

Health Care Law

Mid-Atlantic Ethics Committee Newsletter

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Mid-Atlantic Ethics Committee
Newsletter, Summer 2006

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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 2006

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The Mid-Atlantic Ethics Committee Newsletter is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland School of Law's Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities 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

CONSCIENCE-BASED REFUSALS IN HEALTH CARE: EXPAND OR REIN IN?

Which of the following would you consider a valid act of conscientious objection by a health care provider?

- An Oregon physician refuses to comply with a patient's request for assisted suicide.
- A pharmacist refuses to fill a woman's prescription for emergency contraception.
- A neonatal intensive care unit nurse refuses to provide what she considers futile and painful treatment to a severely premature infant.

A one-day conference on June 20, co-sponsored by the Maryland Health Care Ethics Committee Network (MHECN), set out to explore this and other questions.

Dr. James Childress, Hollingsworth Professor of Ethics and Professor of Medical Education at the University of Virginia and co-author of the classic bioethics text, *Principles of Biomedical Ethics*, provided a theoretical overview of conscientious objection. According to Childress, "conscience" is more readily defined using subjective rather than objective standards. A subjective standard takes into account the feelings of the actor. For example, one feels a sense of inner peace and wholeness when acting according to one's conscience. In contrast, acting against one's conscience produces feelings of guilt, moral conflict, and loss of integrity. Childress asserts

that one has a moral obligation to follow the dictates of one's conscience—an obligation that is protected by a right to recuse oneself from providing certain medical procedures that run counter to one's core convictions. However, since one's conscience can be ill-informed, there is a dual obligation to cultivate it by continually questioning and correcting it. In addition, Childress pointed out that following one's conscience is only a *prima facie* value. It can be trumped if it conflicts with a more important value. For example, respecting a Jehovah's Witness patient's refusal of blood products (autonomy) may trump a health care provider's (HCPs) deeply held conviction that she should not let a patient die who could be saved by her providing standard medical care (beneficence). Justifying which moral value or principle "wins out" in a situation like this is a familiar task for health care ethicists and ethics committee members.

Generally, the health care system has struck a balance between allowing individual HCPs to maintain their moral integrity by not forcing them to compromise their core convictions, as long as this doesn't interfere with the provision of standard medical care. Virtually all states, for example, have allowed HCPs to refuse to participate in abortions and sterilizations. However, recent state conscience clauses seek to expand the scope of conscience-based refusals to allow HCPs to refuse a broader spectrum of health care interventions. This initiative is a result of a growing movement among religious conservatives

NETWORK NEWS

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is not intended to provide legal advice
or opinion and should not be acted
upon without consulting an attorney.

MARYLAND HEALTH CARE ETHICS COMMITTEE NETWORK (MHECN)

MHECN co-sponsored the
conference, "Should
Conscience Be Your Guide?
Exploring Conscience-Based Refusals in
Health Care," on June 20, 2006, at the
University of Maryland School of Law.
Co-sponsors included the University of
Maryland School of Law, the Johns
Hopkins Ethics Committee and
Consultation Service, the University of
Maryland School of Medicine, and the
Health Facilities Association of
Maryland. In addition, the American
Society for Bioethics and Humanities
endorsed the conference. MHECN's Fall
2006 educational event will be announced
via flyers and through e-mail notification.

For more information about MHECN,
contact MHECN Program Coordinator
Anita J. Tarzian, PhD, RN at
MHECN@law.umaryland.edu or
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THE METROPOLITAN WASHINGTON BIOETHICS NETWORK (MWBN)

The Metropolitan Washington
Bioethics Network members
attended ethics committee
member training workshops sponsored by
the Inova Health System Center for Ethics
& Inova Learning Network this spring.
MWBN continues its guardian training
sessions with the D.C. Superior Court
Probate Division.

For more information about MWBN,
contact MWBN Executive Director Joan
Lewis at jlewis@iona.org or
(202)895-9408.

RICHMOND BIOETHICS CONSORTIUM (RBC)

RBC held a strategic planning
session in June to craft new
mission and vision statements
and goals. This involved surveying all
current Board and Institutional
Representatives to see what they think
the future direction of the RBC should
be—a process that yielded insightful
responses.

RBC continues its efforts to secure
grant funding for a program to encourage
science teachers to address bioethical
issues in their classrooms. RBC members
will be available as resource people. They
hope to present the grant information to
VAST (Virginia Association of Science
Teachers) at their conference in
November 2006 in Richmond, VA.

RBC members attended a three-day
educational program in March for those
who are new to the work of ethics
committees. The workshop, "Orientation
to Clinical Ethics: Three Days of
Education for Those Who are New to
Ethics Committees," was hosted by the
Hunter Holmes McGuire Veterans Affairs
Medical Center. This educational program
was a great success, as judged by
numbers of attendees and feedback from
those who participated.

For more information about RBC,
contact RBC President Gloria Taylor, RN,
MA, CPTC at taylorgj@unos.org.

