COMMUNITY ETHICS

From the Editor
James Dwyer, Ph.D.
Associate Director of the CEP

A year and a half ago, I moved to Pittsburgh to become the Associate Director of the CEP. When I pause and look back at the last 18 months, I get a sense of just how busy and satisfying they have been. And when I look forward, I have some ideas and hopes about what might be ahead.

Since I came to the CEP, I’ve attended two retreats, taught a number of classes, given over forty talks, visited many hospitals, and met with several ethics committees. I’ve now been to a lot of places in western Pennsylvania, and even one in Ohio. Although I’ve gotten lost a few times, I’ve only been late once. Wherever I’ve gone, it’s been worth the trip. I value the chance to hear about the work people are doing and the problems they encounter. I like to listen to people’s experiences and ideas.

I realize now more than ever that I need two things in life: practical engagement and philosophical reflection. Okay, I need a lot of other things too: food, sleep, exercise, money, friends, love, support, some quiet moments, and so on. But in my work-life, I would not be happy if I could not combine practical engagement and philosophical reflection. And my work with you has given me that. We are engaged in caring for people’s health and well-being, and we get together to think about what this means and how we might do better. I like that. I like to reflect on how we ought to live and work. I always try to learn from experience and to enrich that experience with meaning.

In this edition of the newsletter, you’ll find three articles that describe very rich experiences. One article is a story entitled “Mrs. Tetley Wants to Go Home.” This is a fictional story that grew out of an ethics consult that I did. Many of you must have encountered similar stories in your work. Mrs. Tetley is an elderly patient who wants to go home, but the staff doesn’t think that going home is a safe discharge plan. I hope we can discuss this story, bring different perspectives to bear on it, and learn from each other’s experience.

Two articles in this newsletter describe the Community Medical Ethics Project in Greenville, Pennsylvania. Rev. Roth gives a detailed account of how

(continued, page 2)

Table of Contents

From the Editor .......................................................... 1
A Note of Thanks From the CEP Director .................. 3
Mrs. Tetley Wants to Go Home ................................. 4
The Greenville Community Medical Ethics Project ........ 6
The Community Medical Ethics Education Project as a Learning Experience .................. 7
CEP Calendar ............................................................. 8
Current Controversies Conference ......................... 9
Events and Announcements ................................. 10
Ethics in Non-Acute Settings .............................. 11

*Visit the CEP on the World Wide Web at http://www.pitt.edu/~cep/*
he and others put together a very innovative and important educational program for the community. Prof. White describes why he got his college students involved and what they gained from participating. I urge all of you to reflect on their experience, and to think about what could be done in your community. When I studied the ethics surveys, I saw that CEP members rank community education as very important, but that few members have active programs aimed to educate their communities.

The CEP now has a new way for us to discuss our experiences, reflect on their meaning, and suggest new ideas. It's the online CEP Discussion Board. The purpose of this discussion board is to enhance the ethics education of all CEP members by overcoming distance and time barriers. The site will enable members to post cases, discuss issues, and share their experience with other members. I urge all of you to read the description in this newsletter and sign up today. I want my next 18 months to be as busy and satisfying as the last 18 months.

Facts to Think About

In Australia, Japan, Sweden, and Switzerland, life expectancy at birth is now greater than 80 years. But in Angola, Botswana, Malawi, Zambia, and Zimbabwe, life expectancy is less than 40 years.

The Ethics Corner

In this edition of Community Ethics, we have included seven short informational articles, each a separate issue of The Ethics Corner. These articles were designed by the Consortium Ethics Program as ethics resources for health care professionals, particularly for use in hospital or organizational newsletters. We encourage you to distribute them, post them, or make use of them in your institution's publications. You may obtain an electronic copy of any of these articles by contacting the CEP by phone (412-647-5834) or e-mail (estow@pitt.edu).

Topics for The Ethics Corner include:

Bioethics and Multimedia
Conflict Resolution Resources for Health Care Professionals
The Forgotten Patient: Stress and the Professional Caregiver
The Importance of Advising Patients on Advance Care Planning
Medical Futility Policies: Good, Bad, or Just Plain Necessary?
Religion & Ethics: Going Against the Grain?
Singing the Blues? (Depression vs. a Bad Day)
A Note of Thanks From the CEP Director

Rosa Lynn Pinkus, Ph.D.
Director, Consortium Ethics Program

"...Public sensibilities and moral values legitimately influence not the findings but the topic of one's academic work. Such sensitivities often affected my research selections. Should this admission be held against me when I arrive at the gates of heaven, and I am not allowed into the chambers in which pure scientists rest, so be it.”

—Adapted from My Brother’s Keeper: A Memoir and a Message by Amitai Etzioni (Rowman & Littlefield, 2003).

The quotation at the beginning of this article is from an essay written by Amitai Etzioni, the accomplished sociologist, about his decision to pursue a career that combined the “pure” academic life with a life of social activism. Many of the remarks in his essay rang true to me as I thought about the 14 years I have directed the CEP—or rather, let the CEP direct and play a central role in my work. It’s one thing to write about the issues of determining a patient’s decision-making capacity, and quite another to be faced with an ethics consult that involves helping others: family members and caretakers on the healthcare team, sort out whether this actual patient’s refusal of surgery for a life-threatening, reversible problem is a “competent” decision. Many of you have called the CEP office—to “run an ethics consultation by us”—as you grapple with the conflicts these issues raise. In our capacity as teachers, Jim and I can walk you through the steps but then you have to use your unique personal touch to determine the way it’s actually carried out. As ethics consultants, Jim and I do the same. Then Jim adds his unique talent to the mix and writes remarkable stories about the people he meets and the conflicts that occur. This “back and forth” is what fascinates me about our work.

Bioethicists describe this very practical application of our work in many ways: “where the rubber meets the road,” “jumping from the frying pan into the fire,” “putting oneself on the line,” etc. As academics, this “action-oriented” work is not common fare. Etzioni reflects on how his dual work has affected him and the wider social concerns he has taken on, and he is “…confident that if more academics voluntarily took into account social relevance when choosing the subjects of their study, both academia and society would be better for it.” As I read Jim’s note, I remembered that I directed the search committee to look for this quality when we selected the new Associate Director. It’s always a struggle for us here in academia to meet the dual demands of publishing in the very best journals, doing what the tenure track demands, and then deciding to take that work one step further into the clinic or the public sphere to test it out in practice. Not every academic values this and of those who do, not everyone can carry it off. The CEP has a remarkable faculty that both want to do this work and do it very well.

