THE ROLE OF ETHICS COMMITTEES IN ALLOCATING SCARCE MEDICAL RESOURCES

Faced with a potential crisis, in late October the Centers for Disease Control (CDC) appointed a permanent ethics panel to help it think through who should receive priority in the allocation of the scarce supply of the flu vaccine and how it should deal with future epidemics. According to a New York Times article, this was the “first time in its history” that the CDC had created such an entity. Perhaps it is a sign of the emerging legitimacy of public health ethics.

Although ethics panels at the national level are not new, their use in the area of public health is a recent development. Prior and existing national ethics commissions have dealt with questions of life sustaining treatment, stem cell research, cloning, research on the decisionally impaired, and new reproductive technologies, but they have not generally addressed the thorny issues created by public health problems. Arguably, one of the most challenging of these is the allocation of scarce medical supplies and services during a potential public health crisis.

While most institutional ethics committees deal with health care treatment issues that raise ethical principles of autonomy, beneficence, or nonmaleficence, they deal less frequently with issues of distributive justice. These latter issues are more likely to arise for policy makers at the local, state or national level when decisions need to be made about rationing scarce resources. But the situation with the distribution of the flu vaccine may have required hospitals, nursing homes, and possibly their ethics committees, to make some difficult rationing decisions.

CDC Allocation Criteria

On Oct. 5th when Chiron Corporation announced that none of its influenza vaccine would be available for distribution in the U.S. for the 2004-05 flu season, the CDC announced its...
MARYLAND HEALTH CARE ETHICS COMMITTEE NETWORK (MHECN)

Recently, MHECN distributed its member resource binder to MHECN institutional members. The binder includes resources for ethics committee members, including relevant Maryland legislation, previous newsletter case studies, and video, website, and bibliographic resources. The binder will be a living resource, intended to house MHECN newsletters and future mailed additions.

Educational Programs
On November 17, 2004 MHECN sponsored a conference on DNR issues at Charleston Retirement Community in Catonsville, MD (see p. 5 for highlights of the conference).

In Summer 2005 MHECN is planning a basic ethics education conference. Stay tuned for more details.

Contact MHECN at (410) 706-4457; e-mail: www.MHCN@law.umaryland.edu

MHECN Program Coordinator: Anita J. Tarzian, PhD, RN

THE METROPOLITAN WASHINGTON BIOETHICS NETWORK

The Metropolitan Washington Bioethics Network co-sponsored Georgetown University’s Bioethics Colloquium on November 11, 2004. Edmund Pellegrino, MD, Member of the International Bioethics Committee of UNESCO, spoke on “UNESCO’s International Bioethics Committee: The Quest for Universal Norms of Bioethics.”

MWBN also continues its guardian training sessions with the D.C. Superior Court Probate Division.

Contact: Joan Lewis, Executive Director, 202-895-9408, jlewis@iona.org

The Role of Ethics Committees
Cont. from page 1

plans to limit the remaining supply of the vaccine to adults 65 years of age and older, children 6 to 23 months of age, individuals with certain chronic illnesses, pregnant women, residents of nursing homes and children on chronic aspirin therapy. In addition, it recommended the vaccine for individuals who might spread the flu to high-risk individuals, including household contacts of infants under 6 months of age and health care workers providing direct patient care. In early November the CDC developed a second allocation plan for distribution of the remaining doses of the vaccine to the states based on 1) the number of high-priority individuals in the state, 2) the number of doses the state had already received and 3) the state’s unmet needs. Each state was then to distribute its allocation to its high priority groups.

The Need for Additional Guidance
While the CDC made it clear that the vaccines should only be given to the very young, the very old, and the chronically ill, state and local health authorities, concerned that they might not have sufficient supplies to cover everyone in these categories, asked for additional guidance as to who should receive priority within this group. This was the case in southeastern Pennsylvania. On November 30th, the front page headline in the Philadelphia Inquirer was “Healthy seniors asked to forgo flu shots.” According to the article, healthy seniors in southeast Philadelphia were asked to skip the flu shot this season to make sure the vaccine would be sufficient supply for the elderly with significant health problems. The proposal was made by the Delaware Valley Healthcare Council, which was responding to concerns that the federal guidelines had not been specific enough, especially to help nursing homes to make tough decisions on how to allocate the vaccine between residents and workers and among residents. In other states, public health authorities asked for guidance as to whether to send the vaccines to nursing homes or pediatrics’ offices.