Conscience-Based Refusals Cont. from p. 1

to limit access to reproductive services, stem cell therapies and certain end of life choices. Is it possible that a spillover effect could result, in which HCPs across the board might increasingly appeal to conscience as a basis for refusing participation in a broader scope of health care interventions they find objectionable? How might we evaluate the cases presented at the beginning of this article?

Oregon physician refuses to comply with a patient's request for assisted suicide.

Oregon law allows, but does not require, physicians to provide physician-assisted suicide (PAS). Physicians may object to involvement in PAS based on personal conscience (i.e., a religious and/or moral belief that one should not aid in suicide) as well as professional values (i.e., the values of not harming patients and nurturing trust are compromised by physicians assisting in suicide). There is little controversy that Oregon physicians who morally object to PAS are not obligated to participate in it. Distinguishing a "valid objector" in this case from an "invalid objector" may require a lower threshold of evidence than that required for cases where there is less consensus. If the number of physicians objecting began interfering with access to a valid PAS request in Oregon, this would certainly have implications for patients seeking PAS. However, because PAS is not considered standard medical care, the concern that mounting physician refusals to participate in Oregon would limit its access is of less concern than it would be for procedures considered to be the standard of care.

Pharmacist refuses to fill a woman's prescription for emergency contraception.

Assuming that an individual pharmacist ensures that another pharmacist is available to fill the prescription he finds morally objectionable, is this a "valid" objection? Does the pharmacist need to explain the source of his objection to his employer? What if he believes that emergency contraception is immoral because it kills an implanted embryo and thus is an abortifacient, even if this belief is contradicted by scientific evidence? It

seems reasonable to expect that, at a minimum, a valid conscientious objection is one in which there is congruity between the beliefs underlying a HCP's conscience-based refusal and available scientific evidence. Another example of an invalid refusal based on lack of such congruity would be the nurse who refuses to administer a high dose of morphine to a dying patient because she objects to euthanasia. This should not be considered a valid conscience-based refusal if the patient had been getting morphine and needed a higher dose to effectively manage pain. Research has shown that in such cases, the morphine does not hasten the patient's death (and even if it did, ethicists do not consider unintended hastening of death to relieve suffering as "euthanasia").

Neonatal intensive care unit (NICU) nurse refuses to provide what she considers medically ineffective and painful treatment to a severely premature infant.

Can a nurse refuse to provide an intervention (s)he considers to be medically ineffective and/or outside the standard of care? Is conscientious objection an acceptable framework for such a refusal? One conclusion drawn at the June 20 conference was that conscience-based refusals should be reserved for situations when no other means of justification are available. Thus, appeals to standard of care should be made before appeals to conscience. Why? If an HCP appeals to conscience to refuse an intervention that is medically inappropriate (i.e., based on it deviating from the standard of care, being medically ineffective, or not in line with a valid patient request), that HCP acts as a good patient advocate. Claims of conscience, on the other hand, are designed to protect the moral integrity of the HCP, not to advocate for the patient. If a nurse refuses to follow a physician's order based on personal conscience when (s)he can justly refuse based on professional duty, (s)he misses a chance to reform a broken system (e.g., a physician who refuses to order standard of care treatments or who prolongs a neonate's dying through the use of medical technology without just reason). However, in the NICU, it is often difficult to identify "medically inappropriate" treatment. If there is a 1 in 100,000 chance of "saving" a premature baby, but doing so would involve administering painful daily

treatments, could a nurse refuse to comply based on this being "medically inappropriate"?¹ Medical science and society have yet to answer such questions. Until that happens, NICU nurses may continue their current practice of reluctantly providing medical interventions they believe cause more harm than benefit to severely compromised neonates. Or, possibly, they may turn to conscientious objection as a way of managing the moral distress they feel and regaining their moral integrity.²

Obviously, how conscience influences HCPs' treatment decisions and behaviors is a layered and complicated topic, one that a one-day conference can only partly explore. MHECN looks forward to future opportunities to further the dialogue.

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Endnotes

¹ Anita Catlin, PhD, RN, conducted research-based focus groups surrounding the concept of conscientious objection as it applies to NICU nurses. One focus group participant provided the following example of how she experienced administering life-prolonging treatments to a dying neonate:

"The chest x-rays are the worst I have seen in 25 years. The baby has 20 significant desaturations a day. I have the feeling and it is the feeling of the whole neonatal team that we are only prolonging his dying. The parents are oblivious to his suffering. It breaks my heart to watch this and be part of it."

² Dr. Catlin found that NICU nurses coped with moral distress in the following ways: attempting to work within the team, choosing other patients, attempting to convince others, performing the objectionable intervention but experiencing moral distress, having anger internally or externally focused, experiencing burnout and leaving their position, asking for an ethics committee referral, joining the ethics committee, and gaining power through education.

References

Catlin, A. (June 20, 2006). "Issues in the NICU & Pediatrics." Breakout session

Cont. on page 10

CASE PRESENTATION

One of the regular features of the Newsletter is the presentation of a case and an analysis of the ethical issues involved. Readers are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information about patients and others in the case should only be provided with the permission of the patient. Unless otherwise indicated, our policy is not to identify the submitter or institution.

