Thinking about “Allow Natural Death” Orders
By: Kathy Kinlaw, M.Div.

In caring for patients near the end of life extraordinary care in communication, especially around difficult decisions, is essential. When weighing decisions about whether to institute resuscitative efforts or intubation or other treatments, patients and families need to know how the patient will be cared for, what goals can be accomplished, and what the patient will likely experience whatever course is chosen. Being able to let patients and families know what care WILL be provided, rather than what specific treatments will NOT be administered, shifts the conversation in important ways that should empower the patient and/or family surrogate. There is always a course of care that can and must be intentionally adopted and implemented.

This shift – away from what will NOT be done - is what is so engaging about moving toward an order that would read “Allow Natural Death” (AND) instead of “Do Not Resuscitate” (DNR). Two recent articles referenced below describe health care systems’ moves to adopt AND orders, one at the Wellstar Health System in Marietta and one in Texas. The Meyer article indicates that the concept has been presented to approximately 100 hospitals. At the urging of one of our HCECG members, we recently informally surveyed HCECG members on-line. Of the 29 institutions responding two(2) HCECG member institutions indicated that they are currently in the process of incorporating AND with DNR. Five respondents indicated that they were looking into AND and planning discussions with their ethics committees. Six respondents indicated that they would like further information about AND.

I believe that incorporating the language of AND into our discussions and into our overall process of palliative and end-of-life care planning shows great promise. I do not believe that we can use AND orders as a substitute for all of our resuscitation decisions. Two objections to a simple substitution follow:

(1) AND and Life-Threatening Illness: The power of the AND approach really returns us to the communication process. If the patient has been diagnosed with a life-threatening illness, discussing the option of allowing death to occur naturally provides important information and a sense of the “permissibility” of making a choice AWAY from aggressive interventions. Patients and families often feel that they must try the next intervention offered or that saying NO to something that could be tried is “giving up.” Knowing that it is an acceptable option to let the illness or condition advance naturally, without instituting “last resort” interventions, and to provide aggressive comfort measures, is powerful for patients and families. Patients also need to be informed, with great care and respect, that aggressive interventions may have very little chance of succeeding (overall 14% of all patients resuscitated in the hospital survive to discharge) and may cause the patient additional suffering.
This discussion is really a much broader discussion than a resuscitation discussion. Patients and family are invited to think ahead, to begin planning in advance about how they want the health care system to be involved in their care. Discussions about intubation, use of antibiotics, hospice care, artificial hydration and nutrition, and even location of care (hospital, home, long term care, etc.) may be involved. The AND discussion and resulting instructions to the team are closer to the “Comfort Care” orders or utilizing the Oregon-created POLST form (Physician Orders for Life Sustaining Treatment). Incorporating AND language into these broader end of life discussions is important. Patient care orders for AND might include resuscitation decisions and, potentially, many other treatment preferences.

(2) Not all traditional DNR orders are written for patients who are currently facing a life-threatening illness. For example, at the point of admission to many long term care facilities, residents will be asked whether they want to be resuscitated in case of cardiopulmonary arrest. A Do Not Resuscitate (DNR) order entered at this point indicates our traditional understanding of DNR – that in the case of cardiopulmonary arrest resuscitation is not to be attempted. A DNR order does not mean that other treatments should not be provided. This new nursing home resident (with no known life-threatening illness) has not been asked to decide whether transfer to the hospital should be avoided, or antibiotics or artificial hydration and nutrition foregone. Thus, DNR in this case is not equivalent with Allow Natural Death. Other patients with chronic illness may also wish to have a standing non-resuscitation order, but have not made decisions about other end-of-life care. We will continue to need a designation for such resuscitation decisions that is not as broad as AND. In these cases, use of the DNAR (Do Not Attempt Resuscitation) language may aid compassionate conversation. We continue to struggle with a way to shift from what we health providers will not do. “Refrain from Resuscitating Me” or “Do Not Put Me Through Resuscitation” may better represent the patient’s perspective.

The Ethics Consortium will continue to follow this language shift and would like to hear from you as you consider this issue at your organization. Policy changes, patient information sheet changes, and staff education that incorporate the allow death to occur naturally language into existing resuscitation procedures are promising. Shifting away from DNR language completely would necessitate another look at the Georgia legal code dealing with resuscitation.

With August well underway, we are fast approaching fall programming with several in-depth ethics workshop opportunities (see related articles). Several Consortium members have invited us to join you as speakers for upcoming events in your community. We look forward to working with you in the months to come!

