Community Ethics is the official newsletter of the Consortium Ethics Program (CEP), the ethics resource-sharing network of Western Pennsylvania. The newsletter presents information on current events and issues in medical ethics and also includes experiential knowledge from CEP members. This issue is noteworthy along each of these lines.

The Spring ethics season is upon us and you may wish to mark your calendars for upcoming CEP activities and other local programs listed in the "Upcoming Events" section. We also call your attention to the "Ethics Roundtable" where three prominent members of the Consortium share their experience in organizing, running, or revitalizing an ethics committee. We're sure that their ideas will strike a chord with many of our readers.

The "Truly Useful Literature" feature also reviews four articles dealing with various aspects of managing and evaluating ethics committees and clinical ethics services.

I would also like to tell you about some features in our upcoming editions and encourage you to contribute your insights. In the next couple of issues, we will discuss writing and reviewing ethics policies (such as those on forgoing life-sustaining treatment), preparing for the ethics portion of a JCAHO review, and the role of nursing ethics committees. If any of these topics strike close to home, I encourage you to consider sharing your experiences and thoughts in writing with our readers. Furthermore, we recognize that issues of national significance are important to our readers. One topic that is both controversial and timely is the recent Oregon referendum on physician-assisted suicide. In the next Community Ethics, we will have some thoughts on this law by one of the nation's leading legal experts on end-of-life decisions, Alan Meisel, J.D.

--Mark Kuczewski, Ph.D.
Editor, Community Ethics

The Consortium Ethics Program (CEP) is taking applications for 2 new three-year modules: one to begin in September 1995, the other in September 1996. The CEP is a continuing ethics education program and resource network of the Hospital Council of Western Pennsylvania and the Center for Medical Ethics. The CEP, a genuinely collaborative and cooperative endeavor that cuts across all lines of institutional affiliation, is a cost-effective way for local hospitals and health care institutions to meet their ethics needs. This is accomplished in several ways.

The CEP provides in-depth education in medical ethics to two representatives of each member institution. Annual retreats and monthly seminars help to make these health care professionals into ethics resource persons for their colleagues. The Consortium also brings ethics education and support directly to the health care facility. CEP faculty conduct on-site staff and community education programs to meet the needs of each particular hospital. Furthermore, the representatives of the CEP-member institutions form professional relationships that facilitate the sharing of experience regarding ethical issues. Thus, the CEP is the "ethics network" of Western Pennsylvania.

The experience we have gained in the first five years of the Consortium suggests that a number of additional goals need to be addressed in the coming years. For instance, we hope further to assist neighboring health care facilities collaboratively to address ethical issues that arise in the transfer of patients along the continuum of care. Furthermore, many member institutions have accreditation concerns related to medical ethics, e.g., JCAHO requirements. The CEP faculty is devising materials to help our members systematically address these matters.

The Consortium Ethics Program currently has 28 member institutions. The new three-year modules will accept 12 - 28 additional institutions. Acute care hospitals, nursing homes, rehabilitation centers, and similar health care facilities are encouraged to consider the benefits that membership in the CEP would bring to their institutions. For the first time, the network will also make available a limited number of individual memberships to professionals who wish to join. A prospectus detailing membership in the CEP is available by phoning (412) 624-3481.
Hold These Dates!

Sixth Annual CEP Retreat at Hidden Valley

Ethics Retreat VI of the Consortium Ethics Program will be held at Hidden Valley Resort on September 29, 30, and October 1, 1995. All current members and prospective members of the Consortium Ethics Program should mark their calendars. The Retreat sets the tone for the year's classes as topics are introduced that will be covered in depth at each of the seminars. Once again, local faculty will be joined by several nationally-recognized bioethicists to discuss theoretical and practical issues in medical ethics.

This year's retreat will be an unprecedented opportunity for networking among hospital representatives as it is "two retreats in one." The representatives of the current 28 member institutions will be joined by those from new member health care facilities. A series of sessions on core topics in medical ethics will be held for the new representatives concurrent with advanced classes for the returning members. Some sessions that will bring the groups together for discussion are planned.

