

*Health Care Law*

*Mid-Atlantic Ethics Committee Newsletter*

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Mid-Atlantic Ethics Committee  
Newsletter, Spring-Summer 2011

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# MID-ATLANTIC ETHICS COMMITTEE

## NEWSLETTER

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

Spring/Summer 2011

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### BEYOND ETHICS CONSULTATION

Ethics committees traditionally provide a triad of services that include ethics consultation, policy development and review, and ethics education. These services have evolved, in large part, to address the many questions and dilemmas brought by new medical technologies such as mechanical ventilation, cardiopulmonary resuscitation, organ dialysis and transplantation, and artificial reproductive technologies, to name a few. Much of the training for ethics committee members has focused on ethics case consultation. This is not surprising, as ethics committee review of individual cases has been recommended by judicial opinions, and mandated by state laws (including Maryland's Health Care Decisions Act and Patient Care Advisory Committee Act) and the Joint Commission's accreditation standards. While many would agree that ethics consultation provided by qualified individuals is a valuable service that should be available in health care facilities, some have questioned whether there has been too much focus on ethics case consultation at the expense of other health care ethics services.

The conference, "Ethics Consultation and Beyond: A Primer for Ethics Committee Members," held at Harbor Hospital on June 29, 2011 and co-sponsored by MHECN, Harbor Hospital, and the Center for Ethics at Washington Hospital Center, focused on this broader range of services, in addition to case consultation. These services included proactive (also called "preventive") ethics initiatives and

quality improvement (QI) activities.

Much of the ethics education provided by ethics committees falls in this category of proactive ethics. The goal is to improve the knowledge and skills of health care staff so they can identify ethical issues, resolve basic ethical questions and conflicts, and know when and how to ask for help. Brian Childs, PhD, Director of Ethics at Shore Health System in Easton, Maryland and participant in the "Proactive Ethics Applied" panel at the June 29 conference, described how he provides formal ethics education to new clinical staff at Shore Health. Fellow panelist Robert Shabanowitz, PhD, Director of the ART/Andrology Laboratory and Chairman of the Bioethics Review and Advisory Committee at Geisinger Medical Center, shared educational resources that Geisinger's ethics committee provides online (<http://www.geisinger.org/professionals/services/bioethics/>). Dr. Shabanowitz raised a key concept—like ethics consultation, proactive ethics services should also be evaluated to determine if those services are achieving their identified goal. For example, he evaluated the number of hits different components of their bioethics web page received to know whether their educational offerings were being accessed.

A more formal approach to proactive ethics is found in QI activities. QI refers to the process of evaluating service quality, identifying quality gaps and goals to address the gaps, implementing systems or processes to achieve identified goals,

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*Editor*

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is not intended to provide legal  
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acted upon without consulting an  
attorney.**

***Ethics Consultation***  
*Cont. from page 1*

and re-evaluating whether identified goals were met. Proactive activities come into play in the step where systems and processes are identified to address a quality gap, such as a systemic source of recurring ethics consultations. Carol Taylor, RN, PhD, senior research scholar at the Kennedy Institute of Ethics, and professor in the Department of Medicine and in the School of Nursing and Health Studies at Georgetown University, addressed this topic at the June 29 conference. She provided three examples of quality gaps identified through ethics case consultations and how to address them at the organizational level. These included a “problem physician,” patients “not dying well,” and provision of non-beneficial treatment causing moral distress among staff.

The QI approach is consistent with the IntegratedEthics resources developed by the Veterans Affairs National Center for Ethics in Health Care, which identify three components

of ethics quality in health care: particular decisions and actions that are facilitated by ethics consultation (Fox, Berkowitz & Chanko, 2006), systems and processes that are facilitated by preventive ethics activities (Fox, Bottrell, Foglia & Stoeckle, 2006), and ethics environment and culture that is facilitated by ethics leadership (Fox, Crigger, Bottrell & Bauck, 2006). Preventive ethics involves the same steps applied in QI: identifying ethics quality gaps and the upstream systems and processes that contributed to or sustained the gaps, and intervening to minimize these gaps.

