Community Ethics (CE) is the official newsletter of the Consortium Ethics Program (CEP). It links the member hospitals of the CEP and assists them in sharing ethics resources with each other and with professionals in Western Pennsylvania. CE carries a variety of articles on substantive ethical issues and problems, calls attention to "truly useful literature," and conveys information on noteworthy medical ethics events in the area. And to be sure we don't get too self-congratulatory, from time to time we also have features from ethicists around the nation. A quick perusal of this issue is sure to satisfy your appetite for any of these genres.

This issue continues the dialogue on guardianship issues and extends it to a variety of other related topics including decision making for incapacitated elderly and mentally impaired patients. If these features are of special interest to you, we would welcome a contributed article for an upcoming newsletter or a suggestion on a related aspect you'd like to see addressed in greater depth. In our next issue, we also hope to discuss the relationship between medical ethics and religion or spirituality. If the spirit moves you to write an article or submit a case, please contact me at the address on page 8.

Mark Kuczewski, Editor

BIOETHICS "MEGA-MEETING" COMES TO PITTSBURGH

The four major professional societies in biomedical ethics will, for the first time, hold their annual meetings conjointly. From October 6-10, 1994, the world of medical ethics will revolve around the Pittsburgh Hilton and Towers at Gateway Center as the members of the Society for Health and Human Values (SHHV), Society for Bioethics Consultation (SBC), American Society of Law, Medicine & Ethics (ASLME), and the newly-formed American Association of Bioethics (AAB) descend on downtown Pittsburgh. For your convenience, we have included a registration form for these events. This is a unique opportunity for local professionals to tap national resources and the latest scholarship in medical ethics.

Each society has a registration fee for its meeting but also offers a package that allows attendance at all sessions for a small additional fee. For instance, a non-member can register for the SHHV Annual Meeting for $175.00 but may attend any meeting by paying an additional $75.00 ($250.00 total).

We encourage you to find the sessions that fit your interests. Although professional ethicists usually belong to all or most of these organizations, the University of Pittsburgh Center for Medical Ethics has a long and special relationship with the Society for Health and Human Values. We hope that you will look carefully at the resources available through the SHHV, the oldest, and possibly most prestigious, society devoted to medical ethics. CEP Director Rosa Lynn Pinkus, Ph.D., was a member of the society during its formative years and Joel Frader, M.D., Associate Director for Consultation at the Center for Medical Ethics served as its President for the 1993-94 year. Mark Kuczewski, Ph.D., the CEP's Associate Director, will present a paper on method in bioethics at a Sunday session of the SHHV and Lisa S. Parker, Ph.D., Director of Graduate Studies at the Center for Medical Ethics, will do a presentation on the image of women in public health. See you at the Hilton!!!

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LONG-TERM CARE AND THE LAW: Forbes' Experience

by Andrew Thurman, J.D., M.P.H.,
General Legal Council and Senior Vice President of the Forbes Health System, and
Chairman of the Ethics Task Force of the Hospital Council of Western Pennsylvania.

Forbes Health System operates the Forbes Nursing Center, a 126 bed skilled nursing facility located at the site of the former Pittsburgh Hospital. At a conference on inspection and licensure issues for skilled nursing facilities - attended by several members of the administrative team of Forbes Nursing Center - a representative of the State Department of Health responsible for inspection and licensure of nursing homes made a disturbing statement. She noted that nursing homes would be required to have on file an advance directive, durable power of attorney, or guardianship for each of their residents in the event that the resident became incapable of making medical decisions.

The management team at the nursing center contacted me about this, since I was counsel for the System and since it was not our policy to require that such a document be on file. I became very concerned because the Patient Self-Determination Act expressly provides at 42 U.S.C. § 1395 cc (a) (1) (f) (1) (C) that a health care provider, including a nursing home, may not condition the provision of services upon having an advance directive. Encouraging residents of skilled nursing facilities to have a surrogate or other alternative to make health care decisions, should they become incapable of doing so, is a very worthwhile goal. However, to require the resident to do so or to require the facility to make such arrangements on the resident's behalf is not only a violation of law, but is arguably an offense to the resident's privacy and autonomy. I called the Department of Health in Harrisburg and informed them of my concerns. The individual to whom I spoke assured me that they were aware of the law and that no such requirement would be imposed.

