

*Health Care Law*

*Mid-Atlantic Ethics Committee Newsletter*

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University of Maryland Francis King Carey School of Law    *Year 2014*

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Mid-Atlantic Ethics Committee  
Newsletter, Winter 2014

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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

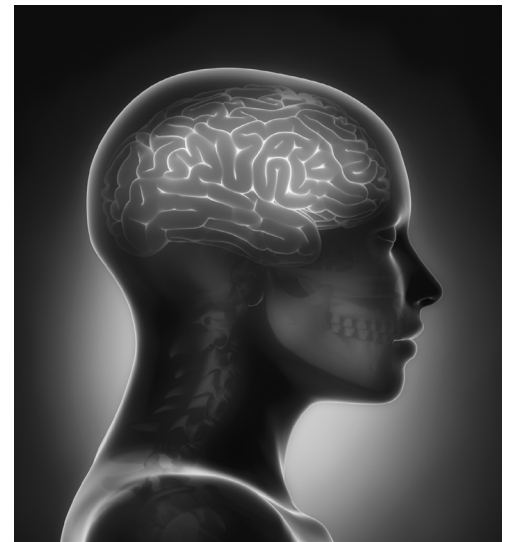
Winter 2014

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## BRAIN DEATH, ETHICS COMMITTEES & COURTS

The case of 13 year old Jahi McMath has been widely reported in the media. Jahi had her tonsils, adenoids, and extra sinus tissue removed on December 9, 2013 to treat sleep apnea. She suffered a hemorrhage and subsequent cardiac arrest and was pronounced brain dead in a California hospital on December 12, 2013. However, her parents sought court intervention to continue ventilator support and tube feedings as they hoped for a miracle to bring her back to life. This case raises questions about how far we should go to assuage the grief of bereaved family members when a patient has died.



For decades in the U.S. and other countries, a person who is pronounced dead by neurologic criteria (i.e., “brain dead” – no response to pain, no cranial nerve reflexes, no spontaneous respirations) is considered legally dead. This allows for organs of the deceased to be donated, death rituals to be enacted, and medical resources to be freed up for other patients who stand to benefit. Family members are generally provided a short period of time to “say goodbye” before medical interventions (e.g., ventilator, intravenous fluids or tube feedings) are stopped. This usually occurs within hours of the brain death diagnosis. The McMath case is unusual in that the family requested that Jahi continue to receive medical technologies after being pronounced dead, and a judge granted that request.

While patients are routinely pronounced dead by neurologic criteria at acute care hospitals, it’s a rare event for a child undergoing routine surgery to die. Questions about usual surgical risk versus medical error are likely to come up, and thus it would be appropriate to involve risk management. If medical error may have contributed to the patient’s death, staff should implement standard protocols for error disclosure (Bell et al., 2010; Petronio et al., 2013; ToughTalk, n.d.). All hospitals in Maryland are required to have a patient safety program in place that, among other things: identifies, assesses and responds to near-misses and adverse events relating to patient care; conducts root cause analyses; and reports required information to the Maryland Department

How might you handle such a case if it came before your ethics committee?

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The *Mid-Atlantic Ethics Committee Newsletter* is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland Francis King Carey School of Law’s Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

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*Editor*

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advice or opinion and should not be  
acted upon without consulting an  
attorney.**

## ***Brain Death***

*Cont. from page 1*

of Health and Mental Hygiene (Md. Code Ann. 2013).

It may be tempting in such cases to defer to loved ones to “give them as much time as they need” to grieve before stopping medical technology, but this would run counter to the principle of justice in ethics that requires “treating like cases alike.” Furthermore, while hospice and palliative care providers often report implementing certain interventions more to benefit the dying patient’s family members than the patient, the point at which a dead body is subjected to medical technology intended only for the living purely to ease the grief of the family raises the concern of disrespecting the body by using it solely as a means to the family members’ emotional ends. How family members are respected and emotionally supported to minimize their regrets and assist in their grieving process is pivotal. However, the assumption that “doing whatever the family asks” is the best way to provide such support is untested, and thus should be challenged. Death of a loved one is often met by anguish and demands from the bereaved to “do everything,” but sometimes it is human compassion and connection, rather than medical technology, that is required to help heal a broken heart.

Can there be another interpretation of “doing everything” in such cases? What might this look like in

the context of ethics consultation? Ethics consultants called in on such a case should facilitate meaningful communication among those involved to ensure that the staff’s empathy and regret have been expressed to the family, that the accuracy of the diagnosis of brain death has been clearly explained, and that the parents’ concerns are heard. Assuming that best efforts are undertaken to communicate effectively with the parents and to establish trust and provide emotional support, and yet the parents continue to insist that the ventilator and tube feedings be maintained indefinitely, it would be appropriate to recommend that the hospital set a date to stop the ventilator and tube feedings according to the medical standard of care. Stopping a ventilator after pronouncing death is a routine medical procedure, and thus not typically handled as a certification of medically ineffective treatment under Maryland’s Health Care Decisions Act (HCDA). However, whether or not the process defined in Maryland’s HCDA is followed, the parents have a right to pursue court intervention. This is an appropriate due process “check and balance” that helps protect the rights of those low in the power hierarchy. Unfortunately, not all judges are equally versed in bioethics, and thus it would be important for the ethics committee to include sufficient background and justification to support

*Faculty from Union Graduate College-Icahn School of Medicine at Mount Sinai Bioethics Program have introduced a novel, asynchronous "online symposium" on the McMath and Munoz cases on their program's blog. The McMath case is featured in this issue's lead article. The Munoz case involved a pregnant Texas woman whose body was maintained on a ventilator, with artificial nutrition/hydration, against her family's wishes, based on the hospital's interpretation of Texas law. These cases raise questions about the role of court involvement in end-of-life decision-making, particularly regarding determinations of brain death. Access the symposium by searching "McMath Munoz online symposium" in Google.*

its recommendation, and to provide this to the judge.

