*Health Care Law*

*Mid-Atlantic Ethics Committee Newsletter*

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# Mid-Atlantic Ethics Committee Newsletter, Spring 2009

# 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 Law & Health Care Program, University of Maryland School of Law
and the Maryland Health Care Ethics Committee Network

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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 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

# PROFESSIONALIZING CLINICAL ETHICS CONSULTATION—ARE WE THERE YET?

Most everyone would agree that people doing the work of clinical ethics consultation (CEC) should be qualified. Relevant stakeholders in situations where the help of a CEC is requested are often at their most vulnerable emotionally, physically, and spiritually. Typically, the stakes are high. The last thing we would want is for someone without the requisite qualifications, however well-meaning, to make the situation worse, or even simply to fail to help.

Concerns along these lines are creating momentum to professionalize the field of CEC. When a field is fully professionalized, it self-regulates its membership and educational institutions in the name of some public good, and ensures that formal standards (e.g., standards of practice and a code of ethics) are upheld by practitioners and taught by programs that educate and train those practitioners (i.e., through accreditation, certificates and/or diplomas) (Baker, 1997). Proponents argue that "professionalization" is needed to ensure quality and accountability of those responding to ethical questions, concerns, and conflicts in health care settings.

Toward this effort, a group of health care ethicists has begun to identify the scope of CEC services and the specialized knowledge and skills competencies of its practitioners. These services and competencies are delineated in the American Society for Bioethics and Humanities' Core Competencies for Health Care Ethics Consultation (1998). Yet, there is currently no credentialing process by which clinical ethics (CE) consultants can demonstrate that they possess these Core Competencies, nor any accreditation process by which to judge graduate programs as meeting minimum standards for educating and training CE consultants. Moreover, there is no code of ethics for the field.

One might ask whether professionalizing the field of CEC is necessary to improve CEC services. One way of answering that question is to determine whether those performing CEC services are qualified. Fox and colleagues' estimated that 29,000 individuals devote more than 314,000 hours to performing ethics consultations in U.S. hospitals each year (Fox, *et al.*, 2007). According to survey findings, only 5% of these individuals completed a fellowship or graduate degree program in bioethics. This mirrors findings from a survey of Maryland hospital ethics committees, which showed that the majority of ethics committee members had little formal education or training in ethics (Hoffmann, *et al.*, 2000). Yet, there is currently no evidence that individuals who completed a graduate degree or fellowship program in bioethics are competent to perform CEC. What about others? According to Fox, *et al.*'s survey, 41% of CE consultants learned how to perform ethics consultation via formal, direct supervision by an experienced member of an ethics consultation service, and 45% learned independently, without formal, direct supervision. While we can agree that those with no education or training in CEC are unlikely to possess all the requisite competencies, what evidence do we have that individuals trained through an independent learning or apprenticeship model are not fully qualified to perform CEC?

Before addressing the question of which training model produces the most qualified CE consultant, we need to understand the nature of CEC.

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# NETWORK NEWS

**The Maryland Health Care Ethics Committee Network** co-sponsored the conference, "Health Care Ethics Committees and Maryland Law—Time for a Change?" on December 3, 2008 *(*see the article in this issue for a recap of conference highlights). Proceedings and discussions generated by the conference are informing efforts to explore whether to propose changes to Maryland's Patient Care Advisory Committee Act or Health Care Decisions Act. MHECN is planning to survey risk managers and hospital counsel regarding interpretations of medically ineffective determinations to further inform these efforts. In June, 2009, MHECN will sponsor a basic ethics education conference. Details about this conference will be announced soon. For more information, e-mail MHECN@law.umaryland.edu, or phone (410) 706-4457.

**The West Virginia Network of Ethics Committees** (WVNEC) is coordinated by the Center for Health Ethics and Law of the Robert C. Byrd Health Sciences Center of West Virginia University. WVNEC has a new website featuring links to member resources (including ethics committee tools, WV advance directive forms and laws, and an upcoming calendar of events). Contact Cindy Jamison for more information at cjamison@hsc.wvu.edu.

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

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

Near-life experience

*Cont. from page 1*

## WHAT IS CLINICAL ETHICS CONSULTATION, AND HOW DO WE KNOW IT HELPS?

Innovations in medicine have expanded health care options while increasing the complexity of medical decision-making. Our fragmented U.S. health care system, rising health care costs, and growing numbers of under- and uninsured, are just some of the contributors to ethics questions, concerns, and conflicts, being encountered daily in health care settings across the country. Health care ethics committees, and more specifically, CEC services, have evolved as one way of addressing these issues. CEC refers to "services provided by an individual or a group to help patients, families, surrogates, health care providers, or other involved parties address uncertainty or conflict regarding value-laden concerns that emerge in health care" (ASBH, in press). Evidence that qualified CEC services produce a valued benefit may be extrapolated from the fact that high-volume, well-functioning CEC services attract repeat requests for these services (Fox, *et al.*, 2007). This assumes that individuals at health care facilities with a well-functioning CEC service learn to recognize ethics questions and concerns, and request help from the CEC service to help resolve them. Under-qualified CE consultants most likely fail to demonstrate the full potential of CEC because they lack the specialized knowledge or skills to effectively address ethics concerns, and to distinguish CEC from other types of consultations (e.g., medicine, chaplaincy, palliative care, social work).

## WHAT SHOULD THE MINIMUM STANDARDS BE TO DEEM A CONSULTANT AS QUALIFIED?

The Core Competencies lists basic skills and knowledge competencies that everyone involved in a consultation must possess, as well as advanced skills and knowledge competencies that at least one person involved in a consult must possess. For example, everyone involved in CEC services should have a basic ability to analyze the value uncertainty or conflict in the case brought to them (e.g., recognize different stakeholders' interpretations of promoting the patient's well-being), but at least one individual should have advanced skills in this area (e.g., mediation skills to resolve a conflict). To advance the goal of professionalizing the field of CEC, the minimum standards for a CE professional would be set at the level of an advanced practitioner—that is, someone who demonstrates all the identified skills and knowledge competencies in the Core Competencies, and any other recognized "standards of practice" for an advanced CEC practitioner.*

This admittedly leaves out other individuals performing CEC who only possess some of the required competencies. The Core Competencies acknowledges that not all health care facilities will have a professional ethicist, and provides two alternatives for meeting minimum standards: (1) a team CEC approach, in which all members of the team possess the required basic competencies, and individual members in combination possess the required advanced competencies (but no one individual possesses all the basic and advanced competencies), or (2) a qualified CE consultant with advanced CEC knowledge and skills leads each ethics consultation, and others who have at least basic competency are also involved.

Establishing a method to demonstrate only basic CEC knowledge and skills competencies would not address the issue at hand, since the basic competencies are necessary but not sufficient to effectively perform CEC. Notwithstanding situation #1 above in which the necessary advanced knowledge and skills are found at the collective level of the team rather than in one individual, a move toward professionalizing CEC is a way to ensure that at least one individual responding to a consultation request has both basic and advanced CEC knowledge and skills.

## ACCREDITING OR CREDENTIALING?

Methods by which individuals could demonstrate meeting necessary expert CEC competencies include accrediting training programs and credentialing individuals. Accreditation involves an external body ensuring that standards for training competent CE consultants have been met—similar to how the Joint Commission accredits hospitals—and to how the Liaison Committee on Medical Education accredits medical schools. Such efforts would ensure consistency across graduate bioethics programs, which currently vary tremendously in their ability to prepare qualified CE consultants. One criticism of such programs is their lack of a mandatory clinical practicum, particularly for individuals with no prior clinical background. Another concern with this approach is that individuals who have not met competency benchmarks might still graduate from such a program and thus be recognized as a professional CE consultant despite failing to meet minimum standards.

