

# THE JOURNAL OF HOSPITAL ETHICS

VOLUME 1

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SUMMER 2007

THE CENTER FOR ETHICS AT WASHINGTON HOSPITAL CENTER

## features

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**Moving Bioethics Forward:** How the Past Shapes the Present and Points Us Toward the Future

*by* John J. Lynch, MD

**The Future of Hospital Bioethics:** Using Technology to Increase the Utility and Productivity of Clinical Bioethics

*by* Nneka O. Mokuwunye, MA, PhD Candidate

## the consult corner

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*by* Staff of The Center for Ethics at Washington Hospital Center

**Case 1**

Withdrawal of Life-Sustaining Technology from a Patient in a Persistent Vegetative State

**Case 2**

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**Case 3**

Family Presence: Allowing Family Members to Be Present During Cardiopulmonary Resuscitation

## policy in practice

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**Should Hospitals Allow Families to Be Present During a Code Blue?:**

An Overview of the Draft Family Presence Guidelines for Washington Hospital Center

*by* Daria C. Grayer, MA

### MOVING BIOETHICS FORWARD

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Future



Washington  
Hospital Center

MedStar Health

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## Beginning Our *Journal of Hospital Ethics* Journey Together

Dear Readers,

Welcome to the *Journal of Hospital Ethics (JOHE)*. *JOHE* is a new journal, specifically focused on hospital ethics. We have created *JOHE* to help clinicians and other hospital staff, administrators, and related personnel in meeting the ethical demands of contemporary clinical care. Most specifically, *JOHE* is written for hospital physicians and the many who support them.

Unlike Hippocratic medicine practiced in patients' homes, much of today's medical care is provided in hospitals. And much of that care is ethically complex.

In our experience, cases or situations are ethically complex in two main ways:

1. When most people agree about what is ethically optimal but one or a few of the primary participants disagree
2. When there is a bona fide ethical dilemma

The first type of complexity poses for the clinical team, the hospital, the bioethicist, and all others involved a frustrating situation, but not one that presents much of an intellectual challenge. It is a situation in which the ethical issues and the ethically optimal choice are clear. These cases are nondilemmatic, ethically.

Where no bona fide ethical dilemma exists, the ethical complexities usually spring from miscommunications or hurt feelings. Such cases and/or situations can be, however, quite complex logistically

because they have multiple and layered ethical issues or tensions across a variety of persons and/or institutional systems. Although identifying the ethically optimal choice may not be too difficult because, when thoughtfully examined, no layer includes any true ethical dilemma, the case or situation may still be complicated by the sheer weight of the multiple layers. Regardless of the etiology of the nondilemmatic cases, the complexity is in the details, ie, the procedural ethics aspects of bringing the case or situation to positive resolution.

At other times, however, coming to decisions or shaping recommendations actually pose true ethical dilemmas. We define an ethical dilemma as a situation in which knowledge of what is good or right is confused, contradictory, or absent, and/or where the justification of choice of one option over the other is not convincing. When making a recommendation and/or taking an action in the clinical setting that has substantive moral weight (ie, a decision, action, or recommendation with implications for the medical and/or non-medical well-being of a patient and/or surrogate, clinicians, or the hospital), and there is reason to suspect that persons of good judgment might disagree, one has a moral dilemma on one's hands.

Dilemmatic cases may be more interesting for the bioethicist, but they are the source of immeasurable frustration and discomfort for clinicians

and other hospital personnel. Because clinicians need to figure out how to act in the best interest of each patient, which is what the Center for Ethics believes is the clinician's first obligation, and such actions must occur in real time, working through a clinical care ethical dilemma is a difficult task for everyone.

