Community Ethics

In This Issue:
Theory and Practice: Brain-Death, Nursing Ethics

Mark Kuczewski, Ph.D., Editor

Community Ethics prides itself on trying to bridge the gaps between the theory and the clinical practice of medical ethics and between the academic bioethicist and the community healthcare provider. In this vein, we consider some problems involving brain-death. While brain-death gained a legal consensus relatively quickly, its philosophical puzzles and practical application in the clinic have remained problematic since its inception. For some, the concept of brain-death and the accompanying practices such as organ-donation have been counted among the “settled” issues in medical ethics. Nevertheless, the philosophical and practical debates remained in the background.

This issue of Community Ethics focuses on problems related to brain-death posed within clinical practice. What are clinicians’ obligations and options when a patient’s family refuses to accept the diagnosis of brain-death? Clinicians are placed in a position where they must educate the families and loved ones of patients at the same time that they are breaking bad news to them. Lance Stell contributes some reflections on an innovative institutional policy from the Carolinas Medical Center. This policy highlights ways to facilitate the educational process of the patient’s loved ones. But, there will always be those who do not accept “consensus” even when this process is optimized. Patrick McCruden and Jon Merz comment on one such case and Alan Joyce suggests some further reading on this topic in “Truly Useful Literature.”

Benjamin Phillips also presents some tips for nurses who wish to be effective participants on hospital ethics committees. This kind of supportive advice should prove of value to those who wish to transcend the ethos of their particular healthcare profession and to join the multidisciplinary dialogue within their institution.

As always, I encourage your help to keep these important discussions going. Far more could be said about each of these topics and we’d be happy to print an original article or letter from you.

CEP & YSU Sponsor
Spring 1998 SHHV Meeting

Mark your calendars for April 17 & 18, 1998, when the Consortium Ethics Program will team with the Dale Ethics Center of Youngstown State University to conduct the conference "Whose Ethics? Which Medicine? The Tacit and Explicit Development of a Medical Ethic," under the auspices of the Society for Health and Human Values. This meeting will examine the assumption that there is a single field of bioethics and medical humanities that shares principles, a vocabulary, and methods. In order to see if this is the case, clinicians, social scientists, and scholars from the humanities will team up to examine the development of clinical ethics in a variety of specialties and subspecialties. The conference will provide a forum for those engaged in these reflective assessments to examine the ways in which various approaches to bioethics determine our conception of medicine and its ethical issues. Why have some voices emerged louder than others? Is a “new” common voice achievable? These and other themes will be explored. Community Ethics will carry additional information on the conference as plans take shape -- stay tuned.

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Death is an inherently complicated topic. Its metaphysics are one thing ("What makes it true that a formerly living person has become dead?"); its epistemology is another ("By what criteria can we know that a person has died?"); and bedside tests to diagnose it are yet another ("Is auscultation of the chest and holding a mirror close to the nostrils sufficient to reach a diagnosis?"). Not surprisingly, social, religious and personal understandings of death can vary considerably. Definitions range from spiritual to secular. There may be disagreement about when the occurrence of death can be reliably determined and by what methods. Philosophically, we can understand why Nancy Cruzan's father believed that her personal life ended the night of her accident. Yet we may recoil at the suggestion that a successfully resuscitated but neurologically devastated individual whose vital functions are artificially supported should be delivered to the undertaker. The possibility for further biographical elaboration about her may be gone, but it is not otiose to wonder how someone who shows "signs of life" can be said to be dead. Should the social protection of human life be circumscribed by a philosophical theory of personhood? Or should it extend to vegetative bodies of former persons? Or should it extend to vegetative bodies that are biologically human irrespective of whether they have ever supported "personal life?" If a human body requires artificial support for respiration, heartbeat, blood pressure and metabolism, at what point does it cease to be "vegetative" and become dead?

The complexity of the subject and divergent understandings regarding death notwithstanding, the state has an interest in uniform criteria for death. It gives physicians a legally privileged status in diagnosing and pronouncing death. For example, state statutes typically provide that the determination of death shall be made by a physician licensed to practice medicine, applying ordinary and accepted standards of medical practice. When medicine acquired the ability to sustain the vital functions of neurologically devastated individuals (some of whom might be considered candidates for organ donation), it became practically important to clarify what standards medicine should use in determining whether and when a person has died.

In 1968, the ad hoc committee of the Harvard Medical School published a path-breaking paper in which it attempted to resolve the issue. The Committee did not intend novelty. On the contrary, it used the idea of "brain-death" to emphasize that, except for heartbeat, all of the traditional bedside criteria for diagnosing death (namely, general unresponsiveness, pupillary non-reactivity and apnea) directly implicated brain functions and that heartbeat, because of its dependence on breathing, implicated brain function indirectly. Thus it recommended that a person who has suffered irreversible loss of function of the whole brain, including the stem, should be considered legally dead.

All states have since modified their statutes to provide that "brain-death," when diagnosed according to accepted medical standards, may be used as a sole basis for determining that a person has died. An individual who has been given this diagnosis is a corpse, not a patient. If it is ever appropriate for a physician to order treatment stopped unilaterally on grounds of futility, irrespective what families or roving strangers may wish, this is it. Surely we can (and should) draw a "bright line" at "treating" the dead. Or, so it can be argued.

Despite the intent to underscore the neurological basis of traditional criteria for death, the term "brain-death" has itself exacerbated confusion. To many laypersons (and to some medical professionals too, unfortunately), "brain-death" suggests that there is more than one kind of death ("brain-death" and "cardio-respiratory death"), or that there is more than one way to be dead (in a brain-sort-of-way and in a heart-sort-of-way), or that there are degrees of being dead ("brain-dead" and "really dead" or "dead-dead"), or that one might die more than once (first, when one's brain dies and again later when one's heart stops).

Recently, I consulted on a case in which an ICU patient's attending physician, an experienced nephrologist, said the following to her family: "I am sorry to tell you that your daughter is "brain-dead." I will keep her on life-support at least until you decide what you want to do." Not surprisingly, the patient's father asked, "What are her chances of recovery, doctor?"

Needless misunderstanding had complicated a tragedy. Since the patient had been diagnosed "dead" by medically accepted neurological criteria, it was no longer appropriate to refer to the medical equipment attached to her as "life support." Nor should the attending physician have offered dialysis. After several hours, the confusion was resolved. All interventions were withdrawn. The patient was pronounced dead (when her heart stopped!).

This experience prompted me to investigate what guidance the hospital's policy might have offered in the circun-
stances. In pertinent part, it provided that “the attending physician has the right to decide that extraordinary means are not to be employed or are to be removed in those instances where the patient has sustained brain-death.” Seemingly, the policy would have provided clear direction where the attending had waffled. Not so! In North Carolina law, “extraordinary means” are defined as “any procedure or intervention which in the judgment of the attending physician would serve only to postpone artificially the moment of death...” A patient who has been diagnosed “dead” by medically accepted neurological criteria is dead by law, really dead. Her death has occurred and can no longer be “postponed artificially.”