The program accreditation method would not address how to recognize those currently functioning as expert CE consultants. Given that, according to Fox, *et al.*'s estimate, 95% of individuals currently doing CEC have no formal training, and the remaining 5% have received formal training from a non-accredited program, we can

*Cont. on page 9*

**The American Society for Bioethics and Humanities (ASBH)** is a professional organization for people engaged in clinical and academic bioethics and the medical humanities. ASBH has formed a new standing committee on Clinical Ethics Consultation Affairs, which will work on standards for the field and address possibilities for credentialing clinical ethics consultants and accrediting graduate training programs. An ASBH task force is also updating the Core Competencies for Health Care Ethics Consultation, a document that outlines what skills and knowledge competencies one must have to respond to ethics consultation requests in health care facilities. Anita Tarzian is chairing both the task force and the new committee. Learn more about ASBH, including the annual conference that will be held in Washington, D.C. in October, by visiting http://www.asbh.org.

# THE CASE OF MR. M— A STUDY OF DICHOTOMIES

Mr. M had fashioned a reasonable life for himself after surviving an assault in which he was stabbed in the neck 10 years ago. The knife had penetrated one side of his cervical spine and brainstem. He was hemiplegic with a hemi-diaphragm paralysis. He had various problems with motor function (uncoordinated muscle movements, dizziness or fainting in certain upright positions, and difficulty tracking objects with his eyes). He had a tracheostomy (an opening in the throat used to connect to a ventilator), and was initially ventilator dependent, but regained the ability to breathe on his own during the day, spending his nights on the ventilator. He spent his days in a wheelchair and mobilized himself independently with his good leg and arm. He could feed himself, but required some assistance with transfers, bathing, dressing and grooming. He was continent of bowel but incontinent of bladder and used an external catheter. He suffered muscle spasms that were controlled with benzodiazepines. Other than an occasional urinary tract infection, his medical status was quite stable over the years.

Mr. M had expert computer skills. He spent much of his days on the Internet. He was entrusted with computer repair work and computer troubleshooting by the staff of the chronic care hospital, where he resided for the eight years after his injury. He mobilized around the grounds of the chronic care hospital. He received visitors from the surrounding neighborhood, where he had lived prior to his injury. He had befriended some of the staff, who brought him treats from local grocers and delis. Despite these social strengths, Mr. M's care was very difficult for the staff. He often refused his daily care and was typically angry and verbally abusive to the staff. He smoked heavily each day. The pulmonology staff caring for him felt he might be a candidate for a less invasive form of nocturnal ventilation, since he used a cuffless tracheostomy, receiving high volume air flow without significant pressure support from the ventilator. He refused to be evaluated for this. Although his health care team felt he might eventually be able to transition back into a less restrictive community setting, he refused to consider this possibility. He did not qualify for Social Security or Medicare Disability benefits, because he had not paid any taxes on his income for the ten years prior to his injury. When encouraged to participate in vocational rehabilitation and enter the work force again, he scoffed at the idea, deriding it as bourgeois and beneath him.

***"The agency determined that his physical needs could be met and should be met at a nursing facility level of care, which would cut his daily Medicaid rate approximately in half. Since the chronic care hospital in which he had resided did not offer a skilled nursing level of care for ventilator patients within its facility, Mr. M was forced to leave his home of eight years. As he put it, 'I got an eviction notice from the state and the hospital.'"***

The cost of his daily care as a Medicaid recipient who was ventilator dependent living within the chronic care hospital was approximately $1500 per day. Over the course of eight years, the Maryland Medicaid program had paid over $4 million for his care. When the State of Maryland contracted with a new agency to evaluate level of care designations, the agency decided that Mr. M did not qualify for a chronic care hospital level of care. Rather, the agency determined that his physical needs could be met and should be met at a nursing facility level of care, which would cut his daily Medicaid rate approximately in half. Since the chronic care hospital in which he had resided did not offer a skilled nursing level of care for ventilator patients within its facility, Mr. M was forced to leave his home of eight years. As he put it, "I got an eviction notice from the state and the hospital."

I met Mr. M in my role as the medical director of the skilled nursing facility accepting him in transfer from the chronic care hospital. I became directly involved in his care when he fired all of his physicians. As I listened to his rants, I let him know that I would try to help him. He saw me as a potential tool to achieve his objectives and interacted with me very reasonably. He told me his assailant would be getting out of prison soon on parole, just as he, Mr. M, was being handed a life sentence to be confined to the nursing home. As I made phone calls on Mr. M's behalf, it was clear he could not return to the chronic care hospital. He did not need the level of care offered there, and the chronic care hospital had determined that it was not to their financial benefit to offer the skilled nursing level of care he required within their walls. Although he never really accepted that he could not go back, he amended his request, stating he just wanted to get out of that particular nursing facility. He was accepted by a second facility further away from his home community. They made arrangements for him to visit. He seemed genuinely pleased with the new alternative, and was transferred.

The new locale in short order, however, predictably failed to meet his expectations, and he once again fell into his angry rants and abusive behaviors with staff. He was also verbally and physically abusive to

his roommate and the roommate's visitors. He was given a private room. His high volume Internet use, which involved downloading huge files, disrupted the Internet connections for the general users and his Internet access was administratively curtailed. He then developed a paranoid ideation that I personally had conspired to bring him and confine him to this place. Social work staff made applications for him at every other skilled nursing ventilator program in the state, and everyone turned him down for admission. He refused to get out of bed. He refused to come off the ventilator during the day. He refused his daily care and personal hygiene. He refused psychiatric consultation at the facility. He refused any psychoactive medication. One day when he appeared physically ill and mentally incapable of making his own decisions due to depression, I sent him out of the facility on an emergency petition for both psychiatric and medical evaluation. After 24 hours in the ER, and having refused both medical and psychiatric intervention, he returned to the nursing facility with the de facto diagnosis of "angry young man." He told the social worker that he wanted to change his advance directive to read "do not resuscitate, do not intubate, do not hospitalize and do not give any medical treatments." The psychiatry team was called again and the patient angrily dismissed them. He refused to engage in discussions regarding his decisions and refused medication. He started to ask his pulmonologist about terminal "one way" weaning. She felt he was capable of making his own decisions. He refused to discuss his request with other staff members. A hospice medical director performed an ethics consultation and agreed with the pulmonologist that the patient was capable of making his own decisions. The patient was offered transfer to a local inpatient hospice for his terminal weaning, but declined. He actually said that he wanted to stay at the nursing facility and said, "It's not such a bad place." He wanted the option for terminal weaning, but wasn't ready to exercise it.

Several months later, the patient suddenly decided to get out of bed and come off the ventilator one day. He was much weaker than before, having been self-confined to bed and ventilator for many months. He went out for a smoke. He called in a friend from his old neighborhood. He summoned me to discuss the medical technicalities of one-way weaning. He had chosen the date. He was engaging and upbeat. He had made his decision. He told the staff to leave him off the ventilator that night. They told him they would be glad to place him back on the ventilator at any time, if he wished. Meds were ordered for his comfort, as needed. Morphine relieved his sense of dyspnea, but he spent the night wide-awake, fearing that if he went to sleep, he would forget to breathe. He asked me for a sleeping pill for the next night off the vent. We discussed that the morphine and the sleeping pill together would likely depress his respirations and cause his breathing to cease. He said that was exactly what he desired. That evening, he refused the ventilator for the second night. He took his morphine and sleeping pill and died in his sleep.