For example, consider that your ethics consultation service has handled repeated consultation requests from a renal dialysis center affiliated with your facility. A prior initiative to increase advance directive completion rates was successful, so the majority of patients have an advance directive on record. However, the documents are not routinely updated, and so there have been instances where patients communicated

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

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

informally to dialysis center staff that they wanted limits placed on the use of technology to prolong their life, but because this was not reflected in their written advance directive or witnessed as an oral directive, staff are uncertain how to proceed when the patient loses decision-making capacity. The quality ethics gap in this case could be framed as follows: “As confirmed by chart audit, 42% of the advance directives of dialysis patients are not updated annually or after a significant change in the patient’s health status, making it unclear if the document reflects current preferences.” A goal to address the gap could be: “Increase the percent of advance directives of dialysis patients that are updated annually or after a significant change in health status from 58% to 90% by [date]” (adapted from Foglia & Fox, 2010). The next steps would be to identify and implement process measures to achieve the goal, choose an appropriate outcome measure (e.g., % updated advance directives), and evaluate whether the goal was met.

Evan DeRenzo, PhD, Senior Clinical Bioethicist with the Center for Ethics at Washington Hospital Center (WHC), and Christina Emrich, RN, MS, Assistant Director for Quality at WHC, gave two examples of process measures that were implemented at WHC in response to an identified ethics quality gap involving staff not recognizing an ethical issue before it developed into a more intractable ethical conflict. Such conflicts impeded the ethical climate of the organization and the staff’s ability to provide excellent patient care. The process measures that were implemented served to educate and empower staff members to identify and address ethical issues earlier in the course of a patient’s care trajectory. They were: (1) clinical ethicists joining “working rounds” in the intensive care unit (ICU) to help address ethical issues earlier in order to avoid future conflicts, dilemmas, or moral distress later; and (2) a clinical

ethicist joining “interdisciplinary rounds” in the ICU, which focus on patient care coordination through in-depth discussion of complex patients, allowing ethical issues to be integrated into the patient’s plan of care. These interventions also demonstrate an effective approach to informal ethics education within an institution—similar to the type of ethics education that should occur during ethics case consultations. As pointed out above, effective ethics education is a proactive ethics service that should be part of a health care institution’s broader ethics program.

Another example of a measure to provide incentive for health care personnel to take action to “do the right thing” (i.e., implement ethically appropriate actions) is the John J. Lynch, MD, Moral Courage Awards established by WHC. These are separate awards to honor all categories of personnel at WHC who demonstrate moral courage, enhancing WHC’s culture by shining a light on the value that a “pro-ethics” environment brings to a health care institution. This underscores the importance of effective ethics champions and leaders in the institution.

MaryLou Lewis, MD, MA, Clinical Ethicist at Charleston Area Medical Center (CAMC) in West Virginia, spoke at the June 29 conference on how to obtain buy-in from institutional leaders to support ethics programs in health care organizations. Actually, Dr. Lewis prefers the term “systems” over “organization,” as the former conveys how parts of an organization combine to form a complex and unitary whole, which is the focus of systems ethics. Indeed, CAMC has a “systems ethics subcommittee” as part of its ethics program. Its mission is to address the ethical issues arising between internal hospital programs and departments within the clinical setting. Dr. Lewis gave practical suggestions for how to get institutional support for ethics services (see box on p. 4).

What is needed at any health care institution are qualified individuals to advocate for and sustain an ethics program that provides effective ethics consultation, education, systems ethics, and QI activities to ensure quality across the board. Leadership buy-in and at least one qualified “ethics champion” are essential.

*Anita J. Tarzian, PhD, RN  
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## HOW TO “SELL” AN ETHICS PROGRAM

### *Why is an Effective Ethics Program of Value?*

- Improves the tone and atmosphere for the delivery of superior patient care.
- Allows for the development of appropriate institutional policies.
- Provides a forum for the discussion of ethical issues that affect services as they arise within and outside of the institution.
- Raises ethical consciousness at all levels of the institution, which fosters a patient-centered and caring environment.
- Addresses moral distress among staff, which affects job satisfaction, productivity, and quality of care provided.
- Allows for the development of appropriate services and policies which protect the rights and responsibilities of both patient and health care providers.
- Adds to the “bottom line.”
- Raises safety issues, which are ethical issues.
- Identifies issues for risk management.
- Addresses new ethical issues arising due to new medical technology and scarce medical resources.
- Provides a good community liaison if community members participate.

