

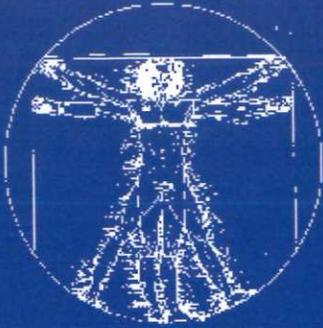
Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 2001*

Mid-Atlantic Ethics Committee
Newsletter, Summer 2001

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MID-ATLANTIC ETHICS COMMITTEE

N E W S L E T T E R

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

Summer 2001

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TAKING A POSITION ON TAKING A POSITION

Last Fall, at the annual meeting of the American Society for Bioethics and Humanities (ASBH), the seeds for a heated debate sprouted. They had been planted a couple of years earlier at the first annual meeting of the newly christened ASBH.¹ Some board members moved to change the new bylaws to allow the organization to take public positions on certain issues. That suggestion did not attract much enthusiasm, until the October, 2000 annual meeting in Salt Lake City, Utah. Since then, the following arguments have been made on each side of the debate.

Three arguments made *against* the ASBH taking public positions:

- The richness of debate on both theoretical and practical issues that concern ASBH members is enhanced by those with divergent views. Overriding the voices of such members, who are typically in the minority, would likely risk silencing their voices. This would severely interfere with the promotion of scholarship and diversity of thought that is the main purpose of professional organizations like the ASBH. Trying to “present all sides of an issue” as a solution to this problem precludes position-taking. Opposing injustices for which there is

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

Diane E. Hoffmann, JD, MS
Editor

no disagreement (e.g., “human torture is unethical”) would likewise serve no meaningful purpose.

- ASBH is not a political organization. Taking public stands on controversial issues (a just system of health care access, for example) may be considered a form of political lobbying in which the ASBH is prevented from participating to qualify for its tax-exempt status.

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The information in this newsletter is not intended to
provide legal advice or opinion and should not
be acted upon without consulting an attorney.

NETWORK NEWS

Maryland Health Care Ethics Committee Network (MHECN)

MHECN held a full day workshop on
June 15, 2001 titled "Two Topics in
End-of-Life Care: African American
Perspectives and Conflict Resolution"
(see article on page 7). Plans are
underway for MHECN's Third Annual
Meeting on November 15, 2001. Jack
Schwartz, JD, Director of Health
Policy Development at the Maryland
Office of the Attorney General will be
the featured speaker. At the meeting,
dinner will be provided and the Net-
work will hold elections for the Board
of Directors. MHECN recently submit-
ted a proposal for funding to hold a
conference on "Spirituality, Healthcare,
and the Role of Ethics Committees." If
successful, the Network will hold a
conference on the topic in late spring
2002. MHECN will also hold a one-day
Basic Ethics Education Course at Shore
Memorial Hospital in Easton on Sep-
tember 8, 2001.

Contact: Anne O'Neil,
Executive Director
aoneil@law.umaryland.edu

Metropolitan Washington Bioethics Network (MWBN)

MWBN's June program featuring the
Washington Regional Transplant
Consortium was cancelled due to
conflicting schedules. The fall
schedule of co-sponsored presentations
will begin at Washington Hospital
Center on September 25, 2001 from
4:00 to 6:30 p.m. The topic will be
"Lying for Patients." Victor Freeman,
MD, Medical Director for Quality at
Fairfax Hospital and Jan Vinicky, PhD,
Director of the Bioethics Program at
Washington Hospital Center will
present and lead a discussion. The
presenters suggest that those coming to
the presentation read "Lying for
Patients: Physician Deception of Third-

Party Payers" by Freeman, Rathore,
Weinfurt, Schulman, and Sulmasy.
The article can be found in the
Archives of Internal Medicine, Vol.
159, October 25, 1999. Anyone having
difficulty finding the article should e-
mail Joan Lewis (see below) and she
will send you a copy. Joan would also
like to hear from anyone with possible
program ideas for the fall and early
2002.

Contact: Joan Lewis, Coordinator
jlewis@dcha.org

Northern Virginia Healthcare Ethics Network (NoVaHEN)

The Network held its most recent
meeting on May 18, 2001. Jim
Fletcher led a discussion on the
purpose of the Network, individual
projects and members' concerns. All
agreed there has been an increased
awareness and use of bioethics in areas
such as guardianship and in the court-
room.

Some of the issues discussed included:

- Organizational ethics at the INOVA
hospital system—multidisciplinary
group discussion and analysis of
hypothetical issues, such as opening
a pharmacy in the facility; INOVA's
system-wide (four facilities) ethics
council, which includes subgroups
for education, policy, consultation,
end-of-life, etc.
- Recently enacted federal legislation
that will provide Medicaid funds for
treatment of breast and/or cervical
cancer for medically indigent
women. Two nurse-attorneys have
volunteered to formulate guidelines
and assist the general counsel and the
Department of Health of the District
of Columbia in implementing the
legislation.
- The case of a Hospice patient on
Dilaudid, admitted for the purpose of
pain management. The patient's pain
medication was allegedly misappro-

Cont. on page 10

Taking a Position on Taking A Position

Cont. from page 1

- Would consensus require majority vote, supermajority, or unanimous vote? Logistics of how consensus would be defined for an ASBH public position raise concerns noted in the first argument above.