The Consortium’s Annual Conference, held on March 31 – April 1, 2004, was truly a milestone event. The conference theme, “A Decade of Ethics Experience: Looking Back, Looking Forward,” served to both educate attendees on future challenges and to celebrate the consortium’s role in facilitating ethical dialogue in Georgia over the past ten years.

In recognition of the special anniversary, and with an eye toward expanding conference programs in the coming years, the conference offered two full days of education and conversation, with a celebratory banquet on the evening of March 31. To the delight of consortium staff and the planning committee, Albert Jonsen, Ph.D., Emeritus Professor of Ethics at the University of Washington School of Medicine and author of The Birth of Bioethics, accepted our invitation to serve as the conference’s opening keynote speaker. He gave a highly engaging program, “The Ghosts of Ethics Past,” tracing the evolution of bioethical discourse in healthcare from the 1960s to the present day. The audience was captivated by images of Frankenstein’s monster and references to Dickens’ ghosts that haunted Ebenezer Scrooge, used to illustrate his presentation. That evening, Dr. Jonsen gave the banquet address, offering his insights into the “Spirit of Bioethics Future.”

Throughout both days, attendees were engaged in programs and small-group discussions in several key areas reflecting ongoing challenges from the past and issues that lurk in the future. Among the presentations was an analysis by Kathy Kinlaw and Dr. Jonsen of the current Terry Schiavo case and its potential impact in areas of autonomy, advance directives, and surrogate decision-making; an entertaining and interactive examination of different communication styles by Tammie Quest, M.D.; an indepth examination of the relationships between law and ethics provided by Georgia State University law professor, Charity Scott, J.D.; and a truly personal look at the growing need to embrace palliative care by oncologist, Wendy Hawke, M.D.

Panel presentations on important topics like “Respecting Diversity in Health Care,” “Ethical Voices in Our Midst” (the respective roles of organizational leaders in framing ethical dialogue), and the emergence and importance of palliative care in “Palliative Care: Global Positioning for the Road Ahead,” served to educate and engage attendees in conversation with scholars and clinicians expert in these areas.

The conference closed with a global perspective on the ethical challenges facing health care today, with particular emphasis on future directions in public health, given by Associate Dean of the Emory University School of Medicine and former Director of the CDC, Jeffery Koplan, M.D.

The Tenth Anniversary conference also marked the introduction of the “Heroes in Health Care Ethics Award,” endowed by the law firm of King and Spalding. The award acknowledges exemplary achievements in the field of bioethics by an individual or group representing an HCECG member organization. Consortium executive director and Associate Director of the Emory Ethics Center, Kathy Kinlaw, was surprised by the board with her recognition as the inaugural award recipient.

We hope you will mark your calendars for April 13 – 14, 2005 for our next Annual Conference. If you have suggestions for topics or speakers, please contact Karen Trotochaud at 404-727-2796 or ktrotoc@emory.edu.
The case of Terri Schiavo has raised important questions about the ethical permissibility of withdrawal of treatment, who best represents a patient’s interests, and the role of other organizations who may be recognized as sources of moral authority in health care decision making. In 1990, at age 26 Terri Schiavo collapsed at her home in Florida. Though the cause of her collapse is not agreed upon, treating physicians indicated that a low potassium level led to a cardiac arrest, cutting off oxygen to Terri’s brain. Terri’s husband, Michael Schiavo, would later sue successfully for medical malpractice (Terri was under the care of a physician who was charged with improperly diagnosing the potassium deficiency), recovering around $1,000,000.

Terri was diagnosed to be in a persistent vegetative state (PVS), but Terri’s parents, the Schindlers, disagree with this diagnosis, desiring rehabilitation and believing that Terri does respond to stimuli, tracks moving objects with her eyes and has the ability to improve. Patients with PVS are in a permanent and irreversible condition in which there is no cognitive brain function, no awareness of surroundings, and no ability to communicate or interact with the environment. Patients with PVS retain normal breathing, circulation, normal sleep patterns; may open their eyes to external stimuli, may grimace, laugh or cry; but are unable to respond to commands, track visual stimuli or use eye blinks for communication. (National Institute for Neurological Disorders and Stroke)