### *Ways to Gain Institutional Support*

- Communicate your values, mission and goals through a mission statement, purpose and responsibilities. Educate, educate, educate.
- Request an opportunity to attend other meetings within your institution, e.g., performance improvement, quality, mortality, departmental. Contribute practical solutions. Volunteer.
- Document activities, achievements, educational events, and services provided. Make it a part of the annual report to the quality committee of the Board of Trustees.
- Develop a job description and reporting mechanism for the ethicist or support person.
- Develop a business plan with a budget and justification.
- Share your vision with the chief executive officer, chief operating officer, quality and compliance officers. Discuss “their” problems and offer assistance. Show how ethics services can decrease hospital length-of-stay while improving quality of care, and resolve conflict.

### *Core Essentials of an Ethics Champion*

- Be a Visionary: a person of unusually keen foresight. Present a vision of an ethics *program*, not just an ethics *committee*.
- Be a Communicator. Learn to express your ideas clearly and to listen equally.
- Be Tenacious and Patient (i.e., Persevere). Maintain the ethics program concept.
- Be a low key Salesperson. Be willing to talk to anyone, anytime, about the program.

### **MaryLou Lewis, MD, MA**

*Clinical Ethicist, Charleston Area Medical Center  
Charleston, West Virginia*

From: *How to “Sell” Ethics in Hard Times*, Invited talk at “Ethics Consultation & Beyond: A Primer for Ethics Committee Members” held at Harbor Hospital, Baltimore, MD on June 29, 2011.

# TEN THINGS HEALTH CARE PROFESSIONALS SHOULD KNOW ABOUT MARYLAND MOLST

*On May 19, 2011, Governor Martin O'Malley signed House Bill 82 into law, which recognizes the "Medical Orders for Life-Sustaining Treatment" (MOLST) form as a medical order form containing a patient's preferences for treatment based on the patient's current conditions and wishes. The Department's initial plan aimed for implementation of this form on October 1, 2011. However, the period for public comment was extended. Check the web link at the bottom of this page for updates.*

1. Maryland MOLST is a portable and enduring medical order form signed by a physician or nurse practitioner. It contains orders about cardiopulmonary resuscitation and other life-sustaining treatments. The Department's initial plan aimed for implementation of this form on October 1, 2011. However, the period for public comment was extended. Check the web link at the bottom of this page for updates.
2. MOLST orders are based on an informed discussion with a patient or authorized decision maker, a patient's advance directive, or the determination of medical ineffectiveness. If the patient or authorized decision maker has not limited [medical] care, except as otherwise provided by law, CPR will be attempted and other treatments will be given. A patient has the right to decline to discuss these topics.
3. MOLST helps to ensure that a patient's wishes to receive or decline care are honored throughout the health care system. In every section of the order form, there are options to accept all medically indicated treatments or to limit interventions.
4. A copy of a completed MOLST form shall be given to the patient or authorized decision maker within 48 hours of completion or sooner if the patient is discharged or transferred.
5. MOLST replaces the Maryland EMS DNR order form and the Life-Sustaining Treatment Options form that were previously used, primarily in nursing homes. The original, a copy, and a faxed MOLST form are all valid orders.
6. Beginning October 1, 2011, MOLST must be completed for all individuals admitted to nursing homes, assisted living programs, hospices, home health agencies, and dialysis centers and for certain individuals admitted to hospitals. The form must also be completed for anyone who wants limitations on CPR or life-sustaining treatments in any setting.
7. Any individual who has the capacity to make decisions may request that their physician or nurse practitioner complete the MOLST form for them.
8. Even if the practitioner who signs the MOLST form is not on a facility's medical staff, the MOLST form is valid. MOLST orders are valid for EMS providers and for all health care professionals, providers, facilities, and programs across Maryland.
9. MOLST does not change the Health Care Decisions Act or an individual's advance directive. It does not change who has the legal authority to make decisions on behalf of an individual who lacks the capacity to make health care decisions.
10. Orders on the MOLST form do not expire, but may be revised. To make sure the orders accurately reflect the patient's current wishes, it must be reviewed annually. It must also be reviewed whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.