Apparently, the drafters of hospital policy noticed this problem. They attempted to resolve it in the “definitions section” of the policy by re-defining “extraordinary means” as follows:

“Extraordinary means is defined as any medical procedure or intervention which in the judgment of the attending physician would serve only to artificially postpone the moment of respiratory and circulatory death by sustaining, restoring or supplanting a vital function.”

This innovation traded what would have been a contradiction (referring to “death postponing” interventions in connection with a person who has been diagnosed “dead”) for a dubious “two ways to be dead” theory. This theory invites the unfortunate thought that a patient who has already suffered one sort of death (“brain-death”), should be spared the second sort (“respiratory and circulatory death”) as long as possible.

What should be done? It is naive to suppose that all confusions and disagreements about death can be resolved by education and more precise language. Nevertheless, our language concerning death could use some “cleaning and pressing.” Thus I propose that hospitals consider eliminating “brain-death” from their policies. In its place, I suggest “Determination of death by neurological criteria.” This language invites a more accurate way of thinking, namely, that death is one condition (not many, nor admitting of degrees), that irreversible cessation of total brain function is a sufficient condition for death, and that medically accepted neurological criteria may be used to diagnose it.

This suggestion cannot prevent families and loved ones from denying the diagnosis. And in their defense, we must acknowledge how puzzling it is that an individual who shows “signs of life” (albeit, artificially supported) can nevertheless be dead. Thus we should avoid heavy-handed, precipitous orders to stop treatment when such circumstances present themselves.

When our hospital policy was rewritten, (now entitled “Determination of death by neurological criteria”), the following language was included:

By applying ordinary and accepted standards of medical practice, a physician member of the medical staff may use neurological criteria as the sole basis for determining that a person has died. The validity of neurological criteria for determining death shall not preclude the use of other medically recognized criteria for determining whether and when a person has died. When a physician member of the medical staff has pronounced a patient dead, he or she may order all treatment stopped. Nevertheless, the physician should recognize that “disclosing the death of a patient to the patient’s family is a duty which goes to the very heart of the physician-patient relationship. The emotional needs of the family and the integrity of the physician-patient relationship must at all times be given foremost consideration.” The timing of the order to stop treatment of a patient pronounced dead on the basis of neurological criteria should reflect the physician’s judgment how best to respect these values.

It doesn’t take an especially keen mind to spot difficulties with this policy. Those inclined to accept the “two-ways-to-be-dead” theory may feel validated by the acknowledgment that there is more than one way to diagnose death. Similarly, by emphasizing the physician’s discretion in timing the order to stop treatment, the policy does not forestall families from insisting that they be permitted to take their dead, loved one home “on life support.” On the other hand, the policy itself is no longer inherently confused. It can now provide a useful focus for clearer, more respectful thinking about the diagnosis of death.

NOTES


(See next page for the Carolinas Medical Center policy on the physician’s obligations in the event of a diagnosis of "death by neurological criteria")
CASE PRESENTATION:

BRAIN-DEATH
AND THE OPTIMISTIC FAMILY

Mr. H. was a 23 year old man admitted through the emergency department post respiratory arrest. He had been at home, sleeping on the sofa, when his wife noted that he had not been breathing for several minutes. His wife attempted to revive him and began CPR. By the time EMT's arrived, Mr. H. had spontaneous but weak respirations and good pulses, but was unconscious.

The patient was transported to the ICU on ventilator support. Upon admission, it was thought the patient had suffered a stroke and also seemed to suffer from some sort of cardiac myopathy. Over the next forty-eight hours his condition deteriorated. After three days, neurological evaluations resulted in a determination of brain-death utilizing several diagnostic tests: EEG, Brain Flow Scan, and Physical exam with apnea test.

The surviving H. family consisted of the patient's wife, father, and two siblings. The family had come to this country from Pakistan a decade prior. They would not accept the diagnosis of brain-death but this position seemed to be premised upon a "common sense" approach rather than religion or any special world-view. They had once had a family member in a drug induced coma, who had subsequently recovered after a prolonged period of unconsciousness, and the family continued to compare this situation with their past experience.

The attending physician was willing to give the family time to adjust/accept the diagnosis. The patient was highly unstable and was requiring large doses of epinephrine and levophed. The family reported that they believed the patient was responding to them (via changes in pulse rate on the monitor). A second neurologist was consulted to confirm the brain-death diagnosis. This neurologist happened to be fluent in the family's native tongue (although they spoke English quite well). He concurred in the diagnosis of brain-death. The H. family refused to accept the validity of the diagnosis, i.e. that the patient would not recover.

The original neurologist ordered another EEG with the family present. The EEG technologist explained the test and results in detail. Pages were copied from a textbook showing electrocerebral silence on an EEG. The family continued, to deny the brain-death determination. The consulting neurologist requested a third consulting opinion from yet another independent neurologist. This was carried out, with the same determination. The H. family was unimpressed by the parade of experts. They felt the doctors and the hospital were attempting to kill the patient due to his lack of medical insurance.

Two days after the initial determination of brain-death, the attending physician and consulting neurologist requested ethics committee consultation. The hospital's ethics committee met the following morning and noted that three competent
案例评论#1：当病人无法好转时

由Patrick J. McCruden, M.T.S., 院长牧师护理
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“不只她真的死了，她真的很诚恳地死了”
（Munchkin Coronet in the Wizard of Oz, after examining the Wicked Witch of the East）

当病人完全一样为真正死了？当然不！从开始的以时间死亡已被符号化于
心的停止和呼吸性。也许从
一个法律观点看脑死 = 真正死了，但从
一个精神/心理的观察点看却有很大的不同。
它将不会超过的几个声明或法律
决定，而不是近几十年来改变人们对
的观念。脑死，在我的看法，是
一种正常和健康的
判断，已经被广泛地接受在
医疗社区。

我接受并支持这个判断。大多数人接受这个判断而且需要将器官捐赠或“同
意”于停止支持。但是，在多数情况下，
脑死亡的判断是不接受。为什么？他
可能对医学界而言，可以是一个宗教
信念的“经典”定义死亡，但在多数情况下，我
认为是纯粹和简单的denial that their loved one will not get better。注意这个案
例家人作的并不
在于一些精神的死亡或需要一种科
学地了解关于死亡和脑死的
关系。在这种情况下，对于许多其他人来说，他们需要重振士气来好于更
好。当然，一个准确的和确认的脑死亡的判断是足够的知道，这个家庭的希望
是无效，无论是不是脑死是死亡的简化。

