

# CASE 17

## Regional Memorial's Institutional Ethics Committee: Work To Do

"And learn to play the game fair, no self-deception, no shrinking from the truth; mercy and consideration for the other man, but none for yourself, upon whom you have to keep an incessant watch."

**Sir William Osler**  
*Physician and Educator (1849–1919)*

### Prologue

Mr. Blackwell decided to consult the Institutional Ethics Committee (IEC) of Regional Memorial Hospital. Blackwell was the CEO of this large, public health facility that had over 900 beds and serviced a countywide population of over 1.2 million. His concerns centered around several cases that plagued his medical and administrative staffs for months. The questions just did not go away. The cases of Baby Boy-X and Annie O. were not typical, and neither were the free baby formula case and the vendor ethics case, but they all raised ethical issues that were troublesome, fairly common, and not easily managed.

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This case was written by John M. Lincourt, The University of North Carolina at Charlotte. The first two situations come from *Ethics Without a Net, a Case Workbook in Bioethics* by John M. Lincourt (Dubuque, IA: Kendall/Hunt Publishing Company, 1991). Reproduction of the cases is by permission of the publisher. The prologue, background sections, and latter two cases were written especially for *Strategic Management of Health Care Organizations*, 5th edn. Used with permission from John Lincourt.

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Even with a combined expenditure of over \$0.5 million, questions about the nature, duration, and efficacy of care provided remained in the cases of Baby Boy-X and Annie O. As CEO, Blackwell sought the advice of the hospital's IEC on the appropriateness of the care given and special help on what would constitute a fair level of care in these medical cases.

Because of perceived conflicts of interest in the other two cases, Blackwell sought the advice of the hospital's IEC on the fair course of action. In his book, W. H. Shaw explained the problems associated with the free baby formula and the vendor ethics clearly when he wrote that "a conflict of interest arises when employees at any level have a private interest in a transaction substantial enough that it does or reasonably might affect their independent judgment."<sup>1</sup> Patients had the right and hospitals had the responsibility to expect those who made decisions to be as free as possible from conflicts of interest.

**Background**

R. E. Cranford and A. E. Doudera's description of hospital ethics committees was useful: "Institutional ethics committees are interdisciplinary groups within health care institutions that advise about pressing ethical problems that arise in clinical care."<sup>2</sup> IECs were founded on the primary assumption that cooperative, reasoned reflection was likely to assist decision makers to reach better conclusions. These committees provided information and education to staff and the surrounding communities about ethical questions, proposed policies related to ethically difficult issues, and reviewed patient care situations (prospectively and retrospectively) in which ethical questions were at stake. Assets provided by IECs were that: (1) they served as a locus for discussion, clarification, dialogue, and advice (not decisions); (2) they supplied protection and support for health care providers making difficult decisions; and (3) they increased awareness of and sensitivity to ethical dimensions of clinical cases.

IECs were not without their critics. Some claimed such advisory groups threatened to undermine the traditional doctor-patient relationship and imposed new and untested regulatory burdens on patients, families, physicians, and hospitals. Labeling an issue as "ethical" removed it from the category of those that were strictly medical or managerial and declared that relevant considerations were not just technical in nature. Many health care providers were unaccustomed to working in this area of ethical values, and some insisted their training and experience provided scant preparation for it. Conversely, others claimed that ethical values were woven into the very fabric of medical practice and management, thereby rendering them eminently suitable, if not the most suitable, as the basis for making such decisions. These individuals tended to view IECs as "God Squads" – that is, generally lacking in moral authority and ill-equipped to handle the ethical challenges of vexing and sometimes urgent hospital decisions. Such attitudes still persisted in some quarters.<sup>3</sup>

The operation of IECs was similar to other hospital committees, but there were some important differences. These included the interdisciplinary composition,

sliding orientation period, and varied utilization pattern. IECs tended to be large committees having between 10 and 20 members. Membership included: nurses and physicians (frequently from oncology and pediatrics); administrators, including an outside attorney; members of the clergy and social services; a citizen or two; plus an ethicist (if available). Orientation for a new committee or new members ranged from a week or two up to a full year. Typically this period was devoted to a careful review of institutional and community standards of care, and introduction to the bioethical literature (which was becoming vast), and, most importantly, practice sessions involving ethics cases. Such reviews were usually retrospective in nature and came from that institution, one of similar status, or the literature.

