

*Health Care Law*

*Mid-Atlantic Ethics Committee Newsletter*

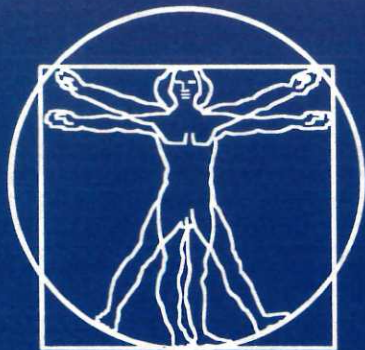
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Mid-Atlantic Ethics Committee  
Newsletter, Spring 1992

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# The Mid-Atlantic Ethics Committee Newsletter

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

Spring, 1992

## Ethics Committee Networks - What Can They Do For You?

**J**ohn Fletcher, PhD., director of the Center for Biomedical Ethics at the University of Virginia and an instrumental force in the formation of biomedical ethics networks in Virginia, proposes three reasons why networks are important: 1) to educate the public, as well as health care professionals, on ethical issues and problems that arise in the clinical encounter; 2) to assist health care institutions establish or strengthen an institutional ethics program through educational activities; 3) to provide a vehicle for those in biomedical ethics to communicate with and support one another, to continue their education and training, and to serve others.

Fletcher emphasizes that institutions cannot just "wish ethics committees into being," and that experience and evaluation show that hospital ethics committees can easily "fail to thrive." He suggests that ethics networks can help by establishing training programs for individuals and providing assistance to institutions that want to design their own education programs.

The following regional networks are already up and running: the West Virginia Network of Hospital Ethics Committees (contact: Alvin Moss, M.D., Center for Health Ethics and Law, Health Sciences Center, Morgantown, WV 26506); the Washington Metropolitan Bioethics Network (contact: John H. Lewis, D.C. Hospital Association, 1250 Eye St., N.W., Washington, D.C. 20005-3922); and the Bioethics Resource Group, Ltd.

### About this newsletter

This is the first issue of the Mid-Atlantic Ethics Committee Newsletter. Its target audience is ethics committee members in Maryland, the District of Columbia and Virginia. The Newsletter will be published four times a year. Regular features will include summaries of court cases and proposed legislation in each of the three jurisdictions, educational programs undertaken by ethics committees, a calendar of events, a case presentation, letters to the editor, and network news. The Newsletter is being published by the recently formed Maryland Institutional Ethics Committee Resource Network, a project of the Law and Health Care Program at the University of Maryland School of Law. The purpose of the Network is to assist hospitals and nursing homes in establishing fully functioning and effective ethics committees through educational and research projects. We hope this newsletter becomes a vehicle for ethics committees to share thoughts and concerns and that members will submit articles, cases, comments, news, and events they wish to communicate with other readers. Your suggestions and thoughts are always welcome.

Diane E. Hoffmann, Editor

(contact: Katherine Thompson, executive director, 118 Colonial Ave., Charlotte, NC 28207).

Ethics committee networks are in the process of being formed in the Richmond, Virginia area (contact: Bette O. Kramer, 1803 Hanover Avenue, Richmond, VA 23220); the Norfolk, Virginia area (contact: Melissa D. Warfield, M.D., Children's Hospital of the King's Daughters, 800 West Olney Road, Norfolk, VA 23507); and in Baltimore, Maryland (contact: Diane E. Hoffmann, University of Maryland School of Law, 500 West Baltimore St., Baltimore, MD 21201).

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upon without consulting an attorney.

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## Network News

### Baltimore Area Ethics Committee Network

The first Baltimore area Network meeting will be held on May 6, 1992 at the University of Maryland, School of Law at 5:00 p.m. The Network will provide an opportunity for ethics committee members in the Baltimore area to get together on a regular basis, share experiences, and learn from each other about what is going on in the legal and ethical community. Speakers at the first meeting will include Rachel Wohl, J.D. and Clark Watts, M.D., J.D. Ms. Wohl is representing Deanna Mack in the case of Ronald W. Mack and Dr. Watts, a neurosurgeon, testified for Ms. Mack in the Circuit Court case. (See Mack case, page 3.) If you are interested in attending or would like more information call (410)328-7191.