*These, along with other educational resources, are provided by the Maryland Department of Health and Mental Hygiene at <http://dhmh.maryland.gov/marylandmolst>.*

## ETHICS EDUCATION AVAILABLE VIA PODCAST

The use of technology as an educational tool has been increasing in popularity since the 1990s. Learners of all types find education via mixed media valuable and interesting. In 2010, Dr. David Perlman from the University of Pennsylvania School of Nursing developed the Bioethics 2.0™ podcast series. These podcasts were grant funded and are freely available to the public through <http://www.bioethics2.net> and iTunes University. The 14 podcasts cover a variety of the most common issues in medical ethics, including:

- Introduction to ethical theory
- Reasons and values in bioethics
- Clinical pragmatism framework
- Health law and clinical ethics
- Privacy and confidentiality
- Informed consent
- Death and dying
- Pediatrics

Each podcast begins with learning objectives and then gives a citation as to where the section of the podcast was taken. The two main texts drawn from in these podcasts are Fletcher's *Introduction to Clinical Ethics* and Schroeter's *Practical Ethics for Nursing Students: A Short Reference Manual*.

The podcast series was originally designed as a supplement to classroom learning for Dr. Perlman's undergraduate nursing students, but he quickly realized that by making the podcasts available free of charge to anyone, people who serve on ethics committees might find them equally useful. As Dr. Perlman commented at his talk, "Strategies for Training Ethics Committee Members" at the June 29 conference at Harbor Hospital (see article on p. 1), the literature shows that frequently there is inadequate funding to educate ethics committee members and that such education varies greatly in quality and quantity. The Bioethics 2.0™ Podcasts are designed to bridge this gap. Dr. Perlman hopes to develop an eBook on this topic, which will be available in the Bioethics 2.0 Amazon.com Store.

Dr. Perlman's podcasts exemplify the increased flexibility in the mediums used for education available to learners today.

*Kathryn G. Murphy*  
*David Perlman, PhD*

## CASE PRESENTATION

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

### CASE STUDY FROM A MARYLAND HOSPITAL

**A**n 89 year old man, D.S., is admitted to the Emergency Department for trauma from a self-inflicted gunshot wound to the head. About three months earlier, he was diagnosed with Progressive

Supranuclear Palsy, a degenerative neurological condition often confused with Parkinson's that affects balance, among other things, leading to falls. The patient was treated for a shoulder fracture from a fall and then insisted on going back to his home. He was used to taking his daily walks and

being independent. According to his 82 year old brother, who was also his designated health care agent, D.S. was always very independent and resisted help from others. He has no living children or spouse. He has no living will.

He is transferred from the ED to the

ICU and maintained on a ventilator with other life support measures in place. His prognosis for surviving is uncertain, but if he does survive, he would require intensive rehabilitation and would most likely have substantial cognitive and physical impairments. His brother requests that life support be removed and a Do-Not-Attempt-Resuscitation (DNAR) order be written, arguing that his brother was fiercely independent and had lived his life and was now ready to die. The ICU staff call for an ethics consultation because some staff are concerned that if they remove life support, they will be complicit in the patient's suicide.

### **RESPONSE FROM A PHYSICIAN & ETHICS COMMITTEE CHAIR**

This case is difficult to discuss because it involves a voluntary act that some people believe to be socially and/or ethically unacceptable, that is, suicide. Suicide is unimaginable for many of us, but there are times when even the most staunch critic of suicide has to pause, as when people jumped to their death from the windows of the World Trade Center in 2001. In addition, there is a widespread belief and established tradition that physicians or health care providers should never contribute to an activity that is non-benevolent, such as interrogation, homicide or suicide. Suicide is a polarizing subject, somewhat like abortion, and it is hard to discuss such matters without personal involvement.

Suicide also involves, to the ultimate degree, the "A-Word," autonomy; and suicide may actually be the most extreme instance of autonomous action. When an autonomous individual makes a very genuine attempt to take his own life he makes an extremely strong statement about his most deeply held wishes.