Ethical Approaches to Distributive Justice
Allocation decisions put into play issues about who is most in “need” or most deserving or who can most “benefit” from the limited service or treatment. An ethics panel may be helpful in making recommendations under such circumstances. Beauchamp and Chisholm have articulated a number of approaches to distributive justice. These include egalitarian, libertarian and utilitarian theories. Much debate in the field focuses on which of these approaches should have priority. Under an egalitarian approach we would give everyone an equal share or an equal opportunity. In the context of the flu vaccine this might mean the young would have priority over the old as they deserve an equal opportunity at life; the elderly have had their opportunity. John Arran, a member of the CDC ethics panel and a professor of bioethics at the University of Virginia characterizes this as the “fair innings approach” in which “people are supposed to get a certain number of fair innings in a life time.” A libertarian approach would be to allocate the vaccine according to market exchanges or the ability to pay. While this may be an appropriate approach for certain goods and services, it seems ill suited to health care supplies that can influence who lives and dies. There were reports in the press about schools receiving offers from “greedy wholesalers eager to supply them with flu shots for $800 when a shot should cost about $10.” Even if hospitals or individuals were willing to pay this amount, it seems unfair that only those who could afford to pay such high prices would have access to the scarce good. Utilitarian theories focus on distribution that will achieve the best outcomes or greatest good but leave us to debate how to define those concepts. Does it mean to distribute the vaccine in a way that will 1) prevent those who are most at risk of contracting the flu from acquiring it; 2) save society the most money (i.e., give it to those who would cost society the most if they contracted the flu); 3) result in the greatest number of additional years of life (or “quality-adjusted life years”) for those who receive it; or 4) result in the greatest number of lives saved of individuals who are most productive, wise or compassionate? These are all possible utilitarian approaches.

The Role of Ethics Panels and Committees
While an ethics panel may help public health authorities think through these approaches by articulating them and helping apply them to various scenarios, such panels should not be the scapegoats when “wrong” decisions are made. The ultimate decision-makers must be those who are accountable to the public. If they are to rely on the recommendations of ethics panels, they should ensure that such panels not only include experts in the field of bioethics but also include a broad representation of views on what constitutes the public good so that our public officials are not hemmed in by a particular professional or personal perspective. On the institutional level, ethics committees must also be viewed as fair and impartial bodies with both expertise and representation from the community the institution serves. For either a national or local ethics committee to have any credibility it must be viewed as fair, knowledgeable and representative.

Notes
3Testimony of Dr. Julie Louise Gerberding, Director, CDC, before the House Energy and Commerce Committee, Subcommittee on Health (Nov. 18, 2004). Available at http://energycommerce.house.gov/hr.hearings/11182004hearing1404 Gerberding2234.
EMS/DNR ORDERS

On September 21, Samantha Freed, a third year law student and research assistant for MHCEN, spoke with paramedics at the Woodbine Fire Department about Do-Not-Resuscitate (DNR) orders in the pre-hospital (outpatient) setting. This article is based on excerpts from Freed’s presentation.

Paramedics may recognize several types of EMS (emergency medical services)/DNR Orders as valid. These include:

• An original or copy of the Maryland EMS/DNR and Medical Care Order Form
• An oral EMS/DNR Order presented in Maryland
• A Maryland EMS/DNR Bracelet insert
• A Med-Emer Alert EMS/DNR Bracelet or Necklace

An oral EMS/DNR Order provided by an on-line, EMS medical command and control physician

An oral EMS/DNR Order provided by a physician who is physically present on the scene with the patient and the EMS personnel in the outpatient setting

EMS personnel in the pre-hospital setting may NOT acknowledge the following DNR order:

• An advance directive without an EMS/DNR Order
• Facility-specific DNR orders

Physician’s notes in medical records or prescription pad orders

• DNR stickers
• An oral request from someone other than a physician

• An oral order from an attending physician who is not on-site

Any other device or instrument not listed as acceptable in the MIEMSS protocols

The Maryland EMS/DNR and Medical Care Order form was created to eliminate the burden on EMS personnel trying to decipher whether they may follow a DNR Order provided by a patient’s family member. The EMS/DNR Order form takes the second-guessing out of a situation which is already hectic, and where every minute is vital to life. For example, if paramedics are presented with an advance directive barring resuscitation attempts, but there is no EMS/DNR Order Form, family members can very persuasively insist that the paramedic follow the advance directive (that is, not try to resuscitate the patient). But in this situation, EMS personnel are obligated to try to resuscitate the patient. Paramedics have so little time to evaluate the situation and act appropriately, it is not practical to ask them to interpret documents that vary in form and content. This is also the reason that the EMS/DNR Order must be in a particular form.