### Washington Metropolitan Bioethics Network

In February, the Washington Metropolitan Bioethics Network meeting was held at Montgomery General Hospital, in Olney, Maryland. The topic was whether DNR Orders should be suspended in the Operating Room. A summary of the discussion appears on pp. 8-9.

The March meeting of the D.C. Network was held at Thomas House in Washington, D.C. The

*Cont. on page 3*

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### *Washington Network News (cont.)*

topic was "Physical and Chemical Restraints: Uses and Misuses in Nursing Homes and Hospitals."

The Network's next meeting will be held on Saturday, April 25th, at 9:30 a.m., at the D.C. Visiting Nurses Association, 5151 Wisconsin Avenue. The topic for discussion will be getting ethics committees off the ground. Randy Howe, M.D., J.D., will moderate a panel discussion.

## Court Decisions

### First Termination of Life Support Case in Maryland Courts

**O**n March 10, 1992, a Maryland Circuit Court issued the state's first judicial opinion on a case involving termination of life support. The case, *In re Mack*, involved a 31 yr. old man, Ronald W. Mack, who has been in a persistent vegetative state for over eight years. He is being cared for in the Fort Howard Veteran's Administration Hospital in Baltimore. In May, 1991, Ronald Mack's father sought to be appointed his personal guardian. At the time, his wife, Deanna Mack, had already been appointed his personal guardian by a Florida court. Mrs. Mack sought recognition of the Florida guardianship in Maryland and additionally sought permission of the court to discontinue the supply of artificial nutrition and hydration to her husband due to his incurable persistent vegetative condition and to her belief that her husband would not want to be kept alive in such a state. Mr. Mack's father and sister opposed the request for termination of life support. At the trial, the court heard evidence including statements Ronald Mack had made concerning termination of life support for others (his grandmother, his mother and a friend), and about his own values regarding quality of life. Medical experts also testified as to the ability of a patient in a persistent vegetative state to feel pain.

Judge Fader, in his opinion, determined that the appropriate evidentiary standard for termination of life support in Maryland is clear and convincing evidence and that Mrs. Mack had not been able to meet this burden of proof. He further stated that there was no reason to shift to a more objective best interest test, as Mr. Mack is unable to feel pain in his current condition. Finally, Judge Fader

did not recognize Mrs. Mack's Florida guardianship and gave guardianship of Mr. Mack to his father.

Mrs. Mack is appealing the case directly to the Maryland Court of Appeals, the state's highest court. The case is significant as it is one of the only termination of life support cases nationally involving a conflict among family members to go to a court of appeals.

## Legislative Update

### Status of Maryland Legislation on Durable Powers of Attorney for Health Care

**A**s some observers saw it, 1992 was to be the year in which durable power of attorney for health care ("DPA") legislation would finally be enacted by the Maryland General Assembly. Senate Bill 377, drafted by the Health Law Section of the Maryland State Bar Association and introduced by Senators Hollinger and Boozer, had the support of an array of legal, health care provider, and citizen groups. The bill was intended as a relatively straightforward legislative endorsement of the right of competent adults to use this form of advance directive, a right previously recognized in opinions of the Attorney General.

The bill had an unanticipated ripple effect, however. A direct counterpoint was introduced at the urging of the Maryland Catholic Conference. Senate Bill 648, sponsored by Senator Collins, would have imposed various restrictions on the use of a power of attorney for health care. Moreover, the push for enactment of DPA legislation led to a strong reaction, most notably from Judge John Carroll Byrnes of the Circuit Court for Baltimore City, that the topic of decisionmaking regarding life-sustaining treatment should be dealt with comprehensively, rather than in piecemeal fashion. In his view, since the overall policy choices by the legislature would affect not only DPA but all other forms of decisions, such as family and guardian decisionmaking, the issue should be treated comprehensively, and legislation to do so, Senate Bill 745, was introduced by Senator Pica.