It goes without saying that any medical center would mount a full resuscitative effort when a patient like D.S. arrives at the ED. After all, this is

the purpose of the ED unit, to provide immediate care for patients who are seriously sick or wounded. However, when the younger brother arrives, and he is verified to be the designated health care agent (and it is important to examine the document, which needs to have two signed witnesses), the "stage" is reset, and autonomy again takes a major role.

Under the Maryland Health Care Decisions Act, a health care agent appointed in writing by a patient has considerably more power as a decision-maker than a surrogate decision-maker. A surrogate decision-maker cannot decide to withdraw life support unless the patient has been declared to be either end-stage, terminal or in a persistent vegetative state, but the health care agent has no such restrictions. Just as a competent patient can do, a health care agent can decide to forego intensive care if he or she feels that the patient would not desire such care. This authority of the healthcare agent is spelled out in Maryland HG §5-602; surrogate decision makers have significantly restricted powers regarding the authorization of withdrawal of life-sustaining care, as described in Maryland HG §5-606.

Often health care agents are named in a document that provides some general guidelines for decision-making, but in this case there is no such document that we know of. Such accompanying documents are desirable and should reflect the general attitudes and preferences of the patient, without being too restrictive. The information contained in such documents is not only helpful to the agent, but it is also helpful to health care providers who may want some supportive information to ensure that the agent is following the patient's wishes.

Because there is no written confirmation of R.S.'s views, we have to rely on the credibility of the agent, and the brother's statements about the patient sound very plausible. Since

the patient, if he survives this period of intensive care, would very likely have massive disabilities, and since the agent is making a decision to withdraw life-sustaining care that is clearly consistent with what the patient himself would want if he could speak, it seems ethically acceptable that the patient should be declared DNAR and the ventilator turned off. This is a very reasonable example of respect for individual autonomy.

What if the brother were not the health care agent, but rather the only sibling and only surrogate? Of course, the case would be entirely different because, under the Health Care Decisions Act, the brother would not have legal authority to consent to withdrawing life-sustaining treatment (unless the patient became end-stage or terminal). However, a DNAR order might still be in the patient's best interest, given the grim prognosis. It would also be legally appropriate because, by definition, the patient would be terminal if he were to arrest (Schwartz, 1999).

As an aside, just to illustrate how the case of D.S. might proceed if the caregivers were to refuse to honor the instructions of the health care agent, a recent ethics consult at my institution concerned a patient admitted to the ED with altered mental status and sepsis as the result of extremely poor personal care and substance abuse. He was also morbidly obese, had prior myocardial infarctions and had a long history of refusing medical care. The patient had no advance directive and no living family members. The patient was not considered to be in either an end-stage or terminal condition. A friend, who knew him well for 42 years, stated that the patient wanted to die and that he would not want the intensive care that he was receiving. The friend's testimony was entirely convincing, but because the Health Care Decisions Act was seen as limiting his authority to

*Cont. on page 8*



## Case Presentation

Cont. from page 7

withdraw life-sustaining treatment, the patient proceeded to get a tracheostomy and a percutaneous gastric feeding tube, with the friend's consent, and the patient was eventually placed in a long-term care facility. I don't think that any of the healthcare providers or ethics consultants involved in this case were comfortable with the outcome, but the absence of clear legal authority for the friend to decline these interventions seemed to preclude a more palliative approach.

Even though the case of D.S. may appear straightforward from a legal perspective, it is still ethically charged: the ICU staff is understandably upset about their possible complicity in a "suicide" of a patient under their care. Perhaps there are two components to this "concern:" 1) professional ethics and 2) personal difficulties with moral subjectivity.

The AMA Code of Medical Ethics regards physician-assisted suicide as "fundamentally incompatible with the physician's role as healer" (AMA Code of Medical Ethics, Opinion 2.211). Physicians might regard withdrawing life-sustaining care in a situation where the patient is neither end-stage nor terminal as assisting in a suicide, and this professional discomfort may trump their concerns for patient autonomy. Further, the Maryland Healthcare Decisions Act states in §5-611 that "nothing in this subtitle may be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be ethically inappropriate." This would support not compelling health care providers to withholding life-sustaining treatment from D.S. if they consider this to be assisting with a suicide. Similarly, the American Nurses Association's Code of Ethics states that "nurses may not act with the sole intent of ending a patient's

life even though such action may be motivated by compassion, respect for patient autonomy and quality of life considerations" (ANA Code of Ethics for Nurses, Provision 1.3).