The complexity of such dilemmas, coupled with the complexities of nondilemmatic but procedurally complex care, has produced the subset of bioethicists who practice the new art of clinical bioethics. Our experience in our own hospital over the past decades has taught us that ethically complex cases occur every day within our own system, across the country, and around the world. We are launching *JOHE* to help clinicians sharpen their ethical analysis skills so that ethical problems can be prevented, for example, by catching potential problems upstream before they become ethical conflicts further along in

the course of a patient's hospital stay. When prevention doesn't work, we hope *JOHE* provides clinicians and other hospital professionals insights into both dilemmatic and nondilemmatic ethical cases, helping them take care of similarly situated patients and, on occasion research subjects, in hospital settings. These settings include patient care that moves patients in and out of the hospital from such other settings as nursing homes, home health agencies, patients' homes, and the broader outpatient environment.

We are taking this step into the journal world because we believe that hospital professionals, especially clinicians, want practical help with the ethical aspects of the care of their patients. We have found this to be the case throughout MedStar Health, our not-for-profit, multi-hospital and

health care facilities system in the Baltimore-Washington, DC, area, in which the Center for Ethics is seated at Washington Hospital Center. Further afield, nationally and internationally, other clinicians have told us they want this kind of help, as well.

That our clinicians are comfortable seeking such help from the bioethics staff of the Center for Ethics is the relevant point here. Figuring out how best to usefully serve the needs of our patients, families, clinicians, and other hospital professionals is no easy task. The field of bioethics is still young and immature. The literature has not yet made it clear what it means to be a clinical bioethicist, much less what it means to be a helpful one.

We believe, however, from our experience as one of the oldest clinical ethics hospital programs in the country, that we have learned what it means to be helpful bioethicists. Being a helpful bioethicist for our hospital system means to

provide practical ethics input where needed. It means helping our clinicians become more alert to the ethical aspects inherent in routine hospital care. It means providing our clinicians with the education and training necessary for them to seamlessly integrate the ethical and technical components of medical care, including logistics and social supports, provided in the hospital. It means, also, to be sufficiently scholarly, skilled, and trained to work with clinicians, patients, families, and with other hospital professionals, to bring complex ethics cases and/or situations to good ethics outcome. We define a good ethics outcome as excellence in patient care; advancing trust in medicine; increasing moral imagination; refining ethical analysis among clinicians, trainees, and others; nourishing a morally safe environment within the hospital;

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and strengthening moral courage in all of us.

We, however, do not presume to suggest that we are teaching physicians and other hospital personnel about being ethical. We assume, and our experience confirms, that clinicians and others who go into hospital work do so because they are decent, smart, other-oriented people who want to take care of sick patients. What we do at the Center for Ethics, and what we hope to do in the pages of *JOHE*, is to help hospital clinicians and other personnel, especially hospital physicians and those who admit patients to hospitals, to systematically and broadly think through the complex and refined issues that make for reasonable differences of opinion on ethical judgments required in the care of hospital patients.

That does not mean that every recommendation we make is “right” in the abstract sense of the word. We do not profess to be arbiters of truth or the ideal. In fact, we stay away from saying there is a “right” answer or that we should “do the right thing.” Rather, we talk in terms of finding the ethically optimal choice or making the ethically optimal decision. And even then we expect that there will be disagreement, and we welcome discussion of the disagreement. Where issues are dilemmatic, there will inevitably be thoughtful disagreement.<sup>1</sup> The notion, held by some, that if bioethicists, en masse, don’t agree, then there is something wrong with the field of bioethics, to us seems totally wrongheaded. Rather, that there is disagreement among persons knowledgeable and skilled in bioethics means that agreement on a particular issue is not yet to be found; that ethical thinking has not yet evolved sufficiently to produce a strong moral consensus.<sup>2</sup> (That is not to say that we believe in ethical relativism. We don’t. But we shall

hold that lengthy discussion for another issue of *JOHE*.) For now, we simply note that where *JOHE* articles, cases, or policy discussions are focused on ethical issues that have a reasonable moral consensus, they will tend to be sparsely referenced. But when we move into highly unsettled areas, we shall do so transparently and provide a denser set of references. This citation practice is designed to provide the interested reader only foundational reading in reasonably well-considered areas, and a fuller range

of thinking in areas that are still being, or are beginning to be, debated. While not wanting to overwhelm busy clinicians with more reading, we want to reference enough of the scholarship necessary to demonstrate firm justification of our thinking.

