MEDIATING CARE CONFLICTS IN NURSING HOMES

Recently, many ethics committees have begun to ask what is the appropriate process to use when trying to deal with patient care conflicts. Some have explored or are beginning to explore mediation as an alternative to a consultative process or process in which the committee comes up with a recommendation. Mediation differs from these options in that a neutral facilitator helps parties reach their own agreement based on their own best interests. While mediation is starting to be used by some ethics committees, there is little if any empirical data on whether it is appropriate or effective in dealing with bioethical disputes.

In an effort to provide some of that necessary empirical data, the American Bar Association Commission on Legal Problems of the Elderly has undertaken a three year project funded by the AARP Andrus Foundation and The Commonwealth Fund. The Project, which began in mid-1994 aims to show that mediation can provide a viable method of resolving patient care conflicts in nursing homes by assisting parties communicate with one another, unlock rigid positions, expand options for agreement and move toward consensus. Mediation advocates argue that the solutions that emerge from a mediated process can be more creative and more suited to individual needs than might be possible through more traditional channels. This is because the solutions are not imposed by the committee but fashioned by the parties, thus fostering a sense of "ownership" in the decision and commitment to its implementation. Skeptics of the process argue that it is not necessarily workable in the long term setting for a number of reasons. First, parties in

Letter From the Editor

This issue initiates a change in the Mid-Atlantic Ethics Committee Newsletter publication schedule. Faced with increased production costs and a shrinking subscriber base, we have decided to reduce the number of issues we publish each year from four to three. We made this decision reluctantly, and we are determined that it will not affect the quality of our newsletter. We will continue to publish articles that are timely, relevant and on the cutting edge of issues that are of interest to ethics committees.

Our first 1996 issue deals with a variety of topics—mediation, discrimination, and medical ethics in China. We hope that you find it both stimulating and educational and that you will continue to support the newsletter. As always, your comments and suggestions are welcome.

Diane E. Hoffmann

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NETWORK NEWS

Baltimore Area Ethics Committee Network (BAECN)

The BAECN’s March meeting will feature Father Philip Keane speaking on the topic of “Ethical Directives for Catholic Hospitals.” The meeting will take place on March 21 at 4:30 p.m. at Good Samaritan Hospital in Baltimore. For further information, contact Jack Syme, M.D., at (410) 368-3020.

Over the past few months, the BAECN’s Task Force on Standards for Education and Ethics Committee Qualifications has made substantial revisions in the proposed standards for member ethics committees. A copy of the revised standards will be sent to each BAECN member for further commentary and review. The final version of the standards will be made available to the public.

West Virginia Network of Ethics Committees (WVNEC)

The WVNEC is sponsoring a day-long conference on May 17, 1996 in Morgantown, West Virginia. The conference, titled “Ethics Consultation 1996: The State of the Art,” will feature panelists from ethics committee networks in Ohio, Pennsylvania, West Virginia, Virginia, Maryland and Delaware. The organizers hope that the conference will serve as a forum in which participants can evaluate the process and outcome of ethics committee consultations and discuss ways in which such consultancies may be improved. For detailed conference information, contact Cindy Jamison at (304) 293-7618.

A Summer Intensive Course in Medical Ethics will be held July 25-27 at the Robert C. Byrd Health Sciences Center in Morgantown. Looking further ahead, mark your calendars for a WVNEC-sponsored forum on “Complying with JCAHO’s Standards on Organizational Ethics.” The forum will take place at the Days Inn in Flatwoods, West Virginia on October 4, 1996. For information about either of these events, call (304) 293-7618.

Metropolitan Washington Bioethics Network (MWBN)

At the request of Superior Court judges in the District of Columbia, WMBN is organizing a half-day seminar for the judges on issues such as the withholding or withdrawal of artificial nutrition or hydration, Do-Not-Resuscitate orders, surrogate health care decision making and guardianship. The WMBN hopes to establish permanent channels to facilitate the exchange of information between health care ethics committees and the attorneys and judges who become involved in cases in which these issues arise. The seminar is scheduled for Saturday, April 27. For details, call Joan Lewis at (202) 682-1581.

The Center for Biomedical Ethics at the University of Virginia in Charlottesville presents Developing Ethics Programs in Long-Term Care (DEPLTC) on April 17-19. This highly interactive program focuses attention on the needs of long-term care facilities in the development of ethics programs. For information on this program, please call (804) 924-5974 (Charlottesville) or (804) 353-3209 (Richmond).

The Center for Biomedical Ethics is also considering offering an intensive two-day workshop focusing on the new JCAHO regulations concerning organizational ethics standards. The program, which would be geared towards health care and administrative professionals...
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conflict may not agree to come to the table. Second, power imbalances—as are common in health care institutions—may be too great to overcome.