正如Georgetown的“信仰”：自主，包容性，非男性角色和公义是熟悉的，那些
伦理学家，所以这个“死亡”和“脑死亡”的判断，是首要的和 foremost a normal and health response to tragic loss。当情绪的痛苦是如此大
的，我们的精神无法忍受它，我们的第一反应是拒绝。

那些对继续要求的照顾。说到拒绝，它
并不是说，它不会说，它应当不接受或调整于他们的损失，他们
是“助长”更大的拒绝，通过寻求更多的
咨询，重复诊断测试，所有这些行动，将要促进家庭的
拒绝。这个家庭的过去的经验与一个苏醒
从一个昏迷是相似的足以是最终的慰籍
于他们的拒绝。

应该让医生和医院尊重这个家庭的
拒绝，他们的爱的人不会让他们更好地？当然他们应该尊重这个家庭的
相当正常和适当的感觉，但是，他们不应该感到，这尊重意味着接受于
于继续要求的照顾。说拒绝是正常的
和基本上主要是不接受，是不能告诉，它应当是
被人工地促进。这种家庭正在试图避免自然是
不可避免的。作为医生有可能是，他们
并不帮助他们接受、接受或调整于他们的损失，他们
是“助长”更大的拒绝，通过寻求更多的
测试，更多的咨询。

在脑死亡的情况下，它应当是明确的，一次
于那一次的确认的诊断已经被确定
于普通的法律和或医院政策，即“生命”支持
措施将要被中断。停止的停止
应当是被加上所有的同情和理解于
的家庭需要保持和现实的死亡的时间。
这种停止应当尽可能被测量于几小时和
数天。
的“同意”停止治疗
拒绝不应寻求。推荐的
于伦理委员会和医院的
行动在案例
前我们似乎相当的适当的但可能是有延迟。
一个清楚的政策在这类和特别的沟通
于家庭可能会帮助避免重复的这
个情况。
Case Commentary #2:
How Much Do We Do
and For Whom Do We Do It?

by Jon Merz, J.D., Assistant Professor of Bioethics,
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How much needs be done, in light of clear and unequivocal medical agreement about brain-death and the inappropriateness of continued “treatment”, when faced with a dissenting family? This begs the question: done for whom? Clearly, there is nothing to be done medically for the deceased — he’s dead. But what about the family? They have substantial interests that can and should be addressed by the healthcare providers. The facts of this case at least raise the question of whether the process followed here adequately addressed those interests.

The physicians took numerous steps to honor the family’s wishes and sensibilities, securing three diagnoses (all of which agreed), having the consultants try to explain the medical facts to the family, presenting the case to the hospital ethics committee, and giving the family 24 hours to locate a facility that would accept transfer of the decedent or seek a court order preventing extubation. But at the end, by calling the police and hospital security (which is prudent for staff safety), the medical team expected (and got) a potentially violent confrontation with the family. This was traumatic for both the bereaved family as well as for the hospital staff, and could be dangerous as well. Possible publication about the incident — if the family contacts their local representatives or the press — could damage the institution’s reputation and the public’s respect and trust.

The family may sue, of course. If they do not have the resources to pay a lawyer, then they may only sue if they find an attorney willing to take this case on contingency. This is not likely, although a lawyer could press a claim for outrage and infliction of emotional distress, and liability would turn on the reasonableness of the acts taken by the providers, details of which are beyond the scope of the case.

Despite medical agreement, the family may have different cultural values and beliefs, a distrust of the physicians and their motives, and disbelief of diagnostic and prognostic information that is inconsistent with their beliefs, experiences, and current observations. They confuse brain-death with coma, from which a relative recovered. The family has been given mixed signals that undoubtedly contribute to their disbelief and mistrust. Their loved one’s heart is beating as demonstrated by the heart monitor, and they’ve misinterpreted cardiac instability to show responsiveness. The fact that the deceased did not suffer a traumatic injury possibly adds to this, because he looks fine. This all occurred within about 6 days of admission, during which time the family had obviously not come to terms with the medical situation, much less the death of their son, husband, brother. Perhaps no time would be enough.

They have also been told that they are free to seek a court order to prevent extubation, or to locate a facility that will accept transfer. This raises expectations that the law may provide relief from what the family views to be the imminent killing of their loved one, and suggests that there may be adequate medical uncertainty about the decedent’s prognosis that some other doctors at another hospital would agree to continue “treatment”.

In reality, there were no such options. Regarding transfer, given that the decedent was brain-dead and that the accepted medical standard of care was not to continue ventilatory support, transfer was not an option at all. The decedent’s lack of insurance ensured this. Regarding judicial relief, 24 hours is generally enough time for those versed with the legal system to secure a court order, given the resources and an attorney willing to take the case and a factual and legal basis on which a court could enjoin the planned action. As one would expect, the law provides some general directions but does not completely resolve the difficult position the hospital finds itself in.

The young man here was dead, and providers must turn over the body of a deceased person to the family. In Stratchan v. John F. Kennedy Mem. Hosp., 109 N.J. 523, 538 A.2d 346 (1988), a New Jersey hospital kept a young brain-dead man sustained on machines for 3 days after the family said to extubate, during which time the hospital staff attempted to convince the family to donate the decedent’s organs. Because the providers failed to give the family the body after the family expressed its wish, the hospital was liable for damages to the family.

If brain-death is death, then is there a concomitant obligation of physicians to extubate the body and yield it up to the family? The law provides little direction when the family in effect refuses to take the body and demands continued “treatment”. This may reflect continued ambivalence about brain-death as a universal standard, and the underlying value judgment regarding the definition of death. Nonetheless, this case is at once similar to and yet importantly different from In re Baby “K”, 16 F.3d 590 (4th Cir. 1994). Baby K was anencephalic, and was intubated at birth because of breathing difficulty. After diagnosing Baby K’s condition, her physicians recommended nutrition and hydration be provided, but that the child not receive any resuscitative efforts. The mother objected, demanding that the child be intubated when she had difficulty breathing. The child was transferred to a nursing home, and subsequently was readmitted to the hospital for ventilatory support on 2 occasions. The hospital, joined by the father, sought a court order that it bore no continuing obligation to provide treatment that was outside the accepted standard of care for anencephalics. The court held the hospital had a duty under the Emergency Medical Treatment and Active Labor Act (EMTALA) to provide stabilizing care to a patient presenting in the emergency room, which the court interpreted to be the periodic stabilization of her breathing problems regardless of the underlying cause.

