up."²

The ethics consultant's "solution," is limited but straightforward. The nephrologist, consultant, psychiatrist, and/or someone else should be with Mr. B until (and then after) he feels understood. Unfortunately from the standpoint of available (caring) human resources, what Haley says is sometimes all too true: "A therapist must be willing to go to the mat with a client and struggle with the problem until it is solved or the participants are dead."³

But this leaves remaining the aforementioned ethical questions: What level of resources *should* be devoted to this patient and who should decide? These questions are and should be the source of unending debate, but in regard to the first question three considerations should reign: First, the analysis, as I stated earlier, must begin with an honest understanding of what such patients need, no matter how "unreasonable" their needs may be. Second, it should be recognized that meeting such patients' needs is the *raison d'être* of medicine, that justice (according to need) also requires this, and as a result, whoever opposes this priority has the burden of showing why this shouldn't be done. Third, this burden can be met especially, as a matter of justice. While utility often is used to justify not providing additional resources in similar cases, it is justice that usually should be the governing principle.

Who should decide? Whoever does decide, this decision should be made with the input of persons savvy about the needs of persons who are suffering and about the ethical arguments for, and especially against, neglecting those patients who are most in need.

References:

¹. Eric J. Cassell, *The Nature of Suffering and the Goals of Medicine* (New York: Oxford University Press, 1991), at 206.

². Jay Haley, *Reflections on Therapy* (Chevy Chase, Md.: The Family Therapy Institute of Washington, D.C., 1981), at 242.

³. *Id.*

Edmund G. Howe, MD, JD
Professor of Psychiatry
Director of Programs in Ethics
USUHS

Response from a Hospital Attorney

This appears to be a straightforward legal issue. This gentleman apparently has decided to use the hospital's emergency department as his own doctor's office. Regardless of the number of previous fruitless visits to the emergency department, the hospital is under a duty under EMTALA to triage the patient and stabilize his medical condition. In this case, the on-call cardiology team apparently felt that the patient's condition was such that the only way he could be stabilized was on an inpatient basis. The hospital properly admitted him and had no choice but to provide all services within its capabilities until he was stable.

This patient repeatedly has refused to consent to a coronary angiogram because he is concerned that invasive cardiac testing will hasten the need for dialysis because of his chronic renal insufficiency. A competent adult patient may refuse the procedure. Assuming he is competent, he is within his rights to refuse the procedure. If there is any doubt about his competency, a psychiatric evaluation should be done.

The patient became dissatisfied with his nephrologists because they did not advocate alternatives to dialysis. Apparently, there really aren't any alternatives. As far as the new nephrologist is concerned, there is no legal obligation on his part to see the patient. There has been no agreement to enter into the physician-patient relationship. The new nephrologist may politely decline.

This patient has been in the hospital for over a week. He has refused

medically necessary treatments. Entries in the medical record should so reflect. Apparently, he is as stable as he can be under the circumstances. He obviously cannot remain hospitalized indefinitely while he seeks what appears to be futile therapy. If he is stable, administrative discharge seems to be the only alternative. In order to protect itself against a claim of abandonment, the hospital should advise him in writing that (1) he has refused to cooperate with reasonable treatments, (2) that he is being administratively discharged since he is medically stable, and (3) the names and addresses of other nephrologists and health care facilities he may contact for follow up care.

Unfortunately, unless someone can reason with this patient he is likely to return to the emergency department again. Perhaps intervention by a member of the clergy, an ethicist, or a social worker may change his mind.

IN MEMORIAM

Janice Popick Rosenzweig, a health law attorney, former editor of the Mid-Atlantic Ethics Committee Newsletter (MAECN), and 1992 graduate of the University of Maryland School of Law, died at Greater Baltimore Medical Center on November 22, 1999. According to an article in the Baltimore *Sun* newspaper, Rosenzweig died of an infection stemming from treatment of primary pulmonary hypertension, a rare disease causing shortness of breath, fatigue and fainting spells. In some cases, the disease requires a heart lung transplant. Rosenzweig struggled with the illness for many years while being treated with available drug therapies.

Rosenzweig graduated from Brandeis University with a degree in psychology in 1972. Prior to enrolling in law school, she married and had a daughter, Rachel Pearlstein, who survives her. For the last sixteen years she has been married to Norman Rosenzweig.