In the end, none of the bills emerged from

### *Status of Maryland Legislation (cont.)*

committee. The near-impossibility of drafting comprehensive legislation in the midst of the session and the difficulty of trying to find compromises in DPA legislation that would not effectively determine the larger questions led virtually all participants in the process to agree that action on all pertinent legislation (including the bills mentioned above, a DPA bill introduced by Delegate Callas, House Bill 21, and a Living Will Law amendment introduced by Delegate Hixson, House Bill 519) should be deferred pending further study.

A process for grappling with the issues is already in place. A committee of Maryland circuit court judges, chaired by Judge G. R. Hovey Johnson of Prince George's County, has undertaken the task of soliciting comment from the participants in the legislative debate and other interested persons. The goal of the committee is to present a draft of comprehensive life-sustaining medical treatment legislation to the General Assembly in advance of the 1993 session.

Submitted by: Jack Schwartz, J.D.

## **Virginia's Health Care Decisions Act of 1992**

**T**he Health Care Decisions Act passed both houses of the Virginia General Assembly in its 1992 session. The legislation was inspired by implementation of the Patient Self-Determination Act ("PSDA") which revealed a number of discrepancies in Virginia laws affecting advance directives and surrogate decision making.

### **Most important new provisions**

The Health Care Decisions Act:

1. Contains a new suggested form of advance directive that combines a living will with a health care proxy by permitting the declarant to appoint a health care agent to act in the event of the declarant's incapacity and also to provide instructions, including terminal care instructions.

2. Clarifies that in an advance directive an individual may request certain treatment to be

provided as well as, or instead of, requesting that certain treatment be withheld or withdrawn.

3. Clarifies that a physician must obtain informed consent directly from a competent adult patient and should only look to the advance directive for treatment instructions or proxy appointment if the patient is determined to be incapable of giving informed consent.

4. Eliminates the restriction on health care proxy appointments which previously disallowed employees of the patient's health care provider from serving in that capacity. The new law enables spouses or other family members who are employed in such institutions to serve as health care agents for family members.

5. Affirms that an advance directive executed in compliance with the laws of another state will be recognized in Virginia.

6. Affirms that distribution of advance directive forms by health care institutions to patients does not constitute the unauthorized practice of law.

7. Clarifies that employees of health care facilities and physicians' offices, including nurses, are permitted to serve as witnesses for advance directives.

8. Eliminates the notary requirement for the health care proxy appointment. Whether a health care proxy is appointed separately or in combination with a living will directive, it must be signed in the presence of two witnesses, but is not required to be notarized.

9. Clarifies that all determinations of patient incapacity to make decisions must be made by the physician who has primary responsibility for the patient and another physician or a licensed clinical psychologist.

10. Affirms that the right of patients to request treatment in an advance directive, or of the patient's proxy to request treatment for the patient, does not create an obligation for a physician to provide treatment he or she believes is medically unnecessary. (This provision is explained further below.)

## Unnecessary treatment provision

**Section 54.1-2990. Medically unnecessary treatment not required...** *Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate. However, in such a case, if the physician's determination is contrary to the terms of an advance directive of a qualified patient or the treatment decisions of a person designated to make the decision under this article, the physician shall make a reasonable effort to transfer the patient to another physician.*

As with virtually all legislative processes, this one involved compromise and negotiation, particularly over this section. The intent of the drafters here was to clarify the already-established medical practice standards which do not require physicians to prescribe medication or perform any intervention which is not necessary or medically indicated, or provides no benefit. "Unnecessary" and "inappropriate" are not defined, nor is the boundary between clinical judgment and ethical judgment delineated. It was the view of the drafters that none of these terms can be precisely defined, but rather that they depend on a case by case analysis and inevitably involve some subjective value judgments.