This bent toward making and justifying practical moral judgments may be the primary distinguisher between *JOHE* and other journals in medical ethics. *JOHE* is going to be an ethics journal that takes specific

moral positions that we, in the Center for Ethics, have found to produce good ethical outcomes.

One of these moral preferences is to avoid having ethical problems arise. We take as a given that ethical judgments are part of virtually every decision made in the course of treating a hospital patient, and that those judgments are made without a bioethicist in sight. That is why our model for hospital bioethics is an educational model in which we see our greatest value as helping to educate and train our clinical staff. Clinicians are lifelong learners by temperamental bent and necessity, and, at least the gifted ones, are intellectually flexible and open to new information and ways of approaching a problem. A little discussion about the ethics of a case goes a long way. Once the initial suspiciousness of clinical bioethicists as ethics

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police has passed, and a clinician realizes that we are there to be another resource to help him or her take good care of the patient, the kind of trust that, for example, an internist has for a cardiologist who has previously provided a helpful consultation, develops. And, like the helpful consulting cardiologist, the information and guidance the bioethicist provides must be backed up with sound and scholarly reasoning.

Unfortunately for bioethics, the empirical data available to the consulting cardiologist is vast and more objective than data in the field of bioethics. Because contemporary bioethics is such a relatively new field, and one that comes out of a philosophical tradition rather than out of the sciences, the kind of justifications for recommendations that rests on evidence-based medicine for the consulting cardiologist is essentially lacking in bioethics. Nonetheless, because we define helpfulness in clinical bioethics as ethically good outcome, the Center for

Ethics works to provide *evidence-based ethics*. We have coined the term because it epitomizes, for us, what makes the practice of clinical bioethics a special subset of bioethics and illuminates why *JOHE* is needed. In discussing a case as it unfolds, we must provide guidance that is helpful. We must not merely lay out the possible ethically permissible options and end the consult there. More likely than not, the clinician needing the help has already gone through those possibilities. What makes us helpful is knowing the literature and the scholarship sufficiently to say what others think, analyzing what the particulars of the case raise in terms of norms of ancient medical ethics and current literature, mounting a convincing argument for

going in one direction or the other, and usually doing all of this at the bedside in a very short time.

The *evidence-based ethics* comes in evaluating the outcome.<sup>3,4</sup> If the ethics recommendations were followed, was resolution of the situation one that advanced excellence in medical practice? Does the patient and/or family feel that they were treated fairly and respectfully? If the patient died, do those left behind feel they were cradled and the patient's dying was dignified and comfortable? Are

working relationships on the clinical team stronger and more respectful than before the issue arose? Do all the clinicians involved (ie, physicians, nurses, residents, and the like) believe they each were respectfully involved? Is the moral climate on the unit where the case occurred more open and less hierarchical related to discussion of the ethical aspects of patient care? Where one's preferred direction was not followed, does that person feel that the actions taken for the patient were reasonable? Were the bio-

ethics recommendations clearly documented in the chart? If the bioethics recommendations were not followed, and things went from bad to worse, that kind of outcome provides useful evidence for the helpfulness of the clinical bioethicist, as well.

Because so much rides on good ethical outcome, we approach our work with humility. As bioethicists who work closely with our treating clinicians and the many others who serve our patients, we are daily reminded of the devotion to the care of our patients all give. Our motto at Washington Hospital Center is "Patient First," and we mean it.

One demonstration of how our Patient First motto is lived out is in the resources devoted to assisting our clinicians with the ethical issues that

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ethics."