It's unclear whether an ethics committee was consulted in the McMath case. Perhaps this may have changed the course of events. Due to the media attention, the case was erroneously covered as a "right-to-life" case and funds were donated to support care for Jahi's body outside of the hospital at an undisclosed long-term care facility. The family reports taking time away from the media spotlight to "heal up." One wonders whether the same could have been achieved with more effective

communication and support for both family and staff. Clearly, more needs to be done to educate the public, the press, and health care providers about goals and limits of medicine at the end of life.

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#### REFERENCES

Bell SK, Moorman DW, Delbanco T. (2010). Improving the patient, family, and clinician experience after harmful events: The "when things go wrong" curriculum.

Acad Med, 85(6),1010-7.

Md. Code Ann., Health-Gen. § 19-308 and § 19-319 (2013), COMAR 10.07.06.00 (Hospital Patient Safety Program).

Petronio S, Torke A, Bosslet G, Isenberg S, Wocial L, Helft PR. (2013). Disclosing medical mistakes: A communication management plan for physicians. Perm J, 17(2), 73-9.

ToughTalk (n.d.). Teaching Module: Talking about Harmful Medical Errors with Patients. Available at <http://depts.washington.edu/toolbox/errors.html> .

*Death of a loved one is often met by anguish and demands from the bereaved to "do everything," but sometimes it is human compassion and connection, rather than medical technology, that is required to help heal a broken heart.*

## MOLST CONFERENCE FOCUSES ON SUCCESSSES AND CHALLENGES

On December 9, 2013, MHECN and Harbor Hospital co-sponsored the conference, Maryland Medical Orders for Life-sustaining Treatment (MOLST): A six month check-up, at the UM Carey School of Law. The focus of the conference was on successes and challenges encountered in implementing the MOLST form in Maryland healthcare facilities.

Anonymous online survey data presented at the conference revealed reasons for both satisfaction and dissatisfaction with the MOLST form. Satisfied users pointed to the form being completed correctly at their institution (e.g., the form is on patients' charts and sent out with transfers), and the form actually improving patient care (e.g., by opening up dialogue with patients and family about end of life issues, increasing awareness of assigning a health care agent or completing an advance directive, and helping avoid

unwanted and unnecessary medical care). The satisfied users tended to report having a process in place at their facility to ensure successful MOLST implementation (e.g., educating all parties on the process, getting buy-in from administration to hold clinicians accountable for completing MOLST forms on the initial visit to the facility, and replacing the system Do-Not-Attempt-Resuscitation order with the MOLST form).

Dissatisfied users identified problems with how clinicians completed the form (e.g., the wrong or no decision-maker was identified,



the form was not signed, conflicting preferences selected such as "palliative care" on page 1 but "do everything" on p. 2, and the form was not sent with the patient when it should have been). In addition, they identified instances where (1) the form did not reflect the patient's wishes (e.g., patients did not remember discussing the form or didn't agree with how it was filled

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## **MOLST**

*Cont. from page 3*

out; (2) surrogates overrode MOLST orders; (3) clinicians defaulted to full cardio-pulmonary resuscitation (CPR) without discussing this with the patient, simply assuming that the patient would want to be a full code.); and (4) the MOLST form was inappropriately voided by a clinician (e.g., one clinician takes time to complete a MOLST form after discussion with a patient and another clinician completes a new MOLST form with no clear indication that the latter MOLST form reflects the patient's wishes more accurately than the prior form). Other barriers to successful implementation included clinician errors interpreting the MOLST form, difficulty finding the most recently completed MOLST form, and concerns that the completed

form was inconsistent with Maryland's Health Care Decisions Act (e.g., by not recognizing the authorized decision maker for an incapacitated person, or overlooking procedures to certify medical conditions such as decisional incapacity, an end-stage or terminal condition or persistent vegetative state, or treatments considered medically ineffective).

Perceived barriers to effective MOLST implementation include poor end-of-life communication skills among clinicians explaining MOLST to patients and families and clinicians completing the MOLST form, perceived lack of time among health care providers to complete the MOLST form, lack of buy-in from physicians and other key stakeholders regarding the MOLST process,

clinicians not trusting the MOLST order form, and difficult timing of end-of-life decision-making in acute care settings. Many identified a functioning state MOLST and advance directive registry as a necessary step to ensure successful MOLST implementation.

Conference speakers presented strategies to address barriers to effective MOLST implementation, including communication skills and organizational approaches to effective MOLST adoption. Video-recordings of the conference sessions are available on MHECN's website at <http://www.law.umaryland.edu/mhecn> (click on Conferences).

## **ELEVENTH HOUR**

by K.D. Hayes

*Reprinted with permission from Pulse—voices from the heart of medicine, which reveals the personal side of health care through weekly stories, poems and images. Subscribe at [pulsevoices.org](http://pulsevoices.org).*

Uncle Walt died this morning. Finally.

I say "finally" because I believed this day would come four months ago, when he had emergency bypass surgery.

At the time, I didn't believe Walt would live; he was an ailing, seventy-seven year-old man with severe pulmonary disease. When his heart started to hurt one Friday, his doctors told him, "With bypass surgery, you might live. Without it, you'll be dead before the weekend is over."

Walt's oldest daughter and my parents, who were with him, told me about the doctors' recommendations.

As a retired paramedic, I'd seen this scenario before—often enough to have a strong opinion, and my own advance directives.

I didn't think that Walt should have the surgery. I thought it would cost too much suffering and money and ultimately lead to the same predictable outcome. I expressed concern that the medical community was pushing, even coercing, Walt to agree to surgery.

My parents assured me that Walt understood the severity of his condition. He knew that he was a poor surgical candidate, that he might not survive the surgery, that he would suffer.

And Walt said, "I want to live."

I disagreed with Walt's choice for another reason: I believed that it would thrust suffering upon his family members, who were also my loved ones.

His four children, who said he'd abused and molested them, would

suffer, dragged into advising and decision-making roles. My father would suffer because he loved his older brother deeply—despite my cousins' assertions and despite Walt's drinking away the first decades of his life, failing to find a successful career, and heading a family driven by dysfunction.

Walt had made our whole family suffer, and I didn't want him to cause more suffering. I felt angry with him. Over the years, his declarations of remorse had seemed insincere, his oblique admissions and apologies insufficient to heal his children's wounds. I felt he'd given them good reason to leave him. And though he had never mistreated me, I'd maintained a cool reserve.