I have served as medical director and attending physician for both chronic care hospital and skilled nursing facility ventilator programs over the past 20 years. I have participated in dozens of terminal weaning situations. I firmly believe in the right of people to refuse unwanted medical interventions, even if such refusal hastens death. Usually in medicine, we do not allow suicidally depressed patients to end their lives. We try to treat suicidal depression, even if it means involuntary commitment for inpatient psychiatric treatment. However, in Maryland, we do not have any programs or facilities that can treat the psychiatric needs of suicidally depressed patients who also need chronic mechanical ventilation. His was a death by dichotomy —the dichotomy of chronic care hospital versus skilled nursing levels of care and funding; the dichotomy of medical versus psychiatric health care programs; the dichotomy of an autonomous personality disordered individual versus a suicidally depressed patient; the dichotomy of prescribing to relieve symptoms versus prescribing to end a life.

Some patients are untreatable within the confines of our current health care system. Mr. M was one of the few "untreatables" that I have encountered in my medical career. I believe he might have been treatable 20 years ago. That he was untreatable in 2008 reflects how the dichotomies have changed in the past 20 years.

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## UPDATE: LEGAL AID SUES MARYLAND OVER CARE OF PATIENTS

The Maryland Legal Aid Bureau sued the state on March 6 to try to stop it from moving low-income patients on ventilators out of chronic care hospitals and into nursing homes. The suit, filed in Baltimore Circuit Court, argues that the state Health Department didn't follow legal requirements in 2006 when it altered guidelines for patients' eligibility for government-funded hospital care. It maintains that the state is enforcing the rule only to save money in the Medicaid program amid a serious budget crunch. *See* http://www.baltimoresun.com/news/health/bal-md.ventilator06mar06,0,3039041.story.

# SHOULD MARYLAND CHANGE ITS PATIENT CARE ADVISORY COMMITTEE ACT?

On December 3, 2008, MHECN co-sponsored the conference, "Health Care Ethics Committees and Maryland Law—Time for a Change?" Jack Schwartz, JD, Health Care Law and Policy Fellow with the Law & Health Care Program at the University of Maryland School of Law, opened the day with an overview of relevant Maryland law. The Patient Care Advisory Committee (PCAC) Act requires hospitals and nursing homes in Maryland to establish an advisory committee (i.e., "ethics committee") to give advice in cases involving individuals with life-threatening conditions, in order to help lay out ethically justifiable options for care and treatment. The committee may also educate patients and staff regarding health care decision-making, and review and recommend institutional policies and guidelines concerning the withholding of medical treatment. The ethics committee (EC) must include at least the following: a physician, a nurse, a social worker, the CEO or his/her designee, and, in cases involving medical care of a child with a life-threatening condition, a medical professional with expertise in pediatric end-of-life care. The institution must adopt written procedures for handling petitions to the EC. Nursing homes may have their own EC or may collaborate with a hospital EC or join with other nursing homes to establish a committee serving multiple facilities.

The Maryland Health Care Decisions Act (HCDA) establishes legal standards for end-of-life medical decision-making, including the use of advance directives, and procedures for identifying a surrogate decision-maker if a patient does not have the capacity to make his or her own medical treatment decisions. If surrogates with equal decision making priority disagree about a health care decision, the attending physician or a surrogate must refer the case to the EC. The physician does not have to follow the EC's recommendations. However, health care providers who take actions based on the HCDA, and health care agents and surrogates who follow the HCDA, are provided immunity from liability or claims that their actions were unauthorized. The EC may also play a role when practitioners believe the decision-maker is not acting within medically accepted standards if requesting that a life-sustaining procedure be withheld or withdrawn.

Schwartz proposed the following questions for conference attendees to consider:

- Should Maryland law say more about the process and outcomes of ECs, or the qualifications of members? If so, what?
- Is there a problem with the law's emphasis on an EC giving "advice"? If so, how might the law be changed to address this problem?

Schwartz recognized the challenge in achieving a balance between tolerating ineffective EC performance via lack of standards, and over-regulating ECs with too much legislative detail.

Diane Hoffmann, JD, MS, law professor and Director of the Law & Health Care Program at the University of Maryland School of Law, explored the question of whether ECs are accomplishing their goals. Hoffmann reviewed findings from survey data of Maryland hospitals on EC functioning. In general, respondents indicated a need for more training of EC members and a more formal process for consultations. Some respondents questioned the role and value of the EC, and called for better role definition.

Hoffmann proposed the following questions for consideration:

- Should case consultation be the primary role for ECs? If so, are ECs doing a good job at it? Do they have the appropriate expertise and composition? Are users satisfied? Do they have sufficient independence from the health care institution, and are they seen as not having a conflict of interest?
- Should the case consultation model be expanded to include organizational ethics? If so, what expertise is needed on ECs to serve that function?
- Do any of these changes require changes in Maryland law?

Anita Tarzian, PhD, RN, Ethics and Research Consultant and MHECN Program Coordinator, gave an overview of current standards for clinical ethics consultation as identified in the Core Competencies for Health Care Ethics Consultation, published by the American Society for Bioethics and Humanities (ASBH, 1998), and currently under revision. Tarzian described approaches to credential qualified clinical ethics consultants and/or accredit programs that train such consultants, and the pros and cons of moves toward professionalizing the field of clinical ethics consultation (*see* lead article in this issue).

Data reveal that most individuals performing ethics consultations lack formal education or training, and are involved in very few consults annually. Tarzian questioned whether this reflects a need to: (1) enhance the consistency and quality of ethics consultations by addressing qualifications of those performing consults, and attend to procedural standards for implementing and evaluating ethics consultation requests, or (2) move toward an integrated ethics model, in which the EC focuses on enhancing institutional staff members' ethical awareness and knowledge and address problems proactively, rather than focusing on case consultations per se. One question she raised is whether Maryland law should require health care facilities to demonstrate competency of its EC members.

A segment of the conference was devoted to sharing various EC performance improvement models. Ellen Fox, MD, Chief Officer for Ethics in Health Care at the National Center for Ethics in Healthcare at the Veterans Health Administration, provided an overview of the Veterans Health Administration's "IntegratedEthics" program, which has a goal of establishing a national, standardized, comprehensive, systematic, integrated approach to ethics in health care. Improving the quality of ethics services in VA hospitals is aimed at improving employee morale, increasing patient satisfaction, reducing legal liability, improving efficiency and productivity, and lowering the use of inappropriate medical treatments.

The IntegratedEthics program includes three core functions:

- ethics consultation (responding to ethics questions in health care)
- preventive ethics (addressing ethics quality gaps on a systems level), and
- ethical leadership (fostering an ethical environment and culture).

Workbooks and resource tools for all these domains are available at www.ethics.va.gov/integratedethics.

