

Medical Humanities Report

Winter, 1993

Pitfalls in Hospital Ethics Policies

By Tom Tomlinson, Ph.D.

Thanks to impetus from the Federal Patient Self-Determination Act, as well as more stringent standards for accreditation by the Joint Commission for the Accreditation of Health Care Organizations, hospitals have been in a flurry of ethics policy-writing over the last year or two, often discovering either that they have no policy on important matters like advance directives, or that the policies they do have are antiquated and in great need of revision.

As a result, I have been asked on a number of occasions to review hospital policies or policy drafts and provide suggestions for their improvement. These consultations have helped me to formulate some ideas about the purposes served by ethics policies, and to better recognize when such policies are not accomplishing their ethics objectives-- to recognize the pitfalls of ethics policy-writing before falling into them.

Goals of Ethics Policies

In my view, hospital ethics policies attempt to serve three major purposes: to express the institution's ethical commitments; to protect the hospital from liability; and to shape the behavior of attendings and staff.

If there is any sense to the idea that institutions, as well as individuals, may have their own ethical commitments or conscience, surely it is to be found in large part in what the institution is willing to commit itself to in writing. Mission statements, of course, do this; but usually in the vaguest sort of moral posturing. If I want to know what the institution's ethical identity really is, I'll look to see what it

permits or prohibits or demands of behavior that takes place on its premises and in its name. Does it prohibit abortions and sterilizations? Will it accommodate Jehovah's Witnesses in its surgical suites? Does it demand anything more than pro forma informed consent? The answers to these and similar questions are to be found mostly, if not exclusively, in policy. Naturally, there are many practices found within hospitals which are not the subject of any policy, and which in their way contribute to the "character" of the place. But without the pledge inherent in a written policy, it is much less certain that these practices represent an ethical commitment of the institution.

Besides this specifically ethical purpose, written policies also help protect the hospital from liability, which in itself is not an unworthy goal. They can do this in two ways. First, if written policies actually affect behavior at the bedside, they can reduce the likelihood that physicians and nurses will be doing things which are egregiously negligent or morally wrong. Second, and even if they don't have any actual effect on behavior, policy provides a possible defense for a hospital named in a suit arising out of some incident occurring on its premises. If the incident involves behavior clearly prohibited by hospital policy, then the attending physician or hospital employee was acting without any sanction or permission of the hospital, which might therefore argue that it should not be held jointly responsible for the results.

Third, written policies might also serve to shape the actual behavior of attendings and

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Hospital Ethics Policy (cont.)

staff. To the extent that individuals are aware of the contents of the policy, and aware that serious consequences may follow from not adhering to the policy, they will be motivated to act in the ways that the policy supports. Of course, the links in this chain might be very tenuous in many cases. Perhaps nobody reads the policies, which gather dust in fat notebooks at the nursing stations; or nothing much ever happens when policy is not followed.

Now let's take a look at some ways that ethics policies fail to achieve these goals.

Failing to Express the Hospital's Ethical Commitments

Start with a statement from a policy on limiting medical treatment:

Patient's Role: Each patient has the right to participate in his/her plan of medical care including the right to change or refuse any portion of that care at any time, unless they are unable to make medical treatment decisions.

One can sympathize with the sentiment behind this declaration of patients' rights of autonomy, but surely this is a bit of ethical hyperbole which the hospital doesn't really want to stand by. If it were literally true that patients could change any portion of care at any time, neither the hospital nor the physicians working in it would have any rightful control over the quality or safety of care they delivered. Too often, policies are written as if the only moral consideration to be accounted for is the rights of patients, and as if these are unbounded by any limits or complexities.

Another common problem is the vagueness that arises out of policy statements which verge on inconsistency, where the policy seems to take away with one hand what it gives with the other. This often happens when one section of a policy conflicts with something written five sections later. But sometimes it happens in the space of a single sentence:

The physician must discuss a DNR order with the patient if the patient is an adult and if such discussion is not medically contraindicated.

Is there any meaningful ethical commitment to discussion of DNR orders with compe-

tent patients at this institution? Who knows, since there is no indication of how "medically contraindicated" is to be understood or applied. Since "medical indications" usually refer to judgments made at the discretion of the individual attending physician, the policy seems to say that attendings must discuss DNR orders with competent adults, unless they think it's a bad idea.