Two arguments made *in favor* of the ASBH taking public positions:

- If a reporter asked for the ASBH's position on, say, the fairness of the current health care system in the U.S., he or she would be told that the organization has no comment, as its bylaws preclude taking a position on public issues. Yet, not taking a position *is* taking a position! Complacency in the face of injustice was an essential component of what ultimately allowed Hitler to pursue his "Final Solution" to such an extreme. Neutrality has a price, and there simply is not a compelling justification for paying this price.
- While bioethicists sit around and theorize about such esoteric topics as the dangers of human cloning or the ethics of post-mortem sperm retrieval, the majority of ethical issues and dilemmas lived by the members of society for whom bioethicists purport to advocate have more to do with inadequate access to quality health care, or the effects of racism, sexism, and other forms of prejudice. Bioethicists, because of their privileged position and special expertise in ethical analysis, have a responsibility to speak out against such injustices. Likewise, the ASBH, as an organization that supports the work of bioethicists and those working in the humanities, should also speak as one voice to denounce blatant injustices that perpetuate unethical practices and/or increased human suffering.

This debate will continue at the 2001 ASBH conference in Nashville, Tennessee, after which members will vote

whether to change the organization's bylaws to allow public position-taking. This issue also has significance for the many ethics committee networks that exist at the state and local level throughout the country. How do members of such organizations go about deciding whether their organization can take public positions? By what criteria are potential positions chosen? How is consensus defined? How does this relate to the Maryland Healthcare Ethics Committee Network (MHECN) or other area ethics networks?

How do members of an organization go about deciding whether their organization can take public positions?

Various professional associations and other non-profit organizations allow for public position-taking, including the American Medical Association, The American Nurses Association, and the American Lung Association. One logical first step in deciding whether the organization may take public positions is to look at its mission/vision statement(s) and decide whether taking public positions falls within its scope. If it doesn't, does the mission statement accurately reflect the organization's purpose, and might it need to be rewritten to allow for position-taking?

One could argue that the tax-exempt status of non-profit organizations obligates them to serve not just their members but the greater society as well. This brings up the question of the relationship between an organization and each individual member, and between the organization and the society in which it resides. One purpose of a professional association, for example, is to nurture an individual to achieve the full capacity of his or her professional role. But sometimes the individual's capacity to act according to his or her code of professional ethics is limited by structures in the greater society. The American Nurses Association (ANA), for example, recognizes that nurses are constrained from practicing according to their code of ethics by various societal barriers, including inadequate health care coverage/access for their patients, and

unsafe workplace environments. Thus, the ANA takes public positions on these and other issues that influence the ethical practice of nursing and the health of individuals whom its member nurses professionally serve.

What about other organizations? Do ethics committee networks, for example, have obligations only to their members, or should they take public positions on issues affecting a broader audience? Currently, MHECN's bylaws state: "The Executive Board's role on public issues is to stimulate debate and discussion on such issues. The Board may not take a public position on an issue (legislative or otherwise) unless all members of the Board agree on the position." Thus, there is a possibility for MHECN to take a public position on an issue if there was a unanimous vote by the executive board. But, how should the board go about deciding which positions to support?

By what criteria would potential positions be identified?

Most often, organizations whose bylaws allow taking public positions are approached for public endorsement of an issue by interested parties, who might be external to the organization or members themselves. The American Medical Association (AMA), for example, allows for "resolutions" (public positions on specific issues) to be written by AMA members, country, state and national medical specialty societies. These resolutions, which relate to issues "important to patients and the nation's health,"¹² are formally introduced into the AMA's House of Delegates twice a year, where they undergo various review processes before being voted on. If approved, they become official AMA policy. For example, at the June, 2001 AMA House of Delegates meeting, the 547 delegates rejected a resolution to endorse the limited use of medical marijuana for seriously ill patients, and approved a resolution calling on the Boy Scouts to reconsider its ban on homosexuals. Thus, the AMA allows for position-

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Ethics Consultants' Emotional Pitfalls

Cont. from page 1

taking if a majority of elected representative members approve. But, is this the correct decision-making strategy for an ethics organization?

How would consensus be defined?

As was stated, the current MHECN bylaws allow for taking public positions based on a unanimous vote of the executive board. It is easier to put a vote to the board than to the entire membership, particularly for issues that need fairly immediate endorsement. When decisions to publicly endorse issues are voted on by a board rather than by all of the members, a stricter standard for consensus might be demanded, as board members are voting on behalf of the entire organization. However, unanimity makes it difficult to approve public positions if any member opposes the move or has a conflict of interest that requires recusal from voting. If voting was extended to members, consensus might be defined less absolutely, perhaps as a supermajority (75% or more), or even as a majority. If this were the case, it would be important to consider the effects on members who were outvoted. If outvoting individual or member institutions caused an exodus of those members from the organization, diversity of membership would be lost, and this might weaken the organization and restrict its ability to effectively pursue its mission and purpose.

