GROUNDING ETHICS IN THE PROFESSIONAL CODE

A health professional confronting an ethical problem that poses a significant difficulty may want to turn to the professional code of ethics to determine what it says regarding the issue at stake. Often the professional code will provide insight based on years of collective experience of the members of the professional group.

Sometimes the apparent answer from the code seems so appropriate that no further consideration is necessary. But in other cases it may not be obvious

to the individual health professional that the profession's collective wisdom is morally definitive. One problem arises because the professional group's code can change over the years. The AMA code, for example, was originally adopted in 1847 and published a year later,[4] but it has been revised many times since then. Major changes occurred in 1903, 1912, 1947, and 1957, and then dramatic changes were adopted in 1980 and published the following year.[5] Some of the differences are substantial. The early versions, for example, said nothing about informed consent. Their understanding of confidentiality was radically different from that of the most recent versions. Changes are reflected not only in the norms for right conduct, but also in the character traits that the codes hold out as praiseworthy. In the most recent principles, a physician is, according to the AMA, supposed to provide medical service with compassion and respect for human dignity; in 1847 the traits of character for the physician were tenderness, steadiness, condescension, and authority.[6] Similar changes have occurred in the codes of the other professions. The American Pharmaceutical Association's code was first written in 1852[7] but was revised in 1922[8] and again in 1952[9] and 1969. Modest changes were made in 1975, 1981, and 1985.[10] Finally, in 1994 a completely revised code was adopted.[11] Each time the code changed, did the ethically correct behavior for pharmacists really change or was it only what the APhA members believed was the correct behavior?

What about health professionals who are not members of their professional associations or who immigrate to the United States from other countries that may have codes that differ? Does this professional code determine what is ethically correct for those who are not members or only for those who are members? Can what is ethically correct for health professionals change, depending on whether they are members of their professional association? And what about health professionals in other nations? Does the American professional code or does their own professional organization's code determine what is right for these persons? It seems odd that what is right could depend on the country in which they practice and when they practice. The following case asks what the role of a professional code should be in determining what is ethically correct conduct.

CASE 3-1

Withholding Nutrition: The AMA, the Government, and the Church in Disagreement

Infant Jimmy McCarthy was born at thirty-four weeks gestation at a rural hospital. The obstetrician, Dr. Herman Nolan, immediately recognized gross abnormalities. The child was determined to have trisomy 21 (Down syndrome), partial duodenal atresia, monosomy 18, liver pathology (which was possibly transient and reversible), and a cardiac septal defect (which was potentially surgically correctable, but could require several operations). He was immediately transferred to St. Luke's

Catholic hospital, a tertiary care hospital in a major city with a high-level neonatal care department capable of caring for the most severely impaired newborns.

When the infant arrived at St. Luke's, an immediate assessment was made by a complex care team. The surgeon considered operation on the duodenal atresia too risky on a premature infant that small. He recommended IV and nasogastric feeding for at least four weeks, waiting to see if the child grew sufficiently to make a surgical procedure possible. He also recommended an immediate consult with a pediatric cardiac surgeon.

The geneticist had never seen convergence of trisomy 21 and monosomy 18 in one infant and could find none in the literature. The trisomy 21 without the other complications could lead to many years of life, if the anatomical problems were corrected. It would leave the child with some undetermined degree of mental retardation.

The monosomy 18 was much rarer. Isolated cases of years of survival were reported in the literature, but it inevitably would involve severe retardation and institutionalization. The best judgment was that the child would be permanently bedridden with severe physical and mental impairment.

The care team believed that the medical problems presented in this combination were synergistic. No one would necessarily be fatal, but combined they all believed the child will not live more than weeks or a few years at best. He would be in discomfort from repeated operations and cardiac complications. On the basis of this prognosis, the care team identified three options. One alternative was "full court press" including correction of the atresia as soon as it was feasible, as well as eventual cardiac procedures necessary to correct the septal defect. A second option was intravenous nutrition and hydration for a period to see if the infant survived long enough for the operation to be performed. The third alternative was immediate cessation of all interventions to sustain life—including omission of the nasogastric feeding, even though it would mean the rapid decline and death of the infant. The team decided to recommend temporary intravenous nutrition and hydration feeding to see if the infant thrived so that the duodenal atresia could be corrected. They also recommended a do-not-attempt-resuscitation (DNAR) order in the interim. Although combining a DNAR order with a plan for eventual surgical intervention was unusual, in this case they believed that, if the infant suffered a cardiac or respiratory arrest before an operation could be performed, it would foretell severe problems for the child.

The care team knew that this was a complex and potentially controversial case. It occurred at a time when the Baby Doe controversies were at their peak. In order to assess the options further, the St. Luke's Ethics Committee was convened. The parents were asked to attend the meeting. The mother was distraught, but she understood the situation. She was quiet and turned to her husband when the chairman asked any questions of them. The father, dressed in a business suit, was a teacher in a local high school.