Mediation Put to the Test
The Commission’s Project is putting mediation to the test. More than 20 nursing facilities in the Washington, D.C. metropolitan area from as far north as Baltimore and as far south as Manassas, Virginia are participating in the project. The facilities are diverse in size, resident composition, and source of payment. All either have, are developing, or participate in ethics committees or patient care advisory committees. Input into the project design was obtained through an advisory committee consisting of facility representatives, long term care ombudsmen, bioethicists, aging professionals, and dispute resolution specialists.

Project staff worked with the facilities in selecting mediators from or designated by the homes’ ethics committees. Each facility sent two representatives to a three day training program provided by the ABA and run by Dr. Leonard Marcus of the Program on Negotiation and Conflict Resolution at the Harvard School of Public Health. The training focused on dispute resolution concepts, mediation skills, and application of those skills to nursing home care conflicts. Additional training included information about bioethical principles, nursing home law, and the project protocol.

The facilities were asked to refer patient care disputes that were not able to be resolved directly by staff intervention to the Project for mediation. Disputes targeted for mediation include those involving medication, use of restraints, dietary restrictions, access to physicians, transfer and discharge care plans and rehabilitation. The Project especially seeks those disputes in which competing values conflict, and in which parties mutually might benefit from a structured way to highlight questions and options, and a process of joint deliberation.

In early 1995, the Commission began intensive outreach to families, residents and facility staff to help them identify cases and refer them to the project. Family nights, resident councils, in-services and presentations to ethics committees helped to get the word out. Brochures, mediation buttons, trainee get-togethers, and newsletters have been used to bolster project visibility. Case intake began in mid-1995.

In order to address concerns about neutrality and the limited training of the facility mediators, facility mediators are paired with an experienced mediator called a “mediator mentor” in a co-mediation model. The Project is being evaluated by the National Institute for Dispute Resolution. Based on project experience, staff will produce a guide on long term care mediation.

Case Profiles
Thus far, cases have been slow to come in. This may be a result of being unable to reach the appropriate individuals, particularly family members, who might take advantage of this new tool. It may also simply be that it is difficult to change the dispute resolution culture of institutions and to foster a paradigm shift to a new way of viewing care conflicts.

Yet, the cases that have come to the Project have been diverse and intriguing. They have involved resident/facility, family/facility, family/family, facility/staff and resident/resident conflicts. They have centered on issues of transfer, communication about a range of care matters, medication, diet, and insertion of a nasogastric tube. Some have concentrated on concerns not originally envisioned as within the project’s scope—roommate quarrels and staffing problems—yet bearing on resident care and quality of life. Three examples illustrate the complexity of the issues and competing moral and ethical values.

Nasogastric tube. An 86-year old resident had difficulty swallowing. His physician sought to insert a nasogastric tube, and one of his two nieces favored this treatment. The other niece advocated spoon feeding, as did the nurses. The case was mediated through the facility’s ethics committee which included a mediator trained by the project. The resident’s capacity was questionable, yet he seemed to indicate he did not want the tube. The parties agreed to continue spoon feeding on a trial basis.

AIDS transfer. A resident with AIDS had been in a skilled bed covered by Medicare. This coverage was exhausted, and the facility wanted to transfer him to a similar private room in the facility. Other issues of care were troubling both the resident and the staff. The Medicare regulations protect the resident’s right to refuse to change beds when coverage is terminated. While the facility recognized the legal right, resident-staff relations continued to be tense. A mediation involved the resident, the resident’s friend, the assistant director of nursing, the social worker and an administrator. An interim agreement provided that staff from the new area temporarily would be assigned to the resident to allow a relationship to develop, a safety gate would be installed to keep wandering residents out of the room, and admissions personnel would inform the resident when a bed became available on the non-certified end of the unit.

Psychiatric problems. A resident had Alzheimer’s Disease and behaved so violently toward other residents and staff that it put others at risk. The facility gave a 30-day notice of discharge. There was a history of tension between the resident’s daughter and the staff. A mediation involved the daughter, her husband, the administrator, director of nursing and social worker. Issues on the table were not only the discharge, but medication, safety, the resident’s mobility, dentures, the resident’s urinary infection, and the parties’ methods of communicating with each other. The parties agreed to suspend the discharge notice while the effectiveness of the medication was evaluated and to give the family more time to investigate other appropriate placements.

Ethical Issues
This mediation project presents three areas of ethical inquiry. First, is there
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an ethic compelling the use of an interactive process like mediation to resolve resident care issues in nursing homes? Second, what ethical principles guide the mediation process, particularly in the long term care setting? Finally, what ethical issues are raised in the nursing home conflicts targeted by the mediation project?

