



Bioethics Notes



a newsletter from the Bioethics Review & Advisory Committee

September 1,
2003

"I like persons better than principles, and I like persons with no principles better than anything else in the world."

Oscar Wilde, *The Picture of Dorian Gray* (1891)

Consult Services

We would like to remind you that the Bioethics Review and Advisory Committee in Danville provides ethics consultation services. We have an alphanumeric pager (2229). Anyone can request an ethics consultation. Page directly by phone, or leave a text message using the Infoweb Phone Directory. Enter "2229" in the Directory Search and then click on the "Quick Page" button.

[Jump to Quick Page](#) to request an ethics consult.

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Open Commentary

The Bioethics Review and Advisory Committee believes the Geisinger community would benefit from increased communication and educational efforts dealing with current issues in bioethics. We are in the process of developing a web page and plan to distribute, on a regular basis, this e-newsletter. We also look forward to your participation in our annual ethics conference to be held March 12, 2004 at Susquehanna University on "Ethical Implications of the Medical Liability Crisis." Also, please utilize a new addition of pre-screened ethics links available on the Health Science Library Infoweb page: <http://infoweb.geisinger.edu/hsl/HSL/www/ethics.shtml>

In this issue, we present a simple case study:

Mrs. K, an 86 year old woman with advanced chronic obstructive pulmonary disease, is brought from her nursing home to the emergency room due to difficulty with breathing. She is awake and alert, but hypoxemic and hypercarbic on her arterial blood gas. Her daughter accompanied the patient to the emergency room and advises that her mother told her she did not want to be intubated if she had trouble breathing. Her daughter tells you her mother does not have an advanced directive. What should you do?

One of the guiding principles of ethical behavior is **respect for patient autonomy**, that is acknowledgment of a person's rights to hold views, to make choices and to take actions based on personal values and beliefs.

Thus, one should attempt to make treatment decisions based on the wishes of a competent, autonomous patient. But, how do you determine if a patient is competent to make decisions about their care? Most observers feel to meet standards of competence, a person must understand the therapy or procedure, be able to deliberate the major risks and benefits, and make a decision in light of this deliberation.

[Advance directives](#) are usually written documents allowing a competent patient the opportunity to guide future health care decisions when they are no longer able to participate directly in medical decision making. A 1991 federal law, the Patient Self-Determination Act, requires that patients be informed about their right to participate in health care decisions, including the right to have an advance directive. These are usually of two types. In a **living will** a patient gives instruction about how they would want to be treated under certain circumstances. A second type of directive is a **proxy directive**, generally a durable power of attorney for health care, in which a patient designates a surrogate decision maker to make medical decisions for the patient in the event he/she is no longer competent. Both of these document-based approaches have been criticized. Living wills are felt to be too vague to allow meaningful application to specific end of life decisions. Likewise, difficulties arise because of the lack of understanding by a proxy

Events

Annual Bioethics Conference

March 12, 2004
Susquehanna University

"Ethical Implications of the Medical
Liability Crisis"

Tentative Speakers

William M. Sage, M.D., J.D.

Professor of Law, Columbia University
School of Law
Principal Investigator for the Project on
Medical Liability in Pennsylvania

Patrick A. Hope, M.A., J.D.

Legislative Counsel, Governmental
Affairs and Public Policy
American College of Physicians,
American Society of Internal Medicine
Washington DC

Dorothy L. Pennachio

Senior Editor, Medical Economics
magazine
Montvale NJ

Mark Cherry, PhD

Assistant Professor
School of Humanities
Dept. Philosophy
St. Edward's University
Austin, TX

Read About It

suggested by one of our readers

Arthur Caplan, *Due Consideration:
Controversy in the Age of Medical
Miracles*. (New York: John Wiley &
Sons, 1998)

e-mail

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The Bioethics Review and
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of a person's values or the unwillingness of the proxy to make decisions based upon the proxy giver's values. As a result, attempts have been made to develop values-based directives (such as the values history) or scenario-based directives (such as the medical directive). More recently, use of a **family covenant** has been proposed to formulate advanced directives in conversation with family members and with the assistance of a physician with the intent of "transform(ing) moral quagmires into meaningful moral conversation" (Doukas DJ, Hardwig J, J Am Geriatr Soc 51: 1155-8, 2003).

"Applied to the planning of end-of life care, the family covenant would be a negotiated set of boundaries about what the family will do when faced with proxy decisions, with the physician agreeing about what care he or she will deliver at the end of this patient's life."

The family covenant is thought of as an open-ended and flexible dialogue, a process rather than simply the execution of a document.

Standards on which the surrogate should make decisions for the patient include **substituted judgment**, that is the surrogate should do what they think the person would do: "don the mental mantel of the incompetent" ([Superintendent of Belchertown State v Saikewicz](#), Mass 370 N.E. 2nd 417b (1977)). A second standard is the **best interests** standard: determine the higher net benefit among options: a good faith determination of what treatment would promote the patient's overall greatest welfare, considering all relevant factors, and made in accordance with ethical and medical standards.

So, what should you do in this case? Well, our first case for presentation is a simple one. The patient is still alert and presumably competent to make her own decisions; we do not need to invoke advanced directives or surrogate decision making.

Respectfully submitted,
Joel Berberich