In the end, Walt had the surgery—

*But what came of those days between the time I thought my uncle would die and the time, four months later, when he did die? Those expensive, painful days, dogged by fear and anxiety, when my cousins were spent and my parents exhausted, when Walt could have died but lived instead? Walt found God.*

and lived through it, although sometimes it hardly seemed living.

Essentially, his bypass saved his heart so that his lungs could kill him. He had a breathing tube in his windpipe and a feeding tube in his stomach; he lived through a week of "ICU psychosis," tormented by hallucinations. After he'd spent nearly a month in surgical intensive care, they moved him to an extended acute-care hospital, then to a skilled-nursing facility.

He had good days—a few. He taught his tired larynx to form words again. He progressed from sitting in a chair to standing to walking a few steps. Once, he walked all the way from his room to the lobby and back. He also had many bad days, when he couldn't even get out of bed. He suffered persistent urinary-tract and *C. difficile* infections. Whenever it seemed that Walt's body might give up the fight for life, the staff would ask Walt whether he wanted to be resuscitated.

He always said, "I want to live."

It was *his* decision; I don't think it would have been mine.

But what came of those days between the time I *thought* my uncle would die and the time, four months later, when he *did* die? Those expensive, painful days, dogged by fear and anxiety, when my cousins were spent and my parents exhausted, when Walt could have died but lived instead?

Walt found God. On the night before his surgery, the fear of death opened up a vulnerability in him, and he accepted a priest—and then God. He confessed. That night, with two of his four children by his side, he wept his confession.

My cousin recorded his father's words in a journal: "Forgive me for the abuse....I abused all of you. I wish

I had been a better man." Walt asked his children for forgiveness, and they gave it.

My cousin emailed this exchange to his brother and sisters, to his mother and aunts and uncles and cousins.

The next morning, huddling with my parents and cousins beside Walt, who lay unconscious after the operation, I did not know how to carry my anger.

But the months that followed gave my father more time to spend with his



older brother.

"Such a beautiful gift, this time," my father says now, even though those days also sucked away my parents' energy.

I doubt that Walt expected that his family would start healing--that his act of contrition would forge new bonds of obligation, responsibility and caring.

But because the operation gave him those months after his "deathbed" confession, his children were able to tell him that they loved him; and their words resonated with a new truth.

"We thanked him and told him he had given us a gift," my cousin wrote.

Several days after Walt's surgery, I stood by his bed and held his hand as he drifted into and out of consciousness.

His oldest daughter stood beside me. Whenever Walt was awake, he'd look at her and mouth the words "I love

you." I felt I was watching them forge a new relationship.

Walt's fractured, estranged family began reaching out, emailing or calling, traveling, reconnecting with each other—and even with Walt. I heard words of remorse, excruciating admissions, and gradually my anger subsided into awe.

I feel certain that Walt knew of the evolution that began in his family that dark night before his surgery, when he felt sure that he would die.

This morning, when Walt finally did die, he left behind a different life—and a different family. His oldest daughter stood in his hospital room, her boyfriend's arm through hers. Her two adult children hovered near their grandfather. My aunt stood at the foot of his bed. I knelt by the railing, my parents standing just behind me.

I held Walt's hand and told him that it was okay to go—and that I loved him. Four months earlier, I'd thought the most pragmatic, least painful choice he could make would be not to fight for life. I'd thought it would be easier, kinder for everyone.

When is the right time to die?

I used to believe that I knew. Just after Walt's surgery, I made plans to fine-tune my own advance directives—to forbid intubation or stomach tubes.

But I have yet to call my lawyer. I'm no longer so certain that choosing a quick, efficient death is selfless and honorable.

Now I know that my choice to die won't be just about me. And that changes everything.

*A writer and retired paramedic, K.D. Hayes has an MA in interdisciplinary studies and an MFA in creative writing.*

# ONE MARYLAND HOSPITAL'S APPROACH TO MEDICALLY INEFFECTIVE TREATMENT

*The responsibility to preserve human life through medical science has moral limits. Extraordinary means that may not alleviate the underlying condition and may excessively burden the patient are not obligatory. Moral decisions about the extent of care should be made in terms of the benefit that may be offered and the burdens that may be imposed, assisted by the medical professional's judgments and a person's sense of what is appropriate. - Maryland Catholic Conference- End of Life, [www.mdcathcon.org/endoflife](http://www.mdcathcon.org/endoflife).*

At the December 9, 2013 conference co-sponsored by MHECN and Harbor Hospital, Maryland Medical Orders for Life-sustaining Treatment (MOLST): A six month check-up, Lee Schwab, MD, FCCP, chair of the ethics committee at Holy Cross Hospital, presented his hospital's approach to requests to provide medically ineffective treatment. One of the more common reasons for an ethics consult in Holy Cross's adult inpatient population is moral distress among staff when negotiations over the care of dying patients breaks down and family members insist that their loved one continue to receive interventions that physicians have determined are medically ineffective in achieving the goals of care. Reasons for cases like these are familiar to ethics committee members: there is an increasing number of terminally ill patients admitted to intensive care units without appropriate prior end-of-life planning; physicians of diverse cultural origins let patients/family members choose which medical interventions to pursue without identifying goals of care and without restrictions on treatments unlikely to achieve the goals of care; physicians view their prime ethical duty as advocating for the individual patient rather than stewardship to the institution and the community;

physicians and patients alike shy away from open discussions about death, dying, and goals of care at the end of life; and physicians tend to acquiesce to patient/family demands for fear of the time and expense involved if they get sued. There was (and still is) misperception among physicians and members of the community that patients/surrogates have the right to demand all medical interventions.