The Baby K case arose in part because of fundamental disagreement between the mother and the physicians about the child’s prognosis and the appropriateness of care, much as in the present case. The family does not believe that the deceased is dead, and they expect recovery. But this case is materially different, in that the patient has died, medically and legally. No court could reasonably impose a duty to provide “treatment” to a dead person, and EMTALA’s mandate regarding stabilizing care is inapposite. While the law does not mandate continued intubation, neither does it help the hospital decide how to ethically, caringly, treat the family.

What could have been done differently? First, it seems the
providers should clearly point out to the family that there are no options. Because of the likely unavailability of legal relief, it was misleading to give the family 24 hours to effect a change in the hospital’s plan. Dead patients are not treated, but they will provide a limited amount of time with the deceased if so wished to let the family pay their respects. A policy about the evidence needed for the death determination, required completion of a certificate of death, and a window of time for the grieving family to spend with the deceased could be written. The policy could address organ donation, which was probably not broached in this case because of the decedent’s drug use and because of the family’s hostility.

Second, an alternative to the confrontational extubation, attended by les gendarmes, must be sought. Violence, potentially resulting in arrests and injuries, is unacceptable for the family, for the staff, and for the medical institution. Perhaps more time could be permitted for mediators, clergy, or other advocates to assist the family in coming to terms with the death.

Finally, the hospital could have instituted litigation, as did the hospital in the case of Baby K. On the downside, the courts have little competence in this area and have little to contribute to the medical decision. Yet, prospective litigation about the process to be followed, perhaps overseen by a dispassionate judge, could avoid the small risk of later lawsuit by the family and minimize the real risks created by confrontation.

Truly Useful Literature: Brain-Death Dilemmas
by Alan Joyce, Managing Editor

As should be clear from Dr. Stell’s article and the case discussion in this issue of CE, the topic of brain-death is far from being a “resolved” ethical issue. We have chosen a few articles which address different aspects of this ongoing debate, and we offer them here as suggested reading for anyone interested in exploring the issue further.


The first of these articles presents the results of an informal survey of 12 neurosurgeons regarding their personal opinions about brain-death and communication with patients’ families. The results (from 1984, but still relevant in some cases today) indicated that while criteria for determining brain-death were generally well understood, the surgeons still encountered problems in making such a diagnosis. Generally, these problems seemed to spring from problems involved in families’ understanding of, and physicians’ ability to communicate, the idea of brain-death itself, and the common misperception that this type of death is not “really” death (see Dr. Stell’s article, p. 2, on the problem of implied “degrees of death”).

Parkinson, a neurosurgeon, responds with the argument that the medical profession should devote itself to effecting a change in law, rather than a change in the definition of death. He suggests that the problems discussed by the surveyed neurosurgeons—including the “agonizing semantic distortion” of explaining brain-death to families—could be avoided simply by changing the law to allow removal of organs when a patient’s brain has passed “beyond the point of no return”. This, argues Parkinson, would avoid the “semantic distortion” needed to explain to a patient’s family that their loved one is dead, though their heart is beating and they continue to receive medical treatment.

Pinkus responds in turn by noting that the examination and revision of the definition of death has not been single-handedly “invited” by the medical profession. Medicine is practiced in particular contexts—technological, cultural, and social—and the attempt to change the definition of death is part of a long and gradual process of development in all of these areas and their relationships to each other. The syndrome which we currently call brain-death, Pinkus points out, seems to have been recognized at least a century ago, but a widespread acceptance of it as a criteria for the pronouncement of death has only developed in the past twenty years. Various legal guidelines have been set down regarding brain-death, but it is a mistake to believe that any alternative approach, legal or otherwise, will entail another set of ethical dilemmas or “semantic distortions”.


Once the idea of brain-death became widely accepted, some people speculated that because we had developed a concept of brain-death, we must also be able to develop a concept of brain life. Such a concept would be a great help in solving dilemmas about such issues as fetal tissue transplantation, abortions, and human embryo research; but the authors argue that formulations of this concept are greatly flawed.

Some theorists have identified specific stages in fetal brain development as the beginning of “brain life”, and Moussa and Shannon respond to these theories with several criticisms. First, they rightly identify the fact that the drive to define and identify “brain life” grows out of the intuitive connection between the concepts of death and life. Because of their wish for linguistic and conceptual symmetry, many theorists simply assert that a concept of brain life must be definable and move quickly on to identify the moments in neuromaturation that herald the beginning of life; but that primary assertion is never really justified in scientific terms. The authors also note that “the central nervous system is among the first systems to begin and probably the last to complete development”, and none of its developmental stages

Another development on the brain-death timeline is the move towards a higher-brain rather than whole-brain definition. Veatch argues that a higher-brain-oriented definition is more in keeping with both current medical knowledge and moral conceptions of personhood.

An early consensus among neurologists acknowledged that although individual brain cells could survive the loss of integrated brain function, this isolated activity was "irrelevant" and was not sufficient cause for withholding a pronouncement of death under the whole-brain definition. A similar situation was later noted regarding the presence of small electrical charges in an otherwise dead brain, and again these charges were deemed to be unimportant in applying the whole-brain standard. Yet another exception was noted by James Bernat in 1992: although functioning "nerve cells" may survive in a brain, they may again be discounted because they do not "contribute significantly to the functioning of the organism as a whole". Veatch argues that these qualifications have already stretched the Uniform Determination of Death Act far beyond its clear insistence on loss of all brain functions. As a result, this Act is not really followed in practice, and assessments of "significant" brain activity have been left up to private citizens.

Veatch also addresses some of the criticisms that have sprung up against the higher-brain-oriented definition of death. One of the more prevalent of these is the "slippery slope" argument that once it is acceptable practice to pronounce death in individuals whose brains show detectable but "insignificant" amounts of activity, the strict criteria for brain-death will be further relaxed to recognize death in people with less severe functional deficits. Veatch points out that because the whole-brain formulation lacks a truly principled reason for its practice and accommodates the qualifications listed above, proponents of this definition are on the slippery slope anyway. In contrast, a higher-brain formulation, based on the idea that human life is present only when there is integrated bodily and mental function, avoids subjective arguments about the relative importance of minor brain functions and provides a more principled reason for drawing the line between life and death in the brain.

In regards to the difficulties inherent in reconciling the religious-philosophical beliefs reflected in each major definition of death, Veatch points to the New Jersey conscience clause that allows religious objectors to declare their desire to be subject to a heart-oriented definition of death. His belief is that a "default" higher-brain-oriented definition, containing a similar conscience clause, would go furthest towards balancing medical knowledge with social interests and personal moral beliefs.


Finally, Spike and Greenlaw's discussion addresses some of the finer points and potential complications of just such a conscience clause. In their case, the body of a brain-dead fifteen-year-old boy had been maintained on a ventilator for six months at the request of his mother, who refused to believe that he was dead and hoped for a miracle. He underwent cardiac arrest and was brought to a hospital emergency room where a pulse was restored. Tests confirmed the diagnosis of brain death, his mother demanded continued ventilator support, and he was transferred to a long-term rehabilitation facility on the grounds that continued support was an "act of compassion" towards his mother.