Other voting considerations include whether *individual* and *affiliate* members would be allowed to vote. Would institutional members get only one vote regardless of the size of their facility or their ethics committee? If so, how would they decide how to cast that vote—a majority or supermajority vote of their ethics committee?

Issue for Consideration

Recently, the MHECN Board was asked if it would support a statewide initiative to provide health insurance to

all Marylanders. The Board Chair would like input from members and readers regarding what they believe the Board should do about this issue and, more generally, how the Board should respond to requests to take policy positions on various issues. Send your thoughts, questions, or comments to MHECN's executive director, Anne O'Neil at aoneil@law.umaryland.edu.

Anita J. Tarzian, PhD., RN
Chair, MHECN Education Committee

1. *The ASBH was born out of a consolidation of the Society for Health and Human Values, the Society for Bioethics Consultation, and the American Association of Bioethics.*

2. www.ama.org

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. Individuals are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information of patients and others in the case should only be provided with the permission of the individual. Unless otherwise indicated, our policy is not to identify the submitter or institution. Cases and comments should be sent to: Diane E. Hoffmann, Editor, Mid-Atlantic Ethics Committee Newsletter, University of Maryland School of Law, 515 W. Lombard St., Baltimore, MD 21201-1786.

CASE STUDY FROM A MARYLAND HOSPITAL

Mrs. Gunderson is a seventy-eight year old woman with a history of chronic obstructive pulmonary disease, multiple strokes, and renal failure. She has been residing at a local nursing

home for over a year. Nine months ago her family was told by her physicians to prepare for her death "tonight." Last week she was readmitted to the hospital after suffering yet another stroke. She is presently comatose and requires thrice weekly dialysis. She did not execute an advance directive.

One of the physicians attending Mrs. Gunderson would like her code status to be "do not resuscitate." He believes that resuscitation would be medically futile and ethically wrong. Her attending physician agrees resuscitation would be futile, but is afraid of potential liability associated with ordering this code status over the objections of her family, particularly her husband. Mr. Gunderson has repeatedly refused "no code" status for his wife. He does not believe the physician's futility assessment because "they" (doctors) were wrong in predicting his wife's death earlier. He wants her to have "every chance." The institution does not have a policy covering requests for futile care.

The physicians have agreed to involvement of the patient care advisory (ethics) committee, but the Gunderson family refuses to meet with the committee, viewing it as simply an effort to coerce them into agreeing to a change of code status.

What should the ethics committee and/or the physicians do?

Comments From a Physician

This is a difficult case, but it is also a good example of an inappropriate emphasis on DNR orders. Even if the patient's husband could be convinced—brow beaten—into consenting to a DNR order, two more serious problems would remain: First, the DNR order only informs the medical team that if the patient should suffer a cardio-pulmonary arrest that no attempt should be made to restart her heart. Although, unfortunately, some team members may believe that the DNR order does imply limitations on

other forms of treatment, it does **not** inform the medical team what should or should not be done to prevent an arrest. Should the patient be intubated if she develops impending respiratory failure? Should agents to raise her blood pressure be used if she goes into shock? Should serious dysrhythmias (ventricular tachycardia) be treated if she is not yet in full cardio-pulmonary arrest? Should the patient be given blood transfusions if she has a gastrointestinal bleed? Should she be given fluid resuscitation if she develops hypotension while on dialysis? Should she be given antibiotics if she develops an infection? Should the Heimlich maneuver be initiated if she is choking on a piece of steak stuck in her throat?

Secondly, the DNR order does not address the patient's continuing need for hemodialysis. As a nephrologist, I could not continue to perform dialysis on a comatose patient with almost no chance of regaining consciousness. Dialysis is not futile treatment in a formal sense because even in this patient it will successfully compensate for her kidney failure and prevent her from dying from kidney failure; however, I believe that this is not the proper use of dialysis therapy. The continued dialysis of this patient is a much more egregious wrong than performing one unsuccessful resuscitation. We don't know if this patient is capable of feeling pain or is capable of suffering, but we do know that no one suffers from an unsuccessful attempt at resuscitation from a full cardio-pulmonary arrest. Within seconds of the heart stopping, the patient loses consciousness and is incapable of any further suffering, unless the heart rhythm is restored. Nevertheless, many physicians seek DNR orders by describing the horrors of resuscitation including cracked ribs and tubes shoved down throats and electric shocks and beating on the chest.

For these two reasons, I believe that seeking a DNR order is a misplaced goal in this case and in many similar cases. So, what should the ethics committee and the physician do? As I noted in the beginning of this discussion, this is a difficult case. It is

difficult for the following reasons: 1. The patient's husband does not trust the prognostic ability of his wife's physicians. It is always risky business to predict when a patient will die, and when one's prediction is off by nine months and counting, one loses credibility. 2. The patient's husband refuses to meet with the ethics committee. As a result, the family's story and the patient's story, as told by the family, may not get heard.