Cases and comments should be sent to MHECN@law.umaryland.edu, or MHECN, the Law & Health Care Program, University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201.

CASE STUDY FROM A NURSING HOME*

Mrs. Dunn is a ninety-one-year-old female who was admitted from the hospital to a geriatric center six months ago. Her admitting diagnosis was a stroke with right-sided paralysis and inability to speak.

As she is unable to swallow, she is fed via a naso-gastric tube. Her family has refused a stomach feeding tube (G-tube), stating that it is inhumane.

Mrs. Dunn seems to be very uncomfortable and is continuously touching and pulling at this tube. She is nonverbal but she seems to be aware of her surroundings. She appears to be somewhat apprehensive in groups (possibly due to the tube or embarrassment). Mrs. Dunn has a do-not-resuscitate (DNR) order but no other advance directives.

Staff from nursing, social services, speech therapy, dietetics, and recreation feel that Mrs. Dunn would be much more comfortable with a G-tube. It would also allow her to be less self-conscious and therefore she would socialize more and receive more stimulation.

What should the nursing home do?

COMMENTS FROM A THEOLOGIAN

Ethics committee members are often amazed that there is some rhyme and reason to moral methodology, but the case of Mrs. Dunn demonstrates that there are some questions that a committee must always ask first. This case clearly raises the question of who should make the decision about the insertion of the G-tube. However, before deferring to the relatives, it is essential to establish whether Mrs. Dunn has the capacity to make this specific decision herself. Even if she is lacking the capacity to make a decision about the G-tube, she might be capable of appointing a relative to be her health care agent. But before moving to this half-way measure, let us consider the first question. Does Mrs. Dunn have the capacity to make a decision about the stomach tube herself?

One assumption ethics committees ought to begin with is that people have decision-making capacity until proven otherwise. Since decision making and self-determination are the foundations of a free society, health care providers ought to be very reluctant—acting with care and only on good evidence—to take that prerogative away from the resident, our fellow citizen. In this case, however, our first intuitions about Mrs. Dunn might call her decision-making capacity into question because she is nonverbal. Even a psychiatrist would find it difficult to estimate her capacity because verbal cues are required to make a psychiatric evaluation. However, all that is needed is a determination of whether the person has an appreciative awareness of the specific decision that needs to be made. The presumption in favor of capacity invites us to look at more than just clear verbal communication as a sign of capacity for health care decisions.

So how do we estimate whether someone has an appreciative awareness of a health care decision? Certainly more facts would be needed, but it is easy to

imagine what an ethics committee should be looking for in this case. It should investigate, for example, whether Mrs. Dunn had made any statement at an earlier time about naso-gastric or stomach tubes. If she had, then a comparison between that statement and her nonverbal motions now would demonstrate consistency and remove some doubt about her decision-making capacity. Also, the committee would want to understand whether it is the naso-gastric tube that is making her unable to communicate verbally. Has she been given alternative means of communicating, such as nodding her head, blinking her eyes, or writing?

If the committee was clear that Mrs. Dunn did not have the appreciative awareness necessary to make the decision about the stomach tube, it ought not immediately defer to her relatives. Although she does not have any advance directive other than a DNR, she might have sufficient awareness to appoint another person to make her health care decisions. It is imaginable—and acceptable in common law and ethics—that Mrs. Dunn might be unable to make a specific health care decision about the stomach tube, but still be capable of appointing a health care agent. Once the health care agent was duly appointed by Mrs. Dunn under the relevant state statute, the agent would be bound only by the known wishes of Mrs. Dunn or, barring that, by her best interest and any limitations specified by the state law. It would be perilous for an ethics committee not to follow the wishes of the agent simply on the grounds that it did not agree with the agent's decisions. However, if the agent's decision were generally agreed to lie outside the realm of the reasonable, the committee would want to check state law to understand when, if ever, a legally appointed health care agent can be overridden and, if so, how.

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COMMENTS FROM A PSYCHIATRIST

The initial question concerning who should decide whether Mrs. Dunn should have her G-tube inserted is perhaps not self-evident. Namely, should it be Mrs. Dunn?

This question must not be overlooked, because Mrs. Dunn may have a reversible depression. Depression can mimic dementia and is sometimes called pseudo-dementia. It is common in residents who have had strokes, and, if untreated, persists in approximately 95 percent of these residents. It is especially frequent in residents with aphasia (inability to speak) and is also more likely to go unidentified because aphasic residents cannot verbally express depressed feelings. Unfortunately, depression of this kind too often goes untreated because care providers tend to believe that they, too, would feel depressed were they in this situation. Treatment may be indicated even if depression is merely suspected, and thus, Mrs. Dunn should be given a trial of antidepressant therapy.

If Mrs. Dunn's preferences are apparent, they should carry substantial moral weight even if she lacks decisional capacity. The preferences of incapacitated residents should be respected, particularly when they resist treatment interventions. Mrs. Dunn's present pulling at her tube may reflect such resistance, but whether this represents her genuine "net" preference or is more a habit or reflexive action is uncertain.