"Ethics In Long-Term Care" Workshop

Physicians, nurses, social workers and administrators who work in long-term care should mark their calendars for April 7, 1995. The day-long workshop "Ethics in Long-Term Care" will be held at the Sheraton Warrendale. The conference will provide a basic introduction to ethical issues in long-term care and give an overview of relevant legal and ethical frameworks to address these issues. The topics to be covered will include legal and ethical principles of end-of-life decision making and issues pertaining to patient transfer and guardianship.

This one-day program is designed for health care professionals and administrators of nursing home facilities but is also ideal for professionals from acute care hospitals who frequently must address ethical issues in collaboration with nursing home representatives. The program is accredited for 4.5 Category 1 CME credits. Nursing home administrator and nursing continuing education credits will also be provided.

This event is sponsored by the Consortium Ethics Program with the help of a wide variety of groups including the Ethics Task Force of the Hospital Council of Western Pennsylvania, the University of Pittsburgh Center for Medical Ethics, the Health Policy Institute of the University of Pittsburgh, the HCWP Committee on Aging, the Southwestern Pennsylvania Partnership for Aging, Hospital Shared Services, and the University of Pittsburgh Center for Continuing Education in the Health Sciences. Registration is $75.00 and includes lunch and refreshments. We include a detachable registration form at the end of this newsletter.

Program highlights include:

Morning Plenary Sessions
"Ethics & Long-Term Care"
Charles W. Pruitt, Jr.
President & CEO
Presbyterian Senior Care System
President, Southwestern PA Partnership On Aging

"Patient Autonomy and End-of-Life Decision Making"
Alan Meisel, J.D.
Professor of Law & Psychiatry
Dir., Center for Medical Ethics
University of Pittsburgh

Keynote Address:
"Communicating Patient Preferences about Life-Sustaining Treatment in the Out-of-Hospital Setting: The Medical Treatment Cover Sheet"
Patrick Dunn, M.D.
Assistant Professor of Medicine
Oregon Health Sciences University
Chairman, Health Ethics Network of Oregon

Afternoon Breakout Sessions
(1) "A Medical-Legal Framework for Guardianship"
Todd Marion, Ph.D. Gary Gushard, Esquire
Director, Geriatric Services Tucker, Arensberg, P.C.
St. Francis Medical Center

(2) "Legal Issues in Aging"
Alan Steinberg, J.D.
Horty, Springer & Mattern, P.C.

(3) "Talking About Death"
Robert Arnold, M.D.
Assoc. Professor of Medicine
Director of Clinical Training
Center for Medical Ethics
University of Pittsburgh
A common concern among health care institutions is the forming and running of an ethics committee. Although most health care facilities wish to have a committee or forum to discuss and address ethical matters, it is difficult to know where to begin and how to proceed. Sometimes, committees run well for an extended period and then lapse into dormancy. Then, revitalization must be undertaken. Once again, "how to" questions arise. Below, three ethics committee officers share their experience. We're sure these descriptions will provide useful ideas for many other institutions.

"Formation and Evolution of the Ethics Committee at The Washington Hospital"

by Colleen Allison, MS; Vice President, Support Services & Risk Management, The Washington Hospital

In April 1985 an Ethics Committee for The Washington Hospital was constituted at the request of the Administration and Medical Staff because of medical-legal concerns. The committee was to consist of six members: a physician, a nurse, an administrator, a clergyman, a social worker, and a community representative. The goals were (1) to provide counsel and support to patients and families, physicians, and other health professionals, (2) to make ethical or social policy for the care of seriously ill and dying patients at the hospital and, (3) to determine educational needs of personnel involved in patient care. The committee was to be an administrative committee and to meet bi-annually. The committee structure was revised in 1987 to add additional physicians. However, the committee as it was constituted never held a single meeting.