Although the husband refuses to meet with the ethics committee, the ethics committee can still play an important role. First, the committee can meet with the physician and clarify the patient's prognosis, and better understand why getting the DNR order is so important to the physicians. It is possible that in this case the physicians want the DNR order as a means to limit other therapy. Second, the committee can engage the physician in a more formal discussion about futility. Is a resuscitation attempt physiologically futile, or is it futile with respect to some goal? Third, the committee could suggest to the physician to approach the husband with a goal of trying to understand the husband's needs and goals. Remember, "Seek first to understand and then to be understood." (The fifth habit of Stephen Covey's *The 7 Habits of Highly Effective People*.) The husband is defensive and may interpret anything that is said as yet another attempt at coercion. Giving the husband an opportunity to be heard may open the door to further communication. For example, if it is discovered that the husband wants to simply give his wife a chance to recover, the physician could offer the husband a therapeutic trial—an agreement to do everything possible for a period of time, say one month—to see if his wife makes any progress toward regaining consciousness. If, after that time period, she has made no progress, then he agrees to withdraw all medical treatments, including dialysis, and to provide comfort care only. Other possibilities may also present themselves, including information about the patient's wishes, if the physician can

reopen the communication channels by bracketing the need for a DNR order.

Eugene Grochowski, PhD, MD, FACP
Associate Professor of Medicine
Johns Hopkins Medical School and
Bioethics Institute

Comments From an Ethicist

The situation facing the Gundersons is not uncommon. This is the case not so much because of the particular circumstances of Mrs. Gunderson's condition (which is not infrequent) but because it follows the pattern we often see in our clinical consultations as ethicists: the idea for discussions about what is best for Mrs. Gunderson has come just too late. I think that we can consider it a failure of total patient care when we are faced with invoking the legal mandate that physicians are not required to provide ineffective medical care. This is compounded by the attending's bowing to the fear of legal liability. This is not an unreasonable concern, but does it trump the physician's moral concern, further closing what conversation could come from the mess that essentially arose because of, more than likely, neglect?

The neglect is two-fold. In spite of our very best efforts as educators and influencers of public policy we have had little impact on the number of advance directives (ADs) that are drafted, and perhaps even on the number of conversations about them. People, including the Gundersons, do not want to talk about ADs. We all believe that had Mrs. Gunderson had an AD that this mess would not have occurred (not a correct premise as she could have ordered "full court press" anyway). Even if she had an AD that requested less aggressive care, according to the oft cited SUPPORT study, the physicians may have ignored it anyway, that is, until the very end. The neglect, even if a failure to have a conversation about the

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Comments From an Ethicist

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patient's wishes, is shared by patient/family and provider alike. One result of this is a very serious breach of trust and a lot of ill will.

I fully understand why Mr. Gunderson does not want to meet with the ethics committee. I would not want to either if I were him. What else is he to assume but that they are there to serve the hospital and the doctors who have not yet been able to predict the end of the life of his wife? In a highly charged climate as described in this case study the worst thing we can do is have families outnumbered by staff, especially if they are labeled as being involved in 'ethics' and 'morals' and 'rights.' Herein lies one of the problems of the 'committee' model of consultation. It stacks the deck against the patient in the controversy due to the power patients/families perceive that health care providers have in the political institution of the hospital as well as in the provider-patient healing relationship. Here is where the single consultant model may be more helpful and in my own institution a model that is used the majority of time. A single ethics consultant, trained in group process and mediation (as well as the attendant other skills necessary in ethics, law, and case history) may be more helpful. One guess I would have is that the major players (Mr. Gunderson, other family, clergy, influential neighbors; physicians, nurses, dialysis techs or anyone else who has had a positive relationship with the Gundersons) have never been in the same room at the same time hearing the same information, in plain language, and then been charged to sit with that and come to some wise counsel.

My own experience is that these 'messes' clean up about 70% of the time with the one room, one meeting strategy and then we can return to caring for our patients even in their dying without contention and animus. As for dealing with our neglect to discuss ADs with patients and health

care providers—maybe we just don't like doing them. To expect that education and legislation will change this is, in the words of my mentor Paul Ramsey, "futile" in that it attempts to rid the human condition of the human condition.

Brian H. Childs, PhD

Director of Ethics

Shore Health Systems of Maryland

ADVANCE DIRECTIVES FOUND KEY TO REDUCING STRESS FOR FAMILIES OF HOSPITALIZED PATIENTS AT THE END OF LIFE¹

Researchers from the Oregon Health Sciences University report that stress levels have been measured as extremely high for family members who must decide whether or not life support should be withdrawn from relatives too incapacitated to decide for themselves. Reported levels of stress are twice as high as those due to other serious crises, such as ferry or construction disasters, or losing a home to fire. Stress was least severe when patients' written advance directives were available and most severe in the absence of written or verbal directives. Funded by the National Institute of Nursing Research (NINR)², the study results appear in the March/April issue of the journal "Nursing Research."

"An advance directive can be very helpful for families making decisions about end of life issues," said NINR Director Patricia A. Grady, PhD, RN. NINR coordinates NIH end-of-life/palliative care research, a relatively new area of science. Dr. Grady indicated that less than 20 percent of adults have advance directives, "which means we must find strategies to significantly increase their use to diminish stress for both patients and families going through life's final phase."