The inference that she is embarrassed in groups as a result of her naso-gastric tube is less likely based on speculation, for residents are known to form negative stereotypes towards those with naso-gastric tubes.¹ One resident stated, for example, "When you have a tube in you, that means that there is something wrong with your head!"

If the resident is determined to lack decision-making capacity, the question becomes whether someone in her family is the appropriate decision maker. Generally,

the family is in the best position to determine what the resident would want or what is in the resident's best interest. When family members disagree with health care providers about what is in the resident's best interest, however, the question arises as to whether the family's authority should be overridden. The family's basis for refusing the G-tube is unclear. They may have inadequate information. Obviously, the staff should ask them their reasons and explore with them the information on which they base their opinion.

The family, alternatively, may be suspicious of the staff. This suggests the need for continued communication between care providers and incapacitated residents' families about the indications for and alternatives to naso-gastric tubes after they have been placed. These discussions should enhance rapport between families and staff, and this greater rapport, in turn, should enhance residents' overall care.

These discussions can also benefit residents more specifically. They may, for instance, make it more likely that naso-gastric tubes will be withdrawn when they are no longer necessary, and that more desirable artificial means of providing food and water—as in the case of Mrs. Dunn—are substituted in a timely manner.

The family's response, finally, may reflect their despair over Mrs. Dunn's situation.² If so, the staff's helping the family respond more positively may be far more important to Mrs. Dunn than inserting the G-tube. Accordingly, the staff should offer the family whatever emotional support they can provide. After these discussions, if the family persists in requesting a course of treatment that is clearly at odds with either the resident's preferences or her best interests, a recommendation should be sought from the institution's ethics committee. If the committee's recommendation is consistent with that of the health care provider, resort to court for appointment of a guardian may be necessary.

If, on the other hand, the committee concludes that Mrs. Dunn's likely benefit is either remote or marginal, the committee should recommend following the family's wishes not to insert the G-tube. Under these two conditions, a rational basis for decision making is absent, and the family is then the most appropriate decision maker for several reasons. First, the family is closest to the resident and will be more affected by the decision. Second, if the family members feel that their wishes are complied with, they will be more likely to cooperate with the staff, and this should benefit them as well as Mrs. Dunn. Third, in Mrs. Dunn's present situation, if she could express herself, she might want, more than anything else, that her family's preference be respected.

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*This case study and responses are reprinted from *Handbook for Nursing Home Ethics Committees* (1995), D.E. Hoffmann, P. Boyle, & S.A. Levenson (Eds.), Washington, D.C., American Association of Homes and Services for the Aging.

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INTERVIEW WITH AN ETHICS COMMITTEE CO-CHAIR

Periodically, MHECN staff interview a member or chair of an ethics committee at a Maryland health care facility in the region. The purpose of reporting on the interview is to provide an opportunity for other committees to learn about how one committee operates, how it relates to its institution, what it has learned, how it has evolved over time, what it has accomplished and what it hopes to accomplish.

University of Maryland law student Brian Kehoe interviewed Rev. Bob Steinke, co-chair of Frederick Memorial Hospital's ethics committee, last Spring. Rev. Steinke (known to many as "Chaplain Bob") holds an undergraduate degree in Aerospace Science, graduate degrees in Counseling Psychology and Religious Education, and a Doctor of Philosophy with emphasis in Divinity and Pastoral Administration. In addition to directing Pastoral Care and serving as a hospital chaplain at Frederick Memorial Hospital, he holds additional certifications as an Addictions Counselor, Medical Ethicist, Palliative Care Specialist, Crisis Counselor, and Field Traumatologist. Over the years, Rev. Steinke has developed and published numerous Continuing Pastoral Education training modules, academic articles, and clinical assessment tools related to ethics, spirituality, and end-of-life care that are in current use in over 300 hospitals and healthcare institutions throughout the country and in Australia.

Frederick Memorial Hospital is a community hospital currently licensed for 232-acute care beds and an additional 57-non-acute beds located in Frederick, Maryland. The ethics committee receives its primary funding from the Medical Staff Committee, with additional monies from the Pastoral Care Department covering expenses such as MHECN membership dues, and printing of educational materials distributed throughout the hospital.

BK: Could you tell me how your committee is structured?

RS: We are a multidisciplinary committee chaired by a physician, made up of both medical staff and hospital personnel. Our committee usually has about twelve people, including representatives from several physician disciplines, critical care nursing, patient relations, and social services. However, we have recently experienced some vacancies due to attrition and new staff coming into our hospital system. I have served as the committee co-chairperson for the past nine years.

BK: How did you become involved with the committee?

RS: I studied ethics in graduate school and then took extra course work in clinical ethics to update my past education, which then qualified me to serve additionally as an ethicist. After becoming the hospital chaplain, I was asked to serve on the ethics committee, and later, on our Institutional Review Board.

BK: How do you think being a chaplain affects your involvement with the committee?

RS: It allows me to represent several dimensions. Being a chaplain and having gone through seminary, I can represent the theological and philosophical perspective. My clinical background makes it easier to communicate with physicians and the medical staff. As co-chair, I am also involved in administration and have a role in education and training. We have community members who participate, as well as a few local clergy. My role as chaplain serves as a bridge to the faith community at large—that is, across faith traditions, from a philosophical and theological perspective.