The CEP was founded with the idea that the faculty and staff and CEP members would find a balance by working in both worlds and that this work would enrich and inform them as well. For me, seeing Community Ethics published is one piece of a puzzle that lets me see that this concept is working. The deep-felt and sincere pride I feel when reading Community Ethics comes from seeing, in print, accounts of the important work being done by the members of this unique ethics education network. As a network of individual healthcare providers, you all do remarkable work. This work occurs in your day-to-day practice. It also occurs after hours, like the sessions on advance directives and end-of-life decision making described here. If we catalogued and wrote about all of that work, we’d have an encyclopedia to publish, not a newsletter. At the CEP office, we often learn about the special programs that you organize at your hospitals and in your communities, but we wish more of you would write about them and share your experiences with others in the network.

So, I would like to thank Martin Roth, Arthur White, Jim Dwyer, Rhonda Hartman, Jody Stockdill, and Betsy Stow. I’m looking forward to our re-enrollment for the next three years, to the creation of a Long-Term Care Ethics Network and to a program on Palliative Care, as well. Who would have predicted, in 1990, when the CEP consisted of 12 acute care hospitals, that it would evolve into this? Without all of your work, it certainly would not have happened. So I would like to thank all of you for making all of this possible.
Mrs. Tetley was 82 years old. Her neighbor brought her to the hospital because she couldn't walk. Something was wrong with her foot. Surgery was supposed to help, and it did for a while. Her heel felt better, and she was looking forward to walking like she used to. But in the last two months she hadn't made any progress.

While she was in the hospital, Mrs. Tetley saw an occupational therapist, a physical therapist, and a podiatrical therapist who made her a special set of insoles. The insoles were nice, but the socks were always a problem. You have to wear cotton socks with the insoles because the grippy socks tear up the foam. But you can't wear cotton socks on the floor because you might slip and fall. And the staff seems especially worried about falls.

"Viva Tetley is a sweet woman," the head nurse said when the man mentioned the patient. "But she needs 24-hour supervision in a skilled nursing home. That's the best discharge plan. In fact, now it's the only discharge plan. Viva's sister was going to move her to a retirement home in Erie, but the two of them had a fight. Words were said, and now that plan is out of the question. Besides, her sister is two years older than she is."

"In the old days," the nurse mused, "we used to give patients a home pass, for a day or two, to see how they would cope at home. But the insurance plans won't let us do that anymore. If the patient is well enough to go home, then no insurance plan is going to pay for a home pass. And if the patient isn't well enough, then risk management says the discharge plan is unsafe. There's no in-between any more. So the plan is to send Viva to a skilled nursing home."

The problem is that Mrs. Tetley doesn't want to go to a nursing home. She wants to go home. Of course, the doctors told her about all the risks. They even wrote them in the chart.

"Viva doesn't get it," the resident said when the man asked about the patient. "There's no obvious dementia and no obvious psychopathology, but she doesn't appreciate the problem. When you point out the risks, she minimizes them. When you ask her about her management plan, she says that her friends will help out. But when you ask about her friends, she's always so vague. You can talk to her yourself. She's down the hall, in occupational therapy."

The young resident and the tall man walked down the hall until they came to a room with chairs, tables, and lots of activities. "Mrs. Tetley," the resident said, looking at the petite woman in a wheel chair. "This gentleman wants to speak to you. So I'm going to wheel you back to your room."

"But I need my blanket first," Mrs. Tetley said. "When I came to therapy, I had my blanket on my lap."

"Have you seen Mrs. Tetley's blanket?" asked the resident, speaking as much to the room as to anyone in particular.

"No, it's not in here," said the therapist as she widened her eyes and looked around the room the way your kindergarten teacher did when she read stories.

"Where did you leave your blanket, Mrs. Tetley?" the resident asked in a clear and loud voice. "In the room with the steps? Okay, we'll stop there on the way back to your room."

As the resident wheeled the patient into another therapy room, she stopped and said, in a low voice, "Mrs. Tetley, it's not in here. Are you sure you brought it with you? I'll tell you what, if we find your blanket, we'll bring it back to your room."

While the resident was pushing the patient down the hall, she turned to the man and said, in a low voice, "You see what I mean. She doesn't get it. How is she going to manage at home?"

When they got back to her room, the man explained his visit. "Mrs. Tetley," the man said, "your doctors asked me to talk with you because there's a conflict. They think you need to be in a nursing home where someone is always around to help you. But you want to go home. Please tell me what you're thinking."

"I've been in the hospital for four months," said Mrs. Tetley. "I don't know who is going to pay for all this. Oh, I had insurance, but it's not going to pay for all this. I'll send the hospital a little money every month; that's
what I'll try to do. The people here are very nice, very professional, but why four months? Just between you and me, I think they are making money.”

With an air of determination, she continued, “It's time to go home. I'm not getting any better here. At first I was, but my heel still hurts when I walk. And people get sick in hospitals. The longer you stay ... you know ... people get sick in hospitals.”

“But why don’t you want to go to a nursing home?” the man asked her,

And who is going to pay for that? And what am I going to do there? Maybe my sister would visit me once a week and wheel me out to sit in the sunshine. No thanks. I'm going home. I've lived there fifty years.”

“No, fifty years.”

“Five, zero,” the man said.

“That's right. My husband and I bought our home in 1952 for $17,000. That was a lot of money in those days. That's a lot of money any day.”

“But how,” the man asked, “are you going to manage by yourself?”

“I've got everything I need on the first floor of my home, and I know my neighbors pretty well. I want to hire someone to grow vegetables in my garden, like my husband and I used to do.”

“The doctors are concerned that you might fall,” the man said. “Do you understand the risks of going home?”

“I didn’t fall here. What happened was that I needed to go the bathroom. I rang the buzzer. Three times. But no one came. I don’t want to speak ill of anyone. The people here are very nice and very professional, but you understand how it is. Well, I wasn’t going to wet the bed, so I got up and started to walk over to the bathroom. My heel hurt, so I sat on the floor to rest. And while I’m sitting on the floor, the nurse came in and everyone made a big brouhaha.”

And then Mrs. Tetley remembered something that brought a smile to her face. “When I was a kid,” she said, “my sister was always falling out of bed. That's why I slept in the top bunk, even though I was younger. About once a week, I'd find my sister on the floor, sleeping like a baby. I never understood how she could fall out of bed with her blanket. Once she fell out of bed with her pillow.”

“Mrs. Tetley,” the man said, “let me ask you something very directly.”

“Go ahead.”

“Would you rather live 10 years in a nursing home or 2 years at home?”

Before the man could even bat an eye, Mrs. Tetley replied, “2 years at home.”

What about 10 weeks in a nursing home or 2 weeks at home?”