Disagreement over diagnosis and some suspicion about use of the malpractice award served as the basis for increasingly contentious court action over the last 14 years about what treatment Terri would have wanted under her current condition and who best speaks for her best interest. Ethically, the principle of autonomy supports the rights of individuals to make decisions about their own treatment, including the right to refuse treatment. This ethical principle has been supported legally. Under the 14th amendment, patients have a right to refuse treatment based on protection of individual liberty. A series of well-known court decisions have supported the right for incompetent patients to have life-sustaining treatment withheld based on evidence of the patient’s preferences (e.g. Nancy Cruzan’s 1990 case regarding removal of artificial hydration and nutrition) or the surrogate’s expression of what was in the patient’s best interests (Karen Ann Quinlan’s 1976 withdrawal of ventilation). A 1990 Florida Supreme Court decision (Estelle Browning vs. Doris Herbert) affirmed a patient’s right to refuse medical treatment, including artificial hydration and nutrition. This decision also upheld that communication with family and friends could constitute “clear and convincing evidence.”

In Terri’s case debate exists over what Terri’s preferences for treatment would be. Because Terri did not write an advance directive, we have no clear, written statement about her wishes. In order to support her autonomy, we must look for other expressions of Terri’s preferences. Michael Schiavo claims that Terri made statements to him in the past that lead him to believe that she would not want to continue to be kept alive under her current condition. Court opinions also cite other verbal statements to family and friends that the court found sufficient to support removing the life sustaining treatment. Terri’s parents disagree; they believe Terri would want to be kept alive. Disagreement about the clarity of Terri’s preferences leads us to consider what might be considered to be in her best interests and who should be able to make that decision. Under Florida’s Health Care Advance Directives law, Terri’s husband is considered her legal surrogate if no court appointed guardian exists. The Schindlers petitioned the court in 1993 to have Michael removed as Terri’s guardian but that case was dismissed. In May 1998 when Michael petitioned the court to have artificial life support removed, he also “invoked the trial court’s jurisdiction to allow the trial court to serve as the surrogate decision maker” (per district court of appeals opinion). Michael invoked the court to serve as surrogate due to the lack of agreement between Michael and the Schindlers and the appearance of conflict of interest due to the malpractice award. The court ruled that Terri’s statements to family and friends
constituted clear and convincing evidence that Terri would want life-sustaining treatment withheld. Throughout the ensuing years decisions about Terri’s care moved slowly forward with multiple new motions filed and rulings appealed. Terri’s feeding tube was removed twice – for 2 days in April 2001, prior to a new motion being filed – and then in October 2003 for 6 days, prior to Governor Jeb Bush’s executive order staying the withholding of nutrition and hydration.

The decision of the Florida legislature to pass House Bill 35-E (which authorized the Governor to issue a one-time stay to prevent the withholding of nutrition and hydration for a patient in PVS, without advance directives, and where a family member has challenged the withholding decision) allowed Governor Jeb Bush to issue an order for Terri’s feeding tube to be replaced. The constitutionality of the bill was immediately challenged and in May 2004 the circuit court found the law unconstitutional. The decision has been appealed. Arguments are scheduled to be heard by the Florida Supreme Court on August 31, 2004.

Constitutionality of the House Bill was challenged on several counts, including violation of the separation of powers between the legislative, executive and judicial branches of government. Also challenged was the unjustified state interference with the autonomy/privacy rights of the individual discussed above. The Bush lawyers’ claim, ethically speaking, is that Terri’s preferences are not adequately represented in prior court proceedings and that the interest in the “preservation of innocent life” justifies the state’s intervention. Underlying the continued court involvement are important ethical conflicts: autonomy interests, who best speaks for the individual, and whether others can claim interests in preserving life that can override the patient’s preferences (as determined by the current ethics process that our society has agreed upon as last resort for negotiating such ethical conflict, i.e., judicial proceedings). Those involved in medical ethics and health law will watch the Florida Supreme Court proceedings with great interest.

The case continues to bolster national efforts to have individuals consider treatment wishes proactively and to communicate these preferences to family members, clinicians, and in written advance directives. Although there continues to be important questions surrounding the usefulness of advance directives – are they specific enough, can those completed in advance reflect the patient’s preferences at the point of implementation, will they be honored, etc. – they are currently our best process for attempting to represent patients’ preferences and for catalyzing conversations with loved ones.