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arise as a natural and inherent part of providing hospital care. As Jack Lynch tells in his article chronicling the evolution of ethics at Washington Hospital Center since the early days of contemporary bioethics, Washington Hospital Center has taken ethics and its elevation seriously for a very long time. As the quite staggering consult numbers presented by Nneka Mokwunye show, the staff of the Center for Ethics has become a trusted and useful adjunct to patient care. These facts of our hospital demonstrate a long and vigorous commitment from the hospital's leadership, a necessary component to elevating the moral climate of any hospital. And, as *JOHE* demonstrates, the commitment to ethics is not only deep, but also cutting edge. Nneka's article unveils a technology advance that promises to enable the kinds of outcomes research that will make evidence-based ethics an everyday part of running a hospital bioethics program. Daria Grayer's discussion of a family presence policy now in development at Washington Hospital Center demonstrates how policy can be created and used to make a novel and, to some, unsettling practice more systematic and comfortable for clinicians and families who choose to remain during a resuscitation attempt. Our Washington Hospital Center leadership supports the launch of *JOHE* to bring what we have learned and continue to learn to a wider audience of clinicians and other hospital professionals, bioethicists, and interested academics. We base our hope that *JOHE* is needed by this wider clinical community on the feedback we have received over the years from our clinicians here. They find us helpful. And it is this helpfulness that we hope to pass on.

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In each issue we will include at least 2, short, feature articles on topics that are particularly timely, ubiquitous, or especially thorny. Some issues will focus on a particular theme, as does our first issue, which takes a past, present, and future look at life-sustaining technologies in critical care. Some issues will focus on a particular topic, such as talking with surrogates or examining the issues associated with blood transfusions. Some issues will focus on a particular department such as pediatrics or nephrology or oncology. Also, we would very much like to hear from our readers about what you want us to cover.

Also included in each issue will be our Consult Corner, which will include 3 cases, some actual, some composite, some hypothetical. Each case will be divided into the sections of Presentation, Bioethics Recommendations and Chart Note, and Reasoning. Sometimes the case will be more a brief scenario than a case. In others, we will include details in the case that we do not mention in the Bioethics Recommendations and Chart Note section or the Reasoning section. Such omissions will be made for teaching purposes to allow us to focus on one or another aspect of the case while keeping the page length to a limit appropriate to quick reading. Where we leave out pieces of a case in our commentaries, we shall make note of that and come back to the omitted issues at a later date if the issue is of sufficient importance, or if our readers write us and ask us to do so.

Each issue will include, also, a Policy and Practice section. Here we will present and discuss a particular policy, including policies that are common to most hospitals and policies leaning toward the cutting edge, as does our opening

policy discussion in this issue on family presence during cardiopulmonary resuscitation. We would love readers to send in any policies that cover novel areas or approach standard issues with a fresh perspective.

Each issue, also, will include questions that physicians can answer to obtain continuing medical education (CME) credits. Some issues will include additional sections presenting articles by guest contributors as well as articles by students and other trainees rotating through our office for internships in clinical bioethics. We also expect to include Letters and Cases to the Editor. Although the Letters to the Editor section will look much like such a section in other journals, we have decided to create a Cases to the Editor section, as well. In it, we welcome cases from other institutions seeking a second opinion and willing for our second opinion to be published in *JOHE*. We can imagine the Cases to the Editor section, as well as the Letters to the Editor, resulting in useful dialogue, furthering the prospects of developing an evidence-based ethics. We encourage enthusiastically such dialogue.

In conclusion, we are doing with *JOHE* what we believe the helpful clinical bioethicist must do every day—step out on a limb. We hope that the limb grows thick and strong rather than breaking,

but only time will tell. You, our readers, will produce the outcome data about whether or not you find *JOHE* helpful in the care of your patients. We hope we are helpful, and we look forward to hearing your thoughts.

As always,



Evan G. DeRenzo, PhD

#### References

1. Fox E, Daskal FC, Stocking C. Ethics consultants' recommendations for life-prolonging treatment of patients in persistent vegetative state: A follow-up study. *The J Clin Ethics*. 2007;18(1):64-71.
2. Moreno J. *Deciding Together: Bioethics and Moral Consensus*. New York, NY: *Oxford University Press*; 1995.
3. Schneiderman, LJ, Gilmer, T., Teetzel, HD. Impact of ethics consultations in the intensive care setting: A randomized, controlled trial. *Crit Care Med*. 2000;28(2):3920-3924.
4. Schneiderman, LJ et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: A randomized controlled trial. *JAMA*. 2003; 290(9):1166-1172.