The Role of the Hospital Ethics Committee

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Medical Ethics

Can we...? Medical question
May we...? Legal question
Should we...? Ethics question
Ethics is about drawing boundaries

ethically permissible

ethically impermissible

ethically impermissible
“And what criteria do you use to determine who is naughty and who is nice?”
Ethical Theories

- **Normative ethics**
  - classifies actions as right and wrong
  - what the population *should* believe is right and wrong

- **Descriptive ethics**
  - what the population believes to be right and wrong
  - different cultures have different attitudes towards right and wrong
Medical Ethics

- Hippocratic Oath
- Hippocratic tradition of Western Medicine
  “As to diseases, make a habit of two things – to help, or at least to do no harm”
  Hippocrates, *Epidemics*, Bk. 1, Sect. XI
- Principles of Beneficence (to help) and Nonmaleficence (do no harm)
- *Primum non nocere* (first do no harm)
“First, admit no harm.”
Manchester experienced a heavy outbreak of typhus and typhoid in 1789.

The trustees of the Manchester Infirmary decided to double the medical staff.

The incumbent physicians resigned *en masse*.

Dr. Thomas Percival was asked by the trustees and the physicians to provide guidance.
Descriptive Ethical Theories

- Cultural relativism – different cultures have differing standards of right and wrong (when in Rome, do as the Romans do)
- Ethical subjectivism – what is right for me is right and what is right for you is right (postmodern)
- Conventionalism – cultural acceptance determines morality
World War II

“Read Vivien Spitz’s personal memoir with its shattering memories from the Nuremberg trials and you will encounter physicians who, corrupted by Nazi ideology, brought shame to their profession.”
—NOBEL LAUREATE ELIE WIESEL

DOCTORS FROM HELL
The Horrific Account of Nazi Experiments on Humans

Vivien Spitz
Nuremberg Trials
Nuremberg Trials

Nuremberg Code (1949)
- “The voluntary consent of the human subject is absolutely essential”

Belmont Report (1979)
- Basic Ethical Principles
  - Respect for persons
  - Beneficence
  - Justice
Principles of Bioethics

- Beneficence – do good
- Nonmaleficence – do no harm
- Justice – loyalty and fairness
- Autonomy – self determination
The Evolution of Autonomy

- Respect for persons
- Respect for autonomy
- Principle (one of four)
- Dominant principle
- Right
  - Right to refuse treatment
    - Karen Ann Quinlan - 1976
    - Nancy Curzan - 1990
  - Right to demand treatment
Karen Ann Quinlan
1976

- 21-year-old collapsed at a party after swallowing alcohol and Valium on April 14, 1975
- ceased breathing for at least two 15 minute periods
- received some ineffectual mouth-to-mouth resuscitation from friends then was taken by ambulance to a local hospital
Karen Ann Quinlan
1976

- Remained in a persistent vegetative state
- Parents wanted to withdraw ventilator
- Catholic Priest and Bishop agreed
- Physicians refused; not standard of care
- NJ Supreme Court ruled in favor of the parents
- Respirator removed but she continued to breathe
- Lived in a PVS for 10 years
Impact of the Quinlan Case

- Widespread publicity for medical ethics
- Supported shared decision making
- Encouraged hospital ethics committees
- Keep these cases out of court
- Legal protection from prosecution
Clarence Herbert
1985

- 55 yo cardiopulmonary arrest in recovery room
- Resuscitated but remained comatose
- Physician and family agreed to withdraw vent.
- Continued to breathe and family requested that IV fluids be discontinued
- He died 6 days later
- After a heated confrontation with the physician, a nurse contacted the district attorney who charged the physician with murder
Clarence Herbert
1985

- The court dismissed all charges
- The ruling changed the concept of “ordinary” and “extraordinary” care
- Declared the benefits of artificial nutrition should be weighed against the burdens
- Stopping life sustaining treatment is not the same as active euthanasia
- Physicians are not obligated to continue ineffective treatments
- Families may serve as surrogate decision makers
- Substituted judgment and best interest decisions
Nancy Cruzan
1990

- 33 yo in a PVS after an automobile accident
- After 3 years, the parents requested that the feeding tube be discontinued
- Hospital insisted on a court order
- A year before the accident, she indicated to her housemate that she would not want to live as a “vegetable”
Supreme Court
5-4 decision