BK: What are the backgrounds of the members of your committee?

RS: Several members have a background in clinical ethics. I don't know if anyone has formal education in philosophy or ethics, but most have gone through a

training program, such as the program offered at Georgetown.

BK: Do you have any type of formal education for new members?

RS: We use formal and informal teaching methods. The formal teaching involves a Clinical Ethics educational training module that is presented to ethics committee members. We offer CEU credit for anyone taking the course. I am currently working on developing a practical training module that is to be placed on our web site. This module will contain information specific to understanding our institution's approach to ethics deliberation and consultation (for example, what is the Patient Care Advisory Committee, how do you access the committee, what is the committee's function or role in supporting patients, their families, and the staff responsible for delivering their care?).

We also subscribe to several journals, and we circulate articles about current ethical issues and case studies that complement the formal training.

BK: How are your members selected?

RS: The Hospital Chief of Staff appoints the Chair & Co-Chair of the committee, since the committee is identified as a Medical Staff Committee.

Representatives from the other disciplines are appointed by the Senior Vice President for Patient Care Services in collaboration with the nominee's department director or supervisor. The nominee sits in on one meeting and the committee then decides whether he/she is a good fit. Regarding community members, their names and bio's are brought before the committee and everyone has a chance to comment and then approve. They are then invited to attend the next scheduled meeting.

BK: What kinds of things do you do for the education part of the committee meeting?

RS: We read through case studies and review consultation requests we've performed. After a consultation request and response, the committee member will

Cont. on page 10

ALLOCATION OF BLOOD PRODUCTS— RESPONSE TO NEWSLETTER CASE STUDY

My colleagues and I read with interest the case study in the Fall 2005-Winter 2006 Newsletter, which featured a patient with end-stage cancer who requested continued blood transfusions for cancer-related hemorrhage, despite doubts on the part of his oncologist regarding the appropriateness of unlimited blood transfusions for a dying patient. At about that time, our ethics committee was presented with a somewhat similar case.

Mr. Cutting* was a man in his early 80's who had metastatic prostate cancer and myelodysplasia. For the past year, he had many hospital admissions for blood loss from arteriovenous malformations (AVM's) in his colon, and had multiple therapeutic procedures attempted with limited benefit. During his current hospital admission, he underwent procedures by specialists in gastroenterology and interventional radiology without success. Colectomy was considered, but his physicians determined it was not an option due to Mr. Cutting's poor health status and his developing sepsis. Thus, no treatment was available to control the bleeding.

At the point of our ethics evaluation, Mr. Cutting had received nearly 50 units of blood and many units of platelets, being transfused nearly every day. The attending physician discussed the situation with Mr. Cutting and his family. Mr. Cutting said that, although he did not want resuscitation attempts if his heart or breathing stopped, he wanted to continue receiving transfusions as long as he was able to interact with his family. He was told that he would almost certainly spend the rest of his life in the hospital in his current condition, bedbound and having repeated bloody stools.

Our ethics committee was asked to evaluate this case as regards the ethics of continued transfusions without an apparent end-point. There were two basic questions: (1) were the transfusions medically effective?, and (2) was it ethically appropriate to provide an unlimited amount of a somewhat limited resource?

Regarding the first question, the ethics committee discussed what might constitute a benefit to Mr. Cutting. First, he was alert and requested that the transfusions continue, therefore exercising his autonomy. While the transfusions were not effectively addressing the multiple AVM's causing continued bleeding, they were seemingly extending Mr. Cutting's life. Were they enhancing his quality of life? That is up for debate, since daily provision of blood products required that Mr. Cutting stayed in the hospital. Might his final days have been better spent at home, with hospice support, rather than in the hospital? A psychiatrist evaluating Mr. Cutting's ability to make decisions about his care questioned how fully he understood the gravity of his condition. For example, the psychiatrist determined that Mr. Cutting thought surgery was still an option, and that he had only a rudimentary understanding of why he was getting blood transfusions. Mr. Cutting's daughter, who was his health care agent, wanted to abide by her father's wishes to continue the transfusions, while his son questioned whether the transfusions should be stopped. Thus, a family conference may have helped clarify the role of blood transfusions and the goals of care for this patient.

Regarding the second question, we struggled with effective answers. Dr. Vanessa Ajayi and Dr. Paul Van Nice, responding to the previous Newsletter case study, cautioned against limiting blood transfusions based on rationing justifications. Dr. Ajayi stated, "Discontinuing blood transfusions that are not benefiting a patient is well within the scope of practice for the oncologist. Mentioning the cost or availability of the blood to the patient or family member is what may cause controversy." Furthermore, Dr. Van Nice cautioned that even if it were determined that the blood transfusions were medically futile, there is a tendency for patients and family members to interpret this as a "devaluation of the patient's life, i.e. 'this

patient's life is not worth extending.'" He suggested a careful review of facts to determine if it is indeed true that other patients are being deprived of blood being given to the patient in question. Our ethics committee was more willing to question the unlimited use of blood products, which are in short supply across the board. The committee was divided over whether blood should be provided without limits to a dying patient who could be kept alive with continued transfusions. In the absence of meeting the definition of being "medically ineffective," about half the committee felt that transfusions should be continued as long as the patient or his proxy requested them and they were meeting an established goal of care. The other half of the ethics committee thought some limits could be placed on blood transfusions for such a patient. For example, the patient could be told upon initial transfusion therapy that this would be provided for a limited period of time and then the goals of care would be re-evaluated.