Secondly, the healthcare providers may simply be experiencing personal difficulty with "moral subjectivity," as discussed by Mark Repenshek (2010) in a recent MAEC newsletter. Even if D.S.'s physicians and nurses are comfortable with the brother's authority as the designated health agent, they don't have to be comfortable with his decision.

No matter what the outcome of this case, there needs to be one or more meetings between ethics committee consultants and the concerned personnel in the ICU in order to work through the various bioethical and legal issues.

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*The author acknowledges the suggestions of Carol Chandler, RN, and Sigrid Haines, JD, regarding some aspects of the above article.*

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## RESPONSE FROM A STAFF PHYSICIAN

*The following commentary was written in response to a different, but similar, case: Bartlett, VL, Killu, C, Finder, S, & Hackner, D (2010). Clinical Ethics in the ICU: A Case of Attempted Suicide. ICU Director, 1(6), 312-317. It is reprinted here with permission.*

Suicide victims present an ethical dilemma to the medical community. The dilemma rises when a patient committing suicide is in the hands of physicians who face two contrasting decisions of life and death and whether to treat or not. This dilemma is especially challenging when complicated by autonomy and the "right to die." The challenge becomes even larger when decisional capacity of the suicidal person is questioned or the patient temporarily lacks capacity. Even in the situation of attempted suicide, the cornerstones of assessment are founded on medical ethics and the four moral principles familiar to clinicians: respect for autonomy, nonmaleficence, beneficence, and (distributive) justice (Beauchamp & Childress, 2001). These principles are guideposts for clinicians in their practice and conduct in such difficult cases. Autonomy deals with respect for individual self-determination and calls for respect, dignity, and choice for all suicidal patients. But beneficence calls for doing the greatest good possible, and physicians must not discard this moral principle for a seemingly "autonomous" choice when a patient who has attempted suicide was acting irrationally and indeed without capacity. While nonmaleficence calls for minimizing and preventing harm, physicians must strive to protect their patients, especially in a situation where the physician's act will cause harm, to avoid doing harm. The challenge here is what does the patient construe as benefit and harm? Finally,

distributive justice would ask us to establish principles that are broadly and fairly applicable.

Is it fair to treat one patient differently from another simply because of a bias regarding suicide? Suicide is considered an irrational act, and the assistance of a patient's suicidal wishes prior to committing suicide is generally accepted as irrational and illegal. However, there is indeed support in some societies for physician-assisted suicide, even giving rise to the "suicide tourist" (PBS Frontline, 2010). In most cultures, actively assisting suicide has been rejected, and the code of ethics, for example, from the American Medical Association states that "Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks" (AMA, 1992). The argument is both from the standpoint of nonmaleficence as well as distributive justice. In most societies, suicide completes only when a patient dies without medical treatment, before reaching a hospital, or as a result of massive, untreatable injuries. The case of an uncompleted suicide poses a dilemma for clinicians.

When a patient seeks medical attention himself or is brought to a hospital by a health proxy, the implication is that this is a patient needing assistance. Most cases of attempted suicide seen in the emergency department are suicide "gestures" with entirely different motives than the carefully planning "suicide tourist." Thirty percent to 80% of suicide attempts are impulsive and related to self-limiting crises such as a break up of a romantic relationship, loss of a job, or criminal justice encounter (Simon, Swann, & Powell, 2001). Furthermore, 90% of persons who survive a suicide attempt, wheth-

er intended as a gesture or as a lethal act, survive to die by other natural and accidental causes (Id.) Most patients in such circumstances do not necessarily seek to end their lives but perhaps to change their lives; they are looking for help and not to be abandoned. Even among older adults aged 65 years and above, there are approximately four suicide attempts for every completed suicides (Suominen, et al., 2004; Gaynes, et al., 2004). Attempted suicide patients most frequently need help, mentally and physically, and they do not access the care they need, sometimes seeking it in the form of a suicide attempt or perhaps abandoning help they think is not available. Would we hesitate to pull an individual away from an oncoming train in a last minute change of mind? Even if we make a distinction between two broad categories of suicide attempts, the long-term, volitional planning of a death and the sporadic attempted suicide, when a patient presents for medical care with an uncompleted suicide, it is my opinion that there should be no dilemma or conflict. The most challenging scenario arises from the case of a patient who is brought to the hospital against [his] stated wishes and acts of planning to avoid medical care.