Committee utilization patterns varied as well. The IEC might be convened on a case requiring immediate action, the careful review of past cases that were known to include ethical misjudgment, and cases that after review were not considered to be ethical issues at all but rather some other problem or issue (legal or procedural, for instance). Finally, the Patient Self-Determination Act, passed by Congress as part of the Omnibus Reconciliation Act of 1990 (effective December 1, 1991), helped to legitimize IECs and to socialize them more completely into hospital medical practice.

Increasingly, the arenas of business ethics and biomedical ethics intersected in important ways. No longer was the assertion heard that health care was not a business but rather a profession that somehow stood above the adversarial and competitive features of typical business practices. Hospitals were businesses and health care was an industry. In fact, the business aspects of health care were now the object of much discussion, concern, debate, and study.

## The Case of Baby Boy-X

Baby Boy-X was born to a 37-year-old woman at 36 weeks' gestation. The birth was a spontaneous vaginal delivery and the patient's medical history gave no clue to the future difficulties associated with the birth of this child. The first indications of fetal risk were revealed when the Apgar scores were computed. This child had scores of 2 at one minute and 1 at five minutes. These scores were used to assess the general conditions of the neonate, by rating the child's status using the following criteria: color, pulse, respiration, reflex response, and muscle tone. A total score of 10 denoted a newborn in the best condition. Neonatal mortality rose rapidly as the total Apgar score approached 0. For example, scores of 1 and 2 predicted a 12 to 15 percent survival rate. Baby Boy-X's score was cause for serious concern for the medical staff at Regional Memorial.

The patient's clinical, physical, and social histories supported the Apgar assessment. These included:

- Deformed right leg;
- Hydrocephalus;
- Nonfunctioning GI track;

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- Irregular cessation of breathing that required a ventilator;
- Chronic anemia, requiring transfusions and nutritional supplements;
- Repeated grand mal seizures during the first two months;
- Probable blindness;
- Lowered and malformed ears;
- Severe contraction of the limbs, including fingers and toes;
- Cerebral shrinkage and degeneration caused by lack of oxygen to the brain;
- Little brain activity except during seizures; and
- Gastrostomy, colostomy, and ileostomy tubes inserted surgically for proper nutrition and excretion.

Baby Boy-X was kept in the neonatal intensive care unit (NICU) for four months. He was on a ventilator and given drugs for his seizure disorder. The consensus among the NICU personnel was the prognosis was poor, and they expected the patient to die from massive infection or following violent seizure activity. The cost at four months was \$182,265. The mother and father were separated and the family was on welfare. The father had not visited the child.

On numerous occasions, members of the medical and administrative staffs initiated discussions with the mother about her son's grim prognosis and poor quality of life. These conversations were started in the hopes she would realize the futility of all the heroic measures being employed and allow her son to die naturally and soon. Staff members stated privately that scarce and costly medical resources were being wasted. This patient would never leave the hospital alive and his life in the hospital was severely compromised and painful. Some administrators asked pointed questions about rethinking the "medical full-court press" for this patient. Resources expended here could be redirected to clients whose chances for survival and normal lifestyles were markedly better.

In the face of all these remarks, the mother remained adamant. The following text was taken from the NICU nursing notes and poignantly reflected the mother's attitude at the same time. "She [the mother] does not identify her child as a person with serious health problems. She does not understand the nature and extent of his high-risk problems plus his levels of pain and discomfort. She feels the baby is alright and she seems quite unrealistic about treatment outcomes. Because of car problems, she visits only once each week and usually for about one hour. She holds the baby briefly and combs his hair. The child's father has yet to visit the patient. She continually insists that everything medically possible should be done for her child."