Consider the following scenario:

Two paramedics arrive on-scene to find a 92 year old woman unconscious. Her son does not present any documents but hands the phone to one of the paramedics. There is a voice on the other line that states “I am this woman’s physician and I have in front of me papers signed by the patient that say she does not want any attempts at resuscitation.” Because the physician is not on-scene, this is not a valid EMS/DNR Order. However, if the paramedics in the scenario received orders from an on-line, EMS medical command and control physician not to attempt resuscitation, then the paramedics could refrain from attempting to resuscitate the patient.

Paramedics are put in a difficult situation when nursing home patients have not discussed DNR orders with their care providers, especially involving transport between a nursing home and emergency room. Local paramedics can play a role in educating facilities they work with about the Maryland EMS/DNR and Medical Care Order form.

This is especially true for nursing homes, since paramedics are often called to transport nursing home residents to the hospital or other health care settings. EMS/DNR orders may also apply to children. The Maryland Code authorizes EMS to follow the Maryland EMS/DNR and Medical Care Order form “pertaining to adults in the outpatient setting.” The Attorney General has written an advice letter about this provision and its application to minors. Although the Maryland Code refers only to adults, EMS personnel are authorized to follow the Order form with respect to minor children if a parent or legal guardian has consented.

Notes


2. Id.


6. For the full text of attorney general opinions and letters of advice related to EMS/DNR orders, visit http://www.oag. state.md.us/Healthpol/legal.htm.

If you or your organization is interested in having Ms. Freed give a presentation on EMS/DNR Orders in the pre-hospital setting, you may contact her at MHCEN by e-mail at mhceen@ law.umaryland.edu or phone (410) 706-4457. For a copy of the EMS/DNR Medical Care Order form, visit www.miemss. umaryland.edu/DNROrder. pdf.

DECONSTRUCTING “DO-NOT-RESUSCITATE” ORDERS

On Wednesday, November 17, 2004, MHCEN co-sponsored the conference, “Still Hazy After All These Years: Problems and Solutions,” at Charlestown Retirement Community in Catonsville, MD. Other sponsors included Erickson Retirement Community, Agnes Memorial Hospital, and the Health Facilities Association of Maryland.

The morning began with a provocative keynote address by Glenn Teitren, a physician in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins Hospital. Dr. Teitren spoke about “Unintended Consequences of DNR Orders.” These include health care providers (HCPs) too readily giving up on treatments that can significantly extend the quality of or prolong a patient’s life merely because a DNR order is present. Teitren has little faith in the ability of generic end-of-life wishes expressed in living will documents to effectively guide a physician’s decisions about whether to withhold attempts at CPR. Furthermore, should withholding CPR attempts through the writing of a DNR order carry these “unintended consequences” that are not in the patient’s best interests. Teitren argues that DNR orders should be approached with caution.

A better method of providing patient-centered end-of-life care, Teitren asserts, is for the physician to talk to the patient and the patient’s family to discuss the future of the patient’s care. Teitren believes that in many cases, a physician’s judgment of the incapacitated patient’s best interest should trump the patient’s living will instructions. Attendees challenged this view by arguing that a relationship-centered model is out of touch with how medicine is practiced today, that favoring the goals of LPT and physicians taking the initiative to withdraw LPT if the intended goals have not been achieved. Grochowski doesn’t advocate that physicians discuss a DNR order initially with sick inpatients who can’t make decisions. He thinks it’s not the CPR attempts that most patients fear, but the possibility of surviving in a highly impaired, technology-dependent state. The latter can be avoided by being clear about the goals of LPT and physicians taking the initiative to withdraw LPT if the intended purposes have not been achieved. Grochowski’s view is that DNR orders can be avoided by being clear about the patient’s living will instructions. This opens the door to a more in-depth conversation after some rapport has been established, or, if the patient loses mental capacity, identifies a surrogate decision-maker.