There was a long pause, and the man had to stop himself from interrupting the silence. He had to stop himself from filling up the uncomfortable space.

After what seemed like a long time, she said, in a soft voice, “I don’t know. I need to think about that one. Two weeks isn't very long, is it?”

CEP Online Discussion Board

The CEP Online Discussion Board is up and running! We’d like to invite you to sign up now to participate.

All we need from you is your name, e-mail address, and social security number. We’ll submit this information to the University of Pittsburgh CIDDE department, and they will give you a user name and password for the Blackboard system. The required information can be sent either to Betsy (412-647-5834 or estow@pitt.edu) or to Jody (412-647-5832 or joc10@pitt.edu).
As a participant in the CEP, representing UPMC Horizon, I have considered it my responsibility to make resources for medical ethics education available to the hospital and its ethics committee, as well as to the Greenville community. My exposure to gifted teachers in the CEP contributed to the ideas leading to the Community Medical Ethics Project in Greenville, Pennsylvania.

In attempting to find ways to deliver medical ethics education in the Greenville area, I approached the hospital about the possibility of a partnership between UPMC Horizon and the parish I serve; this congregation has a deep commitment to education and community outreach. In conversations with UPMC Horizon’s Vice President of Planning, Michael Downing, we decided to broaden the sponsorship to include Thiel College, also in Greenville. My membership on the boards of both hospital and college meant that the forging of a sponsorship network was a matter of following leads that already existed.

Representatives from the hospital, college, and congregation formed a planning group to flesh out the original proposal, then the planning group grew into a steering committee for what has become an ongoing project. One person’s idea became a shared vision, and the group adopted the working name of the “Community Medical Ethics Project” (CMEP).

The project’s mission is to provide opportunities for people in the community to gain a basic understanding of medical ethics in an attempt to better equip them for making important decisions related to life and death issues in the course of health care.

The initial resources for the project were the wonderful teachers/ethicists available through the hospital’s relationship to the Consortium Ethics Program. Dr. Rhonda Hartman, who was Interim Assistant Director at the time, agreed to be a part of the early planning. She was excited by what the committee was doing and eager to assist. She suggested that the CEP be included as a sponsoring group. The steering committee concurred and included the CEP as a “sponsor-at-large” for the first three events.

The committee decided that the first subject for the CMEP would be an issue that touched everyone in one way or another. Three sessions (spring, summer, fall) were planned on end-of-life decisions: Knowing Your Rights and Asking Questions, Making Your Choices, Making Your Wishes Known.

Rhonda Hartman was the principal presenter for all three events. The events were held on the campus of Thiel College (easily accessible physically and psychologically). Community members along with students and faculty of related college departments were invited to attend.

A member of the steering committee who worked in public relations coordinated and produced the publicity for the events. The publicity included feature newspaper articles on the project and on Dr. Hartman; flyers distributed through churches, physician offices, faculty and student mailboxes; and posters displayed throughout the community.

On each of the three dates, two sessions—one from 1:00 to 3:00 p.m. and another from 7:00 to 9:00 p.m.—repeated the same content and included such components as: lecture with Power Point, role play, video, and panel discussion (including local clergy, physicians, hospice representatives). Each participant received a packet of resources, and refreshments were provided during a break in each program. The attendance at each of the three events was fifty to one hundred participants. At each event participants were asked to complete an evaluation form, the results of which were used for refining and planning the next event. Following the original three programs, the committee decided to continue CMEP beyond the initial series of events so that its mission could be further pursued.

*The Rev. Martin M. Roth, a member of the CEP, is senior pastor of Holy Trinity Lutheran Church, Greenville, and convener for the Community Medical Ethics Project. He serves as a member on the UPMC Horizon Ethics Committee, the hospital board, and the Thiel College Board.*

*Correspondence and comments regarding this article may be sent to Rev. Roth at holvtrin@infolnet.*
Most college students approach the philosophical study of ethics with reluctance. Many are skeptical that anything can be known (as opposed to believed) about ethical judgments other than (perhaps): ‘this group holds this opinion, that group holds a different one.’ Usually the unstated implication is: ‘and that’s all there is to it!’ Other students, not quite so skeptical, hold a variety of relativisms: cultural, religious or temporal. At the beginning of every semester, or so it seems, someone will say, “19th century Mormons accepted polygamy, 21st century Lutherans do not. There is no way to say one group is right and the other wrong.” While no doubt this is something of an over-generalization, it is still true that these attitudes reinforce student perceptions that the study of philosophic ethics may have some minor academic value but it has limited ‘real world’ use for making their own lives better.

Traditional ethics courses (and most ethics textbooks) do little to address this student attitude. Many classes (mine included) have a goal of informing students of the historically important positions of past thinkers. But Aristotle disagreed with Plato, and Kant disagreed with Bentham. All too often, from a student’s perspective, this means that since the great figures of the past could not agree, there is nothing to agree about. Furthermore, since many examples of ethical dilemmas presented in classroom discussions are far removed from the life experience of traditionally aged college students, the textbook examples have an all-too-artificial air about them. As an instructor at a traditional liberal arts college serving mostly traditional aged students, I am constantly trying to find ways to overcome these attitudes and thus make the study of ethics more productive.

The Community Medical Ethics Project afforded me a wonderful opportunity to have my students deal with real world issues. (See the informative article by Rev. Martin Roth for a complete description of the project (page 6).) As follow up surveys documented, having students participate in this project had a positive impact on shifting students’ attitudes towards the usefulness of ethical reflection.

During the academic year 2002-03, the CEP sponsored a series of three lecture/workshop events. Dr. Rhonda Hartman, along with presenters from Horizon Hospital, Holy Trinity Lutheran Church and Thiel College (all in Greenville, PA) encouraged individuals from the community and health care professions to deal with a number of ‘end of life’ issues ranging from the legal specifics of living wills and durable powers of attorney to coming to grips with the meaning of death itself. I encouraged my students to attend these events (I confess by offering the inducement of extra credit points for reports on the meetings).

Students came into contact with individuals who were directly confronting the agonizing dilemmas of end-of-life choices. Termination of life sustaining equipment, and questions of pain and suffering were no longer merely textbook hypotheticals but were the impassioned life stories of persons willing to share them. Dr. Hartman and the other series participants vividly demonstrated how both the skills and content of work in philosophical ethics are directly relevant to the participants’ lives. As an additional benefit students were able to have the opportunity to meet and hear professionals from a wide range of professions make use of philosophical thought.