Normally, patients diagnosed with brain-death are so physiologically unstable that cardiopulmonary function will fail in a few days, regardless of ventilator support or other medical intervention. However, in some rare instances - such as this one - brain-dead bodies, mostly children, have been maintained in a state of "persistent brain death" for much longer periods. The applicable law in this case included a clause which provided for "reasonable accommodation" of a patient's moral or religious objection to brain-death criteria with regards to the cessation of medical interventions, but the specific nature of this accommodation was not defined. The fear of legal retribution from the mother seemed to be one of the driving forces behind the greatly extended maintenance of the boy's corpse.

The authors acknowledge the value of continuing such support and allowing families time to accept and understand a diagnosis of brain-death. However, they emphasize that any reasonable accommodation should be measured in terms of only a few days, with a clearly stated time at which all treatment will be discontinued (see the case analysis in this issue for more discussion on this topic). In instances where a family member insists on maintenance of a brain-dead body out of a belief in miracles, it is important to remember that the right to refuse treatment on religious grounds does not logically imply the right to demand futile medical treatment.
Survival on the Ethics Committee: A Nurse's Guide

by Benjamin Phillips, R.N., Ph.D., VA Medical Center, Buffalo, NY

When the kidney dialysis machine first came into service in the early 1960s, needy patients outnumbered the rare and expensive devices in discouraging numbers. Patients who got the machines lived, while those who didn’t died. That selection process, about who would get a machine and who would not, in large part marked the beginning of modern bioethics. Today, the study of bioethics has burgeoned into numerous journals and books, is canonized as a formal discipline of study in philosophy departments, and has seen the coming of age of interdisciplinary “bioethics centers” in many American universities. Moreover, bioethics courses are increasingly required for university-level degrees in nursing.

Discussion of bioethical issues has become a fact of everyday life in modern medical centers in the form of ethics committees. A typical hospital ethics committee reviews and develops institutional policy, conducts case reviews where the care of individual patients has brought ethical issues to the fore, and provides a bedside consultation service for cases whose management presents ethical dilemmas.

Not all ethics committees are equal. They differ a great deal from institution to institution both in their makeup as well as by their influence in the medical center as a whole. Some committees focus solely upon literature review, providing time for reflection away from the bedside. Other committees rank on a par with the other organized medical services which report to a Chief of Staff. Some committees have their members assigned by department heads as part of the individual member’s job, while others serve on a strictly voluntary basis as a collateral duty. Finally, some ethics committees confine membership to the traditional healthcare professions while others enroll a full cross section of the entire institution.

Nurses are playing an ever-increasing role on hospital ethics committees. This is as it should be, since nursing, an integral discipline of the multidisciplinary team, brings its own unique perspective to the ethical forum. Though we differ in backgrounds, training, positions, and relative influence within our institution, our ethics and morality, that is, our senses of right and wrong, endure across these differences. Nurses may not agree upon each and every issue, but we can usually share enough experience and appreciate enough of each other’s perspectives to contribute to a provisional decision, a moral consensus among the members of an ethics committee. But to be effective, contributing members of a committee require that we understand the ground rules and context of the normal operation of an ethics committee. I shall explore some observations, insights and suggestions arising from my experience as a member and co-chair of an ethics committee. I hope that nurses who find themselves newly assigned to an ethics committee will find these tips helpful.

Know the Committee’s Constitution

Your committee may balance its membership among physicians, nurses, social workers, and so on. Or, one discipline may dominate the committee. Clergy and legal counsel may be represented. Formally trained bioethicists are becoming more frequent on hospital ethics committees. Meetings may be entirely open for guests to appear at any time, or outsiders permitted by invitation only. Before the first meeting, review your institution’s documents regarding the committee. There you should find an official description of the committee’s role and functions. It will help you to know the duties with which your committee is charged.

Whatever the makeup of your committee, spend early meetings carefully locating the committee’s “moral center”. Let me explain. Healthcare has undergone tremendous change in recent years and it is likely that the committee represents a number of different conceptions of bioethics. Doctors’ and nurses’ experiences in healthcare delivery affect how ethical issues are framed. Some caregivers have been trained under paternalistic models that emphasize the well-being of the patient and so, tend to frame ethical issues around duties to do good. By contrast, those who received professional training when the ethical climate emphasized respect for patient autonomy are often more sensitive to issues of patient rights and informed consent. Your healthcare institution also contributes to its moral identity, i.e. whether your organization is a private-for-profit, public, charitable, research oriented, or with or without religious affiliation. All these variables affect approaches to ethical issues. The pattern they form is the committee’s “moral center”. So, ask yourself: Who seems more at home at this forum? Does the forum seem to “belong” to one profession? Doctors? Nurses? Attorneys? Do some members continually defer to others based upon the disciplines they represent? Notice attendance. Does it seem that members take the committee seriously by regular and prompt attendance, or is there frequent tardiness and absence among members?

Identify the Committee’s Approach to Business

Notice how the committee conducts business. If a prepared agenda and timely reminders are published in advance of meetings, then be prepared for some member (often the chair) to take a directive, task-oriented approach to meetings. Such a chairperson may move through items in a business-like manner which is especially useful when the committee is charged with specific tasks and deadlines. But this style of leader may also hasten or close the meeting as soon as the prepared agenda has been completed, leaving no time for open discussion. On the other hand, if there is neither an advance agenda nor reminder, then your committee may be one which always oper-

Community Ethics 4(1)
mates in informal discussion. Such a mode of discussion is well suited to literature reviews and a forum which has been called “moral space”, i.e., an unrushed, private, and supportive milieu in which to explore moral intuitions and to relay troubling experiences. Yet this style often discourages the completion of specific business.

Learn Your Committee’s Deliberative Style

Deliberative styles on ethics committees differ. Two TV shows of political commentary provide a contrast similar to that which develops among ethics committees. Public television carries both Washington Week in Review and The McLaughlin Group. The moderator on Washington Week maintains a polite demeanor as journalists report their respective political beats of the national news. At the end of each organized account of current affairs, fellow journalist-panelists politely question each other. It’s all very civil. Everyone speaks in turn; no one interrupts; all share equal time; participants are allowed to speak dispassionately. The tone is fact-finding by mutual discussion: “let us reason together”. By contrast, the McLaughlin Group moderator acts more like a sports referee. Several issues occupy the panelists for each half-hour show. Where the Washington Week panelists are quiet and orderly, the McLaughlin panelists contradict, interrupt, and jeer at each other. There is often spirited competition. Where Washington Week concentrates on agreement and consensus, McLaughlin highlights differences and conflicts. McLaughlin ties up each issue with a “yes or no”, “either or”, exit question, so that even the most boisterous sessions end up in some kind of consensus, albeit only by vote. The tone is clearly rough-and-tumble: win the debate; marginalize your opponents; “I’m right and you’re wrong”.