The principal act of a physician is to preserve life, but increasingly, we define life in both biological and functional terms. Surely, complex life and death decisions, especially in cases of attempted suicide ... should not be treated lightly. We should remind ourselves of the language of the Hippocratic Oath (1964, Louis Lasagna): "Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty.

Above all, I must not play at God." Such cases can produce moral distress for care givers. Hence, the team admitting their bias to treat should carefully deliberate with the assistance of a neutral agency such as an ethics team.

*Claude Killu MD  
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## REFERENCES

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- Suominen K, Isometsä E, Suokas J, et al. (2004). "Completed Suicide After a Suicide Attempt: A 37-Year Follow-Up Study." *Am J Psychiatry* 161:562-563.

# CALENDAR OF EVENTS

## SEPTEMBER

### 26 (12:15-1:30 PM)

Noon Seminar Series on Values and Health: Global and Local Perspectives. Speaker: Robert Klitzman, MD, Associate Professor of Clinical Psychiatry at the Columbia University College of Physicians and Surgeons and the Mailman School of Public Health. Sponsored by the Berman Institute of Bioethics Seminar Series. Johns Hopkins University, 615 N Wolfe St, W3008. For more information/to register, visit <http://www.bioethicsinstitute.org>, or contact Michelle Martin-Daniels at [michellemd@jhu.edu](mailto:michellemd@jhu.edu).

## OCTOBER

### 10 (12:15-1:30 PM)

Noon Seminar Series on Values and Health: Global and Local Perspectives. Speakers: Ruth Macklin, PhD, Professor, Department of Epidemiology & Population Health; Dr. Shoshanah Trachtenberg, Frackman Faculty Scholar in Biomedical Ethics, Albert Einstein College of Medicine of Yeshiva University. For more information, visit <http://www.bioethicsinstitute.org/> for title of talks. Sponsored by the Berman Institute of Bioethics Seminar Series, Johns Hopkins University. (See September 26 for location/contact details).

### 12 (5:30-7:30 PM)

Ethics in the Age of the Internet. Presenter: Patti O'Donnell, PhD, LICSW, Director, Center for Ethics, Inova Health System. Inova Fairfax Hospital, Physician Conference Center, Lower Level, Rooms A and C, 3300 Gallows Road, Falls Church, VA. Contact Patti O'Donnell to register, at [Patricia.o'donnell@inova.org](mailto:Patricia.o'donnell@inova.org) or 703-289-7592.

### 13 (3 p.m. – 4:30 p.m. followed by a reception)

Palliative Care: A Bridge of Compassion between Curing and Caring (as told through poetry, plays and prose), Presented by Vivienne Shub, resident member of Everyman Theater, Written by Naomi Greenberg, Dramaturg for Everyman Theater. University of Maryland, Baltimore School of Pharmacy Auditorium, 20 North Pine St., Baltimore, MD. Sponsored by the UMB Geriatrics and Gerontology Education and Research Program. RSVP by October 10 to Reba Cornman, [rcornman@umaryland.edu](mailto:rcornman@umaryland.edu).

### 13-16

American Society for Bioethics & Humanities 13th Annual Meeting, Hyatt Minneapolis, Minneapolis, MN. For more information, visit <http://www.asbh.org>.

### 19 (5:30-7:30 PM)

Ethical Guidelines for Initiating and Discontinuing Dialysis. Presenter: David Mahoney, MD, Medical Staff, Inova Fairfax Hospital. (See October 12 location/contact details.)

### 27-28

Conflicts of Interest in the Practice of Medicine: A National Symposium. American Society of Law, Medicine & Ethics. The University Club, University of Pittsburgh, Pittsburgh, PA. For more information, visit: <http://www.aslme.org/Calendar>.