Students were struck by the high degree of agreement among medical professionals. Their prior skepticism soon gave way to the possibility of rational agreement on ethical matters. While of course there were differences of opinion (some profound) as to both theoretical and practical matters, medical professionals and academics agreed on the justification and usefulness of such medical ethical principles as beneficence, non-malfeasance, and patient autonomy. This agreement across professions was frequently mentioned on student follow-up surveys as causing them to re-think their prior relativism.

It is not surprising that, as a philosophy professor, I hold philosophic work to be among life’s most important tasks. Involving students in the work of the Community Medical Ethics Project proved to be a most effective way of bringing students to see that the value of such work extends well beyond the classroom.
Mark Your Calendars...

CEP Spring Class Series

We've made some changes and confirmed some dates for our Spring Class Series, and just wanted to update you on the schedule so you can mark your calendars and save the dates.

**Basic Class Series**

**Tuesday, March 16, 2004**

9:00 AM – 12:00 PM  
Michael Brannigan, Ph.D.  
LaRoche College  
Title: TBA

1:30 PM – 4:30 PM  
James Dwyer, Ph.D.  
CEP Associate Director  
University of Pittsburgh  
“Ethics Consultations: Stories, Perspectives, and Endings”

**Advanced/Associate Class Series**

**Tuesday, March 16, 2004**

9:00 AM – 12:00 PM  
Rabbi Mark Staitman, Ph.D.  
Pittsburgh, PA  
“Case-Based Reasoning and Jewish Medical Ethics: Theory & Practice”

1:30 PM – 4:30 PM  
David Kelly, Ph.D.  
Duquesne University  
“The Principle of Double Effect in Catholic Medical Ethics”

**Combined Sessions**

**Friday, May 7, 2004**

9:00 AM – 12:00 PM  
Martin Kohn, Ph.D.  
Center for Literature, Medicine, and the Health Care Professions  
“Framing Our Later Years”

1:30 PM – 4:30 PM  
Speaker & Title TBA

**CEP Annual Retreat, 2004**

**Friday, September 10, 2004 and Saturday, September 11, 2004**

Save the date! We have booked a retreat date at Lakeview for the 2004 Annual Retreat. Please note that we have shortened the weekend and will finish up on Saturday afternoon instead of Sunday.
13th Annual Current Controversies in Medical Ethics Conference and 21st Annual Messer Lecture

"Gray Hair & Golden Years: Ethical Care for Our Elders"

Monday, April 26, 2004
University of Pittsburgh
Scalie Hall

The annual LHAS Current Controversies in Medical Ethics Conference challenges attendees to learn ethics by fostering debate between clinicians, experts, and patients. Speakers make the audience aware of the complexity of the issues and their regional, national, and international impact. The audience is a diverse group of concerned physicians, community members, clergy, and health care professionals.

The CEP, in its long-standing tradition of a collaborative approach to health care ethics education, is pleased once again to co-sponsor this important conference. Under the leadership of course directors Michael DeVita, MD, and Elizabeth Chaitin, DHCE, this year's conference investigates several of the most important ethical and clinical issues raised in the care of geriatric patients.

Our population is aging; new (and some old) ethical issues are being recognized and demand attention. We are on the threshold of a large change in demographics that will certainly impact resource availability and strain our current health care system. The ethical debate is manifest on the front pages of both lay and medical/ethical publications. Our society is unified by the recognition that a crisis is looming, and yet divided on what the major problems are and how they are best resolved. The aged are considered a vulnerable population and so are especially protected from risky research. At the same time, high quality studies that inform caregivers regarding the best approach are lacking and needed.

This conference will provide an opportunity for participants to better understand the ethical issues raised in the current and future care of elderly patients. We are fortunate and honored that the 21st Annual Ira R. Messer Memorial Lecturer is the renowned ethicist-physician Joanne Lynn, whose lecture is titled, "Theory, Myth and Reality in Health Care for the Elderly." Other topics for the day include fairness between generations; health care payers and the elderly; long-term care/quality of care; research on the elderly; psychiatric disease in the elderly; transplantation and the elderly; autonomy; age discrimination; pain management and assessment; and new medical therapies for treating dementia.

We would encourage you to take advantage of this excellent opportunity to learn more about a topic which is receiving increasing attention in health care ethics. For more information, please see www.upmc.edu/CCEHS/CME/formal_courses.asp (online registration available) or contact the Center for Continuing Education in the Health Sciences at 412-647-8232.*

*Conference summary and topics were taken from the promotional brochure developed by the Center for Continuing Education in the Health Sciences. The full brochure content is available at the above website.
Events and Announcements

CEP Re-enrollment Reminder

If your institution has not yet turned in an “Intent to Participate” form, we would appreciate your doing so as soon as possible. We are already in the planning stages for another great year at the CEP. If you have questions or need additional forms, please contact the CEP office at 412-647-5834.

Summer Seminar in Clinical Ethics
August 2-6, 2004
University of Washington
Seattle, Washington

This seminar provides an intensive, interactive introduction to the four-box method of analysis of ethical problems in clinical care, developed by Jonsen, et al. in their book Clinical Ethics.

For additional information or to receive a Seminar brochure when available, please contact:

Marilyn J. Barnard, Manager
Continuing Education Program
University of Washington
Department of Medical History & Ethics
Campus Box 357120
Seattle, WA 98195-7120
E-mail: mbarnard@u.washington.edu
Phone: (206) 616-1864
Fax: (206) 685-7515

Where can you get 16 Masters Degrees in Law?

At the University of Pittsburgh School of Law by enrolling in the Master of Studies in Law Program

- Business Law - Constitutional Law - Criminal Justice - Disability Law - Dispute Resolution -
  Education Law - Elderlaw and Estate Planning - Employment Law - Environmental Law -
  Family Law - Health Law - Intellectual Property and Technology Law - International Law -
  Personal Injury - Regulatory Law - Tax Law

... And if that's not enough, design your own

- 30 credits, full or part time
Ethics and Non-Acute Settings

Home Care

With the guidance of the CEP, especially that of faculty member Cynthia McCarthy, DHCE, and CEP Director Rosa Lynn Pinkus, Ph.D., the UPMC Home Care Ethics Committee has been working steadily toward its ethics education goals since it joined the Consortium in 1999.

In addition to establishing and publishing guidelines for ethics consultation among the Home Care business units, the committee has also developed a Home Care Ethics Resource Manual, which will be introducing at a conference for Home Care Administrators on February 24, 2004.

The conference also aims to introduce the Ethics Committee and its accomplishments over the past year. It will explore current issues regarding Advance Directives in Home Care and committee recommendations for the use of two different Advance Directive brochures. The speakers will discuss areas of concern regarding safety in the home care environment and the present committee's resolution of this concern.