Mr. Cutting died of sepsis after receiving nearly 100 units of blood and many units of platelets, neither of which had been limited. His case raises interesting questions about the definition of medical ineffectiveness, which must be viewed from both the patient's and the health care team's perspectives. It also brings to the forefront the issue of whether limited resources can or should be rationed. The complexity of these frequently encountered ethical dilemmas was highlighted by the lack of a consensus of opinion within our ethics committee.

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*Identifying details about this patient were changed to protect confidentiality.

MEDICAL ETHICS EDUCATION IN MYANMAR

Last August (2005), I had the opportunity to travel to Myanmar (formerly Burma, located between Thailand, India, and China) to speak to medical school faculty there about medical ethics teaching in the U.S. Professor Than Nu Shwe, Rector of the University of Medicine 2, invited me to speak at a seminar geared toward integrating medical ethics education into the curriculum of Myanmar's three medical schools. Professor Yali Cong of China was also an invited speaker. Professor Than Nu Shwe and her colleague, Professor Tha Hla Shwe, asked me to give two talks: "Teaching Ethical Theory" and "Medical Ethics Education in U.S. Medical Schools: Pros and Cons." I was somewhat surprised by the offer, wondering how Western bioethics, with its origins in hi-tech medicine, individual rights, and patient autonomy, could be of value to a developing Asian country that is 80% Buddhist and currently run by a military government. What relevance could ethics taught in U.S. medical schools have for Myanmar medical schools? More than I thought.

Current approaches to ethics education in Myanmar medical schools rely heavily on what medical educators refer to as the "hidden curriculum," in which concepts of right and wrong behavior are taught through modeling and clinical encounters with faculty (rather than from formal teaching methods). Whereas U.S. bioethics focuses heavily on individual patients' rights, autonomy, and end-of-life decision-making, medical ethics teaching in Myanmar has focused more on issues related to professionalism (e.g., the doctor-patient relationship, physician etiquette, competence, rational prescribing practices, etc.). However, both systems face similar challenges: how to fit ethics teaching into an already crowded curriculum, how to "teach ethics" in ways that yield observable positive outcomes, how to evaluate



Medical School Skills Training Lab

ethics education, and how to train faculty to model ethical behavior and reasoning. Suggestions from seminar attendees to improve the medical ethics curriculum included teaching ethics content over all five years instead of concentrating it in one year, incorporating critical thinking skills based on ethical theory, employing a diversity of teaching methods (e.g., role play, case scenarios, simulated patients, video clips, and bedside teaching), training faculty in ethics education, and devising better methods of evaluating ethics education.

The Myanmar faculty members were hungry for information and resources. I was awed by their commitment to fostering more ethically competent physicians, and deeply grateful for their gracious hospitality. Over the course of the three day seminar, I had the opportunity to exchange thoughts, questions, and ideas about ethics education with many professors, as well as with the Deputy Minister for Health (himself a former transplant surgeon). I

learned that, while ethical issues in Myanmar are differently prioritized than in the U.S., global trends are introducing familiar dilemmas, such as the recent entry of privatized health care (as a second tier choice to the national health care available in Myanmar). Questions about physician conflicts of interest (e.g. through referral incentives and kickbacks) are surfacing. Emerging medical technology has raised questions about access and rationing. These and other issues require an educated physician population that can contribute thoughtfully to dialogues where bioethics plays a central role. Toward that end, Myanmar physicians may end up ahead of us in the U.S., as they only



Myanmar medical school faculty explore ethics education

have three medical schools, while we have 125 (all with their own curriculum). Perhaps we could then invite them here to share their insights about whether and how "ethical competence" can be taught to health care professionals.

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CURRENT MEDICAL ETHICS CURRICULUM IN MYANMAR MEDICAL SCHOOLS

As summarized by Myanmar August 2005 seminar attendees

Formal teaching (e.g., lecture)	Informal teaching (e.g., discussion, role modeling)
<p>Introduction to morals</p> <p>Definition of ethics and medical etiquette</p> <p>Codes of medical ethics (Hippocratic oath, the Declaration of Geneva, the International Code of Medical Ethics)</p> <p>Professional misconduct and medical negligence in Myanmar (both civil and criminal), current situations of unethical conduct in Myanmar based on deviations from the Myanmar Medical Council (MMC) guidelines on medical practice</p>	<p><u>Anatomy</u>: Respect for cadavers, Prior consent for experimenting on human subjects</p> <p><u>Pharmacology</u>: Rational prescribing practices, over- and under-prescribing, use of generic names in prescribing</p> <p><u>Pathology</u>: Respect for specimens, communication skills in specimen collection</p> <p><u>Microbiology</u>: Use of microbiological weapons and bioterrorism, indiscriminate use of antibiotics</p> <p><u>Obstetrics & Gynecology</u>: Contraception (patient’s informed choice), abortion,* Perinatal mortality (counseling)</p> <p><u>Surgery</u>: Common causes of negligence in surgical procedures.</p> <p><u>Clinical rotations</u>: Professionalism, communication skills/ bedside manner, doctor-patient relationship—especially with psychiatric patients, informed consent, confidentiality (with emphasis on clinical research), respect due to minors and consent of guardians, proper referrals, preventive medicine, brain death and resuscitation</p> <p>*Abortion is illegal in Myanmar, unless to preserve the life of the mother.</p>