The study focused on 74 family members whose relatives had recently

died in hospitals. The researchers focused on hospital deaths because decisions to start and stop life support more often occur in hospitals. Families were interviewed twice — at one to two months after the death of their relatives and again at six to nine months afterwards. Their responses indicated that half a year later their stress was still high but had notably improved. Information was also collected from the doctors and nurses who had cared for the patients.

The researchers also studied how families made decisions. In the absence of advance directives, families were more likely to push for prolonging life for the patient even when the treatments were not working and the patient was suffering. When the patient had a written advance directive to guide the family, the family was more comfortable focusing on the patient's quality of life as the guide to reaching the decision to stop life-sustaining treatments.

Virginia Tilden, DNSc, RN, the principal investigator of the study, stated "With advance directives, families are able to concentrate on improving the patient's quality of life during the time left, rather than futilely prolonging life, with high risk of making patients suffer unnecessarily."

Susan Tolle, M.D., a co-investigator of the study, indicated that "nurses and doctors can play a strong role in encouraging patients before they become gravely ill to complete advance directives and to discuss them with their families. This will reduce stress on their families down the road."

According to the study, families indicated that ending life support was the "hardest thing I have ever done in my life." Typical sentiments were "I wouldn't wish this [reaching a decision] on my worst enemy," and "I can't remember what went on because I was so upset."

Other study findings indicated that clinicians and families believed that poor quality of life and patient preference not to suffer were about equal in importance in deciding whether to withdraw life support. But families gave prolongation of life a stronger

consideration than did clinicians. Both groups indicated a patient's preference, if known, was first among considerations about ending life support.

1. *NIH News Release, March 15, 2001*
2. *The National Institute of Nursing Research is a component of the National Institutes of Health, U.S. Department of Health and Human Services.*

TWO TOPICS IN END-OF-LIFE CARE: AFRICAN AMERICAN PERSPECTIVES AND CONFLICT RESOLUTION

On June 15, 2001, about 70 persons met to hear presentations and discuss two issues of importance to members of ethics committees in Maryland. The conference was co-sponsored by MHECN and Franklin Square Hospital Center and held in Franklin Square's new state-of-the-art conference facility.

The morning was devoted to exploring African American perspectives on end-of-life care. Nationally known bioethicist Annette Dula, Ed.D., presented seven assumptions about end-of-life care (see box) and explained how these assumptions can be challenged when considering African American perspectives.

Her talk was followed by a panel response and discussion. Panelists included Carlton Haywood, Reverend Dr. James Hickey, Dr. John Sampson, and Dr. Anita Tarzian. Each reacted to

Dr. Dula's conclusions and, together with Dr. Dula, responded to questions from the audience. The attendees then broke up into small groups to discuss their responses to Dr. Dula's talk and its implications for their own ethics committee functions and/or end-of-life planning in general. They also discussed a case study involving end-of-life decision-making with an African American patient.

Afternoon sessions focused on the issue of conflict resolution and how ethics committees may work to prevent and/or work through conflict among patients, families, and staff involved in end-of-life decision-making. Shahid Aziz, MD, presented a detailed outline of how ethics committee members can help prevent conflicts from arising in the first place. He then elaborated on the process and steps involved in ethics committee deliberations. He stressed the need for early and frequent case conferences with family and staff and how skilled listening is the key to resolving conflicts. He also reviewed other conflict resolution strategies (e.g., negotiating over *interests*, not *positions*). Concurrent breakout sessions

Assumptions About End-of-Life Care

1. People want to die with dignity – quality is preferred over mere quantity of life.
2. Unwanted and unnecessary care compromises dignity.
3. Advance directives are planning tools. Everybody ought to fill one out.
4. When care becomes futile, treatment should be discontinued.
5. Communication between doctor and patient improves end-of-life care.
6. Properly trained health care providers will give adequate pain medication.
7. Physician assisted suicide = autonomy.

Annette Dula, EdD, June 15, 2001

that followed Dr. Aziz's talk allowed attendees to practice conflict resolution techniques via case study role plays followed by small group discussion. The conflict resolution themes of these

small group case studies included nursing home and maternal-child conflicts, issues of futility, and faulty communication.

As always, the conversations at lunch and during breaks were most invigorating. Conference evaluations indicated participants like the case study format in small groups, which allows both a focus for the discussion and a chance to actively participate.

INTERVIEW WITH MARTHA ANN KNUTSON, JD

Chair, Ethics Committee, Upper Chesapeake Health

This is the first in a series of informal interviews with the Chairs of Ethics Committees throughout the Mid-Atlantic Region. Contributing Editor, Anne O'Neil, conducted the interview.

Q. Could you tell me how your committee is structured?

A. We report to the Upper Chesapeake Health Board of Directors. We have a joint committee for the two hospitals that make up Upper Chesapeake Health (Harford Memorial Hospital and Upper Chesapeake Medical Center) and a member of the administration sits on the committee. At this time I am that administration person. Most of the "grunt work" of the committee is done from my office i.e. meeting minutes, consultation referrals. We do not have a separate budget for the committee so our needs, such as our membership in MHECN (Maryland Healthcare Ethics Committee Network), have been met by specific requests.

