NETWORK NEWS

The newsletter of the Florida Bioethics Network

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A PIECE OF MY MIND: THE CLINICAL ETHICIST AS CONFESSOR

Submitted by **S. Van McCrary, Ph.D., J.D., M.P.H.,** University of Florida College of Medicine, Gainesville.

I met Dr. Johnson[1] soon after I arrived at my first permanent faculty appointment. He was an experienced attending physician at one of the teaching institutions where I consult, who was known among his colleagues as a compassionate physician and among students as a great teacher. Over a period of weeks, he and I became better acquainted as I rounded regularly with his critical care team. One day as I passed Dr. Johnson in the hall, he stopped me and asked if I had a few minutes to talk. We went into a small private conference room, he closed the door and sat on my left, appearing pensive. "There is something I need to discuss with you," he said quietly. He then proceeded to tell me about Robert, a 26 year old man who had died on the previous day from a horrible disease. After a long period of suffering, the decision had been made to withdraw Robert from the ventilator. The family members all agreed that this was what Robert would have wanted. Dr. Johnson gave Robert some morphine to ease his suffering and removed the tube. The family and Dr. Johnson kept vigil. Although the rest of his body was dying, Robert's heart and lungs were strong. It seemed as though he refused to die, the agonal breaths continuing for hours. As he told this part, I was reminded of the flies in Richard Selzer's story "Mercy," which maintain until the moment of death an "awful buzzing as though to swarm again."[2] Dr. Johnson said, "At this point, I felt that I had to do something else, that he was still suffering and I was the only one who could help. I gave him an another injection of morphine and he died quietly after a few minutes." Throughout the story, Dr. Johnson remained calm, yet it seemed to me it was a calm only as the top waters of a lake can remain still while a powerful current runs beneath. "I told my wife about Robert and she thought I did the wrong thing. I just wanted to tell you about this," he finished. As sensitively as possible I assured him that, based on what he had told me, there was no apparent ethical problem with Robert's case[3] and he thanked me. We each went our own way into the other activities of the day, but his story lingered in my mind.

Dr. Johnson's story, and the trust he placed in me, remains with me as a milestone in my journey as a clinical ethicist. Of course, there had been many prior occasions in which physicians had discussed confidential information with me regarding difficult cases. Yet somehow Dr. Johnson's case was different — he had sought me out as a person, as well as an ethicist. No one had ever before confided in me in this manner — as both professional <u>and</u> person simultaneously. Later that day, I came to believe that Dr. Johnson was not asking me to say "You did the right thing," but rather "I understand how difficult this was for you." In this sense, the consultation was a more profound experience for me than any in

previous memory. I appreciated the trust that Dr. Johnson had placed in me and began to feel as though I had become not only a consultant but a confessor[4] as well. Today, I continue to wonder "Why did he pick me? Why tell me this story rather than another physician?" An ethicist colleague once said to me, regarding his consulting experience, "It continues to amaze me the kinds of things that people tell me." I, too, am amazed.

Perhaps clinical ethicists can serve other functions in addition to providing expertise. One of these functions, as Kathryn Hunter has observed, is that of the Greek chorus.[5] In this sense, our job is to listen and reflect the pathos occurring around us rather than taking action.[5]

Sometimes, circumstances demand that we not advise, but be present and absorb the case. So, too, in this role we are like priests. Just as physicians are sometimes compared to priests, consulting ethicists may serve physicians in a similar manner. I am reminded that every priest also has a confessor. Three points make our occasional assumption of a priestly role plausible—first, the nature of disease and death presents physicians with existential, as well as medical problems; second, these problems, perforce, demand personal, as well as professional involvement from physicians; and third, physicians may then perceive a need to share these experiences with other disinterested but sympathetic persons.[6] In some cases, the clinical ethicist may be the person chosen for this powerful encounter.

Of course, few of these thoughts are original. I think, however, that applying them to ethics consultation may stimulate helpful discourse with physicians and add a richer perspective to the practice of clinical bioethics. Frequently, clinical ethicists may think of ourselves as just another consultation service—one that provides a different kind of service, but which still follows the institutional model of expert. Yet my experience with Dr. Johnson reminds me that consulting ethicists can serve other functions as well, and that I am valuable to others in my workplace as a person. Sometimes, we are asked to be not moral arbiters, but simply listeners. I hope that I will gain the ability to discern readily which role I am being asked to play, that thereby I may better serve my physician colleagues, and that their patients will also benefit from this shared experience.