Rosenzweig served as acting editor of the MAEC Newsletter from summer

of 1994 through spring of 1995 while editor and law professor, Diane Hoffmann, was on leave from the law school. Rosenzweig was a student of Hoffmann's while at the University of Maryland. Hoffmann said she selected Rosenzweig for the position partly because of her interest in bioethics. In addition, Hoffmann recalled, "Janice was one of the most memorable and remarkable students I have encountered in my eleven years of teaching at the law school. She was determined, intelligent, articulate, compassionate and courageous."

After law school, Rosenzweig strived to carry a full professional schedule, despite being ill for many years. Active in pro bono legal work since obtaining her law degree, she was particularly dedicated to helping the elderly. She handled a variety of elderlaw cases, including wills, social security, and health insurance matters. She was also a patient advocate and was especially interested in medical-ethical issues.

ORAL DNR ORDERS—A RECENT COMMENT FROM THE MARYLAND ATTORNEY GENERAL'S OFFICE

On October 28, 1999, Jack Schwartz, AAG and Director of Health Policy Development, and Nancy P. Tennis, AAG, Counsel, Board of Nursing, issued the following letter in response to a request from Ms. Donna Dorsey, Executive Director of the State Board of Nursing.

Dear Ms. Dorsey:

You asked us to clarify the law applicable to "oral DNR orders" in nursing homes – that is, a physician's order, given over the telephone to a nurse or other health care professional at the nursing home, that cardiopulmonary resuscitation not be attempted if a patient were to experience a cardiac or respiratory arrest. In brief, oral DNR orders are legally recognized and, if issued pursuant to authority in the Health Care Decisions Act, are encompassed by that Act's grant of immunity.

A DNR order is the carrying out of a decision to forgo efforts at CPR. This decision can be made in a number of ways recognized under Maryland common law or the Health Care Decisions Act: by a competent patient exercising his or her right of informed consent (and informed refusal), see *Wright v. Johns Hopkins Health Systems Corp.*, 353 Md. 568, 592-93 (1999); by a formerly competent patient through an oral or written decisional advance directive, like a living will, that can be given effect under the Act; by a health care agent pursuant to an oral or written proxy advance directive, like a durable power of attorney for health care; by the patient's guardian of the person, if there is one, with appropriate court approval; by a surrogate decision maker acting within the Act's criteria; or by the patient's attending physician, if CPR would be "medically ineffective."¹ See generally 79 *Opinions of the Attorney General* ___ (1994) [Opinion No. 94-023 (May 3, 1994).]

Once a legally authorized decision to forgo attempted CPR has been made, a DNR order should be promptly entered. Given the usual policy in health care facilities that, in the absence of a DNR order, CPR is always attempted, any significant delay in the entry of the DNR order puts the patient at risk of being subjected to the very intervention that has been rejected. A facility's policies and procedures for translating health care decisions into operational orders should honor these decisions, not frustrate them.²

In nursing homes, a resident's attending physician may not be physically present at the facility when he or she issues a DNR order. A DNR order, however, is in this respect no different than other orders about patient care. The regulations governing nursing homes recognize that physician orders will often be communicated orally and expressly validates what the regulation terms "verbal orders," as long as they are later countersigned by the physician:

A physician or authorized prescriber may give a verbal order to a licensed nurse, pharmacist, licensed or

registered therapist, licensed dietitian, or licensed nutritionist who shall document the verbal order; the verbal order is valid if signed by the person accepting the verbal order and by the physician or authorized prescriber; the unit manager or individual who received the order shall ensure that the verbal order is countersigned and dated by the physician or authorized prescriber upon the physician's or authorized prescriber's next visit to the facility.

COMAR 10.07.02.10I. Therefore, the attending physician's oral DNR order is valid and should be given immediate effect by nurses and other staff. Those who forgo CPR in reliance on a DNR order issued pursuant to the Health Care Decisions Act are "not subject to criminal prosecution or civil liability or deemed to have engaged in unprofessional conduct as determined by the appropriate licensing authority . . ." §5-609(a) of the Health-General Article.

We hope that this letter of advice, although not an Opinion of the Attorney General, is fully responsive to your request. Please let us know if we may be of further assistance.³

¹When "a treatment . . . under generally accepted medical practice is life-sustaining in nature . . .," the attending physician ordinarily needs the concurrence of a second physician before certifying the treatment as "medically ineffective." §5-611(b)(2).