In 1991, several Board members expressed their desire to activate the Ethics Committee. In speaking with their colleagues at other institutions, they believed that the Ethics Committee could serve a vital purpose for the organization. To aid the re-activation, in 1992, The Washington Hospital explored joining the Consortium vs. retaining a consultant. The Consortium model appealed to many of the physicians and Board members because of its emphasis on educating multiple disciplines within the hospital, and the support that could be shared among member institutions.

In 1993 the hospital officially joined the Consortium and chose a physician and me to attend the CEP classes. After the first year of participation in the Consortium, the original ethics committee charter was pulled from the archives and reviewed. At that time, the membership and the focus of the committee were changed. Members were recruited who expressed interest in ethical issues. Presently the committee consists of the hospital's CEO, the Vice President of Patient Care Services, the Vice President of Support Services and Risk Management (me), the Director of Social Services, six physicians including the Chairman of the Medical Staff Executive Committee, the past President of the Medical Staff, the physician who serves as one of the hospital’s CEP representatives (Mark Trombetta, M.D.), and four nurses from Administrative Nursing, Post Anesthesia Care, Oncology, and OB. The hospital was also fortunate to recruit a community representative, a pastor who was the former chaplain at Allegheny General Hospital and who had experience with their program. The Ethics Committee's charter was revised to make the primary focus that of education of the hospital staff. Case consultation may be appropriate for the future.

The Ethics Committee met for the first time on September 12, 1994. The Committee was asked to propose a format for committee education and a lecture series for all interested members of the Hospital family with presenters supplied by the Consortium Ethics Program. Committee members felt strongly that they should partake in several educational sessions prior to the lecture series being started. Members decided to meet every other month for these educational sessions and thereafter, to meet quarterly. They selected topics for their own education and also for the lecture series, which would be rolled into the medical staff CME series.

The Ethics Committee met again in October and received basic written material about Ethics Committees and current issues of interest. In November 1994 and January 1995, Mark Kuczewski, Ph.D., presented talks and led case discussion on methods of ethical decision making and on informal determinations of patient decision making capacity, i.e., competence. Four lecture series programs are scheduled for 1995, with speakers from the Consortium. For the committee’s meeting in April, case discussions will be held utilizing the Ethics Casebook for Community Hospitals. The Committee members will also discuss whether they have specific needs for additional self-education programs.

To date the Committee has received substantial support from the hospital’s Board and Administration and has benefited from its participation in the Consortium Ethics Program.
Greene County Memorial Hospital (GCMH) was experiencing internal communication problems between management and professional staff. Through contract negotiation in 1991, brainstorming sessions were set up between these two entities within the hospital. One of the committees that was formed after prioritization of the difficulties we were experiencing was the RBO Ethics Committee. RBO stood for "relationships by objective." At first, this committee was enthusiastic about formulating goals and objectives that we set out to accomplish. Before meeting attendance dwindled and the committee dissolved from lack of interest, we made a recommendation to administration that the hospital develop a formalized way to address ethical dilemmas experienced within our facility. Administration took this recommendation into consideration and saw that this suggestion coincided with JCAHO requirements to have a way to address conflicts surrounding patient rights and ethical issues.

It was approximately at this time that we received correspondence from the Consortium Ethics Program (CEP). When the management at GCMH investigated what the CEP had to offer, it was decided that membership in this Consortium would provide what we needed. I, as Nurse Manager of the Special Care Unit, noticed ethical issues almost daily in my practice. Therefore, I quickly agreed to participate. We felt that we needed a physician to accept responsibility as co-representative to the Consortium. This physician would be a member of the Ethics Committee, which would help to give it weight within our organization. A physician, Martha Nofzger, M.D., graciously accepted the position after several unsuccessful recruitment attempts. Although interest was widespread among the medical staff, time was the problematic factor mentioned when physicians declined to accept responsibility. Coming from a small rural hospital, time was equal to office hours of a private practice. There was no one to respond to the needs of their clients when they were not available. Not to mention the revenue that would be forfeited if they canceled office hours.