The case has also spurred public dialogue among Catholic leaders about withdrawal of treatment for patients with PVS. Pope John Paul II and several archbishops’ statements in favor of the continuation of feeding tubes have raised questions about the Catholic Church’s generally stated position allowing for the withholding or withdrawal of life sustaining treatment for patients in PVS. Theological reflection continues to be an important source of moral authority for many in medical decision making – patients and health care professionals alike. Consideration of Terri’s case from a variety of theological perspectives will be carefully watched as the evolution of decision-making about treatment for similar patients continues.
In 1997 the Health Care Ethics Consortium of Georgia (HCECG) completed and distributed the Report of the Task Force on Futility (1) and in doing so offered a set of guidelines that suggested a method for shaping a constructive, collaborative approach to decision-making when healthcare providers believed further aggressive treatments were futile. These guidelines emphasized two over-arching themes: the importance of effective communication and the necessity for involving a variety of perspectives including the patient and family in the decision making process. Although the Task Force felt strongly about the value of these guidelines, it was also clear that this document stopped short of answering what to do when, despite everyone’s best efforts, no agreement for an appropriate treatment plan could be attained. Clearly, the Task Force understood the need for further discussion on this issue, concluding its report with this challenge to our membership to continue the conversations:

“Not only do we feel strongly about the value of this process in our own thinking about this issue of futility, but we clearly feel this process must be extended beyond the small group of healthcare providers that comprised the Task Force on Futility. To this end, the conclusion of this document truly becomes only a beginning.” (1)

The question of futility persists

Since the release of this report, we have heard repeatedly from HCECG member organizations that they have continued to encounter clinical situations where they face questions about and dilemmas related to requests for what was felt to be futile or medically inappropriate treatment. Some of those reports came from hospitals affiliated with Emory University School of Medicine. Culminating numerous discussions within several ethics committees and following a joint meeting of the three Emory Healthcare hospitals (Emory Hospital, Crawford Long Hospital, and Wesley Woods) focused on a discussion of the evolution of "medical futility/medically inappropriate treatment" guidelines and policies, a recommendation was proposed to pursue this topic more deeply within a larger group to include more that just a single institution’s Ethics Committee.

This recommendation resulted in a series of meetings attended by representatives of the six Emory-affiliated institutions coordinated by HCECG. The purpose of these meetings was to further address the question of futile or medically inappropriate treatment and how best to address patients/families when this occurs. One critical concern within the Emory facilities was the need to address education for medical students, residents, and other healthcare professionals who use the Emory facilities during their training. The initial purpose of this task force was to look at whether consistent guidelines addressing questions around “medical futility” or “medically inappropriate treatment” should be developed. Somewhat similar to a process that unfolded in Houston, Texas, this group was formed with the belief that the magnitude of this issue requires a broad, community-wide discussion.

The Task Force

Focusing on the six hospitals affiliated with The Emory University School of Medicine, an invitation was sent to the chairs for the Ethics Committees of Emory University Hospital, Grady Hospital, Emory Crawford Long Hospital, Wesley Woods, Veteran Administration (VA) Medical Center of Atlanta, and Children’s Healthcare of Atlanta. Responding to this invitation, a Task Force of about 20 individuals was formed. Chairs of all six Ethics Committees participated along with physicians from a variety of clinical specialties. Also represented were nursing, chaplaincy, general counsel, and hospital administration. Six meetings was held over a nine month period.

The process

To assure that everyone was fully aware of current work in this area, the Task Force started with a review of the work done in other areas of the country (including work from Houston, from the Texas State Legislature, from Virginia, from South Florida, and from the American Medical Association [AMA]). The HCECG Report of the Task Force...
on Futility was carefully reviewed and discussed. Based on actual clinical cases faced within their organizations, Task Force members agreed that addressing the issue of treatment determined to be medically futile or medically inappropriate in a fuller and more collaborative manner could be beneficial to all organizations. Of particular importance was the need to create a more uniform approach to these issues for medical students and residents who train in all of these organizations and who have expressed confusion when faced with similar clinical situations in different institutions.

Early in the discussions, the Task Force focused on two key aspects of these difficult clinical interactions: the essential need for good communication and the importance of shared goals for treatment, especially at the end of life. Utilizing subgroups of the task force, draft documents elaborating on these two concepts were written and reviewed by the Task Force. These documents were intended to elaborate more fully on communication and shared values and to provide specific structure and language for implementation of appropriate interactions between provider and patient and family.