Evan DeRenzo, PhD, bioethicist with the Center for Ethics at Washington Hospital Center, described efforts to reduce "non-dilemmatic consults" at Washington Hospital Center through a "train the trainer" educational model, with the "trainer" being the hospital clinicians. One of the primary methods to achieve this is by weekly rounding in different wards or units—that is, joining clinical teams for their regular work rounds. DeRenzo identified problems with the traditional "retrospective" ethics consultation, in that conflict often already exists, and sometimes polarization sets in among involved stakeholders. In contrast, proactive measures such as ethics rounding heads off conflict before it arises, trains the clinicians to handle routine ethics issues themselves, and strengthens moral courage among health care staff. For example, if an attending does not raise an issue that a rounding ethicist identifies, the ethicist raises the issue, which reduces tension produced by other staff involved. The rounding ethicist can ask a question, such as, "Who speaks for this patient?", producing discussion that identifies a previously unrecognized ethical problem (e.g., the team has been talking to the wrong surrogate). Over time, the attending physicians learn to ask the same questions, which teaches them to engage in preventive ethics. This results in the EC only getting the truly "dilemmatic" cases that require the diversity of perspectives from the full committee. DeRenzo acknowledged that the rounding method is resource intensive, but points to research showing that ethics consultation services pay for themselves via a secondary benefit of reduced expenditures (e.g., reduced length of ICU stay) without compromising quality of patient care. More importantly, the "upstream model" of ethics education through rounding elevates the moral discourse within the facility and within the committee, and invigorates and energizes the EC, which can focus on the cases for which it is truly needed.

Henry Silverman, MD, MA, Chair of the Clinical Ethics Committee at the University of Maryland Medical Center, presented approaches taken to enhance the quality of UMMC's EC via, among other things, on-line educational resources for EC members and staff, new employee orientation presentations, presence on the hospital's intranet, ward rounds, and quality improvement activities (such as an ethics consult feedback form). The EC at UMMC has taken steps to address organizational structures and processes that generate particular patterns of unethical behavior. For example, a committee within the hospital developed a Resuscitation Order Form to prevent miscommunication regarding the meaning of Do-Not-Resuscitate (DNR) orders. Also, a hospital-wide survey was conducted to identify sources of ethical conflict among staff in their everyday patient care duties. Findings revealed that there were inadequate opportunities for staff to discuss ethical dilemmas they encountered, and some perceived that open inquiry was not supported in the institution. In response, the following proactive measures were instituted: ward rounds, establishment of weekly neonatal staff meetings to discuss controversial cases, and monthly half-hour discussions with internal medicine residents at which residents choose a patient for whom they think there are ethical issues to discuss.

Thaddeus Pope, JD, PhD, Associate Professor at Widener University Law School, proposed the multi-institutional health care EC as an alternative to the intramural committee. Types of multi-institutional committees include a network (such as MHECN, but one that would provide ethics consultation services), an extramural committee (e.g., a nursing home that uses the services of a hospital's EC), a quasi-appellate committee (e.g., a committee comprised of representatives from various other health care facility ECs who review cases that might present a conflict of interest if reviewed by the home institution's EC), and a shared/joint committee (e.g., two or more facilities that share an extramural, stand-alone EC). Pope proposed that these alternatives may protect against inherent risks of intramural committees, which include making recommendations that may be biased, careless, arbitrary, or corrupted by conflicts of interest or power hierarchies within the institution. However, Pope recognized the obstacles to these alternatives, which include transaction costs, inconvenience, and concerns about confidentiality and liability.

***"Proactive measures such as ethics rounding heads off conflict before it arises, trains the clinicians to handle routine ethics issues themselves, and strengthens moral courage among health care staff."***

In the final conference session, attendees discussed whether current Maryland law should stay the same or be revised. "Brain-storming" suggestions for revisions included:

- Mandate trigger-points for an ethics consult, such as a certain number of days in the ICU.
- Mandate minimum education for EC members involved in ethics consultations.
- Mandate public disclosure of ethics service outcomes or institutional standards.

Others felt that legislative solutions simply create other problems. They believed that ECs should improve their services by addressing the problems highlighted in the conference sessions, such as properly training and educating EC members, developing EC procedural standards, and increasing awareness of ethics services within an institution.

# PHILOSOPHER'S CORNER: DECISION-MAKING COMPETENCE

Ethics committees are frequently called upon to determine whether individuals possess the requisite capacity to consent to, or refuse, a particular medical treatment. A committee might be asked, for example, to determine whether an adult patient with impaired cognitive abilities can refuse a life-saving treatment, or whether a child with cancer can decline further rounds of chemotherapy. In each case, the committee must ascertain whether the patient is competent to make critical health care decisions. What standards of competence should guide the committee's analysis?

The answer to this question emerges at the intersection of law, ethics, and philosophy. Though each discipline has its own methods for assessing competence,[1] there is general interdisciplinary agreement that competent individuals have the capacity for (1) communication, (2) understanding, (3) appreciation, (4) deliberation, and (5) a set of values to guide their choice.

Before describing each of these elements, it is important to keep in mind that competence is "always competence for some task—competence to do something."[2] It is incomplete to say that a person is competent or incompetent without specifying the nature of the choice and the circumstances in which the choice is made. A person who is competent to make his or her meals may not be competent to drive a car, just as a person who is competent to make health care decisions while lucid may not be competent to make those same decisions if cognitively impaired. Determinations about competence should therefore be determinations about an individual's ability to make a certain choice, at a particular time, in a concrete context.[3]

## COMMUNICATION

In assessing competence, the first capacity to evaluate is a person's ability to communicate. Communication involves participating in conversations about the decision at hand and expressing one's choice. Due either to age or disease process, some people with limited linguistic, conceptual, or cognitive abilities may not meet this basic element of capacity. Failure to communicate usually signals a person's inability to satisfy the remaining elements, but ability to communicate is not alone sufficient to determine decision-making competence.

> ***"Most philosophers and ethicists agree that in addition to understanding the facts involved in a particular decision, competent individuals also appreciate the nature, meaning, and significance of their choice."***

## UNDERSTANDING

The second factor to consider is whether a person understands the facts relevant to their decision. Because the process of comprehension involves complex sensory, perceptual, and cognitive functions, people suffering from a wide range of medical conditions may have an impaired ability to understand treatment information.[4]

## APPRECIATION

Most philosophers and ethicists agree that in addition to understanding the facts involved in a particular decision, competent individuals also appreciate the nature, meaning, and significance of their choice. This means that they can envision "what it would be like and 'feel' like to be in possible future states and to undergo potential alternatives."[5] Young children with limited life experiences, for example, may not sufficiently appreciate the consequences of foregoing treatment. Certain psychological states, such as depression, also may hamper an individual's insight into the implications of their decision.

## DELIBERATION

Findings of competence further require that individuals possess the capacity to reason and deliberate. Just what constitutes adequate deliberation is the subject of ongoing academic discussion, but at its most simple, deliberation involves engaging in probabilistic reasoning about uncertain or future outcomes of one's decision. It entails the ability to weigh benefits and risks and arrive at a conclusion, aware of its possible consequences. One cannot engage in deliberation without the capacities for understanding and appreciation.

## VALUES

Though some theorists do not require this fifth element of competence,[6] most philosophers contend that to be a competent decision-maker, one must have a minimally stable and consistent set of values on which to base a decision.[7] These values do not need to be fixed or complete; they can change over time and evolve to meet new circumstances. They should, however, be sufficient to allow an individual to evaluate his or her decision and its likely outcomes against a particular conception of the good. When individuals make decisions that are not internally consistent with their values, further investigation into capacity may be warranted.

