NETWORK NEWS

The newsletter of the Florida Bioethics Network

an affiliate of the Florida Hospital Association • P.O. Box 531107 • Orlando, FL 32853-1107 • 407-841-6230

May 4, 1992 **92-2**

PRESIDENT'S MESSAGE . . . Ray Moseley, Ph.D., Director/Medical Humanities Program, University of Florida, College of Medicine, Gainesville.

This morning, I had two fairly typical phone calls that were directly relevant to the mission of the Florida Bioethics Network. The first call was from a nursing director at a medium size hospital in the Florida Panhandle. She had been charged with setting up a hospital ethics committee (HEC) and wanted some general information and advice. She noted that she had been pushing for an HEC at her hospital for several years, but only recently has the hospital administration and physician staff shown any real interest.

Here is a partial list of her questions: How many members should sit on an HEC? Should the hospital attorney serve on the committee? Should members have "special" training? What are some basic resources for an HEC? Which hospital policies should the HEC review? When should we start doing consults? Do we need to worry about liability protection?

The other phone call was from a physician from a large hospital in central Florida. His HEC has been in existence for several years. They regularly review hospital policies and offer educational forums for the staff every two months. However, the problem, as the second caller noted, was that the HEC only rarely received any requests for case consultation. Furthermore, the consensus of the HEC members was that the last two ethics committee consults resulted in not very useful advice.

This physician's questions focused on who should be allowed to "call" a consult - only the attending physician?, nurses?, the patient? Should a patient be notified that a consult is to take place? Should the patient or family sit in on the consult? Should every member of the HEC be involved in ethics consults or should only more experienced members or those with more training do consults? Should the consult team write a chart note? Should the committee members "see" the patient?

These and others are not atypical questions. Some of these questions have rather straightforward answers. The answers to some of the others are highly debatable, given the variation among the circumstances under which many HECs operate. There is, however, a reservoir of experience with HECs here in Florida, which can offer very useful advice and perspective on these and other questions about HECs. Offering a network where these experiences can be shared is one of the fundamental missions of the FBN. To promote this, along with your membership, you will receive a regularly updated list of FBN members and their addresses, phone and FAX numbers. Additionally, FBN meetings build in plenty of opportunity for learning about the successes and setbacks of other members in their efforts to create and run ethics committees. Our first Annual Meeting is scheduled for October 22-23 in Clearwater.

In this vein, I would invite members of the FBN to write or call if you have questions that could be addressed in future issues of Network News or in future FBN meetings. I will try to answer questions concerning

PRESIDENT'S MESSAGE (continued)

ethics committees. If you have some experiences you would like to share about the development or function of HECs, I would also invite you to submit a piece for the newsletter.

LEGISLATURE COMES THROUGH!

. . . submitted by John Babka, M.D., Senior, Vice President/Director Medical Affairs, Morton Plant Hospital, Clearwater.

During the last session, the Florida Legislature passed HB 1851, The Health Care Advance Directives Act. This act combines all of the statutes regarding living wills, holding or withdrawing of life-prolonging procedures, health care surrogates, and health care proxies in one statute. It improves the procedures for a durable power of attorney and requires them to be governed by this chapter. This bill was developed and proposed by the Florida Hospital Association, the Florida Medical Association, the Florida Bar Association and the Florida League of Catholic Hospitals to simplify and improve handling of all these areas and to conform to the recent Browning decision of the Florida Supreme Court.

The various sections of this act deal with:

1. An improved set of definitions along with legislative intent.

2. Health care surrogates.

3. Life-prolonging procedures and living wills.

4. Direction in the absence of an advance directive including specific directions for the use of a proxy.

5. Revisions to the statute governing durable power of attorney.

The legislative intent is quite straightforward. It states (edited):

1. Every competent adult has the fundamental right of self determination.

2. To ensure that such right is not lost or diminished by virtue of later physical or mental incapacity, the legislature intends that a procedure be established to plan for incapacity by designating another person to direct the course of his medical treatment.

3. Artificial prolongation of life in a person with a terminal condition may secure only a precarious and burdensome existence while providing no medical benefit. We recognize the right of a competent adult to make an advance directive instructing his physician to provide, withhold, or withdraw life-prolonging procedures or to designate another to make treatment decisions for him.

A copy of the law is enclosed for your review. I will describe the implications of the various sections in detail in subsequent issues of Network News.

UPCOMING EDUCATIONAL PROGRAMS

May 28 **The Ethical Challenge of HIV Disease: A Workshop for Ethics Committee Members**
Tampa General Hospital, Conference Room B-104
Co-sponsored by Tampa General Hospital, University of South Florida College of Medicine, and the Florida Bioethics Network
For more information, call Glennys Ulschak at 813/251-6073.