The most controversial aspect the Task Force discussed focused on the current AMA recommendation as defined in their guidelines on “Medical Futility in End-of-Life Care” which states, “All health care institutions, whether large or small, should adopt a policy on medical futility,” and these policies “should follow a due process approach.” (2) Based on these guidelines members of the Task Force outlined a draft for a fair process approach to caring for patients/families when disagreement persists. Because no clear consensus could be arrived on this section within the Task Force, it was decided to take this draft to a broader group for more feedback and input into this process. A draft document with some recommendations and several important questions still unanswered was produced. The chairs of the various Ethics Committees were asked to distribute this document to their members, to discuss the content of the document, and to provide feedback and input to the Task Force on the document. The final meeting of the Task Force followed review by all six Ethics Committees of the draft document. Responses to this draft were varied and often times quite divergent. Some felt defining a process for addressing these dilemmas was needed while others felt the healthcare community was not yet ready to tackle this issue. All of the committees made suggestions for next steps; none of those suggestions included pursuing a single policy based on a fair process approach to medically futile/inappropriate treatment that would allow for unilateral decision-making against the wishes of the patient/family at this time.

Recommendations

The Task Force did conclude with several recommendations for next steps:

1. The critical skills required to address these difficult clinical dilemmas are:
   a. open and productive communication between patient/family and providers and
   b. a systematic process that identifies and fosters those goals shared by all parties.
   Addressing these two areas is greatly needed.

2. Because questions of futile/medically inappropriate treatment are raised almost exclusively when the patient is at the end of life, the broader question is how to better approach end of life care. Placing the question of futile/medically inappropriate treatment within the context of end of life care seems to be the appropriate location for it, rather than addressing it as a stand alone issue.

3. There are a number of initiatives focused on end of life care that currently exist, both within the School of Medicine and within Emory Healthcare. A continued discussion about futile or medically inappropriate treatment should be included in these discussions. A number of the members of Task Force are involved in these initiatives and can raise the questions we have identified in these broader settings.

4. It seems clear that greater education about end of life decision making is needed to help individual providers address futile or medically inappropriate treatment decisions. The Task Force is supportive of providing consistent education in this area for house staff and clinical staff, especially staff in the Intensive Care Units where these questions most frequently occur. However, further work in this area of education would require specific funding.

5. Further discussions about this subject must include a clear voice of the community we serve – the patients
and families most affected by these decisions. This discussion will need to be carefully planned and negotiated so as not to be confused with issues of reducing costs and to be respecting of the values of community and individual values.

6. No recommendation was made about who should be the final arbitrator for these difficult care decisions, whether it should be internal to the institution or external, whether it should include the Ethics Committee or not. As a group, the Task Force was not ready to make any recommendations on this issue.

In no way did the conclusion of this Task Force signal the end of the discussions on futile or medically inappropriate treatment. This will continue to remain one of the most difficult dilemmas faced by hospital ethics committees. Despite the abundance of literature on this topic and some very definite recommendations for resolution of these dilemmas, the reality of establishing defined guidelines for the Emory community could not be achieved in this setting. The challenge not only to keep this conversation going, but to include more voices in the discussion remains. The Consortium will continue to be involved in these discussions and to work along side direct care providers as they grapple with this most difficult dilemma.

References


Grady Shares Guidelines

In the last edition of HCECG Bulletin we reported on a meeting with Barbara Pastirik, a consultant with Adult Protective Services in Georgia, regarding the role of Adult Protective Services in DNR and withdrawal of treatment decisions.” This meeting occurred between the members of the Ethics Committee of Grady Health System, Atlanta, and Barbara Pastirik. Subsequent to this meeting, the Grady Ethics Committee developed “Guidelines for patients under the guardianship of Adult Protective Services where an order for non-resuscitation is felt to be indicated.” Using these guidelines, Grady has been able to address this issue with several patients in manner that honors the needs of the patient and facilitates processes within the system. The Grady Ethics Committee would like to make these guidelines available to others who are also struggling with how to best address this issue.