Failing to Effectively Shape Behavior

As I suggested earlier, written policies are at best a weak force for shaping actual behavior. Other mechanisms such as in-service education, chart review, and direct observation are indispensable, and probably more powerful. Still, ethics policies could be written in ways which improve their potential for affecting actual practice. One improvement would be to drop the "statutory model" of policy organization found so commonly.

Here's an outline of the first section of a policy on informed consent:

1.0 Definitions

1.1 "Adult"

1.2 "Emancipated Minor" (See 1.1)

1.3 "Emergency"

1.4 "Consent Form"

1.5 "Incapacitated Patient"

1.6 "Informed Consent"

1.7 "Legal Guardian"

1.8 "Legal Representative"

1.9 "Minor"

1.10 "Patient Advocate"

This policy looks exactly like a statute passed by a state legislature, or the kind of thing you'd find in a criminal code (which is hardly surprising, since so many hospital policies are drafted by lawyers). However "exact" it may be, this sort of organization is often difficult to

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unravel if one is looking for straightforward answers to problem cases in clinical practice. It usually requires paging back and forth between the definitions section and scattered sections of substantive policy statement.

An alternative organization worth considering is a "flow chart" or "decision tree" model that walks the reader through the sequence of questions they need to ask themselves concerning the application of policy to a case at hand. A policy on informed consent might start with

Step 1: Is the Patient an Adult?

...providing the criteria necessary for making that determination. If the answer is "Yes", the next branch on the tree is

Step 2: Is the Patient Competent?

...providing policy guidance on this question.

The policy would continue in this stepwise fashion, moving through a logical series of questions that would enable the caregiver to more quickly locate those portions of policy concerning the specific problem to be addressed. At the very least, this sort of organization would make policies so much more readable that they might actually get read!!

Conflicts between ethics and risk management

In my experience, the most common problem with ethics policies arises out of the conflict between the goal of clearly expressing the hospital's true ethical commitment, and the goal of using policy to minimize legal liability. This often happens when legal liability is minimized by permitting only that behavior granted legal immunity under statute. Take as an example this statement from a policy on the use of advance directives:

"Advance Directive" means a written instruction, such as a durable power of attorney, recognized under Michigan law, and relating to the provision of care when the individual is unable to participate in medical treatment decisions.

Defining advance directives in this way means that the only advance directives sanc-

tioned by this hospital are those written in accordance with a 1990 statute whose effect is to immunize providers and institutions who follow the directive in good faith. And so this definition well accomplishes the goal of minimizing liability risks. But from an ethical perspective, the meaning of "advance directive" has to be broader than this. The ethical purpose of recognizing advance directives is to empower the patient's individual values and preferences with respect to their future medical treatment. Pursuing this ethical purpose requires recognizing as relevant any reliable expression of the patient's wishes regarding such future care. These would certainly include other written directives, such as Living Wills or non-statutory durable powers of attorney, which don't provide legal immunity, but are by no means illegal to use or honor. I would also argue that from the ethical perspective, an "advance directive" includes verbal statements (to nursing staff, perhaps) which express the patient's competent and informed wishes regarding future care. Yet this policy provides no recognition for these (which it could do, for example, by explicitly encouraging nursing staff to document them). The result is that this policy pursues the goal of legal immunity, at the price of sacrificing all but the narrowest ethical respect for the patient's values and preferences. Before proceeding with a policy like this, the responsible persons at this hospital would need to ask themselves whether they really believe in the ethical goals of advance directives; and whether they think that ethical commitment important enough to take whatever small liability risk might arise outside the protection of legal immunity.

This is not to suggest that a hospital's ethical commitments must always outweigh liability dangers, no matter how great the dangers are. What is important is that policy writers become more acutely aware of the ethical trade-offs made when policy is driven by liability concerns; that those trade-offs be explicitly articulated; and that they be accepted only after careful reflection on the institution's moral ideals.

When Bioethicists Shouldn't Testify in Court: A Case Study

By Howard Brody, M.D., Ph.D.

At the annual meeting of the Society for Bioethics Consultation in September, Lawrence Nelson and Ronald Cranford gave very useful analyses of the role of the bioethicist as expert witness in the courtroom. Their presentations provided a useful set of guidelines for when a bioethicist should not testify. Nelson suggested that this would be true when the ethical issues are not really central to the brief, and may be raised more as a red herring. Cranford pointed out that the "real" bioethics cases, like Quinlan and Cruzan, are cases where no money is at issue; and in negligence cases, where the financial stakes are high, the proceedings are likely to be correspondingly down and dirty, from a bioethical perspective.