Approximately two weeks later, I was contacted by a representative of a non-Forbes Nursing Home who informed me that they had been asked during inspection to show that each of their residents had an advance directive, durable power of attorney, or guardianship on file. The inspector indicated that upon failure to do so, a citation would likely result. At this point, I contacted the office of the Secretary of Health and expressed my concerns about the apparent conflict between this Pennsylvania practice and the federal law.

This particular story ends happily. Forbes Nursing Center was inspected in May and no reference was made to a requirement for advance directives during that inspection.

TELECONFERENCE TO ADDRESS ISSUES INVOLVING NURSING HOMES & ACUTE CARE FACILITIES

November 16, 1994

Teleconference: 9:00 a.m. - 10:30 a.m.
Workshop: 10:45-11:45

Workshop Sites:
Armstrong County Memorial Hospital Bradford Regional Medical Center
Butler Memorial Hospital Citizens General Hospital
Clarion Hospital DuBois Regional Medical Center
Greene County Memorial Hospital Indiana Hospital
Janeson Memorial Hospital Latrobe Area Hospital
Sewickley Valley Hospital Somerset Hospital
The Uniontown Hospital Western Psychiatric Institute and Clinic

On November 16, 1994, the teleconference "Ethics at the Interface: Hospitals, Nursing Homes, & End-of-Life Decisions" will address ethical issues that arise in the transfer of patients from long-term care facilities to acute care hospitals. The teleconference is sponsored by the Consortium Ethics Program and the University of Pittsburgh's Center for Continuing Education in the Health Sciences, and will be followed by on-site workshops at 13 CEP hospitals. The workshops, conducted by CEP representatives, will provide an opportunity for teleconference participants to discuss issues and field questions raised during the program.

The main program will feature Robert M. Arnold, M.D., Associate Professor of Medicine at the University of Pittsburgh, who will speak on the concept of autonomy in long-term care. Alan Steinberg, J.D., will address legal issues in making end-of-life decisions, and Rosa Lynn Pinkus, Ph.D., Associate Professor of Medicine and Neurosurgery at the University of Pittsburgh, will discuss strategies for dealing with ethical issues and end-of-life decision making during patient transfer. Mark Kuczewski, Ph.D., Research Assistant
Professor of Medicine at the University of Pittsburgh, will serve as moderator. This program should be of keen interest to health care providers from both acute and long-term care facilities.

The teleconference will be broadcast to approximately 30 sites from the auditorium of Western Psychiatric Institute and Clinic (WPIC) at the University of Pittsburgh. The hospitals listed above will host an hour-long discussion and workshop after the teleconference.

As mentioned, these workshops will be run by hospital representatives currently enrolled in CEP classes and training. This particular set of workshops promises to be especially exciting because it will give workers from a variety of types of institutions an opportunity to interact with each other and to coordinate ideas and strategies for addressing problems in patient transfer.

**ETHICS ROUNDTABLE:**

**Topic:** Guardianship Problems and the Withdrawal of Life-Sustaining Treatment

**Response:** "Decision-Making for Mentally Retarded Patients"

By Patricia Goodwin, M.S.W., Patient Representative
Centre Community Hospital, State College, PA

As evidenced in previous responses to the roundtable in this newsletter, difficulties continue to arise in making treatment choices for patients who lack decision-making capacity. Centre Community Hospital has been fortunate because we seldom have had to use the costly and slow-moving court system for guardianship proceedings. In most cases, we have been able to locate a suitable family member to act on the patient's behalf. When this has not been possible, informal mechanisms have filled the gap.

An issue that resurfaces periodically involves clients of the County Mental Health/Mental Retardation System. Significant numbers of severely retarded individuals have been released from institutional settings in the past several decades and placed in less restrictive group home settings, often with great benefit to their quality of life. Individuals are closely supervised by county employees and mechanisms for financial management are arranged through "representative payees" so that living expenses and routine health care can be provided. Individuals generally manage quite well in these settings and community supports are largely adequate. However, this population is becoming older and increasingly prone to acute and chronic illnesses related to aging. Hospital care becomes necessary, and often a true guardian or obvious surrogate, able and authorized to make decisions, does not exist.