References

1. In order to protect confidentiality, I have altered names and circumstances of the case.
2. Selzer R. "Mercy." In: Letters to a young doctor. New York: Simon & Schuster, 1982, pp. 70-74.
3. For purposes of brevity and confidentiality, I have omitted some details of the case that led me to this conclusion.
4. I use this term not merely in the sense of a person to whom one confesses wrongdoing, but in the broader sense of a person with whom one shares meaningful experiences.
5. Hunter KM. Limiting treatment in a social vacuum: A Greek chorus for William T. Arch Intern Med 1985; 145: 716-719.
6. Barnard D. The physician as priest, revisited. J Religion and Health 1985; 24: 272-286.

EDITOR'S COMMENTS

Mary Lou Jones, Editor, FBN Secretary and Administrative Director, Maternal Child Services, Florida Hospital Medical Center, Orlando.

With the first issue of the 1994 Network News, a number of standing columns will be featured to enhance this medium for timely information related to bioethical issues. The **Bioethics Advisor**, a question and answer column, is being coordinated by **Ray Moseley, Ph.D.,** newly appointed Ethics Advisor to the FBN. A **Personal Sharing Column** will be used to spotlight views from readers who wish to describe a personal perspective on health care related experiences with ethical implications. Additionally, the **FBN President's Message, Feature Article, Conference Announcements** and **Bibliographic Resources** will continue.

PREHOSPITAL DO NOT RESUSCITATE ORDERS

Submitted by **Glenn R. Singer, M.D., F.A.C.P., F.C.C.P.,** Chairman, Bioethics Committee, Broward General Medical Center, Fort Lauderdale.

Recently, the Department of Health and Rehabilitative Services published an important new policy statement on pre-hospital or outpatient *Do Not Resuscitate (DNR)* orders.

By now, most Florida hospitals have policies and procedures on DNR orders. Chapter 765 of the Florida Statutes provides an outline for patients, their proxies or surrogates to follow if *cardiopulmonary resuscitation (CPR)* is not desired. Not infrequently, however, patients with DNR orders may improve or stabilize and not need acute care hospitals. The new guidelines permit patients or their families to call *Emergency Medical Services (EMS)* for the purpose of either transportation to an acute care hospital or assistance with palliation (e.g., oxygen or narcotics) and still honor the autonomous request for DNR status.

In the policy, EMS personnel are advised to honor only DNR orders and not living wills. It is perfectly appropriate for anyone to have a living will and receive CPR in the event that the individual suffers an arrest from an arrhythmia, drug reaction, or any of the other conditions in which CPR is recognized to have appreciable success. A living will simply means that if an individual has a terminal condition and the physicians believe that there will be no recovery, then the patient desires that prolonging procedures be withheld or withdrawn. CPR could be one of those procedures, but only if in this specific context.

A DNR order, on the other hand, means that a physician has determined that the patient is in a terminal or vegetative state from which there is very little chance for recovery. The patient, proxy or surrogate have been informed of these facts and agree that CPR should not be performed. Therefore, in the absence of a specific DNR order, EMS staff are to administer whatever care is necessary, including CPR.

HRS Form 1896, October 1993 is the official HRS form for DNR orders and can be obtained by writing to Department of Health and Rehabilitative Services, Office of Emergency Medical Services, Attention: Prehospital Services Unit, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700. The fax number is 904/488-2512.

A DNR bracelet is also available and carries the same validity as the appropriately executed form.

THE BIOETHICS ADVISOR

Submitted by **Ray Moseley.**

What, if any, is the appropriate role of hospital attorneys on a hospital's ethics committee?

In recent weeks, I have had several questions concerning this question and it is invariably posed by a non-attorney member of an ethics committee who expresses concern over the "legalization" of their ethics committee discussion and recommendations. Two basic problems must be addressed for a hospital attorney to be an effective committee member.

The first difficulty is that the position of hospital attorney may conflict with the requirements for committee membership. In short, the ethically appropriate recommendations reached by an ethics committee may conflict with the responsibility of the hospital attorney to minimize any possible legal exposure of the hospital. To avoid this problem, the hospital attorney must be able to separate his or her role on the ethics committee from his or her role as a hospital attorney. Although this is possible, it can be quite difficult in practice. Separation of roles requires that the attorney realizes that the advantages of having a committee, which focuses ethically on the best interests of the patient, is also focused on the best interests of the institution. Additionally, both the hospital attorney, as well as the other committee members, should keep in mind that the recommendations of an ethics committee is an important resource; however, it is only one of several resources available to the physician. A particular case may in fact have ethical, legal, and political implications. In that situation, the ethics committee explores the ethical aspects, and legal services explores the legal aspects. Both are integral to an effective resolution.

PRESIDENT'S MESSAGE

James T. Wagner, Ph.D., Director of Pastoral Services, Shands Hospital, University of Florida, Gainesville.