"A Communicative Ethic." The ideal of autonomy and the principle of informed consent long have been guiding lights in the field of bioethics. But thoughtful bioethicists, gerontologists and other aging professionals recently have found these notions less than ideal for resolving health care dilemmas in the long term care setting. Process as well as principles have become an important part of the ethics of long term care decision-making.

Arguing that neither autonomy nor paternalism should dominate long term care decisions, Harry R. Moody submits that "a more subtle and complex set of standards or what could be called negotiated consent" should replace the rule of informed consent. Moody endorses the notion of negotiating to make the best of the tough situation in which frail elderly nursing home residents find themselves. He maintains such negotiation should be within a framework of active participation by the resident or the resident's surrogate, inclusion of all other interested parties, knowledge of legal and ethical rights, opportunity for enforcement of rights through an outside authority and the opportunity to publicize the situation. This decision-making model, he says, should be based on a communicative ethic founded on "the three C's of Communication, Clarification, and Consensus-Building."

Connie Zuckermand, as well, recognizes that "a dogmatic emphasis on individual patient autonomy that dismisses other important issues often does more harm than good in the context of geriatric patient care... Cooperative, interdependent relationships are as vital to the reality of the chronically ill patient as any bold assertion of autonomy and independence." Recognizing that "lines blur between healthcare and social interaction, between ethical considerations and management strategies," Zuckermand underlines the importance of dialogue and cooperation in clinical ethics.

Mediation can fill this need for a collaborative process identified by Moody, Zuckermand and others. Striving to fulfill a communicative ethic is particularly appropriate in nursing homes where ethical dilemmas tend to involve not only tensions between autonomy and paternalism, but also competing interests of multiple residents, staff and families set against a backdrop of limited resources and intense scrutiny.

Mediation ethics. Mediators are ethically bound to ensure that the parties understand the mediation process and that their participation is voluntary. These duties are critically important and extremely challenging to carry out in the nursing home setting. A significant proportion of nursing home residents have limited decisional capacity, or at least fluctuating levels of capacity. Mediators should seek to recognize and respond to any lack of capacity of the disputing parties.

How does a mediator determine whether a party has the capacity to mediate? The mediator might consider such questions as whether the person understands who the parties are; can articulate his or her story; understands the role of the neutral mediator; can listen to and comprehend the story of the opposing party; can generate options for a solution; and can make and keep an agreement. In the ABA Commission's nursing home mediation project, one paramount goal is to ensure that the resident has a voice and to maximize the resident's participation in decisionmaking. Thus, when a resident's capacity to mediate is in question or fluctuates, the project aims to provide all possible support to enhance the resident's abilities. Supports might include: the presence of a trusted person such as a family member, friend or long term care ombudsman; scheduling mediation sessions at times of greatest lucidity and strength; and locating a session in the resident's room or other quiet location.

Ethical issues in resident care conflicts. What are the ethical issues at play in the care disputes to be mediated? This project targets disputes in which competing values conflict and a principled resolution is sought. These ethical dilemmas play out in the bold dramas of life-sustaining treatment cases as well as in the everyday aspects of residential life in nursing homes. Tensions may result from the classic competition between resident autonomy and a professional's view of beneficence, or from opposing needs of an individual resident and the collective interests of all residents in a facility. Other conflicts arise out of differing views of autonomy, differing visions of beneficence (for example, between family members), perhaps a dissonance between a resident's lifelong values and a contemporary "spoken choice." These competing interests in long term care situations have been thoughtfully explored in recent books and articles by Litz and Arnold, Kane and Caplan, and Agich, among others. The challenge for the ABA Commission's pioneering project is to provide a viable way in which these value conflicts can be addressed through an inclusive, mediative approach. For further information on the project, contact the authors at the telephone numbers indicated below.

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MEDICAL ETHICS IN CHINA—AN OLDER TRADITION?

This article reports the author’s observations as a member of a People-to-People Medical Ethics Delegation to the People’s Republic of China in October 1995. It reports uncritically what the Delegation was told (or at least the author’s understanding of what was said) and includes reflections upon a number of underlying ethical issues.

Patient Information and Decision Making

Western liberal democracies have a tradition of respect for individual rights. Since John Stuart Mill’s famous essay *On Liberty*, it has been widely accepted that individuals should enjoy as much freedom as is compatible with respect for the freedom of other people.

Hand in hand with the focus on the individual, the notions of “patient self-determination” and “informed consent” have flourished in Western countries. It is more than sixty years since Justice Cardozo’s much quoted statement that “Every human being of adult years and sound mind has a right to determine what shall be done with his own body” and the development of the American doctrine of informed consent.

The broad ethical principle underlying these doctrine is, of course, that of autonomy. But autonomy is not the only value that is relevant in medical decision-making. Consider the Hippocratic Oath, which has a far longer history than patient autonomy: “I will keep [the sick] from harm and injustice,” and its modern equivalent, The Declaration of Geneva, “The health of my patient will be my first consideration.” These undertakings reflect the doctor’s ethical duty of beneficence—to act in the patient’s best interests.