The law further clarifies the point that decision making authority to refuse treatment has never been presumed to extend to the legal authority to demand treatment of one kind or another. Neither the professional codes of ethics of the medical profession nor the courts have ever said that patients can demand antibiotics for a virus, that a physician is legally compelled to perform a surgery the patient wants but for which there is no medical indication, or to conduct a diagnostic test in the absence of any presenting symptoms. The patient's or surrogate's legal rights to consent to or to refuse treatment have always been presumed to operate within the range of what is appropriate to the patient's condition. There is, as always, room for a second opinion which is provided by the statutory requirement to make a "reasonable effort to transfer" the patient if the physician does not believe the requested treatment is ethically or medically appropriate.

The transfer provision, which may seem objectionable to some at first glance, is not as great a burden as it appears. It does not include a requirement to continue or initiate treatments considered inappropriate while the transfer efforts are underway. Therefore, the transfer will need to be effected fairly quickly in order to happen at all. If, within a fairly short period of time, no physician can be found who will accept the patient and provide the requested treatment, then this will help clarify that the physician's assessment is widely shared and not idiosyncratic. It thus precludes the practice of demanding unnecessary procedures or tests against the professional judgment of the physicians, but also allows room for valid differences in these assessments.

The phrase "medically or ethically inappropriate" was arrived at as a compromise. The previous drafts contained a more "objective" standard ("treatment...that the physician determines, in the exercise of reasonable medical judgment, would neither promote nor improve the health of the patient nor alleviate the patient's suffering"). For reasons not entirely clear, this was believed by some to be a standard which would encourage precipitous termination of treatment in some patients. Some concerns were also raised that the potential for court involvement seemed greater with the "reasonable medical judgment" standard and one of the purposes of this statute is to make recourse to the courts less likely.

Submitted by: Margot L. White, J.D.

## D.C. Health Care Decisions Act Amended

**T**he District of Columbia Health Care Decisions Act of 1988 was recently amended by the D.C. Council. Under the 1988 law if an individual has not executed a durable power of attorney for health care, the following persons in the order listed, can make a health care decision (including termination of life support) after two physicians have certified the patient is incapable of making the health care decision:

- o A court appointed guardian or conservator of the patient if there is one and if the consent is within the scope of the guardianship or conservatorship.

### *D.C. Health Care Decisions Act (cont.)*

- o The spouse of the patient.
- o An adult child of the patient.
- o A parent of the patient.
- o An adult sibling of the patient.
- o The nearest living relative of the patient.

The recent amendments add to the list of those who may make a health care decision for a patient, "A religious superior of the patient, if the patient is a member of a religious order or a diocesan priest." The amendment defines "member of a religious order or diocesan priest" and "religious superior."

## PSDA Regulations

**O**n March 6, 1992, the Health Care Financing Administration published interim final regulations for the implementation of the Patient Self Determination Act in the Federal Register. The regulations went into effect on April 6, 1992 but HCFA will accept comments on the regulations up to May 5, 1992. The regulations primarily track the statute but clarify some questions that had been raised about the law. For example, the regulations and the background discussion make clear that the law does not apply to providers of outpatient hospital services; that in the information it distributes to patients an institution must inform patients if its policy does not allow it to implement certain types of advance directives as a matter of conscience; and that if a patient is incapacitated at the time of admission and is unable to receive information due to the incapacitating condition, the facility should give advance directive information to the patient's family or surrogate. The regulations also attempt to clarify a number of questions raised by HMOs.

One of the more interesting assumptions made by HCFA in drafting the regulations is its estimation of the time it will take each provider institution to collect the information from each patient as to

whether they have executed an advance directive as required under the law. The estimation was made in response to OMB's review under the Paperwork Reduction Act of 1980. HCFA estimates the collection burden for each provider or organization to be approximately three minutes per medical record.

The interim regulations appear in the Federal Register, Vol. 57, No. 45, pp. 8194 - 8204.