²In the *Wright* opinion, the Court of Appeals intimated that, under some circumstances, a facility might be held liable for failure to comply with an individual's advance directive. 353 Md. at 585-86.

³We anticipate supplementing this letter in the near future to address oral DNR orders in other settings.

This and other letters of advice, opinions and legislative news can be found on the Maryland Office of the Attorney General web site: <http://www.oag.state.md.us/Opinions/index.htm>

Guardianship of the Person: An Alternative Resolution?

University of Maryland Law Professor Joan O'Sullivan and physician Kevin Gerold are working with the Maryland Alternative Dispute Resolution Commission to address the problem of obtaining medical treatment for incompetent patients who have no surrogate.

When an incompetent patient needs major medical attention, his/her health care provider has two choices: s/he can look for a surrogate decision maker, or s/he can seek guardianship of the person. The first solution is used most often, but at times the patient has no family member or friend to act for the patient. In that case, someone must petition the Circuit Court to appoint a guardian to consent to or refuse care.

The guardianship process is expensive, time consuming and often complicated. The cost includes fees for two attorneys, as well as court costs, service and filing fees. For the patient with no family or friend, there may be no one willing to petition the court. For those in nursing homes, group homes and institutions, the hurdles to filing for guardianship result in the patient being treated without informed consent, or the patient not being treated until her condition becomes an emergency and she is sent to the hospital emergency department where she can be treated without consent.

Several years ago, a subcommittee of the Maryland Department of Aging Guardianship Task Force concerned with the rights of the disabled, wrote a bill which would divert these decisions away from the court. The idea languished for a number of years, but has been revived as a form of alternative dispute resolution.

The Task Force proposes to address the problem of medical treatment for incompetent patients who have no surrogate by establishing an alternative

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Guardianship

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to guardianship—a panel of volunteers who would act as surrogate decision makers for the patient.

The group is proposing a pilot project to "test out" the idea. The design of the pilot project is based on a similar program which has operated in New York for ten years. Under this proposal, panels composed of three volunteers will meet to consider the health care provider's request for medical treatment and to provide or refuse consent to the treatment. The panel will be drawn from a pool of volunteers, one third of whom will be health care professionals, one third who will be attorneys and one third who will be advocates, friends or relatives of the elderly or disabled. The program will employ a part time administrator, who will receive the hearing request, call together a panel, set a hearing date no later than two weeks from the date of the request, prepare a summary of the case and handle other administrative matters. The patient would have the same due process rights as a person in a guardianship proceeding. The Maryland proposal would apply to patients in all living situations, such as nursing homes, acute care hospitals, assisted living facilities and private homes.

The panel would meet at a local agency office or at the institution requesting the treatment to hold a hearing. The panel will issue a decision about the proposed treatment at the conclusion of the hearing, or within three days of the hearing.

The decision of the panel would be appealable to the Circuit Court. There would be no charge to the patient for the hearing, and perhaps only a small fee to the petitioner to cover administrative costs.

A typical case might be a request from a nursing home administrator for a decision about performing a biopsy of a suspicious lump discovered in the breast of an incompetent resident. The panel would consider whether to authorize performance of the biopsy as well as whether to authorize follow up surgery

and post surgical care if the results of the biopsy indicate the need for further treatment.

The advantages of the program are that decisions would be made more quickly, for less expense, without court involvement, by a panel of knowledgeable practitioners. The person with disabilities would be more comfortable in an informal setting, and providers of services would not have to hire an attorney to get permission to treat a patient who is incompetent. The disadvantages are the cost of administering the program, and that some may use this system when a guardian would be more appropriate.

If the proposal is adopted, ethics committees undoubtedly would interface with these panels, perhaps testifying as to what they believe is the appropriate course of action in a given case.

This article was reprinted with permission from the *Law & Health Care Newsletter*, VII(1), p.10-11, 1999.

Single Payer Program in Maryland?