1) If a patient is under APS guardianship and a DNR order is felt to be indicated:
   a) Assuming there is no Advanced Directive AND no family or designated decision-maker.
   b) Notify the DFACS / APS caseworker that the patient is in the hospital and determine if there is an advance directive, other family members, or other decision-maker.
   c) Notify APS that the patient is being considered as a candidate for non-resuscitation.
   d) Follow the usual process for people without a decision-maker and without decision-making capacity, who meet the candidacy criteria for non-resuscitation, including:
      i) Complete usual protocols for declaring a patient a candidate for non-resuscitation.
      ii) The Ethics Committee acts as a DNR panel to review the medical team's evaluation of DNR candidacy. The appropriate paperwork and entries in the medical record should be completed.
   e) Subsequent to the determination of candidacy for non-resuscitation:
      i) Notify APS again that both the medical team and the Ethics Committee have determined that the patient is a DNR candidate.
      ii) Discuss with the APS caseworker that the patient is a candidate for DNR. Discuss how APS wishes to proceed with patient care.
      iii) If APS concurs or assigns their decision-making capacity to the medical team or Ethics Committee, the medical team may then write the order not to resuscitate.
         If the APS caseworker is contacted by telephone to concur with the Committee in proceeding with a DNR order, a witness to this concurring would be appropriate.
      iv) Provide APS with a copy of documentation of the DNR candidacy process--including our reasoning as well as the substantiating documents.
      v) If APS objects, contact General Counsel for further suggestions.

   NOTE: Even in the presence of a DNR order, continued, full and supportive care should be provided. (See 2. below)

2) If it is felt that the focus of care should shift from aggressive physiological intervention to active palliation (that is, withholding or withdrawal of aggressive physiologic support):
   a) The patient can still be made a DNR by following the usual protocol (as outlined above).
b) Deceleration of care (as distinct from DNR) of an APS patient requires a Superior Court ruling and approval according to APS policy. This may be expedited by:
i) Notifying General Counsel to assist the medical team in pursuing this course.
ii) Having a consultation from the Ethics Committee supporting this decision to decelerate care as an essential part of the consideration process.
iii) Withholding or withdrawal of aggressive physiologic care can only occur after the Superior Court ruling.

Thanks to Dr. William Sexson, co-chair of the Grady Ethics Committee, and the members of that committee for fostering this important conversation with Adult Protective Services of the Department of Family and Children Services and for sharing these guidelines with the members of the Consortium.

Imlay Foundation Funds HCECG Website

As the Health Care Ethics Consortium of Georgia has grown from a grass root effort to a larger statewide organization, a need for timely communication and education about health care ethics has increased. Although HCECG has enjoyed a simple website for several years, it has provided us with only one-way communication. Advances in internet technology could provide us with so much more.

HCECG is pleased to announce that it has been awarded a $26,000 grant from the Imlay Foundation to develop its website and information technology. With this grant its hopes to upgrade its website, introduce a members-only feature, provide for online conference registration and membership renewal, improve data analysis, and provide an online discussion board. Implementation is expected by the end of 2004.

Heroes in Healthcare Ethics Award

Receiving the inaugural Heroes in Healthcare Ethics award was a wonderful surprise! Having worked with the Consortium Board and the conference planning committee to develop the award for next year, I was completely caught off guard when they announced at this year’s banquet that the first award would be given.

It has been a joy to work with each of you over the last 10 years in evolving the Ethics Consortium. The inaugural award really belongs to all of those individuals who worked together throughout the last decade to put ethics into action wherever we work in health care throughout the state.

I strongly encourage those of you who have been invested in this work – whether in day-to-day care of patients, establishing and deepening the work of your ethics committee, presenting an innovative ethics education event, or in other novel ways – to let the broader ethics community know about your work – or that of your nominee – through applying for the Heroes in HealthCare Ethics award.
Heroes in Healthcare Award

This award recognizes an individual or a group associated with a Health Care Ethics Consortium of Georgia member organization for exemplary achievements in the field of healthcare ethics by fostering a culture of ethics within their healthcare organizations and/or communities.

The activities for which the individual or group may be nominated include, but are not limited to:

- An innovative and effective educational program or initiative – within the organization or in the community – that has had an impact on fostering a greater awareness of ethics in the organization/community;
- Effective intervention in a complex ethical dilemma;
- Advocacy for promotion of ethics in healthcare through legislative or regulatory initiatives;
- Development of policies or processes that enhance ethical practice within the organization;
- Longtime commitment to ethics in healthcare at the institutional, local, state or national level as reflected in institutional committee work, active participation in the work of HCECG, leadership positions in professional associations or groups, contributions to ethics knowledge through publication of articles, chapters, books, in the field of healthcare ethics, etc…

Eligibility

An individual who is an employee of or directly associated with a HCECG member organization; a team of individuals associated with a HCECG member organization; or a HCECG member organization.