Until recently, physicians have had little incentive to concern themselves with limiting non-beneficial treatment because they have been reimbursed for the additional acute care services provided to dying patients. The hospital, on the other hand, places itself in financial jeopardy when resource-intensive, non-reimbursable, non-beneficial treatments are provided on demand. Attention to financial sustainability is often downplayed in clinical ethics due to concerns that ethicists and clinicians should not "ration at the bedside." However, there is growing recognition that stewardship of finite medical resources is an important component of ethical analysis that should not be excluded in ethics case consultations. While withholding or withdrawing medically ineffective treatment can be justified for reasons other than resource stewardship (for example, if it is not in the patient's best interests or consistent

with his or her wishes), in some cases where a surrogate demands medical interventions for a non-communicative dying patient that won't achieve established goals, clinicians and ethicists should recognize justice obligations that are based on responsible allocation of medical resources. These obligations must be balanced by other ethical principles, such as the duty to minimize regrets and support the grieving process of bereaved loved ones. Thus, how institutions approach withholding or withdrawing non-beneficial treatments is critical to avoid the pendulum swinging from over-treatment at the end of life to under-treatment.

Holy Cross Hospital addressed this challenge at the organizational level. First, the ethics committee obtained feedback from staff revealing that physicians, in particular, did not view the ethics consultation process as useful in disputes about medical futility. Physicians perceived that they were taking most of the risk when they proceeded with certifications to withhold or withdraw medically ineffective interventions from a patient. Many physicians were unaware or unconvinced that an ethics consultation provided them with liability protection.

The ethics committee proceeded to address this by obtaining support from

*By a show of hands, attendees at the December 9, 2013 MOLST conference supported a process of establishing a hospital policy and procedure "community standard" in the state to withhold or withdraw medically ineffective treatment without a patient/surrogate's consent. This could include clarifying some of the terms in Maryland's HCDA, such as the definition of death being "imminent," a patient being "terminal," and what a "reasonable time" is to arrange transfer. It might also address ways to ensure fairness, such as referral of such cases for ethics consultation.*

senior leadership and hospital counsel to integrate ethical principles with the process outlined in the Maryland Health Care Decisions Act (HCDA). They created a facility-wide policy and process to address determinations of medically ineffective treatment. Dr. Schwab underscored the importance of this step: all staff—physicians in particular—must believe that the hospital is fully supporting them. At Holy Cross Hospital, they have found that physician-to-physician communication is an important component of the process. Another realization involved the greater

comfort level of staff and patients' family members regarding *withholding* non-beneficial treatment rather than *withdrawing* treatment. While in ethics no moral distinction is made between the two, the reality that these acts feel different has been incorporated into Holy Cross's process by allowing for "no escalation of treatment" decisions in some cases, rather than stopping all life support at once. Although ideologically imperfect, Dr. Schwab views this as a worthwhile compromise in the efforts to balance stewardship with compassion toward the emotional needs of grieving loved

ones.

Another important aspect of Holy Cross's process is absolute clarity that physicians, rather than ethics committee members, determine that a patient is in a terminal, end-stage, or vegetative condition, or that a particular intervention is medically ineffective. The ethics consultants may advise that additional medical consultation (e.g., neurology) confirm a treating physician's determination, but those requesting an ethics consultation need to understand that the practice of medicine resides with clinicians.

*Cont. on page 8*

## HOLY CROSS HOSPITAL'S PROCESS FOR WITHHOLDING/WITHDRAWING MEDICALLY INEFFECTIVE TREATMENT

### **Step 1 – Data Collection**

An ethics committee member (at Holy Cross Hospital this is often a physician, to allow direct physician-to-physician communication) collects relevant information from the medical chart and from stakeholders, visits the patient, reviews any advance directive or MOLST documents, identifies a surrogate decision-maker (if the patient lacks decision-making capacity), and reviews certifications for capacity, condition, and medically ineffective treatment. If there are no certifications yet completed, the consultant asks the physician whether he or she is willing to complete certifications if appropriate. The consultant may convene a meeting of the ethics committee if needed. A palliative care consultation may be recommended if not yet done. Recommendations are made and a written consultation note is placed on the chart, after first being reviewed by the Vice President of Mission Services, Vice President of Spiritual Care and Ethics, and Risk Management.

### **Step 2 – Negotiate Goals of Care**

An ethics consultation regarding withholding or withdrawing medically ineffective treatment occurs when a patient or surrogate disagrees with the physician's decision to withhold or withdraw treatment. Thus, an attempt is made to mediate this conflict by negotiating achievable goals of care, sometimes by facilitating a family meeting. Those involved often include the palliative care team, the patient's own primary care physician, chaplaincy, and the patient's own clergy. If, based on negotiations surrounding goals of care for the patient, the patient/surrogate agrees to withhold or withdraw medically ineffective treatment, the ethics consultation is complete. If the patient/family continues to insist that medically ineffective interventions be provided, they are informed that certain treatments may be withheld or withdrawn despite their wishes using the process defined in Maryland's HCDA, including the option of transfer.

### **Step 3 – Implementation**

At this point, all appropriate certifications are completed (e.g., patient incapacity; patient condition, i.e., terminal condition, end-stage condition, vegetative state, or medically ineffective treatment). Holy Cross has developed forms to use for these certifications. The patient or surrogate is informed of treatments to be withheld or withdrawn and is given a reasonable period of time, usually one week, to find a physician and facility willing to provide those treatments. All disputed treatments are provided during that time. Holy Cross will facilitate transfer if one is found. A letter from Senior Management is given to the patient or surrogate explaining this. If an alternative facility cannot be found, orders to withhold/withdraw medically ineffective treatment(s) are written, the patient or surrogate is informed, and the disputed treatments are withheld or withdrawn, with appropriate spiritual and palliative care provided.



## ***Medically Ineffective Treatment***

*Cont. from page 7*

Components of Holy Cross's process that Dr. Schwab identified as being particularly instrumental in its success include having specific wording in ethics consultation notes that physicians find supportive of medically ineffective treatment determinations, use of a standardized Certification of Medically Ineffective Treatment form, and administrative support in the form of a letter given to the patient's surrogate signed by a member of Senior Management, affirming the physician's plan to withhold/withdraw treatment by a given date unless transfer can be arranged.