It is unlikely that you will find such extreme or consistent deliberative styles during meetings. Instead, most committees have a mixture of styles, and often they shift back and forth within a single meeting, depending upon the issues at stake and the personalities involved. But, if one or the other style dominates your meetings, you’ll have to learn how to play by those ground rules.

Be an Equal Player: Take an Equal Stance

Ethics and morals do not belong to one profession more than another. No one, including a professional bioethicist, owns ethics in a way the rest of us cannot. The whole idea behind a multidisciplinary ethics committee is that we need to share perspectives and sound out each other’s intuitions on difficult cases and issues. So, carefully separate professional roles from ethical experience. When the discussion is ethics per se, then insist (both to yourself and to others) that you speak as though among peers. On the other hand, value colleagues for their expertise and defer to them when their technical advice is required. This takes savvy and you may need a number of meetings to develop it. Consider this example.

Suppose your committee reviews a case where the patient’s capacity to make healthcare decisions is an issue. Suppose further that though the patient is now deceased, decision-making capacity was notoriously difficult to establish and was never settled to everyone’s satisfaction. Now, first, appropriate deference to experts for their expertise is in order. The psychiatrist- and/or neurologist-member of the committee properly describes the patient’s level of consciousness and mental status. The attorney properly defines competence in its legal sense. The bioethicist may juxtapose questions about this particular case against formal ethical constructs. But then, notice that all of this technical information does not finally settle the question: Was the treatment this patient received the right thing to do? All the expert data having been given, the perspective of caregivers at the bedside now becomes as important as the technical information.

And, at this juncture, you, the nurse, should speak with equal authority.

Make Your Presence Felt

Your job is to represent a perspective and insight unique to nursing and this requires some advance preparation on your part. Here are a few examples of how you can be effective.

In a literature review take care that the nursing perspective is represented. If an advance agenda is circulated, then review the subject literature. Find material on that subject in the nursing literature, review it carefully, and prepare a brief synopsis of it for your meeting.

A good example is the current wealth of articles on Do-Not-Resuscitate orders in the medical literature. Nurses have a unique perspective since they are usually at the bedside when a patient experiences a cardio-pulmonary arrest. Describe that perspective. Take the actual nursing article with you to the meeting if it raises crucial, pivotal, or controversial issues.

In a case review presented by a member who is not a nurse, explore nursing’s role in the case. (In our institution any caregiver can request a bedside ethics consultation, and the first call is frequently made by a nurse.) If the discussion does not evolve into a consensus, then offer to explore it further on behalf of nursing.

In policy review explain nursing’s unique problems, but avoid turning the meeting into a general gripe session about working conditions or labor-management problems. Rather, use the opportunity to explore ethical concerns specific to the care of patients by nurses. Keep focused upon the ethics of actual care and your experience in its delivery.

The famous Purple-Dot incident is a good example of the kinds of issues your committee will consider. A certain hospital once charged nurses with the duty of marking moribund patients’ records secretly. Purple dots were placed on nursing kardexes as signals that no code was to be called when the patient arrested. There were no orders in the chart and no discussion was documented with the patients whose kardexes were marked. The ethical problem is obvious. The patient’s physician made his/her own decision about care, but then its execution was, first, engineered without informed consent, and second, then had to be carried out by a nurse.

Another example is how nurses in the neonatal ICU were charged with the maintenance of anencephalic infants’ heart and respiratory functions while awaiting organ harvest for
transplant. While physicians had only to write the appropriate orders, the ethical problem beset nurses more poignantly. Nurses had to carry out the hands-on care by working noxious procedures upon those who could never benefit from enduring them.

**Roll with the Punches**

A colleague on our committee once remarked, “I can’t pull my punches”, which is boxing metaphor for “I gotta really hit”. Questioned further, this member would probably have elaborated thus: He feels compelled to communicate plainly and bluntly to avoid softening the “blow” of the truth for the sake of someone’s feelings.

The term ‘argument’ has taken on fighting connotations but it need not in the context of an ethics committee. Sometimes, getting into an argument is taking on a verbal battle: a fight, a “boxing match” with words. Some descriptions of argument encourage this understanding. We attack our opponent’s position, for example; we advance our own point of view; we marshal evidence in support of our position, and so on. Deliberative argument is different. It has more to do with the issues and information than with championing a cause. Here, we reason from premises to conclusions guided by the rules of logic. Arguments are either valid or not, sound or not; a conclusion either follows from its premises or it does not.

Be prepared for both styles of argument in your meetings. Not everyone is comfortable with confrontation, criticism, and competition. Nurses, especially, are often expected to demonstrate the opposite qualities: supportiveness, caring, nurturmg. There are widely recognized reasons for this, mostly having to do with nurses’ historical role in the hospital. Nurses were expected to automatically defer to doctors. Suffice it to say here that our traditional socialization predisposes many of us against rough-and-tumble, back-and-forth debate of the McLaughlin Group style.

Insofar as you can, try to match the deliberative style with the issue under discussion. Differences on matters of fact can generally be handled more bluntly than differing views on matters of value. For example, a dispute about the exact chain of clinical events might be appropriately debated to a definite conclusion. In one meeting three providers (a doctor and two registered nurses) witnessed a patient’s cardiac arrest and resuscitated him. Later, other doctors who attended the recovering patient after his arrival at the hospital, reasoned in the abstract that, given the diagnosis, age, and event, the patient could not possibly have arrested. Spiritual debate ensued.

In another meeting, a member struggled to articulate a troubling intuition. This nurse attempted to share misgivings at administering narcotic analgesics to patients prior to discontinuing ventilatory support. The issue was that narcotics, intended to relieve distress, did so at the expense of an earlier death. She needed time and “moral space” to work this issue through. What she got instead, however, came straight from a television courtroom scene. Other members had already resolved this difficult matter in their minds, and so they promptly turned to “defend” their position, “defeat-
Upcoming Events

The CEP is always proud of the high caliber of educators and the quality of programming that we are fortunate to be able to make available. In this spirit, we'd like to call your attention to a couple of programs that are especially noteworthy. In our advanced seminar series, March 27th is a date to remember. Our advanced participants, those hospital representatives who have been joining us for seminars for more than three years, will first attend a talk by Peter French on personal responsibility in managed care. Professor French, editor of the well-known periodical, The Journal of Social Philosophy, is a leading thinker on corporate ethics and we are looking forward to his insights in this especially relevant area. His presentation will be followed in the afternoon by Rebecca Dresser whose seminar on the women's health movement is rescheduled from November. This is sure to be a day full of provocative discussion that weaves together insights from the public and the personal levels of ethics.