Q. How did you get to be chair of the committee?

A. Well, a few years ago, actually before I got here, there was an administrative decision that having one committee would help create one ethical "culture" within the two

Interview With Martha Ann Knutson, JD

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hospitals which have a large number of the same physicians, nurses, etc. and serve basically the same community (Harford County). They wanted the chair to be someone from administration who was not identified solely with either hospital and would thereby be seen as "neutral." They also felt that someone in an administrative position would have more time to spare for the administrative detail than someone in clinical practice. So when I joined Upper Chesapeake I was asked to join the committee and about a year later when the chair left the organization I was appointed. I had been involved in healthcare ethics when I was in practice with a private law firm. Jan Vinicky at the Washington Hospital Center's Center for Ethics had called on me when legal questions came up during ethics consultations and then I began to give talks on the differences between the legal and ethical issues. So when I decided to come to Upper Chesapeake I was familiar with bioethics and the work of ethics committees.

Q. How do you think being a lawyer affects your leadership of the committee?

A. For me I think it's helpful in that I have a thorough knowledge of the mediation model for use in an ethics consultation and I have a thorough grounding in the Maryland law related to healthcare issues. I do have to watch closely that the committee members don't just turn ethical concerns into legal issues.

Q. What is the background of the members of your committee?

A. We have a broad representation. Half of the members are physicians with a range of specialties such as internal medicine, surgery, psychiatry, intensive care and the ER. We have nurses, social workers, clergy, two other administration staff from guest services and a community member. We'd like to eventually expand our membership of bedside nurses, but for staff nurses, in particular, it is hard for them to get

time to participate in the committee. Our community member is a lobbyist for an insurance company and a very thoughtful contributor to our deliberations.

Q. How many persons sit on the committee and how do they get to become members?

A. Currently we have 21 members on the full committee. No one is assigned, some express an interest, but most were solicited based on informal "nominations" either by their department chairs, supervisor or a committee member. Then the committee votes on them (no one has ever not been accepted during my tenure). So far, we haven't established any time limits on membership and we just bring new members on as members leave the committee. This seems to be working well and I don't see any reason to have a more formal time limit on membership.

Q. Do you have any type of formal education for new members?

A. Not really. I usually gather some basic readings and talk with the new member about process. Then all of our committee meetings have an educational component. This seems to work and of course older members lead the way, which provides time for new members to get their feet wet and become comfortable with the consultation process.

Q. How often does your committee meet?

A. The full committee meets every three months for two hours to undertake a retrospective review of the consultations that have taken place and for some type of educational presentation or discussion. We then have a sub-committee of a physician, nurse, social worker and administrative staff member (usually, but not always, me) that handles ethics consultations as they arise.

Q. What kind of things do you do for the education part of the committee meeting?

A. Sometimes we have used a video clip to simulate a consult (for example, we used the video from ER that was used at the MHECN Meeting a year or so ago). Presently we are

doing a review of ethical theory presented in installments by one of our physician members.

Q. Is the committee involved in any community education?

A. Not directly, but the hospital wanted to revise its booklet on "Advance Directives: Ensuring Your Choices" and we were responsible for that initiative.

Q. How do staff and families know about the ethics committee and the consult service?

A. Staff (we call them "Team Members" at Upper Chesapeake) learn about us at their orientation and through seeing us in action. We also prepare flyers and the existence of the committee is mentioned in various pieces of hospital literature. I suspect, however, that most families hear about us through the Team Members.

Occasionally we run into someone who has knowledge of the function of ethics committees based on prior experiences at another hospital.

Q. How do referrals for consultations get to the committee?

A. Usually they come to me for screening. Anyone can ask for help and folks don't seem to be nervous about asking. If a call comes to me that is clearly not an ethical issue then I just field it or get it to the appropriate person. Usually, these are calls that simply want a straightforward answer to a question such as "That's legal isn't it?" If I can identify an ethical issue, I will call around to gather available committee members who have not been involved in the case. Usually those who have never done a consult want to sit in as an "extra" member for a couple of meetings before they become "official" members of the consultation team. Both the challenge and the rewards come in getting all the involved parties in the same room at the same time. Sometimes we just can't achieve that, but we try very hard. We have had one family that refused to meet with the committee. We primarily use a mediation model for our process. The drawback to using a committee or sub-committee approach is that it is much more time-consuming than the

single consultant way of doing consults. But once we get everyone together, the first task is clarifying the issues. So often you find that someone has this piece of information and someone else has another piece and everyone is operating on different sets of information. Our best results come when we are able to mediate a common solution that is ethically acceptable. We then will come up with an opinion and communicate this to the attending physician and whomever requested the consultation. Technically that is the end of our authority although we may stay in touch with both staff and family if the need is present.