- Cruzan is not brain dead or terminally ill
- Cruzan's right to refuse treatment did not outweigh Missouri's strong policy favoring the preservation of life
- Her conversation with her housemate was unreliable for the purpose of determining her intent
- States may require “clear and convincing evidence”
  - beyond a reasonable doubt (criminal - 99%)
  - clear & convincing evidence
  - preponderance of the evidence (civil - 51%)
Nancy Cruzan
1990

- further witnesses satisfied Missouri courts that such clear and convincing evidence of her wishes did exist
- medically assisted nutrition and hydration were removed in December of 1990
- Cruzan died two weeks later
Impact of the Cruzan case

- State by state variation
- States may insist on “clear and convincing” evidence that the patient would refuse life-sustaining treatment
- Excludes “quality of life” as a consideration
- Err on the side continuing treatment
- Federal Patient Self Determination Act
History of Hospital Ethics Committees

- Belding H. Scribner, MD (1921–2003)
- Perfected the AV shunt for hemodialysis
- Started the first dialysis clinic at Swedish Hospital in Seattle
- Admission and Policy Committee
- Seven anonymous members determined who received dialysis
History of Hospital Ethics Committees

- In 1962, Life magazine called it “Seattle’s God Committee”
- Employed “social worth criteria” for selection
- End-Stage Renal Disease Act in 1972
Medical miracle and a moral burden
They Decide Who Lives, Who Dies

by SHANA ALEXANDER

Julia Myers was 18 months old. She was a healthy baby. After a routine operation to correct a heart defect, she died. Julia Myers' death was a tragic event that raised important ethical questions about the role of medical professionals in making life-and-death decisions. For the family of Julia Myers, the decision to allow her to die was emotionally wrenching.

Julia was born with a congenital heart defect. The operation was considered necessary to improve her chances of survival. However, during the procedure, complications arose, and the doctors were left with a difficult decision. They had to weigh the potential benefits of continuing the treatment against the risks involved.

This case highlights the complex ethical issues that arise in modern medicine. As technology advances, the ability to prolong life becomes more prevalent. However, the decision to intervene can sometimes come at a heavy cost. The family of Julia Myers grappled with the implications of their child's death, questioning the limits of medical intervention and the responsibility of doctors in such situations.

The story of Julia Myers serves as a reminder of the ongoing debates surrounding medical ethics and the moral burden that healthcare professionals carry with them. It underscores the importance of open communication between doctors, families, and the public in addressing these complex issues.
History of Hospital Ethics Committees

- 1967 – Heart transplant using a beating heart from a patient with “fatal brain damage”
- 1968 – Harvard criteria for brain death
- 1971 – Two newborns with Trisomy 21 allowed to die at Johns Hopkins
- 1972 – Tuskegee Syphilis Study exposé in New York Times
- 1973 – Roe v. Wade
- 1976 – Karen Ann Quinlan
  - NJ Supreme Court recommends ethics committees
- 1978 – Louise Brown born via IVF
- 1982 – Baby Doe rules
  - recommend establishment of Infant Care Review Committees
- 1983 – Purple dots for DNR in a Queens hospital
History of Hospital Ethics Committees

- 1979 – President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research
  - Defining Death (1981)
  - Deciding to Forego Life-Sustaining Treatment (1983)
- 1984: Ethics Committees recommended by
  - American Hospital Association
  - Academy of Pediatrics
  - American Medical Association
  - American Academy of Neurologists
  - National Hospice Organization…and others
- 1990 – Nancy Curzan
- 1991 – Patient Self Determination Act
- 1992 – JACHO requirement
Medical Ethics

- Professional ethics
  - Physician behavior (AMA, state medical board, county medical society, hospital medical board)

- Bioethics
  - Public policy (society – the needs of the many)
  - Clinical ethics (patient – the needs of the one)
Role of the Bioethics Committee

- Ethics Education
- Policy Development
- Clinical Ethics Consultation
ECs receive many types of questions and concerns that would be more appropriately addressed through other organizational mechanisms.

ECs should focus on the true values conflicts where their expertise resides and refer non-ethics questions to the proper resources.

ECs should not offer legal advice or medical recommendations.
When conflict between patients and physicians about the best course of action cannot be resolved, it is in the best interest of the patient to involve individuals with expertise in medical ethics to aid in reaching a decision that is ethically sound and, ideally, acceptable to both parties.

This is the role of the ethics consultation.

The ethics consult is not to be construed as a means by which to persuade the family to agree with the physicians or to make a final ruling on how the dilemma should be settled.

Rather, ethics consultants serve as mediators.