LEGISLATIVE UPDATE

The Maryland General Assembly passed two bills relating to advance directives in the 2006 session. Governor Ehrlich signed SB 236/HB 319 into law on May 2, 2006 and SB 369 became law without the Governor’s signature on May 30, 2006.

SB 236: Health- Advance Directives- Registry- Drivers’ Licenses and Identification Cards

SB 236 establishes a registry within the Department of Health and Mental Hygiene where individuals may file an advance directive. Registrants will receive a notation on their drivers license or identification card allowing hospital personnel access to the advance directive in an emergency.

SB 369: Health Care Decisions Act- Advance Directives- Selection of Health Care Agent and Treatment Preferences

SB 369/HB 592 simplifies the statutory advance directive form. The revised form includes three parts: (1) The Selection of Health Care Agent (HCA), (2) Treatment Preferences (“Living Will), (3) Signature and Witnesses. The new form requests additional information not included in the past form. The most notable additions include a third health care agent, a listing of specific people the health care agent is encouraged to consult, an option to allow the HCA not to be bound by a written directive, and additional instructions in case of pregnancy.

Conscience-Based Refusals Cont. from p. 3

moderator, *Should Conscience Be Your Guide? Exploring Conscience-Based Refusals in Health Care*, University of Maryland School of Law, Baltimore, MD.

Childress, J.F. (June 20, 2006). "Exploring Claims of Conscience." Invited lecture, *Should Conscience Be Your Guide? Exploring Conscience-Based Refusals in Health Care*, University of Maryland School of Law, Baltimore, MD.

Interview with an Ethics Co-Chair Cont. from p. 6

write up a consultation response form, which includes the nature of the consult and its outcome. At the next meeting, the consultation is reviewed, both to keep members informed of the committee's activities, and for educational value.

BK: Is the committee involved in any community education?

RS: Yes, we offer the same clinical ethics educational training module we utilize for our staff and make it available as part of our community outreach. I target the faith community, especially as host sites for the community education sessions. We then offer the workshop on a space-available basis to the entire community, and this has been very successful. We have the same type of program for advance directives. We also offer the same program in collaboration with the Hood College Graduate program in Thanatology.

BK: How do the staff and families know about the ethics committee and the consult service?

RS: We developed a brochure that we've circulated and have in key locations in the hospital. It includes information on how to access the ethics committee, what the committee does, and what to expect from a consult. It is available to the entire hospital community. We have recently made a pocket card for quick reference for the committee members. It includes a clinical ethics consultation flowchart. The back of the card has an algorithm showing the process that needs to be followed when making treatment decisions. We posted a placard in the nursing stations for quick reference, which includes a copy

of the same algorithm for making treatment decisions.

BK: How do referrals for consultations get to the committee?

RS: Contact begins with the hospital operator. The request is then passed to the member on call. With the recent hospital reconstruction and refurbishment, we have experienced significant attrition within our committee membership. Therefore, there are currently only a few of us who take calls and we take turns as primary contact with the others remaining available as back-up. The on-call member's first priority is to determine whether the request is appropriate for an ethics consultation. The committee member will make a referral if an ethics consultation is not appropriate. Otherwise, the member has several options depending on the situation. The member may consult over the phone, in person, or with the medical staff involved in the case. If there is no resolution, an ad-hoc committee is assembled, consisting of designated committee members and other individuals, who may not be committee members, i.e., a pharmacist may provide helpful information and support for a question relating specifically to a medication issue. Patients and members of their families and significant others (as identified by the patient) may attend the meeting. In most situations, the full committee does not respond to a consult request.

For example, recently a new nurse contacted us because she was nervous about giving a high dose of morphine. She was not used to giving palliative care at that level. I met with her and called an ad-hoc committee meeting. I invited the doctor and pharmacist to collaborate and address the nurse's concerns. She felt very positive about the conversation, which gave her a greater level of comfort in administering opioids for palliative care. In many instances, the involvement of the entire committee is not essential to achieving a positive outcome. However, the full committee always remains ready to meet in support of our staff and patient community.

BK: How do you report your recommendations?

RS: We have several places where our recommendations are reported. First, the ethics committee member who has been involved in leading the consultation

completes an ethics consultation form, which then is maintained in the Ethics Committee logbook. The nurse and/or physician taking care of the patient, and who requested the ethics consult, may make an entry in the patient's medical chart, if deemed by them to be necessary and appropriate. If either an ad-hoc committee or the full committee has participated in the consult, the chair or co-chair will also make a notation in the patient's chart summarizing or outlining the request and the outcome. The consult response form is kept with the ethics committee minutes.