Presenters for the conference include Cynthia McCarthy, Rosa Lynn Pinkus, and committee members Alice Halterlein, MSW, SLSW, and Mary Ellen Jubeck, RN, MSN, of UPMC/SHHS Home Health; Barb Krug, RN, BSN, of Community Nursing Service, and Jenifer Ashner, RN, of Chartwell PA.

Long-Term Care

Working with Shikha Iyengar, MS, MPH, Administrative Director of the University of Pittsburgh Institute on Aging and Vice President for Geriatric Services UPMC, the CEP is pleased to announce the initiation of a Long-Term Care Ethics Network. Working from the original ethics initiative which sought to form a Long-Term Care (LTC) Ethics Committee among representatives from UPMC LTC facilities, the CEP is expanding its educational program by inviting non-UPMC facilities to join the network.

In addition to these efforts, Rosa Lynn Pinkus, Ph.D., and Monica Ridener, MSW, Director of Resident and Family Services at Canterbury Place in Pittsburgh (a CEP representative since 1999), will be giving a presentation titled “Ethics in LTC: Common Issues and Innovative Approaches to Critical Problem Solving” at the Leadership Health Care Spring 2004 National LTC Conference/Exhibit, to be held March 22-24, 2004 at the Pittsburgh Airport Crowne Plaza Hotel.

Dr. Pinkus is also participating in the conference: “3 Peas Heretofore Not in a Pod: Interest-Based Negotiations in Ethical Dilemmas.” This conference, to be held at the Pittsburgh Hilton on March 31, 2004, will introduce participants to interest-based negotiation as a tool to more effectively resolve common ethical dilemmas in long-term care.

As always, we welcome comments, questions and suggestions from our readers.
Please feel free to contact us!

Consortium Ethics Program
3708 Fifth Avenue, Suite 300
Pittsburgh, PA 15213
Phone: (412) 647-5834
FAX: (412) 647-5877
E-mail: cep@pittedu
As always, we extend special words of thanks to Vira I. Heinz Endowment for contributing the seed money to establish the Consortium Ethics Program. We are also deeply indebted to the University of Pittsburgh Department of Medicine, Division of General Internal Medicine, and the University of Pittsburgh Center for Bioethics and Health Law for their continued co-sponsorship.

If you have suggestions or questions regarding the Consortium Ethics Program, wish to submit information for an upcoming edition of Community Ethics, or wish to receive this newsletter, contact James Dwyer, Ph.D., Consortium Ethics Program, 3708 Fifth Avenue, Suite 300, Pittsburgh, PA 15213, phone (412) 647-5789, FAX (412) 647-5877, e-mail <cep+@pitt.edu>.
THE ETHICS CORNER

Bioethics and Multimedia

The Internet and videos are great resources for more visual and interactive staff training, or individual education. This Ethics Corner offers our suggestions for media that can help enhance the learning and discussion of bioethics. Please contact the Consortium Ethics Program if you would like to borrow copies of these videos or would like to learn how to acquire one.

- **Healthcare Crisis: Who's at Risk?**
  Produced by PBS, and initially run as a television series, this video looks at all aspects of modern medical care. This extremely well done video highlights patients and providers at Newark's Beth Israel Medical Center and covers issues such as long-term care, health insurance and the uninsured, managed care, and chronic care in a hospital setting.
  - **Healthcare Crisis: Who's at Risk website** [http://www.pbs.org/healthcarecrisis](http://www.pbs.org/healthcarecrisis)

  This website provides an extensive and detailed overview of all the issues discussed in the Healthcare Crisis video, introduces the patients and providers featured in the video, and also has a timeline of healthcare, a glossary of terms, interviews with experts, and answers to tough healthcare questions. The site also provides access to teaching materials and a transcript of the video. Well-designed, highly informative, and easy-to-use, the website is a great addition to the video and is well worth a look.

- **The Partnership for Caring website**: [www.partnershipforcaring.org](http://www.partnershipforcaring.org)

  With a focus on strong end-of-life care, Partnership for Caring is detailed, well organized, and full of information. Topics include advance directives (including state-specific downloadable forms), palliative care, healthcare agents, and several links to other helpful sites. The PFC website also has its own newsletter, *Voices*, as well as a moderated discussion and chat room. This source is great for healthcare professionals to gain a better knowledge of end-of-life care, but is also a good recommendation for patients.

- **From Rules to Caring Practices: Ethics and Community-Based Care for Elders**
  This teaching video features four separate scenes that depict various issues of home care and long-term care. For example, in one scene an elderly woman living alone is furious when her daughter sends an in-home nurse to care for her and she clashes with the intruding nurse when the nurse tries to change the woman's apartment and routine. Another scene addresses the issue of elder abuse. The scenes are short—approximately 5-10 minutes each—and are designed to illustrate issues in healthcare and spark discussion on them. This video is great for group discussions, and comes with an instructor's guide and a caregiver's workbook.

- **The American Journal of Bioethics website**: [www.bioethics.net](http://www.bioethics.net)

  Updated and maintained by the Center for Bioethics at the University of Pennsylvania, this site covers some basic issues in bioethics, but also presents articles on more obscure issues, such as the ethics of neonatal male circumcision. Visitors can explore articles and sections from the print magazine, as well as sections on Bioethics for Beginners, Bioethics and Cloning, Bioethics and Genetics, and Bioethics on NBC's ER (each week, a student at the Center for Bioethics analyzes the current ER episode for bioethics issues). The site also has a good search engine for finding more information in bioethics.


  This site is great as a general bioethics resource and it also provides links to other online sources. It discusses research ethics, conflict of interest, end-of-life care, the physician-patient relationship, and palliative care. It also includes links to bioethics organizations and other helpful websites, FAQs, and guideline papers.

- **A Man of Endurance: 20/20 segment on Dax Cowart**
  As a young man, Dax Cowart was severely burned in a propane gas explosion that left him with third-degree burns over 65% of his body. He spent 232 days in the hospital, undergoing extremely painful treatments. Throughout the process, Dax protested, saying he would rather die than face the pain of treatment and decreased quality of life, but his requests were ignored. Today, Dax has carved out a successful career and life, but still maintains that his right to decide should have been respected. This compelling video explores the issues of right to die, competency, and patient autonomy.
THE ETHICS CORNER

Conflict Resolution Resources for Health Care Professionals

No one who works in health care is a stranger to conflict. At times, physicians disagree with patients, patients disagree with their families, and ethics committee members—physicians, nurses, social workers—disagree with one another. Sometimes, these conflicts reach a point where there seems to be no solution in sight, and things are at an impasse. In these cases, mediation by a third person (ethics consultant, trained mediator, or someone else who does not have a direct stake in the conflict) can help everyone involved take a step back and work toward the best possible resolution. Below are several suggestions for resources in conflict mediation and resolution.