Mediators are trained to be impartial and independent; they are equally concerned with the rights of all parties involved in the dispute. Their role is to ensure that the views of all involved parties, both family and caretakers, are expressed and reconciled.
Ethics Committees

- Problems
  - Insufficient resources
  - Confusing law and ethics
  - Transfer of moral responsibility to committee
  - Dominating and silent members
  - Group think
  - Unpopular advice
  - Poor substitute for palliative care
Texas Advance Directive Act

- Advance directive
  - Directive to physicians (living will)
  - Medical power of attorney
  - An out-of-hospital DNR order

- Qualified Patient
  - a patient with a terminal or irreversible condition that has been diagnosed and certified in writing by the attending physician
  - Terminal – less than 6 mos ± life support
  - Irreversible – permanently dependent on life support
If Terminal or Irreversible

- _____I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible
- OR
- _____I request that I be kept alive in this terminal or irreversible condition using available life-sustaining treatment.
If there is no advance directive, the order for decision making is:

- The patient's legal guardian
- The patient’s spouse
- The patient's reasonably available adult children
- The patient's parents
- The patient's nearest living relative
- A person listed above who wishes to challenge a treatment decision must apply for temporary guardianship
- If none of the above are available, it must be concurred by another physician who is not involved in the treatment of the patient or who is a representative of the ethics committee
Treatment Conflicts

- Patient/family REFUSE treatment felt to be appropriate by healthcare professionals
- Patient/family DEMAND treatment felt to be inappropriate by healthcare professionals
Futility

- Hippocrates, *The Art*
  
  “refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless”

- A central notion in end of life decisions
Medical Futility

- Physiologic futility
  - Treatment will not work

- Quantitative futility
  - Treatment probably will not work

- Qualitative futility
  - Treatment will not have a beneficial outcome
### AMA Code of Ethics Changes

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<td>5.5</td>
<td>Medically Ineffective Interventions</td>
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<tr>
<td>2.037</td>
<td>Medical Futility in End-of-Life Care</td>
<td>5.5</td>
<td>Medically Ineffective Interventions</td>
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“… physicians must remember that it is not possible to offer a single, universal definition of futility. The meaning of the term ‘futility’ depends on the values and goals of a particular patient in specific clinical circumstances.”
Physicians should encourage an institutional policy that:

- Supports physicians in exercising their best medical judgment
- Takes into account community and institutional standards for care
- Uses scientifically sound measures of function or outcome
- Ensures consistency and due process in the event of a disagreement regarding an intervention
ATS/AACN/ACCP/ESICM/SCCM Policy Statement:
Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

American Journal of Respiratory and Critical Care Medicine
Volume 191 Number 11, June 1 2015
Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation (palliative care, patient advocate, ethics).

- First, collaborative decision making is a fundamental aspect of good medical care
- Second, once conflicts become intractable, there are only “second best” resolution strategies, which are likely to be protracted and burdensome to all parties involved.
- Third, most disagreements in ICUs arise not from intractable value conflicts but from breakdowns in communication that are amenable to communication interventions.
Defining Futile and Potentially Inappropriate Interventions: A Policy Statement From the Society of Critical Care Medicine Ethics Committee

Critical Care Med 2016; 44:1769–1774
Recommendations

1. Appropriate goals of ICU care include:
   - Treatment that provides a reasonable expectation for survival outside the acute care setting with sufficient cognitive ability to perceive the benefits of treatment.
   - Palliative care that provides comfort to patients through the dying process may be an appropriate goal of care in some ICUs.
ICU interventions should generally be considered inappropriate when there is no reasonable expectation that the patient will improve sufficiently to survive outside the acute care setting, or when there is no reasonable expectation that the patient’s neurologic function will improve sufficiently to allow the patient to perceive the benefits of treatment.
Shared Decision Making in ICUs
American College of Critical Care Medicine and American Thoracic Society Policy Statement

Critical Care Med 2016;44:188–201
Alexander A. Kon, Judy E. Davidson, Wynne Morrison, Marion Danis and Douglas B. White
The Shared Decision-Making Continuum
Alexander A. Kon, MD
“Doctor, I want everything done”

“I will do everything possible that is effective, beneficial and not excessively burdensome”

Use only effective treatments (those that demonstrably change the natural history of a disease for the better or relieve a symptom)

Do not use a treatment which cannot achieve its goal of effectiveness and benefit for the patient and which is disproportionately burdensome
Suggestions in EOL Cases

- Make sure all physicians involved are in agreement with the treatment goals
- Compassionate objectivity
- Only offer treatments options that you are willing to provide
- Informed non-dissent
- Involve Pastoral Care
- Involve Palliative Care