BK: What would you say pleases you most about the work of your committee?

RS: One, it brings us together in a collegial way to discuss issues to better the quality of care in the hospital. It facilitates an awareness of the complexities involved. The consults are not always dramatic and often include matters such as helping a patient or family adjust to a health crisis. We come together with the staff and physicians and create a dialogue. Clinical ethics is heavily driven by medical technology which, in turn, has the potential to influence the choices we make, especially relating to the value, meaning, and purpose we understand for ourselves and our living or dying. I consider all humanity to be morally equal but differentiated by differing levels of power and influence (dependent upon circumstances) and expertise. Technology is increasing our medical capabilities. With all we can do to extend and enhance human life, maybe there are limits we should be imposing. This requires forethought about the best way to implement these new technologies. What are the effects on lives, communities, and humanity?

It is an inspiring dialogue with which to be involved. The ethics committee helps nurture this kind of dialogue by educating and training ethics committee members who then help educate others to work through ethical conflicts in patient care. But ideally, all members of the treatment team should be able to resolve ethical dilemmas at the bedside, relying on the ethics committee as a resource and for support. I, personally, would be disappointed and cautious about any process that would distort, diminish, or otherwise interfere with the relationship between the patient and their physician and those who make up the treatment care team.

CALENDAR OF EVENTS

SEPTEMBER

- 10-11 Creation, Procreation & the New Genetics.** Sponsored by the Academic Coalition for Jewish Bioethics. The Jewish Theological Seminary, New York, NY. For more information, visit www.jewishethics.org (click on the ACJB logo) or e-mail bioethicscoalition@rrc.edu.
- 13 The Absence of Presence: Lessons from American Medicine.** Speaker: Rebecca D. Elon, MD, MPH. Sponsored by BWMC's Medical Ethics Committee. 6:00 PM, Baltimore Washington Medical Center, 301 Hospital Drive, 3rd Floor, Padussis Conference Center, Glen Burnie, MD. **RSVP to 410-787-4242.**
- 14-16 Medical and Normative Horizons of Human Bodies.** The 6th Quandaries in Health Care Conference, sponsored by the Given Institute of the University of Colorado, Aspen. For more information, contact Mary Lou Wallace at 303-315-5096.
- 15 The Whether, How, and When of Race in Biomedical Research: Four Perspectives.** (1 PM–5 PM). Amado Recital Room, Irvine Auditorium, University of Pennsylvania Center for Bioethics, 3401 Market St., Ste. 320, Philadelphia, PA. For more information, visit www.bioethics.upenn.edu.
- 20-22 The 6th International Conference on Priorities in Health Care.** Toronto, Canada. For more information, visit <http://www.healthcarepriorities.org>.
- 29 Ethics in Everyday Clinical Practice.** Sponsored by Inova Health System Center for Ethics & Inova Learning Network. IAMS Conference Center, Inova Health System, Falls Church, VA. Contact: Patti O'Donnell, Ph.D, MSW, 703-321-2658, patricia.o'donnell@inova.com.

OCTOBER

- 20 Resolving Medical Malpractice Disputes: Featuring the Two Track_{sm} Model of Attorney Representation.** Sponsored by the University of Maryland School of Law and CHORDA Conflict Management, Inc. University of Maryland School of Law, Baltimore, MD. For more information, visit <http://www.law.umaryland.edu/conferences.asp>.
- 20 Ethical & Psychosocial Management of the Patient and Family Identified as Difficult.** Sponsored by Inova Health System Center for Ethics & Inova Learning Network. IAMS Conference Center, Inova Health System, Falls Church, VA. Contact: Patti O'Donnell, Ph.D, MSW, 703-321-2658, patricia.o'donnell@inova.com.
- 20-22 Ancillary-Care Obligations in Developing Countries.** Sponsored by the Reflective Engagement Initiative at Georgetown University, in cooperation with the Department of Philosophy and the Kennedy Institute of Ethics. For more information, visit <http://philosophy.georgetown.edu/ancillarycare>, or e-mail ancillarycare@georgetown.edu.
- 26-29 Challenging Voices.** 8th Annual Meeting of the American Society for Bioethics and Humanities. Denver, CO. For more information, visit <http://www.asbh.org>.

NOVEMBER

- 15 Palliative Care in the 21st Century, Fifth International Conference.** Sponsored by the Professional Education Center of The Jewish Home & Hospital Lifecare System. Columbia University, New York, NY. For more information, visit www.jewishhome.org/pdf/Palliative_Care_FINAL.pdf, or contact Naim Gribaa at 212-870-4762, NGribaa@jhha.org.
- 16 Current Controversies in Healthcare Ethics.** Sponsored by Inova Health System Center for Ethics & Inova Learning Network. IAMS Conference Center, Inova Health System, Falls Church, VA. Contact: Patti O'Donnell, Ph.D, MSW, 703-321-2658, patricia.o'donnell@inova.com.