I hope you are already having a productive, successful new year. Take the opportunity now to reserve the dates of September 22-23 for the 1994 Florida Bioethics Network's Annual Meeting in Orlando. The presentations will be diverse, as usual, but emphasize the theme of "cultural/religious issues in bioethics." A one-day workshop on September 21 will precede the two-day program for those interested in a basic introduction to the structure and function of ethics committees.

The FBN Board met on January 7 in Orlando. In addition to planning the annual meeting, we voted to submit a proposal to the Florida Hospital Association Board of Directors, which addresses our concerns regarding membership in FBN for persons not employed by FHA member hospitals. We also formally established a "Resource Center," which is discussed in more detail elsewhere in the Network News.

You are especially invited to communicate your personal and professional interests in contributing to the newsletter. We always want articles which reflect expertise on a particular subject. However, many of us are not "experts," but we do have practical experience from which others can learn. The submission in this edition by **Dr. Van McCrary** is a good example of personal sharing. You might also indicate specific questions you would like addressed or subjects you would like to see discussed or debated. Contact either me or Mary Lou Jones for any assistance you may need.

A list of board members and how to contact each one is also included in this issue of Network News. Thanks to each of you for the sensitive care you provide patients, families, clients, and parishioners.

THE BIOETHICS RESOURCE CENTER

Submitted by **Ray Moseley, Ph.D.,** Medical Humanities Program, University of Florida College of Medicine, Gainesville.

The FBN is now a co-sponsor of The Bioethics Resource Center (BRC) and the services of that Center are now available to FBN members. This Center is affiliated with the Medical Humanities Program at The University of Florida College of Medicine. The holdings include over 1000 books, 10,000 articles and subscriptions to 15 journals. The Center also has an extensive collection of hospital and ethics committee policies on issues ranging from withdrawal of treatment, DNR orders, Advance Directives to HIV testing. Additionally, the latest versions of Florida (and selected other states) law, regulations, and court cases are available. Faculty of the Medical Humanities Program are available to answer your questions or to direct you to additional resources.

The Resource Center is open 8:00 a.m. to 5:00 p.m., Monday through Friday (if you are in Gainesville, please feel free to visit). Please note that the Resource Center and The Medical Humanities Program are located in the Department of Community Health and Family Medicine, so do not be surprised when the telephone is answered "Family Medicine!" An answering machine is available for afterhours and weekend telephone requests. There is no charge for this service to FBN members, although you may be asked to cover copying costs if you request large amounts of printed information.

FBN members may request information from the Bioethics Resource Center as follows: **Ray Moseley, Ph.D., Medical Humanities Program, Box 100222, University of Florida College of Medicine, Gainesville, Florida 32610 -- Phone #: 904/392-4321 -- Fax #: 904/392-7349 -- E-mail address: Moseley @ chfm.health.ufl.edu**

One should remember that, in general, ethics committee members should not be on the committee as representatives of a constituency. (This, however, should not be confused with the notion that diversity is needed on the committee to ensure that all relevant ethical reasons for various courses of action are explored.) Ethical problems are not different for physicians, nurses, social workers, etc., although each may bring different information and insights to the discussion. The optimal ethical solution or solutions are arrived at by analyzing appropriately the supporting arguments, not by balancing the institution's political factions.

A second potential problem with hospital attorneys as ethics committee members is the societal problem or preoccupation with looking for legal answers to problems which are primarily ethical. Thus, there is the tendency for an ethics committee to discuss the ethical ramifications of a case, but to then turn to the attorney for the "legal answer" to settle the matter. This can stop further discussion in its tracks.

Many times the ethical discussion is significantly enhanced by knowledge of the legal situation. This is especially true with familiarity with some of the relevant State and Federal Appeals and Supreme court cases. These cases often depend heavily on ethical principles and arguments; however, on many issues that come before an ethics committee, federal and state legislation and settled precedent-setting court cases may be ambiguous or non-existent. The hospital attorney must be willing to make a distinction between what is clearly covered by law and what in his or her opinion minimizes institutional exposure but for which there is no clear law or legal precedent.

Hospital attorneys can be valuable members of hospital ethics committees but their knowledge of the law must be directed towards enhancing discussion of the ethical issues, not obfuscating them or supplanting them with legal issues.

The issues of deciding appropriate ethics committee membership will continue to be a difficult one, particularly in the case of hospital attorneys. I look forward to any further questions, discussions, or comments regarding this important topic.