Assessing an individual's decision-making competence is challenging, and it would be an oversimplification of the issue to suggest that physicians or ethics committees can merely apply the five elements outlined above to reach a judgment in a particular case. Reasonable people disagree not only about how to evaluate individual capacity within each of the metrics, but also about whether the degree of competence required should vary based on the particular treatment decision at issue.[8] What is clear is that we must take great care in rendering determinations in these cases so as to strike "a proper balance be-

tween respecting the autonomy of patients who are capable of making informed decisions and protecting those with cognitive impairment."[9]

*Leslie Meltzer Henry, JD*
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*University of Maryland School of Law*

[1]State laws, for example, may include other standards or may state the requirements differently.

[2]Allen Buchanan & Dan W. Brock, "Deciding for Others: Competency," 64 *Milbank Quarterly* 67-80 (1986).

[3]This approach contrasts with older, so-called "global" determinations of competency that extended to all choices, across time, regardless of context. For a further discussion comparing decision-relative and global competency determinations, see Allen E. Buchanan & Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making*, 20-23 (1989).

[4]Thomas Grisso & Paul S. Applebaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals* 39-40 (1998).

[5]Buchanan and Brock, *supra* note 3, at 24.

[6]Grisso & Applebaum, *supra* note 4.

[7]Buchanan & Brock, *supra* notes 2 & 3.

[8]Buchanan & Brock advocate a "sliding scale" approach to competence, see *supra* note 2. This position was also taken in The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* (1982). For the opposite view, see Charles M. Culver & Bernard Gert, "The Inadequacy of Incompetence," 68 *Milbank Quarterly* 619-43 (1990).

[9]Paul S. Applebaum, "Assessment of Patients' Competence to Consent to Treatment," 357 *New England Journal of Medicine* 1834 (2007).

## *Professionalizing Clinical Ethics Consultation – Are We There Yet?*

*Cont. from page 3*

assume that a subset of these individuals do possess expert CEC knowledge and skills. The question of how to "grandfather" these individuals must be addressed. Such an approach could take the form of credentialing them by formally evaluating their CEC knowledge and skills competencies. A professional CE consultant would thus have to demonstrate all basic and advanced competencies, whereas a "non-professional CE consultant" (i.e., member of a CEC service who needs only basic competencies as part of a team approach) might undergo a different form of credentialing or certification.

Regardless of whether we pursue an accreditation or credentialing approach to recognize qualified CE consultants, adequate evaluation methods will be needed.

### VALID & RELIABLE EVALUATION METHODS

Current methods of evaluating the competency of CE consultants include having members of the CEC service self-report the degree to which they meet various skills and knowledge competencies. For example, the VA's tool, which was developed using the ASBH's Core Competencies (available at http://www.ethics.va.gov/ethics/integratedethics/index.asp), asks the consultant to "Rate your ability to educate the participants regarding the ethical dimensions of the case." Possible responses include: "not skilled," "somewhat skilled," "skilled," "very skilled," "expert." While self-perception tools provide some information regarding an individual's CEC knowledge and skills, they are not robust measures of actual skills and knowledge. Having a mentor or supervisor who has observed the CE consultant rate that individual's skill level using such a tool would be a more robust approach. However, producing valid and reliable methods at the national level by which CEC competencies can be effectively evaluated is no small task. Knowledge is easier to objectively test than are skills, which typically require resource-intensive observations. However, testing objective knowledge alone (e.g., in a board-type exam) would fail to demonstrate that an individual had the requisite skills to practice CEC at the expert level. Furthermore, objectively testing expert ethics knowledge is difficult, given that ethical analyses often produce more than one "right answer," and that legal standards that inform ethical analyses vary from state to state.

### CONCLUSION

Those favoring staffing a CEC service with at least one professional CE consultant argue that relying on all-volunteer, under-qualified staff to perform CEC as an "add-on" to their other work, without compensation or protected professional time, contributes to poor CEC outcomes. Such individuals may unwittingly cut corners in the CEC process, or conduct ethics consults based on their own professional bent, with little appreciation for how their approach falls short. Advocates for professionalization argue that the time has come to identify expert CEC practitioners, hold them accountable to standards of practice in their field, and devote the requisite resources to allow CEC services to flourish.**

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*MHECN Program Coordinator*

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*These include emerging process standards, such as the ability to properly triage an ethics consult request, to adequately document the request and why it is appropriate for the CEC service, and to evaluate the consultation.

**Evidence exists that effective clinical ethics consultations reduce costs spent on non-beneficial services, and would thus be self-funding. See Gilmer, *et al.* (2005). The costs of non-beneficial treatment in the intensive care setting. *Health Aff.* (Millwood), 24(4):961-71.

# CASE PRESENTATION

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

## CASE STUDY FROM A MARYLAND PHARMACIST

Mr. and Mrs. Smith are frequent customers at ABC pharmacy. Approximately six months ago, the couple began fertility treatments because they were unable to conceive a child on their own. Since then, both Mr. and Mrs. Smith have been on several medications prescribed by their fertility doctor to help increase their chances of conceiving. The Smiths insurance does not cover fertility treatments and the couple has been paying out of pocket for expenses related to their treatment. Mr. Smith once estimated that they pay approximately $10,000 out of pocket per round of treatment. Recently, Mr. Smith took a second part-time job so the couple could afford another round of treatments.

One day, Mrs. Smith came in to the pharmacy with a prescription for birth control pills. The pharmacist asked her if this meant that she and her husband had ceased fertility treatments. Mrs. Smith replied that she had secretly been on birth control for the duration of their attempt to conceive a child, including during fertility treatments. She stated that she had no intention of having a child but that her husband wanted one. She felt that if she did not at least try to conceive a child with her husband that he would end their marriage. Mrs. Smith tells the pharmacist that she had been filling her birth control prescription at a different pharmacy and asked that the pharmacist not tell her husband of her decision to not have a child with him.

Concerned that taking birth control while on fertility treatments was harmful to the patient, the pharmacist called the OB/GYN physician who prescribed the birth control. This doctor informed the pharmacist that he was not aware that the patient was undergoing fertility treatments, but that he would not change his mind about prescribing the birth control pills because the treatment was still therapeutic and not futile, i.e., it was serving the purpose for which it was prescribed, to prevent pregnancy.

The pharmacist then called the fertility doctor and explained the situation. The fertility doctor told the pharmacist to mind his own business, and that as long as he (the fertility doctor) was being paid, he was fine with whatever decisions his patient wanted to make about her personal life.

Feeling that the pharmacist did not have a choice, since there was no medical reason to not dispense the medication, he dispensed Mrs. Smith's birth control pills after documenting his conversations with her and both physicians. To this date, he continues to dispense the wife's birth control pills and the wife's and husband's fertility medications, even though he feels that he is lying to the husband. He wonders if what he is doing is ethically justifiable.

## MEDICAL FACTS

According to Dr. Eugene Katz, Reproductive Endocrinologist at Shady Grove Fertility Center at Greater Baltimore Medical Center, while research has not been published on the concomitant use of oral contraceptives during IVF treatment (i.e., during ovarian stimulation/retrieval or after embryo transfer), it is possible that such medication could impair embryo implantation in the uterus by affecting the woman's uterine lining (endometrium). Dr. Howard McClamrock, Reproductive Endocrinologist at University of Maryland Medical Center, concurs. Both Katz and McClamrock did not view an appreciable increase in risk of harm to the woman from taking oral contraceptives concomitantly with other IVF medications, because the ensuing rise in hormone levels would be relatively negligible. However, McClamrock pointed out that there are appreciable risks of IVF treatment itself that should be balanced by anticipated benefits.