Gibson’s article gives some practical suggestions to those seeking to do mediation in health care. He explains that the duty of a mediator extends beyond simple negotiation tactics; mediators have a responsibility to ensure that the autonomy of the patient is protected by helping keep everyone on the same page, working toward not just a decision, but the best possible decision.

Among Gibson’s points is the idea that “sometimes neutrality...would ideally involve redressing the balance of power.” If two parties are left to themselves to make a decision between them, most often, the more powerful one will use their advantage to gain his or her ends. Gibson emphasizes the need for a mediator to “level the playing field,” so that all parties’ concerns receive equal standing.

Gibson also comments on such issues as the relationship of the final decision to hospital policy and the level of confidentiality which should be maintained throughout the mediation process.


This very brief article discusses the increasing importance of mediation skills for ethics committee members and outlines a few basic strategies for mediation of conflicts in health care. Gibson compares the stages of mediation with typical ethics committee consultation processes, and she demonstrates how mediation skills will complement the skills ethics committee members have already learned through their bioethics training. The stages she discusses are: intake; information gathering and issues identification; resolution; and follow-up.

Gibson also talks about the various types of power which may be held in ethical conflict, such as formal authority, expert/information power, resource power, nuisance power, and personal power. She also lists some important skills for effective mediators: investigation, empathy, management of interaction, strategic direction, invention, persuasion, and substantive knowledge. An especially valuable skill is having numerous strategies for de-escalating conflict and dealing with impasses.


This article, written by three physicians, deals specifically with conflicts which arise in end-of-life care. It attempts to outline some of “the causes of and influences on conflicts between families and health care workers regarding decisions at the end of life.” The factors are discussed from different perspectives, including that of the patient, the family, and the clinician. Some practical suggestions for handling the conflicts are given, and the article includes a list of data-gathering questions practitioners should keep in mind.

The authors point out that “in the hospital, death is a routine occurrence to the caregivers, but not to the patients and families.” For this reason, conflicts are a lot more apt to develop, since families trying to make decisions with or for a dying loved one are grieving, and furthermore, they may not understand some (or any) of what is going on.

The Pittsburgh Mediation Center

On the more practical side, the Pittsburgh Mediation Center (PMC) has developed, based on their three-part training program for the Consortium Ethics Program, a series of in-house workshops for hospital ethics committees and health care providers. Each of these full or half day workshops teaches conflict management skills as they apply to people working in health care settings.

Session 1: Decision-Making in Conflict Situations

Participants will gain an increased awareness of factors that reduce the ability of people to function well in conflict, as well as factors that can enable people to function well in conflict, and will develop a foundation for making choices when responding to conflict.

Session 2: Tools for Addressing Conflict

Participants in this session learn to apply the communication skills, including active listening, to situations they are likely to encounter, determine underlying interest in a conflict, and focus a discussion using a problem statement.

Session 3: Third Party Intervention

Participants use the skills covered in the first two sessions when they must intervene as a third party. They will learn to analyze their role in a situation where they are asked to intervene, and will determine what questions to ask themselves when making decisions about if/how to intervene.

For more information, contact Ellen DeBenedetti or Marc Booker at the PMC (412-365-0400).

~Elizabeth J. Stow
The Forgotten Patient: Stress and the Professional Caregiver

Every day, healthcare professionals experience all the myriad traumatic and dramatic events of life. From the joy of birth to the pain of death, from domestic abuse to car accidents to plain old colds, healthcare professionals have to deal with life at its most beautiful and most brutal. But these images do not always go away when the workday ends. Healthcare professionals spend their days caring for the sick, but at the end of the day, who takes care of them?

Not only is stress unhealthy for the caregiver, it can also spill over into the workplace. Caregivers have an obligation to ensure that their personal stress does not lower their standards of care to patients.

Stress and distress among healthcare professionals is a common, but difficult subject. Many feel that they are not giving the proper and full care to their patients; others, such as nurses, may feel as though they are not able to authorize the appropriate care. Yet, in order to achieve the highest quality of care for patients, and for employees to have a sane, happy life, this issue must be addressed.

According to Judith Erlen, moral distress is quite common among nurses because they often find themselves in situations where they know the right path, but because of system constraints they are not allowed to take it. For example, the doctor may request treatment for a patient that the nurse knows the patient would not agree with. Nurses and others are often torn between advocacy for the patient and loyalty to their healthcare team. Erlen believes the best ways to alleviate this stress are: facilitating dialogue, developing a support system, and providing opportunity for professional development.

Good communication is key to lessening the amount of stress felt by all caregivers—nurses, doctors, social workers, etc. Stress levels may also decrease when each person on a healthcare team feels like a participating member who has input about treatment decisions and agrees with them. A strong team also works well together and presents a unified, comforting, and competent face to patients.

Strong support systems can also help alleviate stress. It is important to realize that stress and an occasional feeling of frustration or helplessness are common when dealing with complex healthcare issues. Professional and personal support systems can help to reduce that frustration. Healthcare professionals should not feel like bad workers by admitting that they need support. Rather, they should recognize that stress is common, natural, and even necessary. The important thing is to realize when the level of stress becomes harmful and to take steps to relieve it.

More Suggestions to Lower Stress

1. Find a neutral environment to discuss stressful issues with others or within yourself. Leave the workplace for a while and rationally consider all sides of the situation—who is involved, what they want, and what you want. Plotting out the stress alone may make you feel stronger when you have to confront it in a group.

2. Make time for yourself. Whether at home or at work, make sure you have time to yourself each day. Shut the door, ignore the computer and phone, and relax.

3. Get enough rest and exercise. Working out, eating well, and getting enough sleep are hard for everyone in our fast-paced lifestyles. But to lower stress and provide optimal patient care, good health is crucial. Even at work, a brisk walk around the building (outside or inside) can relax and energize you.

4. Organize team-building exercises that are not work-related, such as bowling, pizza parties, or even fun professional development classes. Interacting without the stress of work can make team members feel closer and more open and bonded as a team. This equals better care and less stress.

5. Finally, do not hesitate to seek professional help if stress is out of control.

-Jessica L. DiFrancesco

Bibliography


Drv-Wong, Kris and Rosalie Kane. "Job Stress and Decision Making.” Values and Ethics for a Caring Staff in Nursing Homes: A Training Guide. University of Minnesota Long-Term Care DECISIONS Resource Center.
Medical Futility Policies: Good, Bad, or Just Plain Necessary?