As a part of a panel session, Glenna Earle (a nurse at Upper Chesapeake Medical Center/UCMC), Kevin Lynch (a physician at UCMC) and Martha Ann (Marty) Knutson (Legal Compliance Officer at Upper Chesapeake Health) addressed institution-wide problems with DNR orders. UCMC created a “Resuscitation Status” policy and a “Resuscitation Status Order” (a pink sheet for easy charting) that documents: 1) the patient’s diagnosis-making capacity; 2) with whom resuscitation status was discussed; 3) the content of the discussion; 4) reasons for the resuscitation status; 5) whether or not to attempt full or limited CPR; 6) the signature of the physician; and, if applicable, physician certifications of futility. Ms. Earle and Dr. Lynch discussed their various challenges in implementing the policy and form, and educating staff members, patients, and families about it.

Mrs. Earle also discussed “Futility, Liability, and other Legal Aspects of Foregoing CPR Attempts,” including the Maryland legal case, Wright v. HealthCareTrust, Inc. (a faith-based, non-profit corporation) and Maryland legislation allowing emergency treatment (such as CPR attempts) without consent, a patient’s right to have his or her CPR wishes respected by withdrawing CPR attempts, and issues related to medical futility of CPR attempts.

Philip Pananarella, MD, MPH of Franklin Square Hospital and Rev. Dr. Bob Steinke, of Frederick Memorial Hospital presented an interactive session demonstrating appropriate and inappropriate communication related to DNR orders. They used video clips from the End of Life/Palliative Care Conference, “Still Hazy After All These Years—DNR Orders: DECONSTRUCTING ‘DO-NOT-RESUSCITATE’ ORDERS” to illustrate their points. See www. mhp.ucmc.edu. Kelly Nites, MPH, at the Consumer Direct Model in Nursing Home Care and two residents from the Charlestown Retirement Community then spoke about the “Consumer-Directed Model” in which consumers make their own health care choices, with implications for EOL care.

Concurrent sessions included how to proceed when a physician refuses to write medical orders (such as a DNR order) that are consistent with a patient’s wishes; discussing DNR in special settings (the neonatal intensive care unit, the operating room, and hospice); discussing DNR orders with religious- or culturally-based vulnerable populations and ethnic minorities; and an open table discussion of legal issues surrounding DNR orders and the Patient’s Plan of Care Form that is being drafted by the Maryland Attorney General’s Office.

If you have ideas for future MHCEN conferences, or if you would like to sponsor a conference, please e-mail us at MHCEN@law.umaryland.edu, or call (410) 706-4457.
**PHILOSOPHY CORNER – FOCUS ON ‘AUTONOMY’**

Enlightenment is the release of human beings from their self-incurred tutelage. Tutelage is the inability to use one’s own reason without direction from someone else. This tutelage is self-incurred when its cause does not lie in the lack of reason, but in the lack of resolution and courage to use it without direction from someone else. Sappho aude! Have courage to use your own reason!—that is the motto of the enlightenment.

**What is Enlightenment?**  Immanuel Kant, 1784

Autonomy comes from the Greek words autos (‘self’) and nomos (‘law’), evoking the concept of “self-governance” or “self-determination.” It is the cornerstone of the Enlightenment period, when reason was embraced as the key to progress in science, politics, and the moral life. The philosophical origins of the Enlightenment are often attributed to a group of French philosophers who challenged the public’s deference to organized religion and political monarchy, which were responsible for such atrocities as the Christian Crusades in the middle ages, and the burning of ‘witches’ in the 17th century. Instead, the Enlightenment philosophers promoted the concepts of critical thinking, education reform, political democracy, and rational moral conduct. Rene Descartes (1596 – 1650) was one such philosopher. Known for his contributions to mathematics and to what later developed as the field of neuroscience, Descartes pursued fundamental questions about the relationship between external reality and the mind. From this perspective, Descartes concluded that the mind is powered by the body and that the mind can be understood scientifically. However, he also believed that the mind is independent of the body and that it has the ability to reason independently of the body.

Human beings have free will, and that free will is exercised through rational thought. Kant, a prominent Enlightenment philosopher, argued that reason is the key to understanding the human mind, and proposing a method of seeking objective knowledge (the scientific method). Enlightenment thinkers believed that knowledge did not represent an external reality; rather, it was constructed by human minds taking in information and actively making sense of it. According to Kant, a truly moral person must transcend the passive acceptance of rules and norms handed down by his or her culture or religion and actively determine himself or herself what is right or wrong. Kant argued that rational duty-based acts than those motivated by emotions like compassion or love. Emotions can be inconsistent and illogical, whereas applied reason can be consistent and logical. Applied reason can be applied to mundane desires like accumulation of wealth, whereas emotions can be inconsistent and capricious.