UPCOMING EDUCATIONAL PROGRAMS (continued)

August 28 Bioethics in the 90's: Challenges and Opportunities
Sarasota Memorial Hospital
Sponsored by the Bioethics Committee of Sarasota Memorial Hospital
For more information, call Cathy Emmett at 813/953-1750.

DNR ≠ DO NOT TREAT . . . submitted by Judy Gygi, LCSW, Director, Social Work, and **Liz Bromert, R.N.**, Home I.V. Infusion Coordinator, West Florida Regional Medical Center, Pensacola.

Although hospitals are mandated to have a Do Not Resuscitate (DNR) policy, such policy does not always clearly define what is practiced. Reality is that there are conceptual differences among physicians and other hospital caregivers as to the exact meaning of DNR.

Frequently, in patient care conferences, or when critical care beds are needed, questions such as the following are asked, "If he has a DNR order, why is in ICU? or on IV antibiotics? or still receiving dialysis?" These questions presume that a DNR order precludes not only cardiopulmonary resuscitation (CPR) but other therapeutic interventions. Utilizing this definition, the care that ensues is consistent with studies which demonstrate that after a DNR order is written the intensity of care is reduce.

If therapeutic interventions, other than CPR, are withheld or withdrawn, we ignore the possible benefits of these interventions and the patient's and family's wishes. The implication is that the patient should be maintained as comfortable as possible and allowed to die peacefully. On the basis of this presumption, DNR would be defined as comfort care only.

However, even with comfort care only, intensity of care is sometimes reduced for fear of "assisting the patient to die" or fear of being accountable for contributing to a patient's death. This is particularly true in the realm of pain control.

This, then, presents the issue of the practicality of a tiered system of DNR in which two or more levels of care are defined by DNR. In a tiered system, DNR could be written with further explanation. For example, DNR - No CPR or DNR - Comfort Measures Only. Does such a system of defining DNR result in clarification or further ambiguity?

DNR raises issues that are unlikely to be managed by policy alone. These issues may be better resolved by open and direct communication with the patient/family regarding their explicit wishes and physician documentation and communication with caregivers directly involved in the patient's day-to-day hospital care.

ESTABLISHING AN ETHICS COMMITTEE . . . submitted by James T. Wagner, Ph.D., Director/Department of Pastoral Services, Shands Hospital at the University of Florida, Gainesville.

Today, more than half of all hospitals in America and some nursing homes have a Bioethics Committee. Although there are wide differences in their activity levels, the fact there are so many is testimony to the need for an in-house resource to consider biomedical ethical situations that arise in patient care. The courts are available and will, in some paradigm cases, be utilized. But on a day-to-day basis the legal system is not equipped to respond either in a thoughtful or timely manner.

If your institution is thinking of establishing an ethics committee or are in the early stages of doing so, the following questions may provide some guidelines for your consideration.

ESTABLISHING AN ETHICS COMMITTEE (continued)

1. What is the Mission of an Ethics Committee?

An ethics committee should have a mission that focuses primarily on acting in the "best interests" of the patient. While most institutions and health care providers espouse this value and act in accordance with it, the difficult decisions can cloud this value. An ethics committee should be a consistent, dependable resource for issues surrounding the well being of the patient, no matter how complex the case.

If an ethics committee serves the "best interests" of the patient, it will have a growing integrity within the institution. With such a posture, acting in concert with the law when it is clear, it will generally lower the liability risk. Should a case discussed by the ethics committee, particularly a prospective review, become involved in litigation, the finding that the attending physician, who initiated the consult, and the committee tried to act in the "best interests" of the patient is, in fact, one of the greatest defenses the institution has.

2. What is the Purpose of an Ethics Committee?

The purpose of an ethics committee is to assist health care providers in making critical treatment decisions. Assistance is provided through three primary functions. Committees plan and coordinate in-house educational efforts to familiarize all staff with information about bioethics. Second, committees contribute to the review and development of policies and procedures. Third, committees may do retrospective and/or prospective case consultations.

3. Who Usually Serves as Members of a Bioethics Committee?

Committees that have been surveyed evidence a high degree of uniformity regarding membership. Typical members include physicians, nurses, chaplains, social workers, administrators, and a community representative, perhaps someone who has had experience with hospitals and/or hospitalization. When a trained ethicist is available, s/he is usually a valued member. Ten to fifteen persons may comprise a committee, with physicians having the most representatives of any one group.

Disciplines which are debated as to their inclusion are legal representation and risk management. This debate centers around a potential conflict in mission. Can an attorney or risk manager employed to protect the institution set aside this perspective and focus on the patient's best interests? Some committees address their need for legal consultation by having a community based attorney as a member. Or, they may have no attorney associated with the committee. There are also positive examples of attorneys and risk managers who are successful committee members.