Q. How do you report your opinion?

A. We prepare a formal report that goes in the medical record using our own ethics consultation format.

Q. What would you say pleases you most about the work of your committee?

A. I think the halo effect that is created is bigger than each single consult we do and that has been very pleasing. Physicians and other team members not involved in the case see us come in and do a consult that is effective in resolving a critical situation. That then helps to build trust in the whole organization of Upper Chesapeake and a feeling that there is a resource they can call on for their next case. That is very satisfying to me and is well worth the time and commitment the work of the ethics committee takes. I'm also very proud of what my committee members – all volunteers – do to make themselves available for consultations quickly. They regularly rearrange their lives and other commitments to come in on evenings, weekends, early mornings - I'm lucky to work with such a dedicated group of folks.

ATTENDING THE XXVII INTENSIVE BIOETHICS COURSE AT THE KENNEDY INSTITUTE OF ETHICS

Bioethics Beyond the Sound Bite, June 5 –10, 2001

I decided to attend the Intensive Bioethics course this year because I wanted to enhance my understanding of basic ethics principles/theories and to hear some of the leaders in the field of bioethics.

The course definitely lived up to my expectations. I found that the application of those basic theories and principles and the way one thinks about them have changed over time. It was particularly interesting to observe how different experts in the field of bioethics hold different principles at different levels of importance. It was obvious that each faculty member certainly has his/her own favorites among the overall theories.

It was wonderful to hear leaders in the field speak i.e. Edmund Pellegrino, Tom Beauchamp, James Childress, Robert Veatch, Laurie Zoloth, Allen Buchanan, Alisa Carse, Eric Juengst, Le Roy Walters and Kevin Wildes. All names whose work I had read. It was even more exciting to be able to discuss one on one with them topics of personal interest. They were all very approachable, gracious and generous with their time.

The format for the six-day course was a mixture of major speakers and small group discussion. Each group had a faculty member as the facilitator. Participants stayed with the same group for discussions throughout the week. The small group lent itself well to exploring the subject matter that was presented in the large group lecture. All faculty had breakfast and lunch with the participants daily and

there were several evening functions also providing opportunity for discourse. At times, the Q&A session after the presentation was even more stimulating and interesting than the talk itself.

We also had time to explore the National Reference Center for Bioethics Literature. It is an awesome resource for those interested in bioethics. The library's resources are very extensive and the library's staff is very friendly and helpful. They were extremely helpful in finding references and doing searches for topics of interest. The library also held a book sale in conjunction with the Intensive Course and had a wide array of books for sale that are sometimes difficult to find.

About 150 people from all over the United States and the world attended the course. Participants came from South Africa, Kenya, Brazil, India, Korea, Australia, Malaysia and Japan to name a few. Nearly all loved being there and were most attentive and interested. Cultural differences on how different countries come to grips with ethical concerns in health care were fascinating.

In this year's course the emphasis was mostly on philosophical discussion and there was little time devoted to structured presentations on practical, clinical, medical ethics. However, we did get some discussion of the practical side of bioethics in the small discussion group. Being a physician, I appreciated the topics on virtue-based ethics (Pellegrino) and the ethics of care (Carse). I made many contacts with people of similar interests and exchanged personal information in order to stay in touch.

An additional benefit of attending this course is that participants receive a free one-year membership in the Kennedy Institute of Ethics.

Overall it was a very positive experience, although I would have liked to have had more presentations and discussion on clinical/practical ethics. And I would definitely plan on staying in DC for the full course if at all possible. Driving from home

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Bioethics Course

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through DC traffic for six days was a definite negative. I would strongly recommend this course for those interested in the serious study of ethics. It would also be helpful before attending to have some basic background and understanding of health care ethics.

Shahid Aziz, MD
Chair, Ethics Committee
Harbor Hospital Medical Center

Network News

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- riated by her caregiver. A discussion ensued on duty of care and responsibilities of physicians, other health care workers, and the patient's family. The health care providers' duty to report abuse was of particular concern.
- A report on the status of Supporters of Life Affirming Care at End Of Life (SOLACE). SOLACE's educational mission is to increase awareness for advanced care planning. The group provides informational packets on palliative and end-of-life choices, and facilitation of discussions on advanced directives between the patient and the primary care giver.

Spotlight on the RBC

The Richmond Bioethics Consortium is a grass roots organization composed of multi-disciplinary individuals and health care facilities in the greater Richmond area. The RBC's mission is to increase awareness of and education about bioethical issues that arise in healthcare. The Consortium also fosters networking between individuals interested in bioethics and institutional ethics committees.

The RBC publishes a "Bioethics Bulletin" that features bioethics updates, a calendar of educational opportunities, reviews of programs and conferences, and other items of interest. The organization offers a series of three full-day workshops every 18 months targeted for new members of ethics committees, sponsors a Speaker's Bureau, and works with area ethics committees on request.

The RBC Board and institutional representatives meet every other month. Twice a year the group sponsors a program featuring current topics of interest. See below for RBC's recent and planned programs.

- A physician's efforts to address the reluctance of medical staff to discuss "Do Not Resuscitate" (DNR) issues with patients and their families, and to issue appropriate medical orders following those discussions.
- Dialysis resuscitation issues, such as a patient's request to not be resuscitated when the corporate policy is to resuscitate.
The next meeting is planned for September 28th.

Contact: Elizabeth Bray, Co-Chairperson, Brayeliz@aol.com.