It is the faculty of reason that most powerfully connects human beings with each other, and which turns a merely natural society into a human community. In a society where all people base their important judgments on reason, where everyone makes an honest attempt to see things also from other people’s point of view, there will be many unsolvable disagreements. It is only when people are ruled by their unacknowledged drives and unexamined passions that consensus and cooperation eludes them.

Anita J. Tarzian, PhD, RN
Ethics & Research Consultant
Mid-Atlantic Ethics Committee Newsletter

**REFERENCES**


7. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. The Belmont Report, Ethical Principles and Guidelines for the Protection of Human Subjects of Research (commonly known as The Belmont Report). For several reasons, a focus on autonomy has dominated the principled approach in Western bioethics, and has recently been challenged as overly individualistic. Perhaps this is because of the tendency to interpret autonomy in the context of individual rights (things owed to a person), rather than Kant’s conception of autonomy as a commitment to using reason to guide moral actions. As Brannam summarized: It is the faculty of reason that most powerfully connects human beings with each other, and which turns a merely natural society into a human community. In a society where all people base their important judgments on reason, where everyone makes an honest attempt to see things also from other people’s point of view, there will be many unsolvable disagreements. It is only when people are ruled by their unacknowledged drives and unexamined passions that consensus and cooperation eludes them.

Simulated ethics consult video link. Photo courtesy of the Neiwanger Institute for Bioethics & Health Policy. See http://bioethics.lumc.edu.
One of the regular features of the Newsletter is the presentation of a case considered by an ethics committee and an analysis of the ethical issues involved. Individuals are both encouraged to comment on the case or analysis and to submit other cases with which their ethics committee has dealt. In all cases, identifying information is removed and others in the case should only be provided with the permission of the individual. Unless otherwise indicated, our policy is not to identify or institution. Cases and comments should be sent to: Diane E. Hoffmann, Editor; Mid-Atlantic Ethics Committee Newsletter, University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201, or dhoffman@law.umaryland.edu.

M rs. Daniels is a 75 year old woman with a history of dementia who is brought to the emergency room (ER) from a nursing home with a severe gastrointestinal bleed. Her records from the nursing home state that she is a Jehovah’s Witness and does not want a blood transfusion under any circumstances. There is only one Jehovah’s Witness adult in the nursing home that lists her as one of their members. At the time of admission, Mrs. Daniels gave verbal consent for transport to the hospital to treat her symptoms (weakness, vomiting blood, black stools, lightheaded, low blood pressure), and no more blood to be of benefit. Unfortunately, this is a case of too little, too late.

RESPONSE FROM AN EMERGENCY ROOM PHYSICIAN

The physician in this case faced a true ethical dilemma. He wanted to respect Mrs. Daniels’ autonomy, but how? Should he comply with her prior stated wishes not to receive blood transfusions, or go against them by accepting her request for a transfusion as a crucial change of mind? Giving her one or more immediate blood transfusions had the potential to save her physical life while going against a religious prohibition she had not renounced. One might ask, did Mrs. Daniels have the capacity to give informed consent for a blood transfusion? Consent is not legally or ethically valid when a patient who gives it lacks the capacity to understand the consequences of her choice. The family would likely assert that she was there—that her mother lacked the ability to consent to a transfusion. Some might argue that perhaps Mrs. Daniels or another family member had been legally appointed to act in the patient’s stead, Mrs. Daniels had decisional capacity prior to this admission, and it is important to separate the concepts of ‘mental competency’ (a legal judgment based on global mental capacity, often assessed as part of a patient’s hospital processing) and decisional capacity (the ability to communicate a particular choice and understand the consequences of that choice). The fact that Mrs. Daniels had consented to be transfused at the hospital could provide some evidence that she could make specific decisions about her health and that she wanted treatment for this particular life-threatening condition. The physician believed that Mrs. Daniels understood the gravity of the situation she faced—that death was inevitable without a transfusion. She appeared fearful of dying, and articulated a wish to avoid this, even if it meant receiving a transfusion. Is the fact that dementia occluded Mrs. Daniels’ memory of her religious convictions relevant to her request for the transfusion? If one were to defer to her memory, her records, which stated no blood transfusions in accordance with her religious beliefs, one would not proceed to transfuse her. Yet, how is one to know, had she been able to remember her religious convictions, if she still would have chosen the blood transfusion. Mrs. Daniels abandoned those convictions and prior stated wishes surrounding blood transfusions in order to save her own life? Many times patients are brought to emergency rooms with lives will ruling out use of life support technology such as a cardiac monitor. The health care providers abide the [capacitated] patient’s current decision, effectively nullifying his or her living will. All patients have the right to change these kinds of circumstances and medical treatment. Where does autonomy dictate that the physician err in this case on the side of believing Mrs. Daniels’ plea to avoid death or on the other side of abiding by her prior stated wishes?