These talks caused me to reflect uncomfortably upon an experience I had in giving a deposition last year for a Michigan case. Upon reflection aided by Nelson's and Cranford's analyses, I conclude that I displayed poor judgment in agreeing to testify. I describe the case here as a possible warning to others, as well as an example of my view that bioethicists need to be especially diligent in exposing their mistakes to peer scrutiny and criticism.

The Case. Mr. A was suing Dr. X, a family physician. According to the attorney for Dr. X, the sequence of events was as follows:

1. Mrs. A became an established patient of Dr. X.

2. Mr. and Mrs. A were having marital difficulties and came to Dr. X for counselling, which was unsuccessful.

3. Mr. and Mrs. A separated.

4. Dr. X, who was himself having some marital difficulties, met Mrs. A in a restaurant across the street from his office. They got to talking, he invited her to dinner, and a social relationship began.

5. Mr. A had some minor medical problems, unrelated to the marital issues, and sought help from Dr. X, who treated them competently.

6. Dr. X and Mrs. A became more involved with each other and eventually married after both had divorced their former spouses. During at least part of this time Dr. X continued as Mrs. A's personal physician.

These facts were apparently disputed by Mr. A who wished to claim that the relationship between Dr. X and his wife began earlier and that it influenced the way in which the marital counselling was conducted. Ultimately Mr. A may have been successful in convincing the jury that his version was correct; in any event, he won.

The Issues. I was asked to testify on behalf of Dr. X, as an expert in medical ethics who was also a family physician. My role was to show that Dr. X did nothing unethical to Mr. A by behaving as he did. I was specifically not asked to address the question of whether what Dr. X did to Mrs. A was ethical behavior, and I told the attorney frankly that I thought it was not. Mr. A, however, was trying to use a legal approach based on alienation of affection, suggesting that Dr. X had in effect stolen his wife's affections from him, thereby denying him something that he had legitimate title to. The attorney wanted me to say that if anyone was harmed by the above sequence of events, it was not Mr. A, and so he had no standing to claim damages. Mr. A could have filed a complaint with the state licensing board if he thought that Dr. X had acted unethically, but he had no grounds to demand money for harm suffered.

As I had to be out of town on the date set for the trial, I ended up giving a videotaped deposition to this effect. As noted, it did not help Dr. X's case.

The Attraction. Why did I agree to testify at all? Two things, in retrospect, seemed to control my decision. (Money wasn't really an issue.) First, the attorney stressed that there were very few family physicians who could claim to be "experts" in bioethics; and by the nature of tort law, an expert would be required

in the defendant's own medical specialty. "You're our only hope," was basically the message. Second, there was the intellectual attraction of the fine distinctions called for, in determining who was harmed by any unethical behavior that might have occurred.

Morning-After Reflections. I should not have agreed to testify. The case failed the Nelson Test (the ethical issues, as such, were peripheral to the main case) and the Cranford Test (a considerable sum of money was at stake). More basically: assume that it's sleazy behavior to set out to have a sexual relationship with one of your patients,

just because your own marriage is going bust at the time. Also, assume it's sleazy to respond to your wife's desire to divorce you by blaming the guy whom she later fell in love with, and claiming that that guy "robbed" you of some valuable "property" (thus hinting why your wife maybe wanted to leave you in the first place). If we can grant these two assumptions, the question then becomes: what is a supposedly decent and legitimate expert in ethics doing in the middle of a shouting match between these two sleazeballs?

I trust that I have learned my lesson and will be much more circumspect about requests to testify in the future.

Commentary on "When Bioethicists Shouldn't Testify in Court"

By Leonard Weber, Ph.D., Ethics Institute-University of Detroit Mercy

I, too, was asked by the defense attorney to be an expert witness in the case described by Howard Brody. I, too, told the attorney that I would definitely not have supported a defense of Dr. X if Mrs. A were the plaintiff, but I too, did agree to testify in defense of Dr. X.

I too, now have some second thoughts about whether an ethicist has an appropriate role to play in a case like this, now that I have had more opportunity to reflect upon the role of the ethicist as expert witness. I have not, however, concluded that I would not do it again. At this point I am not willing to say, with Howard, that I should not have agreed to testify.