In China, it is not always the patient who decides about treatment. There is a strong tradition of family involvement in decision-making and the patient’s work unit may also be involved. Eighty percent of Chinese employees are still employed by either the government or a state-owned enterprise, both of which pay the patient’s health costs; the patient does not have to pay. For this reason, health care providers often consult a patient’s work unit about proposed treatment.

In some cases, patients themselves may not be told of their condition or prognosis. For example, where a patient has a terminal illness and needs an operation or treatment that is risky, the doctor is required to consult the patient’s family or work unit to make the final decision and sign an agreement for treatment that will list the potential risks of the procedure, but may not tell the patient.

This method of dealing with patients may seem repugnant to Western eyes, but it should, perhaps, be viewed in its cultural context. The Chinese have a tradition of Confucianism which focuses on the community, rather than the individual; and the obligation of people to act for the good of others, rather than the right of individuals to act freely and to control what is done to them. Moreover, the Chinese readiness to subordinate the individual to the community is easily understood in a country so teeming with people, many living in conditions where privacy is impossible. The preference for the community interest, rather than that of the individual, may have provided a particularly fertile ground for socialist and communist political philosophy.

Care of the Dying

Most Chinese people prefer to die at home. Patients diagnosed with a hopeless condition will generally be sent home to their family. Terminally ill patients are not kept in hospitals. Doctors or nurses call on the patient at home and give necessary pain relief.

An especially moving account of care for the dying and terminally ill was given by a doctor at the Red Cross Hospital in Beijing. She said that she teaches the doctors at the hospital to treat the patients like a relative. Each patient should be treated as an individual, with respect for their likes and dislikes. They should be given the type of food and clothing they like and be allowed to see family and visitors when they like. (Each room has an extra bed for a family member to stay permanently with the patient). Religious observances are respected. If a patient resists treatment, the doctor should make jokes or distract the patient with stories. For example, a patient who is afraid to have a pain killing injection may contract the veins and make it hard to insert a needle. By joking with the patient about the trouble in finding a vein, the patient will relax and make the injection easier. If a patient leaves the hospital, the doctors will write to them. On the patients’ birthdays, there are parties for them which the doctors attend and sing birthday songs. If the patients have pain, they are given whatever drugs are necessary to relieve it, massaged, and helped in other ways. But particularly, people are always with them.

Those familiar with the hospice movement in Western countries, Dame Cecily Saunders, *et al.*, will recognize this as “treatment for dying” (or perhaps the “ethic of care” discussed by modern feminist nurse ethicists) rather than the common Western practice of trying to preserve life at all costs—whatever high-tech intervention that requires. The doctors at the Red Cross Hospital accept that the patient is dying (though they may not tell the patient), and they try to allow the patient to die in as dignified, pain-free and “uncluttered” a manner as possible. No ventilation, no intubation, no electronic monitoring, no heroic measures to maintain life at all costs.

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The ethic underlying this method of treatment is not autonomy (the patient may not be involved in the decision-making at all), and it is not “sanctity of life”—at least in its interpretation that all available steps should be taken to preserve life even where it seems the prognosis is hopeless (such as the artificial feeding of patients in a persistent vegetative state).2 It is an ethic of care or an ethic of obligation. The Red Cross Hospital doctor called it “love”—she said the doctors must love the patients. I called it “Agape” in a paper some years ago3 and I described it as the fundamental ethical principle to be balanced against all of the others—autonomy, beneficence, nonmaleficence, justice, utilitarianism. Deontological and intuitive ethicists recognize it in different ways. And I think that Western doctors can learn from it when we are less afraid of death—and our financial resources are even more stretched!

Euthanasia

As in other countries, active euthanasia is sometimes practiced by Chinese doctors even though it is unlawful. Understandably, they are reluctant to give details about this, but some doctors said that they had undertaken euthanasia with terminally ill patients who had pain that could not be treated. (This statement was made after a clear distinction was drawn between a positive act intended to hasten death (active euthanasia), and “passive euthanasia” (withdrawal or withholding treatment) or the administration of extra drugs to relieve pain that incidentally hastened death).

These doctors are acting in what they perceive to be the patient’s best interests (and possibly without consulting the patient, although that was not discussed). It is rare for a doctor to be prosecuted in China,4 though there is a procedure for a doctor’s practices to be investigated by the Medical Malpractice Committee of the Ministry of Health and the doctor may be punished financially or by imprisonment. Doctors may therefore feel less threat of criminal action if they undertake active euthanasia. Nevertheless, this issue was raised by a number of doctors and their attitudes seemed similar to those of many Western doctors considering the same question.