A physician guided by the beneficence principle for this patient would do what (s) he thinks best promotes the patient’s health or well-being, but well-being can be defined as spiritual as well as physiologic outcomes. The dilemma in this case is that it is uncertain which one should have priority. Clearly, ethical principles don’t always point to a definitive course of action. Based on the physician’s other prior stated wishes not to receive blood, the physician may have felt an obligation to protect the patient from any possible family pressure. The issue of family or ecclesial pressure has been discussed by Muramoto.2 Although ethics is distinct from law, physicians must act within the confines of the law when delivering patient care. Regarding the physician’s legal liability, he could be open to liability for wrongful death caused by delaying the blood transfusion, or battery (i.e., giving the transfusion against the patient’s prior stated wishes). However, these outcomes are unlikely given the lack of clarity regarding the patient’s wishes. The Maryland Health Care Decisions Act (§7-505) allows for emergency medical treatment in a patient’s prior consent, as long as the physician is not able to make an informed decision if an authorized surrogate is not immediately available and the attending physician determines that “there is a substantial risk of death or immediate and serious harm to the patient.” In the case of this patient, there is no conclusive information about whether her request was valid. However, this physician should consult with a legal expert to determine whether more blood to be of benefit. Unfortunately, this is a case of too little, too late.

Eva C. Dickinson, M.D.
Department of Emergency Medicine
Shore Health System of Maryland

Note

RESPONSE FROM A JEHOWAH’S WITNESS LAWYER

One of the fundamental principles of Jehovah’s medicine is that patients have the right to control what is done to their own bodies. This principle is formally known as the doctrine of bodily self-determination, places obligations on both patients and their doctors. Patients have an obligation to make their wishes known, especially if they strongly object to certain types of medical treatment on the basis of their religious or personal beliefs. As a corollary, doctors have an obligation to obtain their patients’ informed consent before administering any type of medical treatment or procedure. In the case study, the patient is described as a 75-year-old woman with a history of dementia who was brought to an emergency room from a nursing home with a severe gastrointestinal bleed. She is also described as having records at the nursing home that list her as one of Jehovah’s Witnesses. These records state that she would refuse blood transfusions under any circumstances. Her treating.
Case Study

Cont. from p. 9

physician feels that she needs blood transfusions and apparently the patient has given consent, but the consent is not clear.

The first question facing ER personnel is whether or not the patient has sufficient decision-making capacity to make medical decisions for herself. If she has capacity and is able to clearly express her wishes, her decision should be respected and no further inquiry is needed.

However, in this case, the patient’s history of dementia, her answers to certain basic questions, and her lack of clarity on the issue of whether she would consent to blood transfusions compared to her prior expressed wishes has called into question her capacity. This means that the records maintained by the nursing home have become exceptionally important. In many cases, Jehovah’s Witnesses have executed statutorily valid advance directives that: 1) clearly indicate their refusal of blood transfusions; 2) state their wishes concerning procedures involving the use of their own blood; and, 3) state their wishes concerning end-of-life matters.

These documents, commonly known as a “DPA-card” in the Witness community, are statutorily valid in all 50 states and the District of Columbia, and can be relied on as a legal expression of the person’s wishes.

The nursing home should be contacted to determine whether or not the records they maintain on the patient include a “DPA-card” or a similar advance directive.

Arguably, the state’s attorney and the judge could have been contacted during this time period, presented with the facts, and asked for a decision. In most courts, a judge is available 24 hours a day to handle these types of emergencies.

In the event there is insufficient time for a judicial determination to be made, the physician must use his best judgment in rendering medical care. Of course, there are potential consequences for proceeding without clear direction from the patient or direction from the court. If blood is given, the foremost of these consequences is a potential lawsuit for battery. This is particularly true when, as the case study suggests here, the patient’s family is adamant about the patient’s refusal and is upset about the transfusion.