CCH faced a difficult scenario that illustrates these problems. The patient, Mr. L., was a 70-year-old male with profound mental disability who had been a client of a residential county group home since 1982. From shortly after birth until that time, he had lived in a long-term care institution. Mr. L.'s normal condition was such that he could not speak (or read or write), ambulated with assistance, was able to follow directions for self-care, and had adjusted well to living in a group home. He then suffered a cardiac arrest and was hospitalized. His caretakers initiated CPR upon finding him but it was not clear how long he had been in arrest prior to being discovered. On admission, he was severely hypoxic. Medical evaluation, neurological consultation, and a CT scan confirmed considerable damage to the right hemisphere of his brain. For several days Mr. L. did not regain consciousness, responded to pain only, and was unable to eat. He required 24 hour nursing home care for turning, bathing, etc., was incontinent, and sustained on IV fluids. The prognosis was poor that he would be able to return to his previous condition.

The Ethics Committee was consulted at this point and a meeting was held with the attending physician, ethics committee members, representatives from the County, and the patient's group home care takers. Options for treatment and the possible consequences were identified: maintenance on IV fluids, discontinuing treatment, insertion of a feeding tube, etc. Discussion revolved around the issue of self-determination and what the patient would want. Due to the patient's previous severe retardation, it was impossible to ascertain what he would want. It was highly doubtful that the patient was ever sufficiently able to comprehend the complexities of such a situation or to develop applicable values concerning quality of life, etc. Financial matters were such that long-term medical assistance had and would continue to cover his care in a nursing facility. Issues of pain control and discomfort were felt to be manageable and were therefore minimal considerations.

A significant question arose in trying to determine who would make decisions for the patient. The patient may, at some point, have been capable of deciding who should make decisions. Unfortunately, as far as anyone knew, he had never been asked such a thing and he was clearly not capable of encoding such a choice in an advance
directive on his own. Thus, the problem was how to appoint a surrogate since the patient had not chosen one and had no obvious candidates. The legal authority of the group home and the County was unclear. After researching the issue, a social worker discovered that no process to appoint a legal guardian had ever been instituted and, in fact, the legal documents accompanying his release from institutional care in 1982 made the patient his own legal guardian by default. Searches for relatives turned up two but neither was willing to making decisions for the patient.

Two of the residential group workers who had significant contact with the patient over the years decided to petition on their own to become guardians. For various reasons, these care givers were inclined to favor the temporary placement of a feeding tube. While awaiting the results of the legal guardianship process, the physician inserted the feeding tube. The patient also regained some awareness of his surroundings. Transfer to the County nursing home was arranged and accomplished. Transfer was a peculiarity of this case: placement in the county home was available because he was already so significantly involved in the county system. Normally, CCH will not transfer a patient without authorized approval from the patient/family/guardian. The patient survived in the nursing home for another month before he died. The guardianship proceeding had not been completed at that time.

As a result of this situation, the hospital attorney and the chairman of the Ethics Committee corresponded with the County attorney and the administration of MH/MR services, strongly encouraging action to establish guardians with health care decision-making abilities for their clients who are so severely limited. Scenarios such as the one I've described are likely to recur and informal mechanisms may not always be appropriate. Furthermore, the lengthy nature of the formal procedures means that clinical decisions will have to be made without such guidance. CCH and the County are seeking to work together to provide compassionate, appropriate, and timely care for members of our community.

**Palliative Care: Make It Aggressive**

by John Coulehan, M.D., Professor of Preventive Medicine and Medicine, State University of New York at Stonybrook

Pain is an eloquent voice of suffering, though it is sometimes a voice physicians find irritating or difficult to understand. In the course of giving patients otherwise excellent medical care, we often feel ambivalent about treating pain aggressively. This is particularly strange because "aggressive" treatment is the name of the game in American medicine. We ordinarily visualize ourselves as warriors fighting against disease and we value the soldierly virtues of courage and risk-taking, steadfastness and endurance. Thus, it seems paradoxical that we should balk at aggressive "comfort care" or pain management.