Regarding the fertility physician's response to the pharmacist, Dr. McClamrock pointed out that since IVF clinics publish their success rates, it does not make intuitive sense that the fertility physician in this case would be indifferent to attempts by a patient to thwart the success of an IVF cycle. Since oral contraceptives are often used before the ovarian stimulation phase of IVF treatment, it would be important to clarify whether the fertility physician understood that the pharmacist was questioning an improper use of oral contraceptives during IVF.

## RESPONSE FROM A BIOETHICIST

Faced with two seemingly incompatible prescriptions—actually, with two apparently contradictory treatment plans—the pharmacist's first reaction (after requesting, and receiving, the woman's explanation) was to contact each of the prescribing physicians. Was this a breach of confidentiality?

Some readers will likely find this question somewhat strange. They will rightly consider that confidentiality is generally required (and asserted) with regard to divulging personal information to outside agents, and is not meant to obstruct sharing of information among members of the healthcare team. Now I can imagine circumstances where a pharmacist might be ethically bound not to share certain information with his client's physician; but the case at hand does not seem to call for that. Clearly, in contacting the physician who had prescribed birth control (BC) pills ("Dr. B"), the pharmacist followed the imperative of his professional ethics—verifying that the contradictory medications are not potentially harmful, or may be just futile (more on futility below).

The pharmacist and Dr. B are, with respect to the BC prescription, indeed part

of the same healthcare team. But does the same logic hold with regard to the physician providing fertility treatment ("Dr. F")? At first glance the two relationships seem fully analogous. With regard to the medications taken by the woman for the fertility treatment, the pharmacist's teammate is Dr. F; should not the pharmacist then address to him any concern about the problematic effects of combining this with BC pills? Dr. F, for his part, is clearly involved in a tripartite doctor-patient relationship, since the fertility treatment is directed at the husband and wife as a couple. This seems to imply that there is no problem in sharing the information about the BC pills with Dr. F, even though he is also the husband's doctor.

***"Was there not a breach of confidentiality in sharing her information with a physician serving the couple jointly? In light of Dr. F's unexcited reaction, approaching him does not seem to have harmed anyone. But there is a lesson here: professional duties of confidentiality are relationship-dependent."***

This may well be wrong. After all, the information that the pharmacist is conveying to the husband-and-wife's joint fertility doctor came into his possession in the context of a different professional relationship, one in which the patient is exclusively the wife. Was there not a breach of confidentiality in sharing her information with a physician serving the couple jointly? In light of Dr. F's unexcited reaction, approaching him does not seem to have harmed anyone. But there is a lesson here: professional duties of confidentiality are relationship-dependent.

In any event, calling both physicians resolved only one of the pharmacist's dilemmas, namely that pertaining to safety. This might leave the pharmacist with reservations about facilitating futile treatment (like providing antibiotics for a viral infection). But (I rely here on the medical experts) it seems that neither treatment is entirely futile. The BC might indeed prevent implantation, and on the other hand the fertility medications taken by both wife and husband have a good chance of producing a pregnancy. True, pregnancy is not (I believe) a plausible nor acceptable treatment-goal in itself, so if the woman is determined to have an abortion if the BC fails, the fertility treatment might, overall, be considered futile with relation to its proper goal, that is, having a baby. But in the case as presented there is no report of such determination (that is, that the wife would abort any resulting pregnancy); moreover, a change of heart over that is quite possible.

Is the wife behaving sensibly? In working on her body at cross purposes, is she acting in her own best interests—both in terms of her health and in terms of the convoluted relationship she is trying to sustain? My main response to this is that, with respect to the pharmacist's professional obligations, it does not really matter. Having made sure that both prescriptions together are safe and that neither is futile, it is not for him to oversee the woman's values or sensibility. Her autonomy means her right to make unwise, even self-defeating judgments and choices. As I have argued in other contexts, the healthcare system depends on a commitment to cooperate despite significant disagreements, at least with regard to assisting others in their actions (as distinct from a person being asked to act in person against his or her principles) (Zohar, 2003).

All this leads, obviously, to the most grievous issue: the wife's misleading of her husband, and her expectation that the pharmacist continue to take part in what amounts to cheating his client. I shall address this first in terms of confidentiality, and then in terms of direct complicity. The pharmacist has learned that the wife is misleading her husband, inducing him to take hormonal treatment—and to make all manner of personal and financial sacrifices—while working behind his back to reduce the chances for the outcome toward which he undergoes all that. The decent thing to do, in terms of common morality, would seem to be to tell the husband. If the wife is unwilling to level with her husband, is the pharmacist bound by professional morality to hold back from doing what is right?

In most cases, including those involving diagnosis of STD (and HIV status), I support a strict application of the duty of confidentiality, even if breaching it seems necessary to avert life-threatening eventualities. The main argument for this position—contrary to the famous Tarasoff ruling—was made cogently by Ken Kipnis: reneging on the promise (explicit or implicit) of confidentiality, or even qualifying it up-front, will lead prospective patients to refrain either from seeking treatment or from disclosing crucial information. This will prevent healthcare professionals from delivering effective care, and at the same time prevent them from attaining the kind of information that might help third parties at risk (Kipnis, 2006).

I suppose an argument can be made that the case at hand is different, since the wife could have continued obtaining her BC pills at other pharmacies, without letting her husband's pharmacist know of her subterfuge. Even so, the general threat to trust in healthcare is still a relevant consideration. We can, however, leave this knotty issue aside, because the question here goes well beyond that of confidentiality. That is, because what the wife is requesting of the pharmacist is not merely to keep her secret. He is in effect being asked to continue what he now knows to be active participation in defrauding a client.

Trust is a cornerstone of healthcare, but the imperatives of preserving trust and of being trustworthy cut both ways (Rhoades & Strain, 2000). The pharmacist's duty toward one of his clients cannot be leveraged into a requirement, or even permission, to cheat another client. Thus he cannot continue to fill the husband's prescription in the context of fertility treatment without warning him of his wife's countermeasures. Since there is no easy walk-away option, he will most likely have to explain his refusal to the husband. He might say only "I have learned of a problem involving your wife that makes

*Cont. on page 12*

it impossible for me to fill this prescription." But this will most probably lead to the wife's secret being revealed. For this, however, she cannot fault the pharmacist, as it was she who forced his hand by attempting, in effect, to draw him into her scheme as a co-conspirator.

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Zohar N., "Cooperation Despite Disagreement: From Politics to Healthcare," *Bioethics* 17(2) 2003, 121-141; Zohar N., "Moral Disagreement and Providing Emergency Contraception: A Pluralistic Alternative," *American Journal of Bioethics* 7(6) 2007, 35-36.

## RESPONSE FROM A PHARMACIST-ETHICIST

Dr. Zohar provided me an unearned benefit (a mitzvah perhaps?); I saw a draft of his analysis before I wrote this response. He has done the philosophical heavy lifting for the two of us, which I greatly appreciate. I can focus on certain facts of the case that I believe help resolve the pharmacist's angst and illuminate his options. My mentor, Albert Jonsen, contrasted philosophical ethics with practical judgment as differing mostly in perspective and compared them to viewing a road from a balloon versus a bicycle.[1] Valuable perspectives arise even in applied ethics from the "altitude" at which the ethicist views a case, and if Dr. Zohar has viewed this case from at or above a bicycle level, his commentary allows me to get down on my hands and knees.