As this case study demonstrates, patients should be encouraged to execute advance directives to avoid foreseeable conflicts in their healthcare. This is particularly true when it comes to patients who refuse treatment on the basis of their religious beliefs.

Finally, Jehovah’s Witnesses do not believe that they will be ‘eternally shunned from the kingdom’ for receiving an involuntary blood transfusion. Nonetheless, even involuntary transfusions are viewed as a violation of one’s body and result in many of the same emotions and feelings of spiritual worthlessness experienced by rape victims. Hopefully, by discussing these matters in advance, these types of physician/patient conflicts will be minimized to the benefit of all parties involved.

Adam G. Linett
Associate General Counsel
Watchtower Bible and Tract Society of New York, Inc.
Legal Department

Notes
2 In Re Dubreuil, 629 So. 2d 819, 823 (Fla. 1993).

We welcome comments to this case study, including how cases such as this are handled at your institution. Please e-mail your comments to MHECN@law.umaryland.edu.

CALENDAR OF EVENTS

January
31 12:00PM-1:30PM (free) Human genetic databases: Towards an international frame work. Bernice Elger, Ph.D., The Emanuel & Robert Hart Lecture Series, University Of Pennsylvania Center For Bioethics, 3401 Market Street, Suite 320, Philadelphia, PA. For more information, visit http://www.bioethics.upenn.edu/.

February
10 7:00 PM Leon Wieselstein, Literary Editor, The New Republic. United States Holocaust Memorial Museum Insight Lecture on the exhibit Deadly Medicine: Creating the Master Race. Admission is free, but seating is limited. For reservations call 202-488-8407. The Deadly Medicine exhibit runs through October 16th, 2005, and will be open before and following the program. Doors open at 6 p.m.

14-18 Becoming an Ethics Consultant (intensive training course). St. Francis Medical Center, Honolulu, Hawaii. Speakers include: Howard Brody, MD, PhD, Jing Jih Chin, MD, Lawrence J. Schneiderman, MD and others. For more information visit http://www.bioethicshawaii.org or contact Jan Miyamoto, telephone 808-547-6050; e-mail: janm@sfhc-hi.org.

24 4:00 PM-5:00 PM (free) Andrea Kalfagos, PhD, Reproductive Genetic Engineering Technologies: Hope and Fears For Our Genetic Future, University of Maryland Medical Center Medical Humanities Hour. Shock Trauma Auditorium. Contact: bolvemr@medicine.umaryland.edu.

March
3-4 3:00 PM-4:00 PM Catholic Health Care Ethics: Foundations and Applications. Sponsored by the Catholic Health Association of the United States and the Neiswanger Institute for Bioethics and Health Policy, Loyola University, Chicago, Stritch School of Medicine, Chicago, IL. Visit www.bioethicsuic.edu.

8 12:00PM-1:30PM (free) Barbara Coombs Lee, JD, RN (title of talk to be announced), The Emanuel & Robert Hart Lecture Series, University Of Pennsylvania Center For Bioethics, 3401 Market Street, Suite 320, Philadelphia, PA. For more information visit http://www.bioethics.upenn.edu/.

11 In the Nation's Compelling Interest: Eliminating Racial and Ethnic Disparities in Health Status (Conference), University of Maryland School of Law, Baltimore, MD. Contact Lu Ann Marshall, 410-786-4128, lmarshall@law.umaryland.edu.

17 7:00 PM Leon Kass, MD, University of Chicago. United States Holocaust Memorial Museum Insight Lecture Series on the exhibit Deadly Medicine: Creating the Master Race (see February listing above for contact information).

April
7-9 The Ethics of Bioethics, a Conference co-sponsored by The American Society of Bioethics and Humanities and the Albany Medical College/Graduate College of Union University Bioethics Program. The Albany Medical College and the Inn at College Park of Union College. Abstracts accepted through February 15. For more information visit http://www.bioethics.union.edu, or contact Ann Nolte at bioethics@union.edu, 518-388-8045.

Western Regional Bioethics Conference, sponsored by the Arizona State University Bioethics Club, Bioethics Program at Arizona State University, Tempe, AZ. Contact: Ryan Childers at wrbe@asu.edu or 480-965-8627, or visit http://lifesciences.asu.edu/bioethics/wrbc/.

April
25-26
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All correspondence including articles, cases, events, letters should be sent to:

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