Application Process

Self nominations and nominations of others are welcome. A completed nomination form (attached) should be submitted. A 500-700 word project statement is to be included describing the specific work of the individual, team, or organization in the area of healthcare ethics and its impact on the culture of ethics within the organization. If the project is self nominated, a letter from an individual not directly associated with the nominated project must also be included supporting the nomination.

Award

The recipient of this award will be honored at the HCECG annual conference in the spring of each year. The most outstanding nominee will be presented a glass sculpture handcrafted by Fräbel Studio of Atlanta and commissioned for this award. This sculpture of three supporting glass rods holding a blue sphere represents the achievement of holding ethics to the highest standard. Additional exemplary nominees may be honored with framed certificates recognizing their achievements.

Deadline

Applications must be received by January 15, 2005

Application form may be found at www.hcecg.org or call 404-727-1476 to have a faxed application sent to you.
The Ethics Committee of Hill Valley Medical Center was faced with a particularly difficult case. Ms. Jones, a 55 year old female with a history of hypertension and diabetes, was admitted June 19, 1996 through the Emergency Room. She had been found unresponsive and in cardiac arrest. A nurse who was nearby initiated CPR. When EMS arrived, she was intubated and transported to the hospital. She was given epinephrine, atropine and glucose. In the ER she was found to be unresponsive. She exhibited decerebrate posturing and withdrawal from painful stimuli, as well as myoclonic jerking of face and extremities. She was transferred to the ICU with hypoxic brain injury and, after further evaluation and time, was felt to be in a Persistent Vegetative State (PVS). Eventually a tracheostomy was necessary and a Percutaneous Endoscopic Gastrostomy (PEG) tube was placed for feedings. She was transferred to 5 West and placed in a semi-private room with another patient. Her mother, who lived in Florida, was identified as her next of kin. Ms. Jones had no Advance Directives but her mother felt her daughter would not want to be kept alive in this condition and asked for withdrawal of nutrition and hydration. In June 1997, one year after Ms. Jones was admitted, hospital administration with legal counsel, members of the Ethics Committee and Nursing Service met to discuss withdrawal of nutrition and hydration. After deliberation there was general agreement to do as the mother wanted and to withdraw nutrition and hydration. However, when this decision was reported to the nurses on 5 West who had been caring for Ms. Jones, they became very angry. They objected to withdrawing nutrition and hydration on Ms. Jones while continuing to provide nutrition, hydration and life sustaining treatment for Ms. Smith, the patient in the room with Ms. Jones. Ms. Smith was also in a Persistent Vegetative State being kept alive with PEG tube feedings and other supportive measures. Ms. Smith’s family was adamant about keeping her alive. Ms. Smith also had no Advance Directives and there was no “clear and convincing evidence” of what her wishes were. The nurses objected to allowing Ms. Jones to die by withdrawing nutrition and hydration while keeping Ms. Smith alive.

Ethical questions for discussion:

Jonsen, Siegler and Winslade in *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* discuss contextual features as a major area to be included in the analysis of clinical cases. They define context as “the social, legal, economic, and institutional circumstances in which a particular case of patient care occurs.” In what ways do the contextual features of this case influence your understanding of this case? How can context impact the resolution of this case?

In what ways, if any, does justice, or the fair and equitable distribution of burdens and benefits to the participants in social institutions, play into your analysis if this case?

In what ways does best interest or beneficence affect you understanding of this case? Can a treatment deemed to be in one patient’s best interest not be so for another patient and under what circumstances can this be so?
Upcoming Meetings

HCECG Meetings

September 28, 2004  Advance Workshop on Case Consultation  
Saint Joseph’s Health System, Atlanta

November 9, 2004  Current Updates in Healthcare Law and Ethics  
Crawford Long Hospital, Atlanta

February 10, 2005  Ethics Committee Workshop  
Medical Center of Central Georgia, Macon

April 13-14, 2005  HCECG Annual Conference

National/International Meetings

September 10-11, 2004  Defining the Beginning and the End of Human Life: Implication for Ethics, Policy and Law  
11th Annual Thomas A. Pitts Memorial Lectureship  
Institute of Human Values in Healthcare  
Medical University of South Carolina  
http://www.values.musc.edu/index.html

October 14-15, 2004  Research Integrity and Financial Conflict of Interest  
Charlottesville, Virginia  

October 28-31, 2004  American Society for Bioethics and Humanities Annual Meeting  
Philadelphia Marriott, Philadelphia, Pennsylvania  
www.asbh.org