Dr. Schwab noted that this process has been helpful when the surrogate feels overburdened by having to make decisions about whether their loved one lives or dies, or when a surrogate feels pressured by family or culture to choose aggressive life-prolonging treatments for the patient. Having the physician make the decision may remove the burden from the surrogate. It has also been helpful in some cases where there is no surrogate and the patient is appropriate for "comfort care only," as it precludes going to court to have a guardian appointed. However, staff need to be prepared to handle feelings of anger and resentment

among some family members who disagree with decisions to withhold or withdraw non-beneficial interventions from their loved one.

While Maryland's HCDA does not specify a period of time to await transfer if a surrogate disagrees with a decision to withhold or withdraw medically ineffective treatment, Holy Cross typically allows a seven day period for patients who are hemodynamically stable (i.e., if no transfer can be arranged within that time period, the medically ineffective treatment will be withheld or withdrawn after seven days). For patients who are actively dying and hemodynamically unstable, physicians may determine that transfer is not an option and institute "no escalation of treatment" upon informing the surrogate of this decision. During the discussion period following Dr. Schwab's talk at the December 9, 2013 MOLST conference, Jack Schwartz (formerly



with the Maryland State Attorney General's office) opined that he viewed this as consistent with the HCDA because the reference to "pending transfer" in Maryland's HCDA should be interpreted as awaiting a planned transfer, which wouldn't apply in the case of a patient with no available transfer options.

To view Dr. Schwab's presentation, visit MHECN's website at <http://www.law.umaryland.edu/mhecn> and click on "Conferences."

# 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, or MHECN, Law & Health Care Program, University of Maryland Francis King Carey School of Law, 500 W. Baltimore St., Baltimore, MD 21201.*

***NOTE: A Maryland physician was involved in the case below while working in another state. The hospital's ethics committee was not involved. Details have been changed to protect confidentiality.***

Antonia is a 34 year old woman who is 11 weeks pregnant with twins and hospitalized for complications of pregnancy. The amniotic sac for Twin A has ruptured, but the sac for Twin B is intact. Based on available outcomes literature, Twin A is not expected to survive. Thus, only Twin B is being monitored (via ultrasound once per shift). Antonia is put on inpatient bedrest to minimize the risk that Twin B's sac will prematurely rupture. A neonatal intensive care unit (NICU) fellow is consulted on the case. She proposes that starting at 24 weeks, the team could begin monitoring Twin A and, if either twin showed signs of distress, could deliver both twins early. Antonia, an undocumented immigrant from Mexico who does not speak English, is a devout Catholic. She considers that not intervening to try to save Twin A would be like "killing" the baby, and that even though an early delivery would threaten the life of either twin, she must try to save them both. She requests that both twins be monitored starting at 24 weeks, with the expectation that they be delivered via cesarean section if either show signs of distress. The neonatologists, while concerned that there isn't really a reasonable chance that they can save Twin A, feel that the team made this promise to Antonia and they can't

go back on it. A NICU resident calls a member of the ethics consultation service to discuss the ethics of this situation. She reasons that since it's almost a certainty that Twin A will die regardless of any intervention, there is no benefit to Twin A from the early delivery, but clear harm to Twin B.

## **RESPONSE FROM A NEONATOLOGIST & ETHICS COMMITTEE MEMBER**

The past two decades have seen a near doubling in rates of multiple births across the U.S. and many European countries (Kulkarni, 2013; Boyle, 2013). Some although not all of this increase is the result of growing use of assisted reproduction—technologies with inherent risks of multiple gestation. Multiple gestations have higher rates of congenital anomalies and premature birth than do singleton pregnancies. Usually only one fetus will be affected by the anomaly or premature rupture of the amniotic sac. Hence, it is increasingly common that parents and clinicians face decisions about how to balance competing interests of the affected fetus and the unaffected fetus(es)—and how to balance these with the interests of the mother. The literature in perinatal and pediatric bioethics lags behind this clinical trend, with most discussions of prenatal decision-making limited to maternal-fetal conflicts in singleton pregnancies.

In the case presented here, premature rupture of the amniotic sac for Twin A occurred at 11 weeks, and we assume there is minimal residual amniotic fluid. Antonia does not

appear to be in labor, so the pregnancy could continue for days, weeks, or months. Amniotic fluid is critically important to fetal lung development; without adequate amniotic fluid in the second trimester, fetal lung formation is severely limited. The overwhelming majority of such infants will die before or soon after birth. Rarely, a ruptured amniotic sac can reseal and amniotic fluid reaccumulate; we are not told that this occurred for Antonia. Some small studies suggest that repeated fluid infusions into the uterus until birth can permit neonatal survival for a minority (Locatelli, 2000). For Antonia, this therapy would be yet another intervention with questionable benefit for Twin A and risk for Twin B. In sum, there are no interventions to give Twin A even a modest chance of survival.

Neither of Antonia's twins is viable at 11 weeks, but her pregnancy could continue for months. In general, prior to 23 weeks gestation, neonatal survival is extremely rare and so resuscitation is typically not offered by U.S. clinicians. After 25 weeks, neonatal survival is greater than 50% and so most clinicians feel that resuscitation should be attempted. Between 23-25 weeks, neonatal survival is low but possible, so the standard of care is to allow families to participate in decisions about resuscitation based on their goals and values. These management guidelines must be amended when the fetus has another condition which

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## Case Presentation

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impacts morbidity or mortality—such as Twin A’s abnormal lung development. There are no objective data to guide resuscitation decisions in these situations. If Antonia went into spontaneous labor at 24 weeks, and greatly desires resuscitation for both twins, it is likely that some or most of the neonatologists would have complied with that request. Twin A may not survive resuscitation, but in the case of spontaneous labor, resuscitation of Twin A does not directly harm Twin B.

The issue in this case that most clearly pits the interests of Twin A, Twin B, and the mother against each other is the issue of premature cesarean section. Cesarean section after premature rupture of membranes can improve survival if fetal health is deteriorating. Prior to 24 weeks, the maternal risk from cesarean section is thought to be higher than the chances for neonatal survival, hence surgical delivery is usually only offered after 24 weeks. In a multiple gestation, where only one fetal sac has ruptured, premature cesarean section to optimize survival of that fetus necessarily imposes the risks of prematurity on the other fetus(es), who may not have delivered until term. For Antonia, should both fetuses survive beyond 24 weeks, Twin A will be the most likely to demonstrate fetal distress.