Initial contact with the Consortium consisted of Rosa Lynn Pinkus, CEP Director, and Mark Kuczewski, Associate Director, conducting a site visit to help determine how the Consortium could help us meet our needs. We held a luncheon at our facility so they could meet some of our staff, but more importantly, so they could answer any questions the staff at our hospital may have had. This was very successful as representatives from medical staff, nursing staff, social services, community and patient relations, administration, medical records, nutritional services, and home health attended. This rejuvenated the spark of interest in ethical issues at our facility.

From this meeting the GCMH's two representatives attended the annual retreat sponsored by the ethics consortium and monthly meetings at Warrendale to begin the educational process. Topics of these programs revolved around basic areas of bioethics — just what we needed to provide us with a firm knowledge base of ethical theory, principles, and practice. By January 1994, we had formed an Ethics Committee at Greene County Memorial Hospital. The Consortium played a key role in helping to initiate this committee. CEP faculty occasionally attended our committee meetings to observe our progress, offer expert advice in the topic chosen for education, or provide suggestions for growth as needed. The goal of this committee in its beginning phase was to provide education to the committee members, staff, and community. The representatives of GCMH that attended the Consortium meetings relayed the information received at CEP programs to our ethics committee in order to get all committee members on the same wavelength. In-service programs were offered to employees of GCMH on topics of current interest within our facility. A community program on advance directives and end-of-life decisions was organized and a representative from the Consortium presented the information to those in attendance. The Consortium also played a key role in providing a Continuing Medical Education lecture to the medical staff. They not only arranged for a qualified speaker, but they also provided continuing education credits for attending this lecture.

We are now in the second year of our membership with the Consortium Ethics Program. In this year, our plan seems to be focused heavily on preparation for an upcoming JCAHO review scheduled for September of 1995. The Ethics Committee has broken up into subcommittees for intense and rapid policy review, revision, and formulation. Membership in the Consortium has provided a great way to network for actual policies and/or procedures relating to ethical issues. Also, faculty at the Consortium have readily provided advice and assistance in meeting JCAHO requirements as outlined in the chapter, "Patient rights and organizational ethics."

During our third year of Consortium membership, we plan to implement a structured process to solve ethical issues within our facility. I'm positive that the collaborative experience we've had as CEP members will play a vital role in assisting with implementation of the process.
"The Birth and Journey of The Unontown Hospital Ethics Committee"

by Rebecca Ambrosini, R.N., M.S.N., Vice President, Nursing, The Unontown Hospital

In 1991, the medical and nursing leadership of The Unontown Hospital established an Ethics Task Force, largely to implement the Patient Self-Determination Act and to deal with the increasingly difficult cases on withholding life support. Therefore, the charge of the group was to develop and implement guidelines, policies, or procedures on current ethical issues. The membership of the task force was made up of appointed medical staff and administrative department heads. Since written guidelines, policies, or procedures did not exist on such ethical issues as organ donation, do-not-resuscitate orders, and advance directives, the task force members found both an opportunity and a challenge. The opportunity came from the simple fact that there were no printed policies. This meant the team could create current guidelines from research, networking, and creativity instead of tinkering with outdated documents. The challenge came after the research and writing were completed and the medical staff approval process began. The task force had failed to recognize that since there were no written guidelines, each practitioner developed his/her own framework for dealing with ethical dilemmas. Instead of one guideline to enhance or update, there were several—all of which were unwritten and generally unknown to all but the individual practitioner.

As the new policies and procedures were presented to the medical staff at department meetings, there was great resistance. The resistance came from a genuine concern for the well-being of the patients. The physicians and others on the healthcare team wanted to be assured the new policies would be in the best interest of the patients. Most of these healthcare practitioners were still working through their own feelings about various ethical dilemmas and were concerned about the patients’ and families’ perceptions and, of course, possible liability issues.

The task of writing guidelines, policies, and procedures as a large group did not seem reasonable, so small sub-teams were created for each ethical issue; as each sub-team completed the work, it was presented, reviewed, and approved by the large task force. Sub-team members became experts through research and networking on the assigned ethical issues. Each sub-team was also asked to develop educational and operational implementation plans in anticipation of the policies being approved. These plans included outlines, executive summaries, overheads, and a list of the most anticipated questions and answers. The sub-teams, with the support of key medical staff leaders and the senior executive staff, were also asked to provide literature and education to interested medical staff as well as to be present to answer questions as the policies and procedures flowed through the medical staff approval process.