The Bioethics Advisor is a new regular feature of the Network News, the FBN newsletter. This column will present questions raised by FBN members concerning issues in health care ethics, the function of ethics committees, or any other areas of concern for FBN members. FBN members should forward questions you wish addressed in this column or comments concerning questions or responses to The Bioethics Resource Center, Ray Moseley, Ph.D., Bioethics Advisor, Medical Humanities Program, Box 100222, University of Florida College of Medicine, Gainesville, Florida 32610.

BIBLIOGRAPHIC RESOURCES

Alpert, S. (1993): Smart cards, smarter policy: Medical records, privacy and health care reform, Hasting's Center Report, 23 (6), 13-23.

Block, AJ (1993): Living wills are overrated, Chest, 1645-1646.

Clarke, DE, Goldstein, MK & Raffin, TA (1993): Withholding and withdrawing nutrition and hydration: Surrogates can make this decision for incompetent patients, Chest, 104, 1646-1647.

Diaz, JH (1993): The anencephalic organ donor: A challenge to existing moral and statutory laws, Critical Care Medicine, 21, 1781-1790.

Harris, J. & Holm, S. (1993): If only AIDS were different, Hasting's Center Report, 23, (6), 6-12.

Hertman, E: A proatious role for the ethics committee or ethics consultant, Trends in Health Care, Law and Ethics, 8, (4), 11-16.

Parker, JM, Landry, FJ, & Phillips, YY (1993): Use of do not resuscitate orders in an intensive care setting, Chest, 104, 1592-1596.

Rosner, F (1993): Why nutrition and hydration should not be withheld from patients, Chest, 104, 1892-1896.

Sugarman, J., Powe, N.R., Brillantes, D., Smith, M.K. (1993): The cost of ethics legislation: A look at the patient self-determination act, Kennedy Institute of Ethics Journal, 3, (4), 387-400.

Walsh, J.L. & McQueen, N.M. (1993): The morality of induced delivery of the anencephalic fetus prior to viability, Kennedy Institute of Ethics Journal, 3, (4),357-370.

White, G.B. (1993): Human growth hormone: The dilemma of expanded use in children, Kennedy Institute of Ethics Journal, 3, (4), 401-410.

Winters, G., Glass, E., & Sakurai C. (1993): Ethical issues in oncology nursing practice: An overview of topics and strategies, Oncology Nursing Forum, 20, (10), 21-34.

CONFERENCES AND SEMINARS

Annual Ethics Conference

The Ethics Committee at University Medical Center in Jacksonville will hold its annual Ethics Conference on March 16-18, 1994 in the Learning Resource Center on the campus of University Medical Center. The title of the conference is "Ethical Issues Related to Patient Autonomy." The conference will address the topic of Patient Autonomy from different perspectives, its effect on providing medical care, and the conflicts and challenges that are often associated with it. For more information about the conference, call or write to **Alicia Azouz,** University of Florida Health Science Center, 653-1 West Eighth Street, Jacksonville, Florida 32209 -- 904/549-3158.

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Second Annual Clinical Ethics: Practice and Theory

The Second Annual Clinical Ethics: Practice and Theory, sponsored by Forum for Bioethics and Philosophy, University of Miami, will be held March 18-19, 1994 at the Fontainebleau Hilton Resort and Spa in Miami Beach.

Rapid advances in medicine, biology and related fields continue to challenge our ability to apply ethical theory to clinical practice, especially in multicultural environments. This conference brings together three of the world's leading ethicists who will, in an unprecedented exchange, describe and contrast their approaches, in part by conducting comparative case evaluations. This will provide an unparalleled opportunity for those who practice clinical ethics or have an interest in the field. The conference also features a symposium on Bioethics and Transculturalism, a field in which some of the most pressing problems for clinicians and policy makers arise.

For further information or if you need special assistance, contact Division of Continuing Medical Education, P.O. Box 016960 (D23-3), Miami, Florida 33101 -- 305/547-6716; Fax: 305/547-5613.

WELCOME NEW MEMBERS!

The Florida Bioethics Network welcomes **Mary Lou Carter,** Director of Ambulatory Services, Alachua General Hospital, Inc., Gainesville, 904/338-2199; **Tanya Field,** Director of CV/CC Nursing, St. Joseph's Hospital, Tampa, 813/870-4562; **Dr. Matthew Edward Knight,** Assistant Professor of Pediatrics, Pediatrics Department, University of Florida College of Medicine, Gainesville, 904/392-4195; **Kathryn C. Miller,** Department Head/Critical Care Center, Venice Hospital, 813/483-7800; **Dr. Ben Mulvey,** Assistant Director of Philosophy, Nova University, Department of Liberal Arts, Ft. Lauderdale, 305/475-7432; **Karen G. Reich,** L.C.S.W., St. Joseph's Hospital, Tampa, 813/870-4974.