## Nursing Homes and Ethics Committees

**I**n 1990, the Maryland legislature, amended the Patient Care Advisory Committee Act, to require that in addition to hospitals, all nursing homes in the state establish an ethics committee. Maryland is the only state with such a requirement. Both nursing home trade associations in the state have been actively helping their members to meet this requirement. On February 19, 1992, MANPHA, the Maryland Association of Non-Profit Homes for the Aging, held a half day workshop on "Making Ethics Committees Work." Gladys Benson White, M.S.N., Ph.D., and Director of the Center for Ethics and Human Rights at the American Nurses Association was the invited speaker. HFAM, the Health Facilities Association of Maryland, has also been assisting its members, in a somewhat unique way. The Association, through its four geographic districts, has brought together nursing homes located in close proximity that are interested in forming a joint committee and has held four workshops around the state for them on how to establish and operate a joint committee. Lynn Carr, Assistant Administrator of Bethesda Rehabilitation and Nursing Center, has taken the leadership in the effort. Professor Diane Hoffmann, J.D., of the University of Maryland School of Law, spoke at each of the workshops on procedural issues that committees must consider in hearing cases. She also facilitated several case discussions, in a simulated ethics committee format, of legal/ethical issues that may face ethics committees in the long term care setting.

## Case Presentation

**O**ne of the regular features of the Newsletter will be the presentation of a case considered by an ethics committee in the region 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 individuals. 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 Consultation In A Maryland Hospital

### **PRESENTATION:**

**A** 67 year old female with a previous diagnosis of nasal sinus lymphoma was admitted to the hospital with encephalopathy secondary to spread of lymphoma to the central nervous system. The medical team started to treat the patient with intrathecal chemotherapy, but did not want to perform cardiopulmonary resuscitation (CPR), because they felt that CPR would be "futile" and associated with painful adverse effects. The patient had no advance directives stating her prior wishes and the one time she became lucid during the present hospitalization she said she "wanted to live" when asked about CPR. However, she was not adequately told about the burdens of CPR or the likelihood of a successful resuscitation. The patient's family, consisting of two daughters and three sons, was unsure about DNR; the husband had died three years previously. The attending physician asked for an ethics committee consultation.

### **ETHICS COMMITTEE CONSULTATION PROCESS:**

A meeting was held between the attending physician, the primary nurse, three members of

the ethics committee, and the family, consisting of the two daughters and one son; the other two sons did not want to attend. The attending physician thought that the patient's condition was terminal, even with the current chemotherapy, which might help restore the patient's mental status. He also reasonably determined that CPR would be unsuccessful in reviving the patient and therefore thought that DNR was ethically appropriate, but was concerned about the legal appropriateness of writing a DNR order without consent from the patient herself.

In an attempt to make a decision based on the substituted consent standard, the members of the ethics committee tried to determine what the patient would have wanted. The family was unsure of what the patient would have decided, because she avoided discussions about death and believed that she was not going to die, even with the lymphoma. They thought that if she was asked about CPR, she probably would have avoided answering the question. There was a sense, however, that if she was told what CPR entailed, e.g., electric shocks, chest percussions, line placement, and intubation, she may have refused. This belief was based on the patient's previous behavior when she was first diagnosed with lymphoma. Initially, she refused chemotherapy, because she did not want to take "poisons", but agreed to this treatment on the advice of the attending physician. Similarly, when radiation therapy was suggested, she refused, because she was afraid of being "burned". Again, the attending physician was able to convince her that the radiation treatments would be worthwhile.

Ultimately, the family said that the attending physician should do what he felt was best for the patient, since he knew her for so long. When asked what the other two sons would have wanted, the family said "don't bother asking them, because they rarely visited the patient and if asked, they would say 'do anything to make her live' without bothering to understand the implications of the involved treatment options." The primary nurse confirmed that the other two sons rarely visited the patient.

The attending physician felt that if he told the patient that CPR would not be worthwhile, she would probably listen to him and refuse this procedure.