Howard has summarized the case and the issues well. I was involved in the case through the deposition process but was ultimately not permitted to testify when the judge ruled that I, not being a family physician, could not really present expert testimony on the standards of the profession. (Prior to that point, someone had called the academic vice-president at my university, presumably in an effort to get me to withdraw from the case. I note this as an indication of the "down and dirty" nature of the case.)

The case was presented to me as a question of whether Dr. X violated ethical obliga-

tions owed to the patient, Mr. A., when he began to date Mrs. A. Assuming that the information that I was given was correct (regarding the sequence of events), the claim against the doctor by the husband seemed to be to be, essentially, that the doctor had harmed him by stealing his wife. It was phrased in other terms, in terms of a professional obligation to put the interests of the patient (Mr. A.) first, but I understood the key to be the claim that the doctor had harmed the husband by establishing a social and personal relationship with the wife.

While I was somewhat uncomfortable in being associated with the defense of Dr. X, I was willing to testify on his behalf primarily because it seemed to me that there was one very important ethical point to be made in the case: a wife does not belong to the husband and is not an extension of her husband such that he can legitimately claim that harm is done to him when someone relates to her in a way that he does not want or approve. If the testimony of an ethicist could help to establish this point, I was willing to testify. (And, as I recall the testimony, Howard Brody did clearly speak to this point.)

I remain convinced that this point needed to be made in the case. The question, though is

(Case Study continued on page 6)

Case Study (cont.)

whether one can help clarify issues and contribute to an understanding of ethical priorities while speaking in defense of a sleazeball in an adversarial contest about money. I don't know. But unless I am persuaded that harm is done by trying, it might be worth the effort.

Rejoinder by Howard Brody

Dr. Weber makes a number of important points in his commentary. My only criticism is that, in

keeping with Larry Nelson's categories, I would argue that that question of whether a man owns his wife is not uniquely a bioethical matter. It certainly seems appropriate to address that as a legal question, and the attorney representing Dr. X in this case ought to have been able to make that legal argument all by himself, without calling any expert witnesses, at least from the field of bioethics.

Literature in Review

African-American Perspectives on Biomedical Ethics, edited by Harley E. Flack and Edmund D. Pellegrino. Washington, D.C., Georgetown University Press, 1992. 203 pp., paperback. ISBN 0-87840-532-1.

By Howard Brody, M.D., Ph.D.

An African-American perspective is ultimately a human perspective: a concrete, particular witness to universal truth. My conclusion is that in order to be truly ethical, biomedical ethics must be holistic, inclusive, communalistic and humanistic, if not also spiritual, theistic and improvisational; that is, it ought to reflect both the particularity and universality of the African-American ethos. This ethos should not be regarded as merely an interesting minority perspective or contribution, but should inform the shape and content of the whole discourse.

This quotation from the essay by Cheryl J. Sanders could serve as a summary for this collection of papers, drawn from two conferences on the topic held at Georgetown University. The essays are organized roughly as they address the following broad questions: is there a or the African-American perspective on biomedical ethics? What are the moral foundations of African and African-American cultures? What is the African-American concept of personhood? What does the African-American culture say about the nature of wellness and the role of healers and patients?

The thoughtful critic of the current state of U.S. biomedical ethics from the "majority" viewpoint will find numerous suggestive points,

to the extent that one is willing to be awakened from the Kantian slumber and accept the possibility that not all ethical insight needs to be phrased in a terminology devoid of culture or presumed to be culturally universal. A fragment of a poem by Charles Olson, quoted in another essay, makes this point vividly:

Whatever you have to say, leave
the roots on, let them
dangle
And the dirt
Just to make clear
where they come from.

One will not find here any polished conclusions, or still less theories, of an African-American perspective on biomedical ethics, and this is to be expected from the relative age of the project. (Collections of "majority" essays on biomedical ethics published in the early 1970's look pretty primitive by today's standards, too.) What the project does suggest is that the field of medical ethics will be much the poorer in the future if we do not find ways to cultivate and stimulate these and other minority voices within the discipline.

Notes and Announcements

Howard Brody was a Robert Crede visiting professor from December 2-4 in Primary Care, at the University of California, San Francisco. He is currently serving as chair of Task Force on Physician-Assisted Suicide for Society for Health and Human Values. The New England Journal of Medicine published his article, "Assisted Death--A Compassionate Response to a Medical Failure" in the November 5, 1992 issue (Vol. 327, 1384-1388).