This case touches on the important question of whether it is permissible for a pregnant woman to place a healthy fetus at risk of death in an attempt to save a fetus who is unlikely to survive (Chervenak, 2013). Unfortunately, this option was presented as a valid choice to Antonia before team consensus about that option was achieved. Predictably, in the face of an ethically complex medical case, there are divergent opinions among medical team members about what options

are permissible. Ideally, team members will convene to discuss and reach consensus about permissible and recommended management plans before presenting options to the patient. Interdisciplinary team members, trainees, and ethics consultants should all be invited to engage in this process. Clearly some clinicians in this case do not agree with the option of cesarean section to save Twin A. When a controversial management plan is offered to a patient without team consensus, iatrogenic harm can occur.

Much is unknown about Antonia, the circumstances of her pregnancy, her social supports, or her Catholic beliefs. Few pregnant women are prepared for the possibility of extremely premature labor and months of bedrest with the impact on jobs, childcare, and finances. Antonia is an undocumented immigrant from Mexico, and is likely to have experienced economic insecurity, limited access to healthcare including prenatal care, and multiple social stressors. Identifying persons who can partner with her in these difficult decisions is crucial because she may lack cultural context for sharing serious medical decisions. Her Catholic beliefs appear to be important to her; involving a hospital or community priest may reduce Antonia’s suffering and can help navigate discussions about hope and quality of life. Antonia does not speak English, which may weaken understanding between the patient and the medical team.

A significant question about communication in this case revolves around the issue of what clinicians have told Antonia will happen to or for Twin A if resuscitation is not attempted. Too often this decision is posed as “do nothing,” suggesting that clinicians will abandon the infant after birth. A more skilled approach will emphasize the actions that can

be taken to minimize suffering and maximize comfort, bonding, and memory making, so that the infant’s life is filled with love and gentleness. Perinatal palliative care could begin from the moment of diagnosis, from the moment that Antonia was admitted with pregnancy complications. Irrespective of the pregnancy decisions or outcomes, palliative care can provide support and continuity and can ease suffering. These services are increasingly available through inpatient consultation or through relationships with local hospices.

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## REFERENCES

- Boyle B, McConkey R, Garne, E et al (2013). Trends in the prevalence, risk and pregnancy outcome of multiple births with congenital anomaly: a registry-based study in 14 European countries 1984-2007. *BJOG*, 120(6), 707-16.
- Chervenak FA, McCullough LB. (2013). Ethical challenges in the management of multiple pregnancies: the professional responsibility model of perinatal ethics. *J Perinat Med*, 41(1), 61-4.
- Locatelli A, Vergani B, DiPirro G (2000). Role of amniocentesis in the management of premature rupture of the membranes at <26 weeks' gestation. *183(4)*, 878-82.
- Kulkarni AD, Jamieson DJ, Jones HW Jr, et al (2013). Fertility treatments and multiple births in the United States. *N*, 369(23), 2218-25.

## COMMENTS FROM A CATHOLIC BIOETHICIST

Antonia’s dilemma sheds light on three important facets of clinical bioethics, including the benefit of having faith-trained ethicists, the ability to end an error chain before the error occurs, and the necessity to correct mistakes in a timely manner.

This case presents a complex, controversial ethical situation and Antonia's devout religious beliefs are truly admirable. It should be noted, though, that although Antonia believes attempting to save both twins is mandatory according to her Catholic faith, there are in fact provisions in Catholic doctrine that make it permissible to jeopardize the health of one twin for clear benefit to the other. It is certainly true that every human being has a fundamental right to life and that Catholics believe in the dignity of life from conception to natural death, but it is equally true that the ethical principle of double effect offers an acceptable solution to this complicated situation. Originally outlined by St. Thomas Aquinas in his work *Summa Theologica*, this principle offers an understanding of actions that have both an intended good effect and an unintended evil effect. The principle's concept—that foreseen harm can be done as long as the harm is unintended and the intended good is commensurable—corresponds to the circumstances of this case very well. Indeed, the good of saving Twin A's life is surely proportionate to losing Twin B, as sad and unfortunate as that outcome is (Paris & Elias-Jones, 2001). Without knowing more specifics of the case, but assuming nothing harmful was intentionally or directly done to Twin A, application of the principle of double effect instructs us that delivering Twin B at 25 weeks or soon thereafter (as warranted by the ultrasound monitoring), even with the probable demise of Twin A, is wholly permissible in accordance with Catholic theology (Annas, 2007).

In addition to the principle of double effect, the principle of proportionality must also be considered. The fact of the matter is that early delivery is disproportional for both Twin A and Twin B. The advertised and requested

treatment is disproportional for Twin A because it is not likely to help, is very invasive and expensive, and, more abstractly, would not result in a 'good' death. Similarly, it is disproportional for Twin B because it carries extreme risk (so much so that the benefits do not outweigh the risks) and is equally as invasive and expensive as for Twin A. In this case study, an ethicist with a background in Catholic healthcare ethics would have been immensely helpful to correct the inaccuracies in Antonia's perception of Catholic bioethics. In this way, faith-trained ethicists have the capability (and moral obligation) to correct a patient's misunderstanding by explaining the medical treatments available to the patient and to walk through the morality of each according to the specific faith's doctrine.

Although not an ethical principle, another major theme to extract from this case study is the responsibility of health care teams to recognize potential mistakes before they occur since the Harvard Medical Practice study concluded that 90% of medical errors are preventable (Wolf & Hughes, 2010). The necessity to correct mistakes in a timely manner is a concept that seems intuitively simple and somewhat obvious, but can be surprisingly difficult in clinical situations. Admitting a mistake is never easy, of course, and in the case of medical mistakes, is fraught with worry about lawsuits. Nevertheless, mistakes that could harm a patient must be counteracted and negated as soon as they are recognized. Indeed,



mistakes simply never get better with time and an empty promise of a medical treatment is better than the loss of a life.