One year after being written, and after numerous revisions, we had approved policies and procedures such as Advance Directives, Do-Not-Resuscitate, Organ Donation, and Brain Death Criteria to guide healthcare providers in the care of patients. Twenty months after the first meeting of the Ethics Task Force, the established objectives were accomplished. It was at this point that the task force members agreed to move beyond policy writing and toward the establishment of an Ethics Committee to develop a broader commitment to facilitating a more moral healthcare community.

In order to establish an Ethics Committee, medical staff leaders, senior administrative staff, and several members of the Ethics Task Force carefully reviewed the differences among the most common ethics committee structures. After careful consideration, it was the consensus of the group to establish an Administrative Ethics Committee. The structure was chosen for two main reasons. First, the group felt that an administrative committee gives a clear message that ethical concerns are both medical and administrative problems and therefore, need to be approached jointly. Second, administrative committees usually give greater acknowledgment to the equal status of all members and draw upon the unique expertise of each. Interdisciplinary collaboration and minimizing hierarchical structure is key to a successful committee.

Committee membership of one-third medical staff, one-third nursing staff, and one-third others, i.e., ethicist, attorney, social work service, pastoral, etc., was established to ensure multidisciplinary membership. The leadership of the committee was provided by a physician and an administrative representative. Committee membership was voluntary with a three-year minimum commitment required due to the time necessary for education in ethical principles and case review. Since the committee was administrative versus medical, the President of the Medical Staff agreed to have attendance of physicians at the meetings apply as fulfillment of medical staff committee participation for the credentialing process.

The most controversial membership issue was whether or not to have an attorney be a regular member. The final decision was to exclude an attorney as a member but to consult them when needed. This decision was based on the following: 1) decisions and recommendations made by the committee should be based on ethics, not law; 2) attorneys may have a difficult time separating law and ethics, and; 3) the fear of litigation is so strong that often when an attorney speaks all other discussion stops. In order to balance ethics and the organization’s litigation responsibilities, the Risk Manager was asked to become a member of the committee.

The first Unontown Hospital Ethics Committee meeting was held in May 1993. The first three meetings were dedicated to determining the committee’s purpose, objectives, meeting time and length, and a committee confidentiality statement. The purpose or goal of the committee was to establish, through an educational process, a framework for ethical decision making at the Unontown Hospital. The committee’s functions or objectives were: first, to educate the committee members and all members of the hospital and local community in medical ethics; second, to make ethics policy and procedure recommendations; and third, to provide case
review for educational purposes only. Although consultative
case review was a needed service, the committee agreed that
eighteen to twenty-four months of education should occur
before proceeding with consultation services.

In the Fall of 1993 the Ethics Committee, with support
from administration, made the decision to become a member of
the Consortium Ethics Program. Two representatives from the
Ethics Committee volunteered to participate in ethics education
for a three-year period. The primary function of the committee
is to provide education on ethical issues at every level of
healthcare and this fit perfectly with the mission of the
Consortium.

Drawing on what we were learning at the CEP
educational functions, the two hospital representatives to the
Consortium, Paul Hartley, M.D., and I, began providing
monthly education sessions on ethical principles for committee
members in February 1994. Two weeks prior to the meetings,
we distributed reading materials. These sessions started with
a didactic ten-minute summary of the principle, followed by
case review and discussion with the entire group. It was
impressive how quickly the members created an environment
in which they related well to one another as individuals,
respected opinions, and trusted the commitment to
confidentiality.