Harriet Squier presented her paper, "Professionalism and the Woman Physician: The University of Michigan, 1875" at the November meeting of the Society for Health and Human Values in Memphis. On January 30 she will be presenting her paper, "Do We Practice What We Preach: Medical Student Education and the Biopsychosocial Model" at the Society of Teachers of Family Medicine Predoctoral education conference in New Orleans.

The eighth annual summer course, "Medical Ethics and History of Health Care in London," will be held July 5 - August 12, 1993. The program is open to graduate, undergraduate, and medical students from MSU and elsewhere. For more information, contact Brian Brown (336-2691), Fred Gifford (353-1993), or the Office of Overseas Study (353-8920).

Bioethics Coursework in Chicago and Washington D.C.

Chicago--The Center for Clinical Medical Ethics at the University of Chicago invites applications for 10 competitive positions per year in a year-long educational program beginning July 1993 and July 1994. Since 1985, the Center has trained more than 50 physicians, nurses and philosophers for academic and clinical leadership positions. All trainees participate in supervised ethics consultations and most conduct independent supervised research.

Support costs for the training program are \$10,000 and usually will be paid for by the applicant's home institution. In addition, 3

highly competitive 1 or 2-year fellowships with stipend are available for post-residency applicants preparing for academic careers. Send inquiries to Dr. Mark Siegler, CCME, 5841 S. Maryland Ave., MC-6098, Chicago, IL 60637-1470. Telephone: (312) 702-1453.

Washington, D.C.--The Joseph and Rose Kennedy Institute of Ethics has announced its 1993 bioethics courses.

The Kennedy Institute's nineteenth annual Intensive Bioethics Course will be held June 6-12, 1993, on the Georgetown University campus. The course, open to physicians, nurses, chaplains, lawyers, policymakers, and other health care practitioners, has a lecture/small group discussion format. Lectures will address four principles of biomedical ethics, and will apply these principles to current problems in health care and research. Proposed topics include informed consent, health care allocation, death and dying issues, and human gene therapy. Course cost will be approximately \$1400, to include all materials and most meals. Invited faculty include Tom L. Beauchamp, James F. Childress, Ruth R. Faden, Edmund Pellegrino, Robert Veatch, and LeRoy Walters. Graduate credit and continuing education credit will be available.

Advanced Bioethics Course IV will be held March 6-10, 1993. This course, which builds on the intensive course and has a similar format, will focus on the specific problems in health care micro-and macro-allocation. Cost will be \$950, to include all materials and most meals. Invited course faculty include Dan Brock, James F. Childress, Norman Daniels, Ruth Macklin, Robert Veatch, and other Kennedy Institute of Ethics scholars. Continuing education credit will be available.

The Kennedy Institute of Ethics is located on the Georgetown University campus. For more information about the annual courses, membership, or Georgetown University's graduate program in applied ethics, contact: Diane Michutka, Kennedy Institute of Ethics, Georgetown University, Washington, DC 20057. Phone: (202) 687-6771

Coming Events

The Center for Ethics and Humanities is an academic unit whose faculty teach, write, and consult about bioethics and the other medical humanities. Staff members frequently conduct public discussions about a variety of such topics and we encourage our readers to attend and participate in these forums.

**Physician-Assisted Suicide:
Ethical, Religious, and Patients' Perspectives**

4:00--5:30 Wed, January 27, 1993

105 S. Kedzie

Howard Brody, M.D., Ph.D.

John Foglio, D. Min.

Shaw Livermore, Professor Emeritus of History, representing the Hemlock Society of Michigan.

African-American Perspectives on Bioethics

12:00--1:30 Thursday, January 28, 1993

C-102 East Fee

Annette Dula, Ed.D., Rockefeller Fellow, University of Colorado

**National Health Insurance:
Implications for Michigan State University**

4:00-5:30 Wed, February 24, 1993

105 S. Kedzie

Leonard Fleck, Ph.D.

Andrew Hogan, Ph.D.

**Advanced Health Care Directives:
Controlling Your Future Medical Care**

4:00--5:30 Wed, March 31, 1993

105 S. Kedzie

Tom Tomlinson, Ph.D.

Vence Bonham, Jr., J.D.

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