After exploring the options, the father spoke saying he and his wife were deeply committed Catholics, and they believed there was a message from God here. The committee members feared that the father would demand maximal life support, an option they considered inhumane to a child that was likely to die soon, regardless of medical treatment.

The father began by saying that all life is precious no matter what the intelligence. He said, "Jimmy has been a blessing to us. God will provide." He added that he had consulted with experts at the National Institutes of Health (NIH), a lawyer specializing in treatment decisions for critically ill infants, and their parish priest. He then shocked them by saying, "God's place for Jimmy is in heaven." He wanted all treatment including intravenous nutrition and hydration stopped. He claimed that any suffering in the short term from withholding nutrition and hydration would be more than offset by being spared the pain and suffering of many operations and hospitalizations. He added that the parish priest said that a treatment is morally expendable when it involves grave burden. He was sure that any of the treatments, even the intravenous nutrition feeding, would eventually lead to terrible suffering. The inevitable result of the feeding was, according to the father, at least two major operations, which, if successful, would lead to possible further operations, possible liver failure, residual cardiac problems, and a short life bedridden in a hospital with severe mental and physical impairments.

At least one priest on the hospital's ethics committee confirmed that the church's position was that life support could be forgone if it presented grave burden, if the burdens exceeded the expected benefits. He stressed that the church's position was generally pro-life, but the Vatican had acknowledged that in extraordinary circumstances, treatments could be omitted.

The surgeon was troubled by this. He stressed that the traditional duty of the physician was to preserve life. He was particularly concerned about withholding or withdrawing medically supplied nutrition. He cited the current American Medical Association position:

> Unless it is clearly established that the patient is terminally ill or irreversibly comatose, a physician should not be deterred from appropriately aggressive treatment of a patient.[12]

The surgeon pointed out that Jimmy McCarthy was clearly not irreversibly comatose and that he was not really terminally ill either. He felt morally obliged to continue providing nutrition and hydration.

The hospital ethics committee knew that it was legally obligated to follow federal regulations called the Baby Doe Rule. This required that life support be provided unless a baby was inevitably dying regardless of treatment, irreversibly comatose, or the treatment was virtually futile in prolonging life and inhumane. The members all agreed that Jimmy McCarthy was not comatose and was not inevitably dying regardless of treatment. Some members thought that he could fall into the category of patients for whom treatment was "virtually futile" in prolonging life and also inhumane. They recognized that the burden of the future treatments would be great, possibly sufficient to call the treatment "inhumane." They were divided, however, over whether they could claim that the treatments would be virtually futile in preserving life. Furthermore, the regulations state that, even if the proposed treatment falls under one of the three exceptions, it is still necessary to provide what the regulations called "appropriate treatment."

The committee was left with a dilemma. The regulations seemed to require providing the nutrition and hydration against the parents' wishes and the surgeon was convinced that the AMA Code also required providing them. Nevertheless, the

parents were refusing to consent and the priest on this Catholic hospital's committee held that such treatments were morally expendable according to the teachings of the authorities that sponsored the hospital.

COMMENTARY

The substantive issues of the ethics of withholding medically supplied nutrition and hydration from a patient will be discussed in Chapters 9 and 15 when we examine the ethics of terminal care and of surrogate decision-making. The focus here is on what the parties of this case—the parents, the surgeon, the priest, and the members of the ethics committee—should rely on as their source of moral norms.

Those involved in this decision have several options: a professional code, a hospital ethics committee consensus, government regulations, church teachings, and individual conscience. The surgeon appears to place authority in the position of his professional association.

The problem raised here is whether the professional association code is necessarily always the definitive authority for determining what is ethical for physicians or other health professionals. It seems to make sense to consult the code in difficult cases, but is that because the code *defines* what is right for the health professional or is it because the code simply summarizes the judgment of the health professional's colleagues who have faced somewhat similar situations?

It could be that what is the right behavior for a health professional is whatever the code says. If the code literally defines what is ethical for members of the profession, then it is logically impossible for it to be wrong. Moreover, whenever the code is changed, then what is right for the health professional changes.