**The Case of Annie O.**

This case ranged over three years, cost the taxpayers in excess of \$310,000, and could be considered "a classic worst-case scenario" in allocation. The initial encounter with the patient occurred in the emergency room of Regional Memorial Hospital. A description of some of the medical and nonmedical facts that shaped the case and led to the ethical dilemma follows.

The patient was a 41-year-old white female who was hospitalized 41 times over a period of three years. The hospitalizations ranged from 4 to 21 days, and on several occasions the patient signed herself out of the hospital against medical advice. She was a wheelchair-bound paraplegic subsequent to a gunshot wound to the spine. Her former husband was tried and convicted of the assault and was in prison. The patient's only child was placed in a foster home because the court deemed the patient "an unfit mother."

The patient presented to the emergency room with the following problems and history:

- Fever >103°F;
- Insulin dependent diabetic;
- Chronic urinary track infection;
- Recurrent depression;
- Allergies to most antibiotics;
- Recurrent vaginal infection and pelvic rash;
- Intermittent alcohol and substance abuse;
- Multiple fractures due to osteoporosis (hollowing of bones);
- Poor nutrition and overweight (5'4" and 197 pounds); and
- Deep and pitting ulcers on both buttocks caused by poor hygiene/sanitation.

The social history was relevant. The patient lived in an abandoned garage owned by a local farmer. There was no electricity or running water, and the garage had a dirt floor. Water and electricity were supplied by way of a garden hose and extension cord from the farmer's house. There were no toilet facilities. The patient was well known to the local medical community for her consistent non-compliance. Over the years, many adjectives were used by health care providers and others to describe her behavior. These included: "rude," "hostile," "obstinate," "uncooperative," "cunning," "mean," and "blatantly self-destructive." One physician described Annie as "a bitch on wheels." Although Annie had many serious medical problems, her uncooperative attitude and risky lifestyle made her case extremely difficult to manage. On her most recent admission, she spiked a fever of >103°F, had a raging urinary tract infection, and one of her ulcers had become reinfected. This combination of medical problems, though serious, was fairly typical for this patient. However, a new problem surfaced on this visit to the hospital. Annie O. was also pregnant.

## Free Baby Formula

The business–health care overlap was highlighted in the way three hospitals dealt with the issue of breast-feeding. At question was a curious phenomenon. Health professionals were virtually unanimous in the belief that breast milk was best for infants. Evidence was overwhelming that breast milk reduced a baby's susceptibility to illnesses, such as ear infections and stomach flu, and played a positive role in many other ways, such as mental and hormonal development.

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Why, then, did so many mothers who gave birth in hospitals choose synthetic baby formula? The reasons were many and varied, including opposition to breast-feeding from family and friends, lack of good information, unsympathetic work settings, and trends of custom and fashion. However, in addition, many health professionals believed hospitals undermined breast-feeding by the widespread practice of giving new mothers free formula supplied by formula manufacturers. Research indicated the practice did make a difference. One study at Boston City Hospital, cited in the *Wall Street Journal*, found that 343 low-income women, who received free formula from the hospital, breast-fed their infants for a median duration of 42 days, compared with 60 days for those who received no free formula – a difference of 30 percent. The article concluded with the observation that breast-feeding rates were not much higher than they were ten years ago.

At a joint meeting of the IECs of the three local hospitals, this issue of conflict of interest between formula manufacturers who supplied the free formula and the three hospitals was raised. At the time, all three hospitals accepted free baby formula. One breast-feeding proponent candidly described her suspicion of the close ties between hospitals and formula companies hoping to promote their product. Discussion of the issue by IEC members at this joint meeting resulted in four main options for dealing with the issue: (1) accept no free formula at all despite its availability; (2) give no free formula to those who breast-feed; (3) charge patients a nominal fee for the free formula, so families considered the cost of formula when making the breast-feeding decision; and (4) continue to issue free formula but also distribute information about the benefits of breast-feeding. The four options were not prioritized.

At Mr. Blackwell's request, the IEC of Regional Memorial Hospital was to advise him on a morally justifiable course of action relative to the hospital's free baby formula practice.