Richmond Bioethics Consortium (RBC)

The spring program, held on May 9, 2001, featured Dr. John O'Bannon, a practicing neurologist, ethics committee member and newly elected delegate to Virginia's General Assembly. In the fall, the Consortium will host a program heavily focused on palliative care featuring members of the recently formed Virginia Palliative Care Partnership (see Calendar section). RBC is also developing a website.

Contact: Monica Markowitz
President

CALENDAR OF EVENTS

September

- 14-15 "HIV/AIDS as an Epidemic: Ethical Issues at the 20th Anniversary." Charleston, SC. Co-sponsored by Medical University of South Carolina, Institute of Human Values in Health Care, and the College of Medicine, Office of Continuing Medical Education. Fee - \$195 (before 8/15/01). For further information contact Sharon Kest at 843-792-5278 or values@musc.edu.
- 19 "Living, Aging and Dying Well: Reclaiming the End of Life." North Arundel Hospital, Glen Burnie, MD. 6:30 PM Speaker: Ira Byock, MD, Director, Missoula Demonstration Project. Sponsored by North Arundel Hospital Ethics Committee. For further information contact Debbie Haines at 410-787-4529 or debhai@northarundel.org.
- 20 "Medication Errors and Patient Safety." BWI Embassy Suites Hotel, Baltimore, MD. Sponsored by the University of Maryland School of Pharmacy, Center on Drugs and Public Policy. For further information call the Center at 410-706-0133.

- 20 "Caring for the Chronically Ill and Dying: Options and Opportunities." Children's Hospital Auditorium, Richmond, Virginia. 7:00 PM Speaker: Angus Muir, MD, Director of Palliative Care Program, Mary Washington Hospital, Fredericksburg, VA. Sponsored by the Richmond Bioethics Consortium. For further information call 804-287-7450.
- 20 "Poetry, Prose, and Patient Care: A New Way to Hear our Patients' Stories." Shock Trauma Auditorium, University of Maryland Medical Center, Baltimore, MD. 5:00 PM Speaker: Cortney Davis, MA, RNC, ANP Nurse Practitioner in Women's Health Danbury Hospital, Danbury, CT. Co-sponsored by the Medical Humanities Hour and the Masters in Applied and Professional Ethics, UMBC. For further information contact Anne O'Neil at 410-455-2214 or oneil@umbc7.edu.
- 25 "MEDispute: Resolving Health Care Conflicts." Sheppard Pratt Conference Center, Baltimore, MD. 8:00 AM - 6:00 PM. Sponsored by the Law & Health Care and Dispute Resolution Programs at the University of Maryland School of Law. For further information and to register online visit the conference website: MEDispute.org or call 410-706-3378.
- 25 "Lying for Patients." Washington Hospital Center, Washington, DC. 4:00-6:30 PM Speakers: Victor Freeman, MD, INOVA Fairfax Hospital & Jan Vinicky, Director, Medstar Center for Bioethics. Co-sponsored by Metropolitan Washington Bioethics Network and Washington Hospital Center. For further information contact Joan Lewis at 202-682-1581.
- 26 "The Art and Science of Palliative Care: Legal, Ethical and Medical Skills in Caring for the Seriously Ill and Their Families" Hyatt Regency, Bethesda, MD. 8:30 AM - 3:30 PM Sponsored by Montgomery Hospice. Fee - \$55 full day, \$35 half-day. For further information contact Anna Moretti at 301-279-2567 X 188 or amoretti@montgomeryhospice.org
- 29 - October 1
 "Health, Law and Human Rights: Exploring the Connections." Philadelphia, PA. Sponsored by American Society of Law, Medicine & Ethics. Co-sponsored by UNAIDS and WHO. Fee \$425 - 550. For further information call 617-262-4990 or conferences@aslme.org.

October

- 4 - 5 "Ethics in Healthcare Institutions: New Issues, Controversies and Practical Considerations." Charlottesville, VA. Sponsored by the Center for Biomedical Ethics, University of Virginia. Fee - \$150. For further information contact Carrie Gumm at 804-924-5695 or cg2b@virginia.edu.

November

- 1 "Whose Life is it Anyway? Euthanasia: Pro & Con." Tawes Theatre at Washington College Chestertown, MD. Speakers: Faye Girsh, President, Hemlock Society, USA & Richard Doerflinger, National Conference of Catholic Bishops. Co-sponsored by Kent Hospice Foundation, Inc. Ethics Committee and the Washington College Department of Philosophy & Religion. For further information call 410-778-7058.
- 5 - 6 "Fundamentals of Human Research Ethics." Charlottesville, VA. Sponsored by the Center for Biomedical Ethics, University of Virginia. Fee - \$350. For further information contact Carrie Gumm at 434-924-5695 or cg2b@virginia.edu.
- 15 "Capacity Assessment, Tube Feeding and Other Vital Issues *Before* the End of Life." Third Annual Meeting of the Maryland Healthcare Ethics Committee Network. 5:00 PM - 9:00 PM Speaker: Assistant Attorney General Jack Schwartz, Director of Health Policy Development. Details TBA. For further information contact Anne O'Neil at 410-706-4457 or aoneil@law.umaryland.edu.