The community and patient education efforts of the
committee have been very successful and include participation
in public service radio talk shows, community sponsored ethics
panel discussions, and lectures to the hospital’s Pastoral Care
Group on advance directives, limitations in life support, and
the role of an ethics committee. Through the hospital’s Speakers
Bureau and community pastors, there have been over thirty
presentations on similar topics for local service organizations.
As the community has become more aware of advance
directives and the ethical dilemmas patients and families can
face, we have seen more interaction and questions from the
public and inpatients. The Ethics Committee developed a
packet of materials on advance directives as an educational tool
to meet requests for information. The packet comprises a
commercial publication on advance directives, a document of
questions and answers on advance directives and withholding
life support, sample directives, and the telephone number of
Social Work Services as needed for counseling. These packets
are used in conjunction with speaking engagements and are
mailed out upon request, as well as handed out and discussed
face-to-face with interested patients. The Ethics Committee, in
collaboration with the local Blind Association, also developed
and made available information about advance directives on
audio cassette to assist blind or illiterate persons.

This past Fall, the committee worked with the
Consortium Ethics Program to have The UnUn-town Hospital
serve as an educational teleconference site. This program on
ethical issues in patient transfer was attended by representatives
of local nursing homes and hospitals, in addition to members
of The Uniontown Hospital community. Over fifty people
representing the majority of local nursing homes attended. As
a result, several nursing homes expressed interest in working
with the hospital to assure a seamless continuum of care for all
patients, concentrating for now on those with advance
directives or do-not-resuscitate orders. These relationships with
the nursing homes are being pursued but we are in the very
early stages of development.

Education for the physicians, nursing, and other
hospital staff have primarily occurred in conjunction with new
or updated policy implementation. The committee found that
by taking the in-services to the nursing unit or department,
the attendance and participation was greatly increased. The
traveling in-service concept requires more time because of the
increased number of offerings required. However, the benefits
include increased attendance and increased discussion due to
small class size and the peer comfort level. To further enhance
implementation of policies such as Limitations on Life Support
and Advance Directives, the nursing education department, in
conjunction with the Ethics Committee, developed
competencies to measure registered nursing staff
comprehension. Registered nurses are required to complete
these competencies and meet the established standards on a
yearly basis. For physicians, the physicians of the Ethics
Committee have provided some educational information at the
quarterly medical staff meetings and some luncheon in-services,
complete with continuing medical education (CME) credit, also
have been offered.

The heightened awareness of ethical principles, through
education, required competencies, and new policies and
procedures, have increased the interest of many nurses, as well
as other professionals. As a result of this interest, the Ethics
Committee is now in the process of establishing ethics work
groups. The ethics work groups will be made up of five to
seven multidisciplinary healthcare workers interested in a
further understanding of ethical principles through case review
and discussion. Each group will meet for six one-hour sessions
which will be led by two Ethics Committee members. We
currently have six members who volunteered to facilitate three
groups.

Space will not allow me to explain some of the Ethics
Committee’s additional successes in detail. But allow me to
summarize:

- Review of the Organ, Tissue, and Eye Donation Policy and
Procedure led The UnUn-town Hospital to participate in the
Routine Referral Program of the Center for Organ
Donation, Recovery, and Education (CORE). This
participation contributed to the ten tissue donations made
in the last year from the Uniontown Hospital.

- Review of the Limitations in Life Support Measures
resulted in the establishment of an Operative Do Not
Resuscitate Guideline to assure that patients’ wishes are
followed in the operating room. Several revisions were
made to the form that is used to document
do-not-resuscitate orders. The original form was a
checklist of options that caused confusion for the nursing
staff. So, the form was changed to more a free text format
and, designed to encourage documentation of the
discussions between physician and patient/surrogate. A follow-up Q.A. monitoring project after these changes concluded that a marked improvement was made in clarity of orders and documentation of discussions.

- The Advance Directives Policy lacked a system for record keeping and tracking of directives after discharge or directives presented for record keeping by an individual that has not used our services to date. Such a system was implemented with the collaboration of Medical Records and the Emergency Department, and has made possible the timely recovery of advance directives information.

- The committee has been asked by the medical staff or administration to review and make appropriate recommendations on the following policies and procedures: Physical Restraints, Fall Prevention Program, Pre-Hospital Limitations in Life Support, Confidentiality Policies, and Computer Access Security. Furthermore, an Ethical Concern Referral Policy has been developed.