Recognition of the mistake becomes increasingly difficult with larger healthcare teams. Coming from a military background, I apply the term "error chain" to this problem. That is, each person involved with the care of Antonia and her twins has the ability to halt the series of decisions before it results in a medical error. Since each decision might be small in nature and seemingly insignificant unless taken in aggregate with the other small decisions, error chains are notoriously difficult to identify. Here, in this case, the doctors, nurses, family members, on-call ethicist, and ethics committee members all had an opportunity to identify the mistake of suggesting both twins could be monitored starting at 25 weeks. In other words, they could have corrected that promise either before the patient requested monitoring or before the healthcare team assented to the monitoring, and therefore before anyone ultimately inflicted harm to Twin B.

The expanding number of people involved in many of these ethically challenging cases begs the question, "Who is best suited for identifying the mistake?" Arguably, this responsibility falls particularly on the shoulders of the ethicist because

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the ethicist's fresh eyes approach the case without being intricately or emotionally involved with the day-to-day care of the patient. They bring to the problem a top-down rather than a bottom-up perspective, and this change in thinking permits an opening that might be closed to others. In order for ethicists to capitalize on that opening, they should never become complacent consulting on cases. As ethicists trained to analyze the facts of the case and offer a decision best for the patient based on the circumstances at hand, it is imperative that their judgment is not excessively influenced by the information they gather from others on the health care teams. Doing so will increase the chance of glossing over the error. Instead, they must ask pertinent

questions and examine the entirety of the case for themselves whenever possible so that the succession of small decisions is seen as a whole and the medical mistake is more easily caught. Despite the physician actually disclosing the error to the patient, the ethicist plays an important role in the process of identifying the error and must be firm when discussing his or her recommendations with others. To be clear, this certainly does not clear other healthcare team members of all responsibility, but instead merely lessens the degree of expectation that they would be able to catch the error. It also highlights the necessity of encouraging open communication among all healthcare team members so that anyone who discovers the mistake feels comfortable enough to bring it to

the attention of the physician.

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## REFERENCES

- Annas, George J. (1987). At Law: Siamese Twins: Killing One to Save the Other. The Hastings Center Report, 17(2), 27-29.
- Aquinas, Thomas. Summa Theologiae 2-2, q 64, a 7.
- Paris, JJ; Elias-Janes, AC. (2001). Do we murder Mary to save Jodie? An ethical analysis of the separation of the Manchester conjoined twins. Postgrad Med J, 77, 593-598.

## CALENDAR OF EVENTS

### FEBRUARY

#### 24 (12:15-1:30P)

Disparate Views on the End of Life. Bioethics seminar speaker Sarah Shannon, PhD, RN, sponsored by The Johns Hopkins Berman Institute of Bioethics, 615 N. Wolfe Street, Baltimore, MD, W3008. For more information, visit <http://www.bioethicsinstitute.org/>.

#### 14 (4-8P)

Bioethics Colloquium with Dave Wendler, sponsored by the Center for Bioethics, New York University, New York, NY. For location & further information, and to RSVP, visit <http://bioethics.as.nyu.edu/page/events>.

#### 27

Do Emotions Derail Rationality? Webinar discussing article "When concretized emotional-belief complexes derail decision-making capacity," in Bioethics, 2012, 26(2), 108-16, with author Jodi Halpern, MD, PhD. Sponsored by the American Journal of Bioethics. For time and registration information, contact [cmhc@cmh.edu](mailto:cmhc@cmh.edu), call 816-701-5285, or visit <https://cmhbioethicswebex.com/>.

### MARCH

#### 6

The Culture of Dysthanasia. Webinar discussing article "The culture of dysthanasia: attempting CPR in terminally ill children," in Pediatrics, 2013, 131(3), 572-80, with co-author Jonna Clark, MD, MA. Sponsored by the American Journal of Bioethics. For time and registration information, contact [cmhc@cmh.edu](mailto:cmhc@cmh.edu), call 816-701-5285, or visit <https://cmhbioethicswebex.com/>.

#### 7 (4-7P)

Bioethics Colloquium with Dan Brock, sponsored by the Center for Bioethics, New York University, New York, NY. For location & further information, and to RSVP, visit <http://bioethics.as.nyu.edu/page/events>.

**7-9**

Responding to the Limits and Possibilities of the Body, 3rd Annual Conference on Medicine & Religion. Hyatt Chicago Magnificent Mile, Chicago, IL. For more information, visit <http://www.medicineandreligion.com/registration.html>.

**8**

Difficult Conversations in Healthcare: Teaching and Practice, sponsored by the Institute for Professionalism & Ethical Practice, Boston Children's Hospital and Harvard Medical School. Waltham, MA. Course repeats on May 17 and June 7. For more information, visit [http://www.hms-cme.net/3424265/3424265\\_emailindex2.html](http://www.hms-cme.net/3424265/3424265_emailindex2.html).

**10 (12:15-1:30P)**

Dignity for Patients in the ICU: A Conceptual Model. Bioethics seminar speaker Leslie Meltzer-Henry, JD, sponsored by The Johns Hopkins Berman Institute of Bioethics, 615 N. Wolfe Street, Baltimore, MD, W3008. For more information, visit <http://www.bioethicsinstitute.org/>.

**19**

Dangerousness & Involuntary Treatment: An Applied Ethics Workshop, sponsored by the University of Pennsylvania's Department of Medical Ethics & Health Policy, Claudia Cohen Hall, Terrace Room, Philadelphia, PA. For more information, visit [medicalethics.med.upenn.edu](http://medicalethics.med.upenn.edu).

**20-21**

Embracing Change: Balancing Innovation and Our Humanity. Health Care Ethics Consortium's Annual Conference. Sponsored by Emory University's Center for Ethics and the Health Care Ethics Consortium of Georgia (HCECG). Atlanta, Georgia. For more information, visit [www.hcecg.org](http://www.hcecg.org).

**APRIL****1-4**

Public Health Ethics Intensive, sponsored by the National Center for Bioethics in Research and Health Care located at Tuskegee University. For more information, visit [http://www.tuskegee.edu/about\\_us/centers\\_of\\_excellence/bioethics\\_center.aspx](http://www.tuskegee.edu/about_us/centers_of_excellence/bioethics_center.aspx).