Submitted by
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2. Airedale NHS Trust v Bland [1993] AC 789 (House of Lords). The Court ultimately ruled that it was lawful to withdraw artificial feeding and hydration as the patient’s prognosis was hopeless, but, prior to that, he had been maintained in a “persistent vegetative state” for more than three years.
4. There have been prosecutions in euthanasia cases. In one, a doctor who killed his father/patient who was in great pain was imprisoned for eight years.

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Case Study From a Maryland Hospital

It would seem unlikely that any employer in the United States would deliberately allow gender or racial discrimination to be practiced by an employee. In fact there are a number of laws and regulations at both the state and federal level that prohibit such discrimination. But, what should be the policy of a hospital when a patient wishes to reject a doctor or nurse because of their race, ethnicity, or gender?

This question arose recently at St. Agnes Hospital. A black female medical resident arrived at the bedside of a white male 66 year old patient. She was dismissed immediately by the patient in colorful and vulgar terms. He indicated that both her color and gender were unacceptable to him, and indicated that he would leave the hospital unless his preferences were accepted. The resident, a native of Ethiopia, reported the incident to the Chief Resident, who, being uncertain of the most prudent response, assigned a white male resident to the case.

Subsequently, the problem was referred to the Ethics Committee after inconclusive discussions in the Medical Department and with the Director of Human Resources. The Ethics Committee has been asked to develop a policy on how hospital staff should deal with similar requests in the future. What would you advise?

Case Discussion: Comments From Legal Practitioners

As a society, we would like to believe that people are judged by their abilities, not by their race, ethnicity, or gender. Unfortunately, the reality is quite different and preferences, biases and prejudices often arise during the course of a professional career. If this case involved a health care provider who was refusing to provide treatment
to a patient based on the patient’s race, gender, or ethnicity, the health care provider would clearly be liable for this illegal discrimination under both federal and state anti-discrimination laws. However, as repugnant as a patient’s prejudices may be to us on a personal level, in a non-emergency hospital setting, patients’ wishes concerning who provides treatment to them must be honored except under the circumstances described below.

Patient’s Right to Bodily Integrity
The duty of a health care provider not to treat patients in violation of their wishes is grounded both in constitutional and common law. The Supreme Court has consistently stated that, “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.” This basic premise of personal autonomy has been pervasive throughout the common law decisions of most state and federal courts that have addressed patient care issues and it forms the basis of decisions that require health care practitioners to respect and honor a competent individual’s decision to consent or to refuse to give consent to treatment. To knowingly interfere with this right is to commit not only violations of constitutional magnitude, but also common law battery.

The protection of personal liberty and integrity has always been an important basis for battery and liability for this tort arises when an individual is touched without her consent. The common law clearly recognizes that an individual has the right to demand that she not be touched, whether or not the contact would result in any visible injury. Causing actual physical harm is not necessary for battery to be a legally cognizable cause of action. Further, a health care provider who performs treatment upon an individual without her consent would be liable for any injuries resulting therefrom under the law of informed consent. A patient treated or touched over her objections could also bring a claim based on intentional infliction of emotional distress if the conduct of the health care provider was extreme and outrageous; there was an intent on the part of the health care provider to cause the emotional distress; such emotional distress was in fact suffered by the patient; and, the emotional distress was actually caused by the health care provider’s outrageous conduct.

Hospital Policy Implications
In this case, a resident who performed any treatment on a patient without her consent would, at the very least, be liable for battery. The patient’s consent encompasses not only the treatment provided, but also the specific health care provider who is giving/performing the treatment. If the patient’s wishes were not followed in this case, the hospital may also be liable because a resident would likely be considered an agent, servant and/or employee of the hospital. Thus, it is prudential for a hospital to develop a policy to deal with the demands of patients regarding their health care providers.

If a patient is demanding another health care provider, for whatever reason, the hospital’s policy should provide either for another health care provider to be assigned, if at all possible, or for the patient to be informed in the pre-admission packet that the hospital cannot change its staffing to honor individual patient requests. Thus, the patient in a non-emergency situation may choose to receive care at a different facility, arrange for private duty nursing at the current facility, or a transfer may be arranged to a health care institution that can provide the appropriate care with “accepted” health care providers. This transfer must, of course, comply with applicable federal and state anti-dumping laws, and the risks and benefits of such a transfer must be explained to the patient.

Does this mean that a hospital must advise each and every patient that they have the right to choose all health care providers involved with their care? No. A hospital need not actively insure that each patient has ‘approved’ their health care providers. Must a hospital meet the dietary wishes of a patient whether based on religious tenets or simply personal preferences? Must a hospital comply with roommate preferences or preferences for certain views out the window? There is obviously a whole spectrum of issues that could arise form the wishes of an individual patient as to who treats them and how and where they are treated. However, the legal concepts discussed above that may require a hospital to comply with a patient’s wishes have been less and less applicable the further we get from issues involving the actual treatment of a patient and the interaction between the health care provider and the patient. A hospital can always strive to try to meet the wishes of a patient as too food, roommates and other variables, but the failure to do so, unless discriminatory, or harmful to the patient’s underlying medical condition, would not give rise to the legal violations discussed above.