First then, from an "earthy" view, I think it likely that the story told in this case is apocryphal. The physicians' responses—and the likelihood that two physicians would hold such cavalier attitudes—do not ring true, and the case omits many details that would be readily available in an actual instance. Apocryphal or not, I do believe that the case provides grist for the ethical mill.

Here are case-specific facts about in vitro fertilization (IVF) therapy[2] that a pharmacist should know or very easily discover. The husband (DH, or "darling husband" as he would be described in IVF chat rooms[3]), is apparently being treated for azoospermia. Depending on the underlying cause, his medications may vary, but all treatments expose him to known risks.

As to the wife (DW, in chat room parlance) and her drug therapy, fertility physicians frequently do prescribe birth control pills (BCPs)[4] in advance of the stimulation phase, partly to synchronize the woman's cycle. They then give gonadotropins[5] to stimulate maturation of follicles in her ovaries. Eventually, the fertility physician retrieves the mature follicles (a dozen, on average[6]), fertilizes in vitro the ova contained in them, and later transfers the fertilized ova to the uterus where, hopefully, they will implant and produce a pregnancy. Pregnancy appears to result in between 20% and 50% of IVF cycles.[7] During a normal pregnancy, the follicular remains become the corpus luteum and produces progesterone and estrogen necessary to maintain the pregnancy during the first few weeks. Retrieval removes the follicle from the ovary and no corpus luteum can form, so physicians providing IVF typically prescribe additional progesterone during the first few weeks. Some prescribe additional estrogen.

BCPs prevent pregnancy by suppressing endogenous gonadotropin production and thus preventing ovulation. However, of course, physicians administer exogenous gonadotropins in high doses during IVF cycles. The resulting successful follicular stimulation, oocyte retrieval, IVF, and transfer thwarts the mechanism of BCP action. Current evidence does not support persistent speculation that BCPs may interfere with implantation of a fertilized ovum.[8] The most salient fact related to this case is that it is far from certain that BCPs taken immediately before or after embryo transfer will actually interfere with the pregnancy. If DW persists with IVF therapy, she may very well become pregnant.

Another relevant feature of this case is the distinct possibility that DW was taking birth control pills secretly—at least without telling her husband—well before they started fertility therapy. Thus, she could well be quite fertile, which increases the likelihood she will become pregnant.

> ***"Pharmacists assume the same commitments to beneficence, nonmaleficence, and other prima facie duties as do nurses, physicians, or other health care providers. Here, physicians are initiators of therapy, with roles as risk assessors who evaluate risks, explain them to the patient, and obtain the patient's informed consent. The pharmacist is at the least a risk manager who must help minimize the impact of those risks and help assure proper use of the prescribed drugs."***

Pharmacists assume the same commitments to beneficence, nonmaleficence, and other prima facie duties as do nurses, physicians, or other health care providers. The pharmacist's role does differ somewhat from the physician's in this case. Here, physicians are initiators of therapy, with roles as risk assessors who evaluate risks, explain them to the patient, and obtain the patient's informed consent. The pharmacist is at the least a risk manager who must help minimize the impact of those risks and help assure proper use of the prescribed drugs. He or she must also assume a role as patient advocate.[9]

I agree that Dr. Zohar's question about confidentiality relating to the physician contacts would surprise most pharmacists. The formal codes of ethics of pharmacy have since 1852[10] required the pharmacist to discuss problems in the prescription with the prescriber. The contraindicated use of BCPs in pregnancy and their possible adverse interaction with gonadotropins presents the pharmacist with objective information demanding action. The pharmacist also must question continuing gonadotropin therapy when the patient does not actually desire to conceive. The risks of such therapy clearly outweigh any desired medical benefits. The two prescribers have clear interests in these matters. Under these circumstances, consulting with the physicians is de rigueur.

The pharmacist is right to worry about participating in a deceptive practice that poses both physical and financial risks to DH.[11] I mostly agree with Dr. Zohar: the pharmacist cannot reasonably agree to DW's request for confidentiality concerning her attempts to render her husband's treatment futile, if DW's conduct is actually likely to achieve such an end. A duty to maintain DW's confidentiality, like the duty to avoid deception and possible harm to DH, is a prima facie duty. In weighing what to do when prima facie duties conflict, I believe a Tarasoff-like analysis, based on likely physical harm to a third party, remains an appropriate balancing test for workaday ethics. However, the pharmacist can fairly conclude that DW's IVF therapy is as likely to be successful as any other IVF therapy, in spite of her use of BCPs. Thus, the pharmacist can go to sleep at night knowing that, in spite of DW's intentions, DH is not actually deceived about the likely results of his treatment and financial investment.

I do not think the analysis ends here, however, owing to the ultimate futility of DW's choices. She is deceiving her husband to keep the marriage together. She blames her husband for compelling her to undergo expensive, dangerous, and sometimes painful procedures that she does not actually want to experience. Has she made autonomous informed decisions, autonomous misinformed decisions, or is she acting under duress? Someone in her care team ought to be at least helping her face the reality that in the long run her marriage is not likely to succeed based on her present course of action.

The understanding that marriages and families are undermined by deceit and mistrust is not arcane to medical practice. Here, the pharmacist has the opportunity to help DW rethink her options. Unless he has clearly explained to DW why her strategy of taking BCPs is likely to fail on pharmacological grounds, he has not done the least that he should.

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1. Jonsen AR. Of balloons and bicycles: or, the relationship between ethical theory and practical judgment. *Hastings Cent Rep* 1991; 21(2):14-16.

2. The stated $10,000 cost per cycle virtually identifies this treatment as involving IVF.

3. See, e.g., http://www.inspire.com/groups/finding-a-resolution-for-infertility. These discussions among women seeking to conceive, and to help others through the process, often provide moving insights into the emotional, financial, therapeutic, and other stresses experienced by these families..

4. We do not know from this case whether the BCP being prescribed is a fixed combination pill, sequential estrogen-progrestin regimen, or a progestin-only pill. The latter appears even less likely than the first two to be effective contraception in this case.

5. Typical gonadotropins used in this therapy are recombinant DNA products providing lutenizing hormone (LH), follicle stimulating hormone (FSH), or human chorionic gonadotropin (hCG) activity.

6. Bromer JG, Cetinkaya MB, Arici A. Pretreatments before the induction of ovulation in assisted reproduction technologies: evidence-based medicine in 2007. *Ann NY Acad Sci* 2008; 1127:31-40.

7. See *supra* note 6.

8. Fincham JE, Harris CE, Fassett WE, Richards W. Over-the-counter availability of Plan B emergency contraception: further discussion and commentary. *Ann Pharmacother* 2005; 39:346-51.

9. Schulz RM, Brushwood DB. The pharmacist's role in patient care. *Hastings Cent Rep* 1991; 21(1):12-17.

10. Buerki RA, Vottero LD. *Ethical Responsibility in Pharmacy Practice*, 2nd ed. Madison, WI: American Institute of the History of Pharmacy; 2002. Code of Ethics of the American Pharmaceutical Association, 1852; pp. 193-4.

11. Since I also teach pharmacy law, I feel compelled to note that physicians and pharmacists who engage in deceptive business practices may be sued under a state consumer protection act, whether or not the treatment involved is negligently performed.