Medical futility, both as a concept and as a practical matter, has been discussed and debated in the ethics literature for years. One aspect of futility which has received a good deal of attention is policy formation. While some ethicists and clinicians believe that futility policies are essential, others feel that futility policies are—well, futile.

One of the main arguments against the creation and adoption of a futility policy is that the concept of futility is laden with value judgments, and is therefore nearly impossible to define. The AMA Council on Ethical and Judicial Affairs claims that "a fully objective and concrete definition of futility is unattainable;" Amir Halevy and Baruch Brody state that "the uniqueness of patients and diseases results in judgments of futility that are not easily formulated into a general substantive definition."

Schneiderman and Capron, however, do not think this should be a barrier to the adoption of futility policies, since "many...hospitals independently crafted common definitions of the term." They go on to point out that "if limits to physicians' obligations are not defined, end-of-life outcomes are likely to be determined less by medical circumstances and justifiable standards and more by individual healthcare providers' tolerance for risk, patients' and families' varying degrees of knowledge and rhetorical skills, and economic considerations."

A second difficulty discussed by ethicists, especially Halevy and Brody, was that many existing futility policies have "no ethical framework to ground the physician-institution opposition to the requested intervention." Policies should not only protect patients from being forced to accept unwanted treatment, but they should also support physicians and institutions who justifiably refuse to provide futile or inappropriate treatment.

In answer to this difficulty, some ethicists recommend that futility policies also reflect the ethical principles of professional and institutional integrity and stewardship (or, the best use of available resources), and the legal principle of due process (the AMA calls this "fair process") to balance the principle of patient autonomy in making decisions about treatment. The AMA recommends a seven-step approach to the resolution of cases in which one of the parties believes the treatment to be inappropriate. This approach includes the involvement of an ethics committee (rather than a single consultant), and the eventual transfer of care—either within the institution or to another institution—if no consensus can be reached. Finally, if no other physician and no other institution will agree to accept the case, then "by ethics standards, the intervention in question need not be provided, although the legal ramifications of this course of action are uncertain."

Most of the articles reviewed discussed the legal implications of cases in which treatment may be considered futile. Although admitting that clinicians, institutions, and patients will sometimes have to take a case to court when they have reached an impasse, ethicists (and judges themselves) seem to feel that most cases should be resolved, if possible, without going to court. Almost all the authors agreed that having a futility policy will not keep institutions out of court—or even protect them from litigation—but that a futility policy would give the physicians "a venue in which to present the facts of the medical condition and to predict the futility of the treatment...requested" (Clark), and the courts would have "a fair professional institutional policy on futility...against which to judge compliance or noncompliance" (AMA).

Finally, Robert Orr makes "a small but not insignificant" comment about terminology. He finds it distressing that several authors, including the AMA, refer to "futile care" rather than "futile treatment" or "inappropriate treatment." He points out: "Even when technology and treatment become optional, inappropriate, or even futile, the caring of the bedside professional is always appropriate, even obligatory, and never futile. That caring must be offered both to the patient and to the surrogate, no matter how antagonistic they appear or how tense the situation. Treatment may become futile, but caring does not."

~Elizabeth J. Stow

Bibliography/Further Reading


Religion & Ethics: Going Against the Grain?

The ethical principle of patient autonomy holds that a patient has the right to decide for or against a suggested course of treatment based on his or her values, preferences, and, if applicable, religious beliefs. Sometimes, though, health care practitioners will care for patients whose religious beliefs dictate treatment—or non-treatment—which significantly opposes their own sense of ethics.

A well-known example of religious beliefs conflicting with standard medical practice is when a Jehovah’s Witness refuses a blood transfusion. This refusal seems simple at first, but it becomes more problematic when the transfusion is considered absolutely necessary to save a person’s life. However, a competent adult patient has the right to refuse treatment, even if the refusal endangers his or her life.

The situation may be even more troubling for health care practitioners when a parent refuses a transfusion for a child. The ethical dilemma then involves not only religious issues, but also questions about parents’ rights to make treatment decisions for their children—rights that are substantially limited by society’s interests in the health of these children.

A second example of religious beliefs conflicting with standard medical practice arises from the taboo placed by Amish people on health care insurance. According to Monica J. McCollum, “Buying coverage is thought to show a lack of faith...also, people see it as bringing an alien element into the neighborhood.” The Amish believe that as a community they have the responsibility to see to one another’s needs, and the leaders of the community decide upon what treatments will be paid for by the community.

If a member of the community requires expensive medical treatment, the community will often raise the money to pay for that treatment. Sometimes, though, Amish communities will make the decision that a treatment will not be paid for—that it must be refused. Sometimes Amish people will, at the risk of being ostracized from their community, seek treatment on their own (e.g., borrow money from outside sources or accept Medicaid), but more often they will submit to the community’s decision—much to the frustration of the health care provider(s) who take care of them.

On the other side of this issue are patients and/or families who demand, on the basis of their religious beliefs, what the caregivers believe is inappropriate or futile treatment. The requested course of treatment may be objectionable because it will actually harm the patient, or health care practitioners may be reluctant to provide the treatment because it will not do the patient any good (i.e., it is futile).

One way of addressing demands for inappropriate treatment is to be sure the patient is clear about what his or her religion has to say about the matter at hand. Sometimes, a refusal or request for treatment is made based on a patient’s mistaken conceptions of their religion’s tenets. For example, some Catholics may believe that it’s wrong to discontinue a respirator under any circumstances.

So what do you do if a patient is unsure about his or her religious “rules,” or if a patient makes a decision based on what you are sure are misguided notions about his or her religion’s teachings?

The simplest course is to talk to your hospital’s chaplain. Pastoral care persons are trained ecumenically (across a wide array of faiths), and while they may not be experts on every religion you encounter, they are likely to have resources and contacts they can utilize to answer any questions you might have. In some cases, such as with persons who hold Catholic, Protestant, or Jewish faith, you might ask the patient if he or she would like you to arrange a meeting with their priest, minister, or rabbi.

~Elizabeth J. Stow

Bibliography/Further Reading


To learn more about the Jehovah’s Witnesses’ views on health care, you can visit their website, specifically the section on Health and Medicine, at http://www.jwmedia.org/medical/.
Singing the Blues?

We all have bad days. Days when the sun shines too brightly in our grouchy morning eyes, when the girl at the coffee shop greets us with annoying perkiness; days when we wish we could just crawl into bed, watch TV, and eat junk food. In our trend-conscious society, we often label ourselves on these days as depressed. "I'm just so depressed" have become buzzwords, but the truth of the matter is that most of the people who say that, aren't. In fact, despite the high usage of the term, only 9.5%, 18.8 million, of Americans are indeed diagnosed as depressed in any given year.¹

Healthcare providers have an ethical obligation to their patients to recognize and diagnose the symptoms of depression and to determine when patients need treatment for depression and when they are just having a bad day.