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Case Discussion: Comments From a Bioethicist

This case demonstrates how some in the medical community have taken the autonomy principle dangerously beyond its most illogical extreme. In so sadly misinterpreting the important medical ethical norm of supporting patient self-determination, this case illustrates a hideous contortion of the principle of respect for persons. Who and what could possibly have been respected here?

No one’s best interest was upheld and the perpetuation of discrimination and intimidation was ultimately supported. Such behavior ought never be tolerated. Nondiscriminatory policies ought be written and enforced that cover all conduct within the hospital.

If a patient, even politely, states that he or she will leave the hospital if dissatisfied with a staff member on the basis of race or gender, that is the individual’s choice to make. In a democratic society, we have the right to hold discriminatory beliefs and to act them out in certain ways. When such a problem arises, as described in this case, some accommodation to bigotry may be necessary to satisfactorily resolve the situation.

That is, given that a hospital has an obligation to discharge patients stably, one can imagine, for practical purposes, finding a staff member whose race and gender will not further inflame the situation, to effectuate the transfer or discharge properly. Nonetheless, the transfer or discharge will broadcast to both patients and hospital staff that discrimination will be contained swiftly and dispatched with tactful concern for the welfare of both the patient and involved staff member(s). Decisive explanation of the reasons for the transfer or discharge must be presented emphatically to the patient and well documented.

Simply switching staff to appease the discriminatory behaviors of patients, however, sends quite a different message throughout the hospital. Tolerance of such repugnant demands on the part of patients says to all involved, and the community at large (because such stories get out past hospital walls), that a particular hospital is spineless, that the hospital and its staff are so afraid of lawsuits by patients that it will tolerate behavior that is considered unacceptable by the rest of society.

Beyond the damage such tolerance does to the morale and functioning of a specific hospital staff and an institution’s reputation, such weakness and misguided acceptance of unacceptable patient behavior risks grave harm to the development and reputation of the medical profession, itself. The actions of the Chief Resident in this case say that senior clinical staff are woefully confused about what are reasonable patient requests and what are not. Confusion of this kind feeds into a growing public cynicism about the ability of health care providers to make judgments and recommendations that truly are in the best interest of the patient. Further, such an incident can instill decisional paralysis, or worse, in those at more formative stages of professional development.

And what has this Chief Resident really done for this patient? The Chief Resident has affirmed that bullying and bigotry can win the day. The understanding by this patient that whatever he demands, appropriate or not, should be provided has been solidified. Rather than lead in a way that strengthens the practice of moral medicine, this Chief Resident has caved into the lowest common denominator in our society.

But in this hospital’s haste to assure its staff and community that it will not tolerate discrimination, care must be taken not to make the same mistake by becoming rigidly set in the opposite direction. That is, optimal clinical care calls for individualized attention to patient needs. To the degree hospital resources permit, personalized care should be maximized. For example, consider a woman in for surgery of newly diagnosed ovarian cancer, expressing modesty concerns. She does not say she won’t have a male doctor, only that she is embarrassed at the prospect of so many men examining her so intimately. If one of the surgical residents is female, compassion and good medical practice dictate she be assigned to follow this patient. It is compassionate because the female resident’s presence, amidst all the male physicians, may have a soothing effect on the patient psychologically. It is good medicine because reductions in patient anxiety may contribute to better post-surgical outcome.

What of the African American patient in sickle cell crisis? Is there an African American physician in the hospital knowledgeable about this disease? If so, making such a match, even if only on consultation, gives to the patient a measure of cultural familiarity that has the potential for producing more effective communications and, perhaps, better compliance with medical recommendations.

What of the HIV+ homosexual male close to hospital discharge? If the hospital’s social work department has only heterosexual females, then there is no special match to be made. But if the hospital’s social work department includes a homosexual male or female who could be specifically dedicated to the hospital’s HIV population, it only makes sense to allow such specialization of staff and utilize commonalities where they exist.

None of these examples, however, ought to be confused with the facts of the case under discussion. In none of these hypotheticals does a patient make a racially or gender-based request or demand. Rather, these are exemplars of how to be sensitive to patient characteristics and how to manage a hospital’s staff to build patient trust and confidence, not destroy it.

It is the destructiveness of bigotry that is central to this case. Medicine does not always produce hoped for outcomes - diseases are not cured indefinitely, death comes to us all. But medicine is an aspirational profession - the goal is always to help others. Whether that means aggressively treating or only being able to reduce suffering, the aim is to advance the
patient’s good. Discrimination is a polar opposite, it is like a killing blanket thrown over those upon whom it descends and it is a poison that kills the souls of those who harbor it. Supporting bigotry and discrimination is in nobody’s best interest and hospital policy must reflect that understanding clearly.