*Case Presentation (cont.)***ETHICS COMMITTEE  
RECOMMENDATION:**

The case was discussed with two other members of the ethics committee and all agreed that a DNR order was appropriate for two reasons. One, the committee felt that there was some evidence that the patient would not have wanted the procedure performed based on her previous refusal of therapies that she thought would be harmful. She only agreed to receive these therapies after her physician told her that the treatments would be beneficial. Hence, the committee felt that she would probably listen again to her physician's advice.

Second, the committee thought that the DNR order would be appropriate when based on a best interests standard. Committee members felt that CPR was unlikely to be successful in a patient with advanced malignancy and hence, the harmful effects associated with its performance would definitely outweigh its benefits, which were essentially none. The recommendation was to write a DNR order.

**OUTCOME:**

The DNR order was written with the agreement of the family. The patient continued to receive chemotherapy, but two days later suffered a cardiopulmonary arrest and died.

**Case Comment**

Professor Diane Hoffmann, University of Maryland, School of Law

The case blurs the distinction between those cases where a physician can legitimately withhold or withdrew medical treatment from a patient because the treatment is of no medical benefit and cases where although there may be some medical benefit, the patient or surrogate does not want the treatment either because (s)he perceives it as painful or too burdensome given the patient's expected prognosis and quality of life. The law provides that in the former case, patient informed consent is not necessary. A physician need not offer a patient surgery that he does not believe would benefit the patient. The difficulty in the DNR situation is

defining what of "no medical benefit" means. Definitions have included the following: (1) CPR would do nothing to cure or relieve the underlying terminal illness; (2) Even with CPR the patient would not survive to leave the hospital; (3) the patient would not survive the CPR; (4) the patient would survive the CPR but would very likely be left with significant brain damage; (5) the burdens of CPR outweigh the benefits given the patient's underlying condition. Legally, the narrower the definition, the less a provider is vulnerable to legal attack. From this perspective, the most defensible definition would be #3. Other definitions which put the physician in the position of evaluating someone's quality of life are inappropriate for the physician to make. Those types of decisions should be made by the patient, if possible, or the patient's legal surrogate. In this case, the attending physician believed that the CPR would be unsuccessful in reviving the patient (the narrowest definition of "no medical benefit"). Thus, the patient's or surrogate's consent was not actually necessary.

This comment does not address the secondary question of whether the patient or surrogate should be told about the physician's unilateral decision. Comments on that question are requested.

**DNR Orders in the  
Operating Room**

The topic of the February meeting of the Washington Metropolitan Bioethics Meeting was whether and under what circumstances it is ethically appropriate to suspend a DNR order during surgery. A panel consisting of numerous experts, from various perspectives, addressed the question. At least three positions emerged. Position I, expressed by members of internal and family medicine, was based on the fact that the attending physician usually has a long-standing relationship with the patient in which the physician knows the patient's wishes and values regarding the withholding of life support. Because this relationship includes elements of trust and fidelity, suspending the DNR order intraoperatively breaches that relationship and stands in direct contradiction to the patient's previously expressed wishes. Secondly, under this view, in light of the Patient Self-Determination Act, which confirms the right of an adult patient with capacity to refuse any or all medical interventions, suspension of the

### *DNR Orders (cont.)*

DNR order either routinely or as a matter of policy, is inappropriate.

Position II, argued by an anesthesiologist, was premised on the fact that in the operating room, in some cases, cardiopulmonary compromise is not unusual and is generally easily reversible. Based on the principle of beneficence, one could argue that the anesthesiologist has a duty to resuscitate when the arrest is brought on by an iatrogenic cause and not the patient's underlying disease. Hence, from this perspective, suspension of the DNR order intraoperatively is appropriate.

Position III was articulated by a surgeon who acknowledged the importance of the doctor-patient relationship expressed by proponents of Position I, but admitted that the interface between the surgeon and the patient is considerably shorter than that between a patient and his attending physician. As a result, the surgeon has little knowledge of the patient's value history. Advocates of this view argued that when the intent of the surgical intervention is to provide life-sustaining or comfort measures, it may be appropriate to suspend the DNR order intraoperatively unless the foreseeable outcome of resuscitative efforts would create a greater burden than benefit status post code. Participants also acknowledged that the surgeon as well as the anesthesiologist has the right not to accept the case if retention of the DNR order intraoperatively is morally problematic.