Is it Really Depression?

According to the National Institute of Mental Health (NIHM), depression is distinguished from bad days because it is not a passing mood that will go away on its own. Depression is often regarded as a sign of weakness or personal fault, but it is a medical condition that requires treatment. NIHM has released symptoms and diagnostic guidelines that may help to determine if a patient is depressed or just having a bad day. Healthcare professionals should make sure that they are aware of and informed of the symptoms of depression so that they can recognize it in patients. Examples of these symptoms are: feelings of hopelessness and guilt, insomnia, fatigue, and loss of interest in things previously enjoyed.

When diagnosing someone with depression, it is important to realize that when a person is clinically depressed, this may interfere with their ability to make informed decisions. Formally assessing a patient's decision-making capacity then, while not necessary in ALL cases, is recommended when depression is severe. While society may put stereotypes on persons who are depressed, it is important to remember that depression in all its various forms can strike anyone. However, the elderly are most often misdiagnosed, or undiagnosed completely. According to NIHM, it is a common mistake to think that depression is a normal side effect of aging—this is not true. NIHM and the National Alliance for the Mentally Ill (NAMI) maintain that depression in the elderly is not a side effect of aging, illness, or medication, but a medical condition, just as it is in younger people.² Yet, the elderly, their families, and healthcare workers often confuse the symptoms of illness and age with depression. Elderly with depression have slightly different symptoms from younger people. These include irritability, loss of memory, confusion, and social withdrawal. It is crucial to determine when these are simply effects of illness or age, and when they signal depression. Over 80% of the elderly with depression can be successfully treated. Healthcare professionals have an obligation to their patients to realize that depression can strike anyone, regardless of age or sex, and should be treated as such.

It's Just One of Those Days

When it is determined that a patient is not clinically depressed, but "merely" having bad days compassionate care can greatly enhance their life. Unfortunately, in today's fast-moving healthcare environment, providers cannot devote large amounts of time to patients; yet, this does not mean that providers cannot take certain steps to improve those days when their patients feel blue.

Suggestions to Brighten Your Patient's Day

1. Bring in a radio. Music can be an incredibly soothing source of relaxation. If a patient seems particularly down one day, ask their favorite type of music, bring in a radio and let them hum their blues away.

2. Bring crossword puzzles, magazines, and cards, if the patient is able. Stay for a quick game if you can.

3. Ask patients what their favorite book is and order it from a library nearby or at the hospital. If patients do not read, then perhaps some cassette tapes or even flowers will help! A special surprise of something familiar may only take you five minutes but can brighten a patient's mood for a long time.

4. Talk. Even ten minutes of genuine conversation that has nothing to do with a patient's illness or care, but makes them feel connected to the outside world can improve a patient's mood. How about those Steelers?

- Jessica L. DiFrancesco


The Importance of Advising Patients on Advance Care Planning

The Strawberry Case

When John Davidson, Sr., had a stroke, it devastated the family of this once active man. The stroke left his left side paralyzed, his heart so damaged it supported only minimal body functions, and his kidneys in failure. After much debate, Mr. Davidson's wife and his two sons, Peter and John, agreed a DNR order. John in particular felt that his father would not want his life prolonged under such conditions.

Mr. Davidson was soon moved to a nursing home and while there was given antibiotics by the physician. John protested vehemently until the physician explained to him that the antibiotics in no way violated the DNR order. Shortly after this incident, Mrs. Davidson was feeding her husband lunch. When she turned away briefly, she looked back to find Mr. Davidson choking on a strawberry. She called for help, and a nurse performed the Heimlich maneuver, dislodging the strawberry. John was furious because he believed that the DNR order was not adhered to and filed a complaint with the nursing home.

Case Analysis: Was the DNR Order Violated?

One of the problems in cases such as these is that patients and surrogates often do not fully understand medical terms. Neither the antibiotics nor the Heimlich maneuver violated the DNR order. According to DNR: Guidelines for Practice, a DNR order is “specific to cardiopulmonary resuscitation and does not imply that any other procedures or treatments be withheld or withdrawn. A DNR order does not mean do not treat. It means do not provide CPR if the patient stops breathing or the patient’s heart stops beating.”

DNR orders also function on various levels that sometimes patients and surrogates do not understand. For example, if a patient with a DNR order is in cardiac arrest, resuscitation is going against the DNR order. But, if someone with a DNR order chokes, clearing the obstruction does not violate the DNR order.

Advance Care Planning

Understandably, patients are often unsure of what to do to plan for the end-of-life. Advance care planning is daunting and it is not often talked about. This makes taking appropriate preventive steps all the more difficult.

Advance care planning is something that should be done by people of all ages, not only the elderly, and it includes things such as advance directives and designating a surrogate. While some healthcare professionals, may not be able to counsel their patients on advance care planning prior to an illness or accident, others can and should. And even those who do not see patients until they are ill can make a difference by educating a patient on how to proceed from where they are—it’s never too late. Not only does advance care planning ensure that the healthcare professional, family and the patient are all on the “same page,” it provides guidelines that can prevent the sort of conflicts the Davidson family experienced.

The first step for many people is signing a living will, determining who will have power of attorney, or both. This can be done by anyone who is over the age of 18, a high school graduate, or married. A living will is a document that specifically states what treatment the person wants and does not want should that person be unable to make the choice. Living wills ensure that several parties know what the patient wants so that physicians can provide appropriate and legal care. In Pennsylvania, living wills are only invoked when the patient is terminally ill or permanently unconscious and should be designed to make sure patients receive the type of end-of-life care they desire.

Persons may also designate agents with control of durable power of attorney. These agents have the power to make choices for the patient if they are unable to make the choice themselves. Agents should be people the patient trusts to make the choice most in sync with the patient’s desires. However, patients do not need to be terminally ill or permanently unconscious for Durable Power of Attorney to apply.

Advance care planning can be difficult and unsettling for some patients, but it is crucial to advise patients to pursue them. Good advance care planning can make a stressful time less so for all parties involved. -Jessica L. DiFrancesco

Bibliography

The “Strawberry Case” is included in one of four Teaching Guides in Ethics and Long-term Care.

Information about Advance Directives is from “Pocket Reference Guides” (a set of three) produced by the CEP. Designed to fit into lab coat pockets, these concise guides, as well as the Long-term Care books can be ordered for your hospital by contacting the CEP.