# CALENDAR OF EVENTS

## APRIL

**6** **18th Annual LHAS Medical Ethics Update and the 26th Annual Messer Lecture: "Reducing Obesity: Personal Responsibility or Social Policy?**" University of Pittsburgh School of Medicine, Scaife Hall, Auditorium 6, 3550 Terrace Street, Pittsburgh, PA. Visit http://ccehs.upmc.edu.

**7** (12-1 pm) **"Do Everything!" Truth-telling and Trust Building at the End of Life**. Richard Payne, MD, Duke Divinity School. Annual Shallenberger Lecture in Ethics. Johns Hopkins Hospital, 600 N. Wolfe St., Baltimore, MD, Hurd Hall. Contact: Sharon Mears (410-955-0620, smears@jhmi.edu).

**7** (8 am–4 pm) **Professionalism: Actualizing Values in Clinical Practice and Organizational Base**. Presented by Patricia O'Donnell, PhD, LICSW from Inova Health System Center for Ethics & Inova Learning Network, Inova Fair Oaks Hospital, Medical Plaza Building, 3700 Joseph Siewick Drive, Auditorium, Fairfax, Virginia. To register call Inova Teleservices at 703-750-8843. For more information contact Patti O'Donnell, PhD, Director, Center for Ethics, Inova Health System at 703-321-2658 or patricia.o'donnell@inova.org.

**13** (4 pm) **Why Do Patients Volunteer for Risky Research Studies? Rethinking Informed Consent, Again**. Speaker: Scott Kim, MD, PhD, Associate Professor, Department of Psychiatry Bioethics Program Center, University of Michigan. 3401 Market St., Room 331, Philadelphia, PA 19104, Tel: 215-898-7136. RSVP to clinksca@mail.med.upenn.edu or call the Center for Bioethics at 215-898-7136. For more information visit http://www.bioethics.upenn.edu/colloquium/.

**14** (5:45–8:00 pm) **Talking with Patients About End of Life Issues: Balancing Honesty, Compassion and Hope**. Presented by Inova Fairfax Hospital Ethics Committee, Inova Fairfax Hospital, Cyrus Vesuna Auditorium Physicians Conference Center, Falls Church, VA. To register call 703-750-8800.

**14** (5:30pm- 6:30pm) **Care of an Unresponsive Patient With A Poor Prognosis**. Bioethics Forum Presented by the Ethics Committee of Shady Grove Adventist Hospital: Discussion of New England Journal of Medicine Article: NEJM 360:5:527-531. The NEJM article may be downloaded from the SGAH Ethics Committee website's Calendar page (www.sgahethics.org/calendar.html). Willow Room, Shady Grove Adventist Hospital, 9901 Medical Center Drive, Rockville, MD 20850, 240-826-6000. For more information, contact Paul S. Van Nice, MD, PhD, MA Chairman, Ethics Committee (paul@vannice.com, 301-509-2225).

**22** **Palliative Care Skills for Nursing Home Personnel**, Sponsored by the West Virginia Network of Ethics Committees and West Virginia University. Tamarack Conference Center, Beckley, WV. Visit http://wvnec.org/calendar_of_events for more information, or call 1-877-209-8086.

**23** **A Time to Choose, A Time to Listen**. Rabbi Dayle Friedman will speak about end-of-life decision-making at the Jewish Community Center of Northern Virginia. Sponsored by The Hebrew Home of Greater Washington. Visit http://www.hebrew-home.org/site/PageServer, or contact jmichaels@hebrew-home.org, 301-816-7711.

**23** (7:45 am–12:00 pm) **Communication: the Key to Resolving Conflict and Ethical Dilemmas**. Harbor Hospital, Baltimore, MD, Baum Auditorium. To register, call 410-350-3506 by April 17. For more information, contact Sally Lewis at 410-350-8218 or Linda Grskovich at 410-350-7794.

**24** **Palliative Care Skills for Nursing Home Personnel**, Sponsored by the West Virginia Network of Ethics Committees and West Virginia University. Bridgeport Conference Center, Bridgeport, WV. Visit http://wvnec.org/calendar_of_events for more information, or call 1-877-209-8086.

**27** (12:15 pm) **The Berman Institute of Bioethics Seminar Series** presents Thomas Pogge, PhD, Professorial Fellow, Centre for Applied Philosophy and Public Ethics at the Australian National University, Professor of Political Science, Columbia University, Research Director, Centre for the Study of Mind in Nature, University of Oslo. 615 N. Wolfe St, Baltimore, MD, Room W4030. For more information contact Erin McDonald at elmcdona@jhsph.edu.

**29** (4:30 pm) **Bioethics in Space: Thorny Ethical Issues at NASA**. Speaker Paul Root Wolpe, Director, Center for Ethics, Emory University; bioethics advisor to NASA. Sponsored by the Bioethics Student Association. UMBC, Catonsville, MD. Albin O. Kuhn Library, 7th Floor. Visit: http://www.umbc.edu/socsforum/.

## MAY

**11** (12:15 pm) **The Berman Institute of Bioethics Seminar Series** presents Norman Daniels, PhD, Mary B. Saltonstall Professor of Population Ethics and Professor of Ethics and Population Health, Harvard School of Public Health. 615 N. Wolfe St, Baltimore, MD, Room Located at W4030. For more information contact Erin McDonald at elmcdona@jhsph.edu.

**12** (8 am–4 pm) **Complex Communication Issues in Clinical Practice: Ethical Obligations and Legal Regulations**. Presented by Patricia O'Donnell, PhD, LICSW from Inova Health System Center for Ethics & Inova Learning Network, Inova Fair Oaks Hospital, Medical Plaza Bldg, 3700 Joseph Siewick Drive, Auditorium, Fairfax, Virginia. To register call Inova Teleservices at 703-750-8843. Contact: Patti O'Donnell, PhD, 703-321-2658 (phone) or patricia.o'donnell@inova.org.

**14** (4 pm) **Bioethics Colloquium Series Lecture**: The University of Pennsylvania Center for Bioethics presents a lecture by Ruth Macklin, PhD, Professor of Bioethics, Epidemiology and Population Health, Albert Einstein College of Medicine. 3401 Market St., Room 331, Philadelphia, PA 19104, Tel: 215-898-7136. RSVP to clinksca@mail.med.upenn.edu or call the Center for Bioethics at 215-898-7136. For more information visit http://www.bioethics.upenn.edu/colloquium/

**15** **Communication Skills for End-of-Life Care**, Sponsored by the West Virginia Network of Ethics Committees. Stonewall Resort, Roanoke, WV. Visit http://wvnec.org/calendar_of_events for more information, or call 1-877-209-8086.

**28** (8:30 am) **The Growth and Development of Pediatric Palliative Care**. Speaker Brian Carter, MD. Pediatric Palliative Care Grand Rounds at the University of Maryland Medical Center Auditorium, 22 S. Greene St., Baltimore, MD. Contact: DHARNESS@umm.edu..

## JUNE

**1-5** **Bioethics: Beyond the Sound Bite**. Intensive Bioethics Course, Georgetown University. Washington, D.C. Contact 202-687-8099, schofies@georgetown.edu.

**17-19** **Harvard Bioethics Course**. Sponsored by the Division of Medical Ethics, Harvard Medical School (HMS), Boston, MA. http://medethics.med.harvard.edu/education.

## JULY

**13-16** **Ethics from Boardroom to Bedside**. Clinical Ethics Summer Institute, Hamilton Health Sciences, Hamilton, Ontario (Canada). Visit http://www.clinicalethics.ca.

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