## NOVEMBER

### 2 (5:30-7:30 PM)

The Physicians Order Set for Life Sustaining Treatment (POLST): An Aid to Goals of Care Planning. Presenter: Kristen Smith, MSN, RN, MSW, Palliative Care Liaison, Dept of Care Management, Inova Health System. (See October 12 location/contact details.)

### 3-5

Ethics Consultation Boot Camp, Sponsored by the Provincial Health Ethics Network (PHEN), Banff, Alberta, Canada. For more information, visit <http://www.phen.ab.ca/bootcamp/index.asp>.

# CALENDAR OF EVENTS *(cont'd)*

## **7 (8A-12N)**

Moral Agency and Moral Distress, Carol Taylor, PhD, RN, Georgetown University Center for Clinical Bioethics. Sponsored by the Center for Ethics and Professional Practice, Inova Health System. Inova Fairfax Hospital, Physicians Conference Center Auditorium, Fairfax, VA. Contact Patti O'Donnell to register, at [Patricia.o'donnell@inova.org](mailto:Patricia.o'donnell@inova.org) or 703-289-7592.

## **10-11**

Research Ethics: RE-Examining Key Concerns. Benson Center, Wake Forest University, Winston-Salem, NC. For more information, visit <http://bioethics.wfu.edu/>.

## **11**

Practice and Profession. Sponsored by the Program on Medicine and Religion at the University of Chicago. This symposium will explore what it would mean to set the practice of medicine in the context of a good and faithful life. For more information, visit <https://pmr.uchicago.edu/events>.

## **11 (12:15-1:30 PM)**

Noon Seminar Series on Values and Health: Global and Local Perspectives. Speaker: Christine Grady, MSN, PHD- Acting Chief, Department of Bioethics; Head, Section on Human Subjects Research. For more information, visit <http://www.bioethicsinstitute.org/> for title of talk. Sponsored by the Berman Institute of Bioethics Seminar Series, Johns Hopkins University. (See September 26 for location/contact details).

## **16 (5:30-7:30 PM)**

Futility in the NICU patient: Exploring Perspectives and Achieving Consensus. Presenter: Margot Ahronovich, MD, Neonatologist, Inova Fairfax Hospital for Children. (See October 12 location/contact details.)

## **16**

Palliative Care Network Grand Rounds Audio Conference Series. Sponsored by the Center for Health Ethics and Law at West Virginia University's Robert C. Byrd Health Sciences Center. For more information, contact Cindy Jamison ([cjamison@hsc.wvu.edu](mailto:cjamison@hsc.wvu.edu); 1-877-209-8086), or visit <http://www.wvethics.org/Calendar-of-Events>.

## **28 (12:15-1:30 PM)**

Noon Seminar Series on Values and Health: Global and Local Perspectives. Speaker: Duana Fullwiley, PhD, MA, Associate Professor of Sociology, Columbia University. For more information, visit <http://www.bioethicsinstitute.org/>. Sponsored by the Berman Institute of Bioethics Seminar Series, Johns Hopkins University. (See September 26 for location/contact details).

## **DECEMBER**

### **5 (1 – 2 p.m.)**

Advance Directives and MOLST – Medical Orders for Life Sustaining Treatment; New End-of-Life Care Legislation. Presented by Delegate Dan Morhaim, M.D., Maryland House of Delegates. University of Maryland, Baltimore, SMC Campus Center, Room 351, 621 W. Lombard St., Baltimore, MD. RSVP by December 5 to Reba Cornman, [rcornman@umaryland.edu](mailto:rcornman@umaryland.edu). For additional MOLST training dates, visit <http://dhmh.maryland.gov/marylandmolst/pages/training.htm>.

### **12 (12:15-1:30 PM)**

Noon Seminar Series Speaker: Joanne Lynn, MD, Director of the Center on Elder Care and Advanced Illness, Altarum Institute. For more information, visit <http://www.bioethicsinstitute.org/>. Sponsored by the Berman Institute of Bioethics Seminar Series, Johns Hopkins University. (See September 26 for location/contact details).

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