These three positions were then considered from the perspective of an institution's ethics committee.

The discussion focused on the resolution of the moral dilemma created most notably between Positions I and II.

One set of questions focused on the patient's value history and life-plan; seeking to determine why the DNR order was originally written. Was the decision to write the order based on a clinical judgment of medical futility or patient preference not to prolong life/death? A second set of questions explored the conflict between the principles of beneficence and autonomy. With regard to autonomy, the discussion focused on autonomous choice versus autonomous persons. As regards the principle of beneficence, the conversation centered on foreseeable outcomes (burdens and benefits) following CPR, assuming the order was suspended and the necessity for CPR was due to iatrogenic cause.

Two recommendations emerged from the presentation: 1) anesthesiologists should become more informed about their ethics committees' decisions or guidelines regarding suspension of DNR orders in the operating room; and, 2) in all DNR cases involving surgical and/or anesthetic interventions, the patient should be informed of the institution's policy regarding DNR status intraoperatively (whether suspended or retained) and his/her right to have the case transferred to the care of another physician if the patient's physician cannot comply with the patient's wishes or those of the patient's legal surrogate.

Submitted by: Brian Hunt  
Director, Office of Bioethics  
Montgomery General Hospital

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## Calendar of Events

- April 13th Conference: "Do Not Resuscitate and Beyond -- Life & Death Decisionmaking", Johns Hopkins School of Medicine, 8:00-4:30 p.m., The Thomas B. Turner Building. For information call (410)955-2959.
- April 15th Rome Lecture, "Pregnancy and AIDS: Legal and Ethical Issues" Martha A. Field, Harvard Law School, 5:30 p.m., Brune Room, University of Maryland School of Law. For information call (410)328-7239 or (410)328-3378.
- April 21st NIH Bioethics Lecture Series, "Ethical Limits to Clinical Research: Death, Where is Thy Sting," George A. Kanoti, STD Director, Dept. of Ethics, Cleveland Clinic Foundation -- 12:30 - 1:30, Bldg. 10, Masur Auditorium. For more information call (301)496-2429.
- April 21st Fairfax Hospital, 10th Annual Ethics Conference: "End-of-Life Ethical Issues" -- 12:15 - 3:50 p.m., Fairfax Hospital Cafetorium. (For more information call (703)698-2572.)
- April 25th Washington Metropolitan Area Bioethics Network Meeting -- 9:30 a.m., Visiting Nurses Association, 5151 Wisconsin Avenue. For more information call Joan Lewis (202)682-1581.
- May 2nd Lecture, "The Ethics of Dying -- Physician Assisted Suicide and the Rights of Patients," Robert Veatch, Ph.D., Director, Kennedy Institute of Ethics, The Omni Hotel, Baltimore, 8:30 a.m. For more information call Med-Chi at (410)539-0372.
- May 6th Baltimore Area Ethics Committee Network - First Meeting -- 5:00 p.m., Univ. of Maryland School of Law, Room 433-435. For more information call (410)328-7191.
- May 31st-  
June 6th Intensive Bioethics Course XVIII, Kennedy Institute of Ethics, Georgetown University, Washington, D.C.
- June 11th Conference on Women, AIDS and Reproduction -- University of Maryland School of Law, 8:15 a.m.- 6:00 p.m., Westminster Hall. For more information call (410)328-7239 or (410)328-3378.

August 1992, February 1993 - The Center for Biomedical Ethics at the University of Virginia will sponsor a two-week clinical training program for individuals sponsored by an institution. For more information contact Edward M. Spencer, M.D., Director of Outreach, University of Virginia Center for Biomedical Ethics, (804)982-3758.

Literature and Medicine discussion group, 3rd Wednesday of each month. Children's National Medical Center, Department of Ethics. Contact: Jan Vinicky (202)877-5484.