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The ideas and opinions expressed in this paper are those of Dr. DeRenzo’s only and do not represent any position or policy of the National Institutes of Health, any other Federal agency, or any other institution or organization to which she is affiliated.

TO THE EDITOR

February 7, 1996

Dear Editor:

This is a letter commenting on the case analysis from Fall 1995. I think the comments from Ms. Glover and Dr. Hyman were excellent and insightful. I did want to comment on Dr. Hyman’s opinion that an ethics committee had no role in this situation.

First, ethics committees, and their ability to do ad hoc ethics consultations, are useful because they have the following qualities: they are accessible, multi-disciplinary, and are egalitarian. Each health care institution in Maryland is required by law to have a patient care advisory committee (PAC). This PAC must have a mechanism in place to provide “advice” regarding decisions about treatment in life-threatening conditions, and is most useful when there is a conflict about what decision should be made. At our institution, meetings of ad hoc committee members are usually convened within 24 hours of being contacted and advice is written in the chart at the time of the meeting. The PAC that provides these ethics consultations must, by law, be composed of members from various disciplines including medicine, nursing, social work, and hospital administration. Clergy and lay persons also often serve as members. These groups are egalitarian because a consultation can be requested by anyone involved in the patient’s care including family members, nursing staff, physicians, etc.

Second, an ethics committee is not only potentially helpful in such cases as this, but the deliberation of the PAC may even be required in this situation.

The Maryland Health Care Decisions Act requires that a physician who believes a request by an agent or surrogate to withhold or withdraw life-sustaining treatment is “inconsistent with generally accepted standards of patient care” must either petition the patient care advisory committee for advice or file a petition in court seeking an injunction to prevent the surrogate from carrying out the request.

The decision about standards of medical care is a medical decision, not a legal one. I would argue that if a physician believes that a surrogate’s decision—whether the surrogate is an appointed health care agent or not—is inconsistent with the patient’s previous stated wishes, then to follow this decision without question is not consistent with generally accepted standards of medical care.

The physician in this case was correct to contact the institution’s patient care advisory committee. Not only did the physician have genuine concern about whether or not the surrogate was being “faithful,” but there had also been a breakdown in the communication between the physician and the surrogate. In this instance, an accessible multi-disciplinary committee was able to resolve the situation with the best possible outcome. I agree with Dr. Hyman that if the committee had decided that the agent was “faithless” they would have had to recommend a guardianship proceeding. But, in general, the institutional patient care advisory committee is a helpful, and perhaps compelling, first course of action that is convenient, and capable of handling difficult issues, without resorting to the more cumbersome, and adversarial legal system.

Sincerely,

Jackie A. Syme, Jr. MD
St. Agnes Hospital

Network News
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from institutions with functioning ethics committees, would explore some of the practical responses an ethics committee can make in response to the new regulations. If the proposed workshop would be of interest to your institution, please contact Ann Mills, M.S., at (804) 982-1971.

Finally, the Center wishes to announce that plans are underway for an off-ground M.A. program in Clinical Ethics to serve candidates in Virginia, bordering states, and the District of Columbia. The Center hopes to pilot the program at two regional sites in the academic year 1997-98. The key concept of the program will be the mutual involvement and cooperation of the degree candidate and the health care organization he or she represents. The present program curriculum at the University of Virginia will be taught in a two-year cycle. Participants will be required to complete a two-week residency at the UVA each summer for meetings with core faculty, testing and comprehensive exams and attend “Developing Hospital Ethics Programs” sessions. Courses will also be open to members of ethics committees and others who wish to strengthen their education in clinical ethics and allied areas. For further information on the program, contact John Fletcher, Ph.D., Director of the Center for Biomedical Ethics, at (804) 924-8274, e-mail: jcf4x@virginia.edu.
CALENDAR OF EVENTS

MARCH

14 University of Maryland Medical System, Medical Humanities Hour. “Ethical Issues Involved with Managed Care,” Gail Povar, M.D., George Washington University. 4:30 - 5:30 p.m., at the Shock Trauma Auditorium, University of Maryland Hospital, Baltimore, MD. Call Henry Silverman, M.D., at (410) 706-6250.

19 Georgetown University Center for Clinical Bioethics, Catholic Ethical and Religious Directives Lecture Series. “Beginning of Life,” John Harvey, M.D., Ph.D. 12:00-1:00 p.m., at the Warwick Evans Conference Room, Building D, Georgetown University Medical Center, Washington, D.C. Call Stacy Schultz at (202) 687-1122.