Furthermore, although the weather outside is currently frightful, we are looking forward to the two conferences that have come to dominate the Spring ethics calendar in Pittsburgh. We at the CEP offices are particularly excited about the "Current Controversies in Medical Ethics" conference on April 14, 1997. This day-long event, held at the University of Pittsburgh Medical Center, will be devoted to ethical issues in managed care. Howard Brody, M.D., from the University of Michigan, will be the keynote speaker. This year's program will, for the first time, feature a series of topical break-out sessions that discuss case scenarios. This is sure to be a stimulating program. Our colleague David Kelly at Duquesne University will also be serving up a fine program on the ethics of human genetics on May 14, 1997. Details on these programs are below.

For those readers outside the western Pennsylvania/eastern Ohio region who are unable to avail themselves of the resources of the Consortium Ethics Program, we also provide information on intensive bioethics courses around the nation.

Consortium Ethics Program Classes

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<thead>
<tr>
<th>CEP Series One</th>
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<tr>
<td><strong>March 13, 1997 / 1:00 p.m. - 5:00 p.m.</strong></td>
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<tr>
<td>&quot;Spirituality, Faith Development, and Ethical Thinking&quot;</td>
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<td>Patrick McCruden M.T.S.</td>
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<td>Marian Health Center, Sioux City, Iowa</td>
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<td><strong>April 1, 1997 / 9:00 a.m. - 12:00 p.m.</strong></td>
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<td>&quot;Ethics Consultation: Policy and Practice&quot;</td>
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<tr>
<td>David Kelly, Ph.D.</td>
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<td>Professor of Theology, Duquesne University</td>
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<td><strong>May 5, 1997 / 9:00 a.m. - 12:00 p.m.</strong></td>
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<td>&quot;The Consensus on Forgoing Treatment: It's Status and Prospects&quot;</td>
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<td>Alan Maisel, J.D.</td>
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<td>Professor of Law and Psychiatry</td>
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<td>Director, Center for Medical Ethics, University of Pittsburgh</td>
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<th>CEP Series Two</th>
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<tr>
<td><strong>March 27, 1997 / 9:00 a.m. - 12:00 p.m.</strong></td>
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<tr>
<td>&quot;Issues of Personal Responsibility in Managed Care&quot;</td>
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<td>Peter French, Ph.D.</td>
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<td>Chair in Ethics</td>
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<td>Professor of Philosophy, University of South Florida</td>
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<td><strong>March 27, 1997 / 1:00 p.m. - 5:00 p.m.</strong></td>
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<tr>
<td>&quot;What Bioethics Can Learn From the Women's Health Movement&quot;</td>
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<td>Rebecca Dresser, J.D., M.S.</td>
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<td>John Deaver Drinko-Baker &amp; Hostetter Professor of Law</td>
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<td>Case Western Reserve University</td>
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<td><strong>April 8, 1997 / 9:00 a.m. - 12:00 p.m.</strong></td>
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<td>&quot;Stories, Dreams, and Visions of the Future of Medicine&quot;</td>
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<td>John Lantis, M.D.</td>
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<td>Associate Professor of Pediatrics</td>
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<td>Associate Director, Center for Clinical Medical Ethics, University of Chicago</td>
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<td><strong>May 19, 1997 / 1:00 p.m. - 5:00 p.m.</strong></td>
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<tr>
<td>&quot;The Changing Meanings of Death: From the Fear of Premature Burial to the Debate Over Brain-Death&quot;</td>
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<td>Martin Perrick, Ph.D.</td>
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<td>Professor of History</td>
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<td>University of Michigan</td>
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<td><strong>June 9, 1997 / 1:00 p.m. - 5:00 p.m.</strong></td>
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<td>&quot;Ethical Issues in Pediatric Care&quot;</td>
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<td>Joel Frader, M.D.</td>
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<td>Associate Professor, Pediatrics</td>
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<td>Associate Professor, Anesthesiology &amp; Critical Care Medicine</td>
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April 14, 1997:

**CURRENT CONTROVERSIES IN MEDICAL ETHICS: ETHICAL ISSUES IN MANAGED CARE**

Hosted by the University of Pittsburgh Medical Center. Healthcare professionals and community members welcome. The conference’s goal is to create a unique educational opportunity by facilitating communication between healthcare providers and patients. Howard Brody, M.D., will deliver the keynote address. Ethicists, lawyers, clergy, physicians, nurses, and administrators will lead the remainder of the plenary sessions and the breakout groups. The conference is supported by two local foundations, so tuition for the event is affordable, and assistance is available for non-professionals. For information, contact: Michael DeVita, M.D., Program Director at (412) 647-1705; E-mail preferred: devita@smtp.anes.upmc.edu; or Debbie Andolina, Conference Coordinator at her E-mail address: cedandol@dvs.nb.upmc.edu

May 14, 1997:

**ETHICS OF HUMAN GENETICS: CHRISTIAN, JEWISH, AND SECULAR PERSPECTIVES**

Sponsored by Duquesne University and St. Francis Medical Center. The conference will bring religious insights to bear on the implications of the human genome project for our self-understanding. For information, call Christine Sedlack, (412) 622-4210.

**National Events**

**Intensive Courses in Bioethics**: An approach to bioethics education that differs from the CEP is the short, intensive seminar program. The CEP educates two hospital representatives over a three-year period and provides on-site educational support for these representatives at their institutions. However, not every part of the country has a consortium that is able to provide these services over such an extended duration. As a result, alternatives abound. Some of the best of these provide intensive education for several days to healthcare professionals from various institutions. As a service to our readers, we provide the following list of some highly regarded intensive programs. We also include information on two intensive courses in the medical humanities. These courses differ from the others in that they are not introductions to medical ethics. Rather, they presume a basic comfort level with medical ethics and/or humanistic perspectives on healthcare.