**Vendor Ethics**

Hospitals were not self-sustaining, independent entities. They depended on the goods and services provided by others. These ranged from the rare to the commonplace and included such items as radioactive material, laboratory testing, security apparatus, laundry services, waste removal, and a vast array of drugs, medicines, and surgical instruments. A current label among health care managers to describe this operation was "outsourcing." All of these goods and services were outsourced by hospitals to vendors. Conflicts of interest involving vendors occurred when the self-interest of employees of the hospital led them to carry out their duties in ways that might not be in the best interest of the patients, health care providers, or the hospital itself.

A leading cause of conflict of interest between hospitals and vendors was the perk. Promotional perks were marketing incentives provided by vendors to influence the decisions of hospital purchasing agents. So overzealous were some

of these marketing practices that the distinction between persuasion and bribery was often blurred.

Vendors offered a wide range of incentives. These included dinners and concerts, trips to resorts, tickets to sporting events, frequent flier miles, use of company planes, free drug samples, and other expensive inducements such as computers, fax machines, and cellular phones. Inexpensive gratuities such as pens, doughnuts, and tee-shirts were standard practice. Employees who defended the practice argued that because health care was an industry, it was unrealistic, if not foolish, to think standard business practices would not come into play. They rejected the argument that perks jeopardized their objectivity and independent judgment. They claimed further that if a conflict did arise, it was invariably transparent and easily managed, so as not to compromise the trust the employee held by virtue of his or her office.

Conversely, the practice of offering gratuities to employees who were responsible for vendor access and sales raised important ethical concerns for hospital administrators. They worried about the real or perceived conflict of interest between the employee working for the overall welfare of the institution and the distracting effect gifts from vendors had on such purchasing decisions. One caveat deserved mentioning. This was the mutual need to establish reliable and trustworthy relationships between hospitals and vendors. Hospitals needed to believe that goods ordered from vendors would be delivered on time, in the right way, to the appointed location, and at the agreed price; vendors needed to believe that unreasonable demands would not be made, invoices would be paid on time, and company representatives would not be abused, but treated in a professional and respectful manner.

The specific issue that Mr. Blackwell brought to the IEC was a rumor he heard and later confirmed. It involved a purchasing agent employed by the hospital. She was responsible for overseeing a fairly extensive landscaping project. The work cost over \$100,000 and took a full year to complete. One part of the project involved the purchase and installation of 24 Japanese cherry trees. These were ornamental hybrids – *Prunus serrulata* – with a minimum height of 20 ft. The going price for the trees was reported by the agent to be \$600 per tree.

On visiting the purchasing agent's home, Blackwell saw three 20-ft Japanese cherry trees in the front yard. Somewhat embarrassed by the surprise visit, the agent explained to her CEO that when the nursery learned the agent was relandscaping her property they provided the trees. "It was merely a gesture of goodwill. That's all," the agent explained. Asked if she felt the free trees influenced her choice of nursery for the hospital, she replied: "Absolutely not, I would have chosen Green Thumb Nursery even if they had not given me the trees. I decided objectively. Mr. Blackwell, I know my job and I am always impartial."

Mr. Blackwell's first thoughts were "precedent setting." He knew that his decisions regarding such matters would be the subject of much discussion by a variety of people and indeed set precedent. The purchasing agent had been an excellent employee. He referred this case to the IEC for a full, open hearing.

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At Mr. Blackwell's request, the IEC of Regional Memorial Hospital was to meet to advise him on a morally justifiable course of action relative to the hospital's free baby formula practice and handling of the employee who received "free" trees as well as to offer advice on what to do about Baby Boy-X and Annie O. It would be a full agenda.

**NOTES**

1. W. H. Shaw, *Business Ethics* (Belmont, CA: Wadsworth Publishing Co., 1991), p. 258.
2. R. E. Cranford and A. E. Doudera, "The Emergence of Institutional Ethics Committees," *Proceeding of the American Society of Law and Medicine* (April 1983), p. 13.
3. M. Siegler, "Ethics Committees: Decision by Bureaucracy," *Hastings Center Report* 16 (June/July 1986), pp. 3, 22.