- The committee is currently developing such policies as: Informed Consent and Decision Making Capacity, Death and Dying Care, and Pain Management.

- The Ethics Committee, with the help of the Consortium Ethics Program, is seeking to become engaged in consultative case review. We are currently assessing the most effective way to proceed to meet the needs of our healthcare community.

In conclusion, the journey for the committee has been exciting, challenging, and at times, even fun. This positive aura has been largely due to the caring, committed, and morally accountable individuals that have worked together as a cohesive group over the past two years.

Truly Useful Literature

by Alan Joyce, Editorial Assistant


Slomka suggests that although many healthcare ethics committees (HECs) are primarily consultative bodies, the educational function of the HEC should not be overlooked. A mechanism for education of staff and patients is, of course, mandated by the JCAHO; but it is also desirable because it provides "a common language and shared meanings" for discussion of issues in caregiving. Slomka details the Cleveland Clinic Foundation's "bottom-up" approach to ethics education, which involves self-education of the HEC, followed by educational programs in the institution and in the community.

Committee self-education is accomplished through (1) a standard three-session orientation for all new HEC members; (2) discussion of ethical issues or cases at each meeting; and (3) following current issues in bioethics journals and newsletters. Working from this base, the Department of Bioethics (the administrative arm of the HEC which is responsible for education) teaches others in the institution via monthly Ethics Grand Rounds and teaching rounds in the intensive care units. The Education Subcommittee of the HEC also provides monthly bioethics information sheets for hospital staff and has organized day-long Continuing Education courses. Slomka also notes efforts to add ethics components to regularly scheduled case discussions for clinicians and medical chief residents, and eventually to add case discussions to unit conferences for nurses and other health care workers.

Slomka closes by pointing out the need to provide the public with a sound, unbiased view of bioethical issues in everyday health care. The CCF's approach began with community education on advance directives, presented at a series of monthly public talks. To provide this service most effectively, though, HEC members must continually educate themselves and periodically evaluate the education process.


This article evaluates an ethics education program that differs slightly from the one depicted in Slomka's article. In 1990, the ethics committee at Saint Thomas Hospital in Nashville brought in two ethicists from Vanderbilt University to develop a six-month pilot clinical ethics program in the hospital. The program was based on: (1) staff education, in the form of in-service workshops, unit rounds discussions, ethics conferences with residents, and bi-monthly ethics grand rounds; (2) provision of an ethics consultation service; and (3) participation, by the ethicists, in HEC policy discussion and development.

The most valuable part of this article, however, may be the detailed description of the evaluation process that was applied to this six-month trial period. Results of a pre-program survey were compared to results of a post-program survey to identify changes in nurses' and physicians' views of bioethical dilemmas, the consultation process, and the role
and value of clinical ethicists in the hospital. Evaluation of individual case consultations was also performed shortly after each consult was completed. The evaluation indicated that the clinical ethics program, and the ethicists themselves, were mostly thought of as beneficial in case consultation and resolution of ethical dilemmas; it also helped to identify areas in which further education and revision of consultation mechanisms was needed. This evaluation model could easily be applied to other institutions' ethics programs with similarly useful results.


In this paper, the authors discuss an evaluation of the Cleveland Clinic Foundation’s formal HEC consultation process. A task force solicited information from family members, physicians, nurses, and other health care workers who were involved in 16 cases that had gone before the ethics committee. Surveys (samples of which are included in the article) were developed to determine individuals’ impressions of many aspects of the case consultation they had been involved in, including: the purpose of and their role in the consultation, the environment in which the consultation was conducted, the appropriateness of others’ participation, and the final HEC opinion. Some conclusions were that more of the "caregivers who know that patient best" (i.e. outside referring physician, representative from social work or pastoral care, etc.) need to be included in the consultation process; and that a different process needs to be created to communicate the HEC’s recommendations to family and caregivers alike. It was also determined that evaluation of the consultation process needs to be performed in a more timely manner (the consultations examined here took place over a seven-year period, and many participants could not remember details of the case).