On November 11, 1999, Dr. Peter Beilenson, Commissioner of Health for Baltimore City and President of the Maryland Citizens' Health Initiative Education Fund, Inc. (MCHIEF), spoke at the University of Maryland School of Law about MCHIEF's proposal to initiate a single-payer system for health care reimbursement in Maryland. Dissatisfaction with current health insurance coverage, together with a growing number of uninsured (about 700,000 of Maryland's five million residents), prompted Beilenson and others to propose what they call "Health Care for All." This system would establish an independent agency governed by health care professionals and consumers who would administer and finance fee-for-service health care reimbursement. Maryland residents would receive a health card that functions somewhat like an ATM card. This

would obviate much of the paperwork, as billing would be entered automatically when an individual receives a health care service. Each Maryland resident would have access to a certain amount of primary care health dollars in a given year (e.g., for annual physical exams, PAP smears, cancer screenings, and other benefits agreed upon by the members of the agency administering the plan). Other health care services (e.g., hospitalization for elective or nonelective surgery) would be paid directly to the providers.

Providing health care for all Maryland residents would be possible because of the savings accrued from the dramatically reduced bureaucratic expenditures of the single-payer plan. Employers would pay a tax that would amount to less than what they currently pay for their employees' health coverage. Small business employers would pay a reduced tax, which would be recouped by savings from reduced employee illness and turnover. Waivers would have to be obtained to access Medicare and Medicaid dollars.

In late August, MCHIEF conducted a state-wide poll that indicated widespread dissatisfaction among Marylanders with current managed care plans. Eighty-eight percent of those surveyed believe the present health care system has major problems or is in crisis; over three-quarters agreed that everyone in Maryland is entitled to health coverage, and 87 percent said they would support such coverage (even crossing party lines to vote for a candidate who supports a single-payer system). This gives Beilenson and colleagues the confidence to predict that "Health Care for All" will be supported in the Maryland legislature within the next five years. John Colmers, Executive Director of Maryland's Health Care Commission, responded to Beilenson's proposal by pointing out barriers Maryland faces instituting a single-payer plan. He agreed that health care reform is needed, but suggested other measures that could be taken to address access and affordability issues. For further information on MCHIEF's single-payer proposal, contact them at: demarco@mdinitiative.org, (410) 235-9000.

Network News

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This was the first conference offered for healthcare executives and professionals, which has discussed a global approach to the implementation of a program designed to achieve a consistent and positive ethical climate within a healthcare organization. The conference introduced the central concepts of

healthcare organization ethics to board members, top level executives and healthcare professionals working within healthcare organizations (HCOs). Presentations and discussions focused on the integration of business, professional and clinical ethics within HCOs through a global program; enabled participants to recognize a "healthcare organization ethics" problem at different levels in the organization; and

introduced and explored different models for the development of an organization ethics program within HCOs.

In March the Network and The Center for Biomedical Ethics will be sponsoring a two day conference on spirituality and bioethics (see calendar for more details).

CALENDAR OF EVENTS

January

- 11 Metropolitan Washington Bioethics Network Meeting: IONA Senior Services, 4125 Albemarle Street, NW, 3:30 – 5:30 pm. Program will be a case study presented by the Genethics Consortium. Evan DeRenzo, PhD from the Washington Hospital Center of Bioethics will be the primary presenter. Contact: Valerie Parker at 202-682-1581.
- 13-15 Health Care Systems: Ethical and Economic Considerations, Sacramento, CA. Sponsored by Bioethics Program at the University of California (UC-Davis) and UC-Davis School of Medicine Alumni Association. Contact: Cristal Sumner 916-734-9416, fax 916-451-2637, chsumner@ucdavis.edu

February

- 6-12 Psychology of Health, Immunity, and Disease. Hilton Head, SC. Sponsored by The National Institute for the Clinical Application of Behavioral Medicine. Contact: 800-743-2226, website, www.nicabm.com.
- 22-25 Third International Symposium on Coma and Death. Havana, Cuba. Contact: Stuart J. Youngner, 216-844-3429, fax 216-844-3313, sxy2@po.cwru.edu

March

- 1 Metropolitan Washington Bioethics Network Meeting: Georgetown University, 5:00 pm. "Ethical Issues of Privacy and Electronic Data Systems" sponsored by the Georgetown Center for Clinical Bioethics, Planned by Sister Carol Taylor, with presenters from the Georgetown faculty. Contact: Valerie Parker at 202-682-1581.
- 15-16 Religious Faith and Secular Medical Ethics. Sponsored by the Center for Biomedical Ethics, University of Virginia in cooperation with the Finkelstein Institute, Jewish Theological Seminary. Cosponsored by the Department of Chaplaincy and Pastoral Care and the Department of Religious Studies, University of Virginia. Charlottesville, VA. Contact: Ann Mills, 804-982-3978, amh2h@virginia.edu.