In this case, the AMA had during the 1980s adopted a position that held that patients should be treated with aggressive life support. The 1986 code held that the preference of the patient should prevail if the patient were terminally ill, but that if the patient is neither terminally ill nor irreversibly comatose then "appropriately aggressive treatment" should be provided. Apparently, at this point in the evolution of AMA thinking on these matters, the patient's refusal of life support would not govern the physician's choice if the patient were not terminal or comatose. By 1994 the AMA's position had changed substantially. At that time it held:

Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interest analysis.[13]

This remains the current AMA position. The problem is whether the surgeon in this case needs to feel bound by his professional association's position and, if so, why. The implication seems to be that the foundation for ethics

within the practice of medicine is the consensus of the professional association or, alternatively, that the professional association is in the best position to know what is ethically required in the practice of medicine. If the professional association is authoritative because what is ethical is simply whatever the group agrees is morally required, then some puzzles are created. This would seem to imply that there is no deeper, more fundamental basis for ethical judgment than group consensus. Moreover, there would seem to be no reason why different professional groups could not reach different judgments or that the same group could not change what is right and wrong from time to time. In this case, the surgeon would seem locked in to the view that withholding nutrition and hydration for a baby who was not terminally ill was unacceptable in the 1980s, but became acceptable in 1994. Thus, even if one ignores the perspective of the patient and family (and the related informed consent requirements), ambiguity exists within the professional codes.

The reliance on a consensus expressed in a professional code also poses serious problems for members of other health professions and for medical lay people. Other members of the health care team—nurses, social workers, pharmacists, and allied health professionals—all are members of professional associations that have written codes of ethics for their professions. If what is ethical is determined by the consensus of the professional group, different members of the health care team might be faced with conflicting ethical requirements if their professional association reached a different consensus.

One of the criteria for a norm to be a matter of ethics (rather than mere personal or social preference) is that the norm has its foundation in some ultimate standard—divine authority or reason, for example (depending on whether one's ethics is theologically or secularly grounded). Mere consensus of a professional group does not meet this standard. It could be that those, like this surgeon, who turn to a professional code have a somewhat different view. They may hold that ethical requirements for practice of the profession are not based merely on professional consensus, but that the professional group is the most authoritative in knowing the moral norms for practices within the profession. This poses problems as well, however. It implies that being a member of the profession gives one special knowledge in the area of ethics. This is a controversial position, however. If one's ethics is theological, it implies that becoming a member of a health profession gives one special authority in knowing the divine will or divine law—an odd position to say the least. If, on the other hand, one's ethics is secular, it implies that becoming a member of a health profession gives one special authority in knowing the moral laws of nature or what reason requires in health professional settings. No doubt, being a member of a profession gives one some kinds of expertise—knowledge of medical science, for example, but it is hard to imagine why it would give one expertise in knowing what morality requires, in knowing, for example, whether it is acceptable to forgo nutrition and hydration in a conscious, but critically ill baby like Jimmy McCarthy. There must be some alternative foundation for ethics.

One alternative is that the foundation for ethics in health care is something more basic than the current professional agreement or professional knowledge. For example, for those standing in a religious tradition, what is ethically right and wrong might be determined by the approval or will of the deity. For some secular thinkers what is right is determined by reason, by the moral laws of nature, or by other fundamental standards. The idea is that the standard for ethics is the most ultimate appeal one can make, the point beyond which no further appeal is possible.

Some people have given up hope of recognizing the will of a deity, the moral laws of nature, or what reason requires. They may be convinced that the standard of ethics is a societal one. In that view, an act is right if one's society says it is. In the case of Jimmy McCarthy that might suggest that the current government regulations express a moral consensus of the society—that life support can only be forgone if the infant is terminally ill or permanently unconscious or if the treatment would be inhumane and simultaneously virtually futile. Even in these situations, if we follow the federal Baby Doe regulations, appropriate nutrition and hydration must be provided.

If the moral foundation is a societal consensus, this leaves open the possibility that for other people in other societies some other behavior would be ethical (because in their society some other behavior is approved).

This raises the question of whether ethics is seen as being grounded in some foundation beyond either professional or societal agreement. Both the parish priest and the priest on the ethics committee in Jimmy McCarthy's case seem to believe that ethics is a matter of divine authority and that some complex combination of scripture, tradition, hierarchical authority, and religious revelation provide the standard for moral judgment. They have reached the surprising conclusion that morality accepts the forgoing of life support in cases such as this one, provided the treatment would result in a disproportionately grave burden for the patient. In this conclusion, they are consistent with important teachings of their tradition. The Vatican in 1980 summarized a long tradition within Catholic moral theology that opposes all intentional active euthanasia, but accepts forgoing life support on what is referred to as proportionality grounds.[14] While there is a strong commitment within that tradition to providing nutrition and hydration when these offer net benefit, even those within that tradition, who are quite conservative on matters of medical ethics, acknowledge that there are special cases in which continuing nutrition and hydration offer grave burden with very little benefit.[15] It appears that was the conclusion reached by the priests and the parents in this case. It is an odd set of circumstances in which the AMA and the federal government both were insisting on continued treatment while the church that informed the parents' views as well as those of the hospital would be more permissive. Only by determining the relative importance of the professional code, the government's stance, and the teachings of the church will we know what is ethical in this case. Even then we may be left with the possibility that what is ethical may not be legal.