Regardless of the approach you decide to take, any member of an ethics committee should possess some common characteristics. First, they will facilitate the work of the committee if they are persons who are largely respected throughout the institution. Second, they should be what is referred to by some writers as "reasonable" persons. This means that they make an effort to be thoughtful and sensitive rather than authoritative and dogmatic. Third, they should make use of their respective skills and specialties, but also be able to step outside them to engage in an ethical deliberation where no clear answer may exist. This process is facilitated by all members having taken the time, usually scheduled, structured meetings, to familiarize themselves with some of the literature in the field of bioethics, including both principles and casuistry.

The chairperson of the committee should possess all of the skills listed above, in

addition to commanding the utmost respect of the medical staff. This doesn't necessarily mean a physician is required as chairperson. However, it is wise that medical staff have some participation in and comfort with whomever is selected as chairperson.

4. To Whom is a Committee Administratively Responsible?

Ethics committees may report to a variety of authorities, including the medical staff, a board of directors, or other prominent administrative office. Regardless, the primary issue remains the same. Whatever the administrative authority, it is essential that they endorse the mission and purpose of the committee.

Several alignments may pose conflicts of interest and should be carefully reviewed before being chosen. These include a committee reporting to either the hospital attorney or risk manager. As briefly discussed earlier, the mission of these offices are potentially at odds with the "patient's best interest" focus, so much so that many authorities advise against including either role on the membership.

5. How Should a Committee Begin?

The conclusion of a thoughtful process within an institution usually results in agreement on the need for a committee and an embracing of its mission and purpose. This step is followed by the appointment of a chairperson and the selection of committee members. Many times, members emerge from among those persons who participated in the planning process.

Effective committees often report beginning with a program of study, some for as long as a year, before becoming involved in any of the central functions, especially case consultation. This is a real time commitment, but it is necessary in order for the committee to claim, with any integrity, a level of expertness which justifies its use.

Developing expertise recognizes the need to establish and build trust within the institution. Having patience with this process can be purposeful. For example, during its educational process, one committee invited physicians to present challenging cases for retrospective review. Using this approach, the committee not only developed their skills in consultation, but exposed physicians to what it would be like to call upon the committee.

There are a number of resources available as instructional materials, as well as, programs which can be attended that provide concentrated orientation to bioethics. A brief resource guide is provided at the end of this article.

6. What Has Been The Impact of Ethics Committees?

Contrary to the normal concerns of many physicians, most committees have had the effect of enhancing the physician/patient/family relationship. They have removed some of the loneliness and isolation which can surround the unchartered complexity of some decisions. In other cases, the challenge of making obviously correct but uncomfortable decisions has been supported. Usually the autonomous preferences of the patient has been emphasized, along with the benefits of all caregivers communicating clearly with one another. Committees have raised the consciousness of ethical decision-making throughout the institution, while providing a common language for reasoning through complex issues. They have provided a useful in-house resource which, in many instances, has avoided the need to turn to the courts for resolution.

ESTABLISHING AN ETHICS COMMITTEE (continued)

7. In Florida, Is There a Resource Available to Assist Your Institution?

Yes! The Florida Bioethics Network was established in 1991 for that very purpose. It is a personal membership group of the Florida Hospital Association. Contact Joanne Miner, FHA Director of Membership Services at 407/841-6230 for more information, as well as any of the officers or members of the board.

Some Helpful Resources

Journals and Newsletters

Hastings Center Report. The Hastings Center, 255 Elm Road, Briarcliff Manor, New York 10510.

Health Progress. The Catholic Health Association of the United States, 4455 Woodson Road, St. Louis, Missouri 63134-0889.

Hospital Ethics. American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60637.

Reference Works

"President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research." U.S. Government Printing Office, Washington, D.C. 20402.

a. Deciding to Forego Life Sustaining Treatment
b. Making Health Care Decisions (3 Volumes)
c. Defining Death
d. Securing Access to Health Care (3 Volumes)

"Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying." A Report by the Hastings Center. Indianapolis: Indiana University Press, 1987.

Books

Crawford, R.E. and Doudera, A.E. Institutional Ethics Committees and Health Care Decisionmaking. Ann Arbor: Health Administration Press, 1984.

Macklin, R. and Kupfer, R.B. Hospital Ethics Committees: Manual for a Training Program. Bronx, New York: Albert Einstein College of Medicine, 1988.

Ross, J.W. Handbook for Hospital Ethics Committees. Chicago: American Hospital Publishing Company, 1986.

Organizations/Institutions

American Society of Law and Medicine
765 Commonwealth Avenue, Suite 1634
Boston, Massachusetts 02215

Department of Medical History and Ethics
School of Medicine
University of Washington
Seattle, Washington 98101

Kennedy Institute of Ethics
Georgetown University
Washington, D.C. 20057

Society for Health and Human Values
6728 Old McLean Village Drive
McLean, Virginia 22101