**11 (4:30-7P)**

Bioethics Colloquium with Maggie Little, sponsored by the Center for Bioethics, New York University, New York, NY. For location & further information, and to RSVP, visit <http://bioethics.as.nyu.edu/page/events>.

**14 (12:15-1:30P)**

Moving Beyond Futility: Resolving intractable clinician-family disputes in patients with advanced critical illness. Bioethics seminar speaker Doug White, MD, sponsored by The Johns Hopkins Berman Institute of Bioethics, 615 N. Wolfe Street, Baltimore, MD, W3008. For more information, visit <http://www.bioethicsinstitute.org/>.

**23**

Ethical Dilemmas in the Practice of Obstetrics, Gynecology & Reproductive Medicine, Sponsored by the Cleveland Clinic, Cleveland, Ohio. For more information, visit <http://www.clevelandclinicmeded.com/live/courses/2014/obgyn14/default.asp>.

**24-25**

Ethics Problem Solving and Consultation: The Mayo Approach. Sponsored by The Mayo Clinic, Rochester, MN. For more information, visit <http://www.mayo.edu/cme/special-topics-in-health-care-2014r571>.

**25-26**

Symposium on Ethics and Mental Health, Marietta, OH. For more information, contact [akp004@marietta.edu](mailto:akp004@marietta.edu).

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# CALENDAR OF EVENTS (cont'd)

## APRIL (cont'd)

### 28 (12:15-1:30P)

The Ethics of Personal Responsibility. Bioethics seminar speakers Diane Hoffman, JD, MS & Janyne Althaus, MD, sponsored by The Johns Hopkins Berman Institute of Bioethics, 615 N. Wolfe Street, Baltimore, MD, W3008. For more information, visit <http://www.bioethicsinstitute.org/>.

## MAY

### 1-2

New Stressors and Solutions in Health Care Ethics, sponsored by the Colorado Healthcare Ethics Forum (CHEF), Thornton, CO. For more information, visit <http://coloradoethicsforum.org/>.

### 8-10

Ways and Means: Teaching Professionalism Across the Health Care Spectrum, 2nd annual meeting of the Academy for Professionalism in Health Care. Hilton Garden Inn, Chicago, IL. For more information, visit [http://academy-professionalism.org/index\\_/2014\\_Annual\\_Meeting.html](http://academy-professionalism.org/index_/2014_Annual_Meeting.html).

### 12 (12:15-1:30P)

Berman Bioethics Seminar speaker Brad Malin, PhD (biomedical informatics), sponsored by The Johns Hopkins Berman Institute of Bioethics, 615 N. Wolfe Street, Baltimore, MD, W3008. For more information, visit <http://www.bioethicsinstitute.org/>.

### 17

Difficult Conversations in Healthcare: Teaching and Practice, sponsored by the Institute for Professionalism & Ethical Practice, Boston Children's Hospital and Harvard Medical School. Waltham, MA. Course repeats on June 7. For more information, visit [http://www.hms-cme.net/3424265/3424265\\_emailindex2.html](http://www.hms-cme.net/3424265/3424265_emailindex2.html).

### 19-20 (and June 16-17)

4 Day Intensive Course in Bioethics Consultation Skills, sponsored by Montefiore-Einstein Center for Bioethics, New York, NY. Pre-requisite Montefiore-Einstein Certificate Program in Bioethics and Medical Humanities or permission of instructor. For more information, visit <http://www.einstein.yu.edu/masters-in-bioethics>.

### 25-30

Medical Humanities: Clinical & Pedagogical Perspectives, sponsored by the Doctors Kienle Center for Humanistic Medicine, Penn State College of Medicine, Hershey, PA. For more information, contact [kienlecenter@hmc.psu.edu](mailto:kienlecenter@hmc.psu.edu) or visit <http://www2.med.psu.edu/humanities/kienle-symposium>.

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

Berman Bioethics Seminar, sponsored by The Johns Hopkins Berman Institute of Bioethics, 615 N. Wolfe Street, Baltimore, MD, W3008. For speaker information and topic, visit <http://www.bioethicsinstitute.org/>.

### 28-31

The 25th Annual Canadian Bioethics Society Conference: Looking Back; Looking Forward. Renaissance Vancouver Harbourside Hotel, Vancouver, CA. For more information, visit [www.cbs-scb2014.ca](http://www.cbs-scb2014.ca).

## JUNE

### 2-6

Intensive Bioethics Course sponsored by the Kennedy Institute of Ethics, Georgetown, MD. For more information, visit <http://kennedyinstitute.georgetown.edu/programs/ibc.cfm>.

### 7

Difficult Conversations in Healthcare: Teaching and Practice, sponsored by the Institute for Professionalism & Ethical Practice, Boston Children's Hospital and Harvard Medical School. Waltham, MA. For more information, visit [http://www.hms-cme.net/3424265/3424265\\_emailindex2.html](http://www.hms-cme.net/3424265/3424265_emailindex2.html).

**8-27**

Bioethics Boot Camp at the University of Pennsylvania, sponsored by the University of Pennsylvania's Department of Medical Ethics & Health Policy. Applications due February 17. For more information, visit [medicalethics.med.upenn.edu](http://medicalethics.med.upenn.edu).

**9 (12:15-1:30P)**

Berman Bioethics Seminar, Berman Bioethics Seminar speaker Brad Malin, PhD (biomedical informatics), sponsored by The Johns Hopkins Berman Institute of Bioethics, 615 N. Wolfe Street, Baltimore, MD, W3008. For more information, visit <http://www.bioethicsinstitute.org/>.

**23 (12:15-1:30P)**

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**26-28**

Comics & Medicine: From Private Lives to Public Health. Sponsored by The Johns Hopkins University School of Medicine Department of Art as Applied to Medicine in collaboration with Graphic Medicine, at the Johns Hopkins Medical Campus, Baltimore, MD. For more information, visit <http://www.graphicmedicine.org/comics-and-medicine-conferences/2014-baltimore-conference/>.

***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 attempts to achieve this goal by:

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- 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.

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support.



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