June 7-12, 1997:

**CONTEMPORARY CHALLENGES IN HEALTHCARE ETHICS**

Intensive Bioethics Course from The Kennedy Institute of Ethics at Georgetown University, Washington, D.C. Topics to be explored include: methods of ethical decision-making; beneficence, caring and the good; autonomy; and respect and integrity. For more information, contact: The Kennedy Institute of Ethics, Box 571212, Georgetown University, Washington, D.C. 20057-1212. Phone 202-687-6771; Fax: 202-687-8089; E-mail: KICOURSE@gunet.georgetown.edu; http://guweb.georgetown.edu/kennedy/

June 22-26, 1997:

**MIDWEST INTENSIVE BIOETHICS COURSE (MIBC)**

Sheraton Metrodome, Minneapolis, MN. A joint project of the Bioethics Centers of the University of Minnesota, University of Wisconsin, and the Medical College of Wisconsin, the MIBC provides a unique opportunity to gain a deepened understanding of current issues in bioethics and various methods of approaching them. Nationally and internationally recognized faculty include: Mila Aroskar, R.N., Ed.D.; Dianne Bartels, R.N., M.A.; Muriel Bebeau, Ph.D.; Alan Buchanan, Ph.D.; Alta Charo, J.D.; Ronald Cranford, M.D.; Patricia Crisham, Ph.D., R.N.; Arthur Derse, M.D., J.D.; Kathy Faber-Langendoen, M.D.; Jeffrey Kahn, Ph.D., M.P.H.; Rosalie Kane, D.S.W.; David Mayo, Ph.D.; Steven Miles, M.D.; Robyn Shapiro, J.D.; and Susan Wolf, J.D. Residential tuition is $1200, Non-residential tuition is $950. For information contact: Center for Bioethics, University of Minnesota, 2221 University Avenue SE, Suite 110, Minneapolis, MN 55414. Phone: 612-626-9756, Fax 612-626-9786, or E-mail: holmb006@maroon.tc.umn.edu.
August 4-8, 1997:

**SUMMER SEMINAR IN HEALTHCARE ETHICS**

Sponsored by the Department of Medical History & Ethics, School of Medicine, University of Washington. To be held in Seattle, WA. Directed to physicians, nurses, social workers, chaplains, teachers, and others involved in the care of patients or the education of providers, this annual Summer Seminar provides an intensive introduction to the concepts, methods, and literature of Healthcare ethics. Albert Jonsen, Ph.D., will lead the Seminar, and Linda Emanuel, M.D., Vice President for Medical Ethics at the American Medical Association, and Ezekiel Emanuel, M.D., Ph.D., of Harvard University, will be the guest faculty. The University of Washington School of Medicine designates this course for approximately 30 hours of Category 1 of the Physician’s Recognition Award of the American Medical Association. For further information contact: Marilyn J. Barnard, Program Coordinator; Medical History & Ethics; Box 357120; School of Medicine; University of Washington; Seattle, WA 98195-7120; Phone: (206) 616-1864; FAX: (206) 685-7515, or E-mail: mbarnard@u.washington.edu

Courses in Medical Humanities

June 7-13, 1997:

**NARRATIVES OF CARE: CONSTRUCTING AN ETHIC OF CLINICAL PRACTICE**

Sponsored by the Center for Literature, Medicine, and the Healthcare Professions, a collaborative project of Hiram College and Northeastern Ohio Universities College of Medicine. Seminar Directors: Jack Coulehan and John R. Stone. Faculty Leaders: Cortney Davis, Hilde Nelson, Laurence Thomas, and Rosemarie Tong. Center Faculty: Carol Donley, Martin Kohn, and Delese Wear. Cost for the seminar, including readings and room and board, is $950. Contact the Center for Literature, Medicine, and the Healthcare Professions, Hiram College, Hiram, OH 44234. Application deadline: April 1, 1997. Enrollment limited. For further information phone: (330) 569-5380; FAX: (330) 569-5449; E-mail: DONLEYCC@HIRAM.EDU or mfk@neoucom.edu

July 28-August 3, 1997:

**CASE NARRATIVE AND THE CONSTRUCTION OF OBJECTIVITY**

Sponsored by the Medical Ethics and Humanities Program, Northwestern University Medical School, Chicago, IL. This interactive program will address topics including the uses of narrative reasoning, case genres the representation of fact in medicine and bioethics, the place of the patient’s narrative in medical and bioethics cases, “real” cases and the question of authenticity, whether some medical case histories are more ethical than others, and whether the medium of representation affects response. Faculty include Kathryn Montgomery Hunter, Ph.D., Tod Chambers, Ph.D., William Donnelly, M.D., and Suzanne Poirier, Ph.D.

CME credits available. Tuition is $600, some meals included; reasonable hotel rates available. Application deadline is May 10, 1997. For more information contact Joan Broholm, Phone: (312) 503-7962; E-mail: <j-broholm@nwu.edu>, or send CV and a letter indicating your interest and lodging needs to Kathryn Montgomery Hunter, Ph.D., Director, Medical Ethics and Humanities Program (M-105), Northwestern University Medical School, 303 East Chicago Avenue, Chicago, IL, 60611; E-mail: <k-hunter@nwu.edu>. 
Ethics Grand Rounds
Spring 1997 Schedule

(Formerly “Ethics for Lunch”)
A series of lunch-hour presentations dealing with ethical problems in medical practice.

All sessions take place in lecture room 1, Scaife Hall (University of Pittsburgh)
NOON - 1:00 P.M.

February 13, 1997
“Rabbinical Perspectives on Forgoing Life-Sustaining Treatment”
Rabbi Daniel Schiff
Temple B’nai Israel (McKeesport)
Rabbi Stephen Steindel
Congregation Beth Shalom (Squirrel Hill)
Rabbi Joseph Weiss
Congregation B’nai Emunoh (Squirrel Hill)

*This session is co-sponsored by the “Jewish Responses to Clinical Perspectives” series,
Rabbi Larry Heimer, Course Director.

February 27, 1997
“Ethical Aspects of Genetic Testing for Breast Cancer”
Wendy Rubinstein, M.D., Ph.D.
Assistant Professor of Medicine
Division of Oncology
University of Pittsburgh

March 13, 1997
“The Four Principles of Bioethics & Postmodernism”
Bradley E. Lewis, M.D.
Assistant Professor of Psychiatry
University of Pittsburgh

March 27, 1997
“Defining a “Normal” Life: Patients’ Experience After Liver Transplantation”
Kata Chilag
Department of Anthropology
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).

This course is presented in conjunction with the University of Pittsburgh School of Law. It has been approved by the Pennsylvania Continuing Legal Education Board for 1 hour of ethics CLE. To register for CLE credit, please contact Naomi Barzachski, Esq., (412) 648-1305 or e-mail <naomi@law.pitt.edu>.

Sponsored by the Center for Medical Ethics,
the Center for Continuing Education in the Health Sciences, and the School of Law,
University of Pittsburgh

Community Ethics 4(1)
As always, we extend special words of thanks to the Vira I. Heinz Endowment for its continued support of the Consortium Ethics Program. We are also deeply indebted to the Ethics Committee of the Hospital Council of Western Pennsylvania for the continued encouragement, guidance, and assistance that it lends to the CEP.

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 Mark Kuczewski, Ph.D., Center for Medical Ethics, 3708 Fifth Avenue, Suite 300, Pittsburgh, PA 15213, phone (412) 647-5824, FAX: (412) 647-5877, or e-mail <mak7+@pitt.edu>.