Silverman’s article presents the University of Maryland Medical System’s (UMMS) response to the "failure to thrive syndrome" common to many ethics committees. He begins by discussing structural changes in the HEC itself, such as increasing the frequency of meetings, changing committee leadership to reflect a more multidisciplinary approach to ethics, and formation of subcommittees to handle each major HEC function. Changes accomplished by the consultation subcommittee are described in detail, including development of a specific protocol for case consultation -- which provides for education of those less skilled at the process, and for inclusion of more appropriate individuals in each consultation. Matters of access, anonymity, and documentation are also discussed. Silverman also describes the efforts of the policy subcommittee and, to a greater extent, the education subcommittee, which developed and distributed surveys to determine staff interest in education and evaluations for each session presented. Samples of these forms are included in the article, along with questionnaires and evaluations for ethics committee members, consultation forms, and ethics committee evaluations for family members and staff.

NOTE: Also of great value, though too lengthy and detailed to discuss here, are two publications from the American Hospital Association: Ross, JW et al. Handbook for Hospital Ethics Committees, 1986; and Ross, JW et al. Health Care Ethics Committees: The next generation, 1993. These books provide historical, theoretical, and practical information on all aspects of forming and running a health care ethics committee, from questions of mission and purpose to matters of liability and self-assessment.
Upcoming Events

CEP SERIES ONE CLASSES*
April 18, 1995
1:00 p.m. - 5:00 p.m.
"Religious Perspectives on Ethical Dilemmas"
DAVID KELLY, PH.D.
Professor of Theology
Duquesne University

May 16, 1995
1:00 p.m. - 5:00 p.m.
"AIDS: Disease or Moral Dilemma?"
JACK COULEHAN, M.D.
Professor of Preventive Medicine & Medicine
State University of New York at Stony Brook

June 13, 1995
8:30 a.m. - 12:00 p.m.
"Ethics Committees II: Policy, Consultation & Education"
ROSA LYNN PINKUS, PH.D.
Associate Professor of Medicine & Neurological Surgery
University of Pittsburgh

OTHER EVENTS
April 12, 1995
Auditorium 6, Scaife Hall
University of Pittsburgh
4th Annual Current Controversies in Medical Ethics Workshop
"How We Die: What Every Physician Should Know about Death"
followed by:
The Ira R. Messer Memorial Ethics Lecture
"Physician Assisted Suicide: Progress or Peril?"
Timothy Quill, M.D.

for registration information,
call Debby Andolina at (412) 647-9538

CEP SERIES TWO CLASSES*
May 16, 1995
8:30 a.m. - 12:00 p.m.
"AIDS & Confidentiality"
JACK COULEHAN, M.D.
Professor of Preventive Medicine & Medicine
State University of New York at Stony Brook

June 13, 1995
1:00 p.m. - 5:00 p.m.
"End-of-Life Decisions"
MARYANNE FELLO, R.N., M.E.D.
Assistant Executive Director
Forbes Hospice
&
CHERYL FLINT-BUTCH, R.N.
Chief Nurse, Home Care Division
Forbes Hospice

* All CEP classes are held at the Education Center of the Hospital Council of Western Pennsylvania, Warrrendale, PA.

The University of Pittsburgh
ETHICS FOR LUNCH
ALL SESSIONS TAKE PLACE IN AUDITORIUM 5, SCAIFE HALL: NOON - 1:00 P.M.
Presentations begin promptly at noon.

April 13, 1995
Newborns' Mothers and the Ethics of Screening for HIV
Ronald Bayer, Ph.D.
Professor of Public Health
Columbia University

May 4, 1995
National Health Care Policy Making: Oxymoron or Just Plain Moronic?
Mark A. Peterson, Ph.D.
Associate Professor of Public and International Affairs
University of Pittsburgh

The Center for Continuing Education in the Health Sciences, University of Pittsburgh, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The Center for Continuing Education in the Health Sciences designates this continuing medical education activity for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association. Nurses and other health care professionals are awarded 0.1 continuing education units (CEUs).