26 Washington Metropolitan Bioethics Network Meeting. “Health Care Decision Making in Patients with Diminished Capacity,” Randy Howe, M.D., J.D. 4:00 - 6:00 p.m., location to be announced. Contact Joan Lewis at (202) 682-1581.

APRIL

9 Georgetown University Center for Clinical Bioethics, Bioethics Colloquium. “Genetic Enhancement,” William Ayers, M.D., Georgetown University Medical School. 5:00-6:45 p.m., at the Warwick Evans Room, Building D, Georgetown University Medical Center, Washington, D.C. Call Stacy Schultz at (202) 687-1122.

11 University of Maryland Medical System, Medical Humanities Hour. “Managed Care: An Oxymoron?”, Steve Sharfstein, M.D., University of Maryland at Baltimore and Sheppard Pratt Health Systems. 4:30 - 5:30 p.m., at the Shock Trauma Auditorium, University of Maryland Hospital, Baltimore, MD. Call Henry Silverman, M.D., at (410) 706-6250.

12-13 “Quinlan: A Twenty-Year Retrospective.” Co-sponsored by Shore Memorial Hospital, University of Pennsylvania School of Bioethics, Boston University School of Public Health, Princeton University, Kennedy Institute of Ethics, The Hastings Center, and others. At the Princeton Hyatt Regency and Princeton University, Princeton, N.J. Contact Sally Nunn, R.N., at (609) 653-3828; registration deadline is April 1.

16 Georgetown University Center for Clinical Bioethics, Catholic Ethical and Religious Directives Lecture Series. “Professional-Patient Relationship,” Edmund Pellegrino, M.D. 12:00-1:00 p.m., at the Warwick Evans Conference Room, Building D, Georgetown University Medical Center, Washington, D.C. Call Stacy Schultz at (202) 687-1122.

17-19 University of Virginia, Center for Biomedical Ethics. “Developing Ethics Programs in Long Term Care.” At the University of Virginia, Charlottesville, VA; course limited to 15 participating institutions. Call (804) 924-5974 (Charlottesville) or (804) 353-3209 (Richmond).

18 John E. Jones Symposium on Health Policy. “Health Care for All: How Should We Proceed?” 2:00 - 5:00 p.m., at the Main Auditorium, Robert C. Byrd Health Sciences Center, University of West Virginia, Morgantown, W.V. Call Cindy Jamison at (304) 293-7618.

19-20 American Society of Law, Medicine & Ethics, The Hastings Center and The Law & Health Care Program, University of Maryland School of Law. "Medicare, Medicaid, and Managed Care: A Forum on Corporate Responsibility, Law, Ethics, and Public Policy. The Inn and Conference Center, University of Maryland, College Park, Md. Call the ASLM&E at (301) 262-4990 or email aslme@bu.edu.

CALENDER OF EVENTS (Cont.)


MAY


18 Seventh Annual Ophthalmology Alumni Weekend. “The Doctor-Patient Relationship in Managed Care: What Can We Expect?”, John LaPuma, M.D. At the John E. Jones Conference Center, Morgantown, W.V. Call Cindy Jamison at (304) 293-7618.

21 Georgetown University Center for Clinical Bioethics, Catholic Ethical and Religious Directives Lecture Series. “End of Life,” Daniel Sulmasy, O.F.M., M.D., Ph.D. 12:00-1:00 p.m., at the Warwick Evans Conference Room, Building D, Georgetown University Medical Center, Washington, D.C. Call Stacy Schultz at (202) 687-1122.

23 University of Maryland Medical System, Medical Humanities Hour. “Managed Care and Managed Death,” Dan Sulmasy, M.D., Ph.D., Georgetown University Center for Bioethics. 4:30 - 5:30 p.m., at the Shock Trauma Auditorium, University of Maryland Hospital, Baltimore, MD. Contact Henry Silverman, M.D., at (410) 706-6250.

TBA Baltimore Area Ethics Committee Network Meeting. Details to be announced. Call Jack Syme, M.D., at (410) 368-3020.


JUNE

9-12 University of Washington Department of Medical History and Ethics. “Genomic Information: Ethical Implications.” At the University of Washington, Seattle, WA. Contact Marilyn Barnard at (206) 616-1864, fax (206) 685-7515, e-mail: mbarnard@u.washington.edu; registration deadline is March 18. Last time course will be offered!

18 Georgetown University Center for Clinical Bioethics, Catholic Ethical and Religious Directives Lecture Series. “New Partnerships,” William Byron, S.J. 12:00-1:00 p.m., at the Warwick Evans Conference Room, Building D, Georgetown University Medical Center, Washington, D.C. Call Stacy Schultz at (202) 687-1122.

TBA Washington Metropolitan Bioethics Network Meeting. Details to be announced. Call Joan Lewis at (202) 304-7618.
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