In one sense this ambivalence arises from an extension of the metaphor. If we can't defeat the disease, we've lost the battle and already failed the patient. Thus, palliative care is like the ragged retreat from a battleground, hardly worth the warrior's best effort. Of course, we know the military metaphor doesn't really apply to medical practice. Yet we can hardly help but be influenced by some of the other powerful beliefs about pain in today's medical culture. First, the dichotomy between "subjective" and "objective." We learn very early that objective data are of primary importance in medicine, subjective data are secondary. Pain by its very nature is subjective. Ergo, physicians should devote most of their effort to dealing with the objective cause of pain, rather than with the pain itself. Another widespread (but mistaken) belief is that we should always be on the lookout for addiction. Since opioids are addictive substances, we ought to use them sparingly and almost grudgingly, thereby saving our terminal cancer patients from chemical dependence.

As clinicians, however, we know how misleading these beliefs are. Among the goals of medicine, relief of suffering is the common denominator. Diagnosis and treatment of "objective" disease ordinarily serves this "subjective" goal. However, in this era of chronic and degenerative illness, many of our efforts to treat disease and prolong life are associated with continued, even increased, suffering and disability. Thus, those of us who take care of patients with cancer and other causes of chronic pain should welcome the new practice guidelines for pain management developed by the federal Agency for Health Care Policy and Research. If we must use the military metaphor, we should learn to become as aggressive in making our patients comfortable as we are in fighting their diseases.

There is, however, an additional concern that many physicians have in caring for terminally ill patients. Opioids and barbiturates in sufficiently high doses cause respiratory depression. Since terminally ill patients often require such doses to achieve adequate symptom relief, we find ourselves wrestling with an apparent dilemma: are we benefiting patients by relieving symptoms, or are we harming them by placing them at risk for earlier death? Sometimes physicians are also concerned with the legal aspects of this dilemma: does progressive titration of morphine to higher and higher doses constitute euthanasia? These fears affect behavior. In one major study 41% of physicians and nurses agreed with the statement that "clinicians give inadequate pain medication most often out of fear of hastening a patient's death."2 There are two ways
of responding to such fears. The first is to argue that the risks are really much smaller than anticipated. The actual likelihood of respiratory depression with opioids is probably less than one percent because cancer patients ordinarily develop tolerance to the side effects, just as they develop tolerance to the analgesic properties of these drugs. The second, and more important, response is to argue, as does the New York Task Force on Life and the Law, that "the provision of pain medication is ethically and professionally acceptable even when such treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death."4

Some analyze this in terms of the principle of double effect; that is, an action with both good and evil effects is permitted if the action itself is not intrinsically wrong, the agent intends only the good effect, and there is a proportionate balance between good and evil effects. Others do not accept all the features of the principle of double effect, but agree that intention and benefit/risk ratio are crucial factors in assessing the morality of clinical actions. While the Hippocratic adage "first, do no harm," should serve as a reference point for every treatment plan, "benefit" and "harm" must be individualized. We often overvalue treatments like chemotherapy or antibiotics that have the potential to prolong life. Yet prolonging a patient's life is in some cases almost certainly harmful, while the relief of suffering is virtually always beneficial. The apparent conflict between risk and relief is likely to dissolve when we negotiate an individualized treatment plan with the patient. Once the plan for comfort care is clear, a small risk of earlier death should never be an impediment to providing maximal symptom-relief. Such a therapeutic approach is surely consistent with the law as well. As long as physicians titrate opioids, barbiturates, and other symptomatic medications appropriately: assessing their patients' status at intervals and increasing dosage in response to patient need, the law poses no threat to clinical practice.


4. The New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context, New York, N.Y., 1994. (Copies of this report may be ordered from the Task Force for $11.00 from Health Research Inc., Health Education Services, P.O. Box 7126, Albany, NY 12224 or phone 518-439-7286)

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TRULY USEFUL LITERATURE: Autonomy and the Elderly

by Constanza Rakela, CEP Intern

(Editor's Note: The following articles were reviewed by Constanza Rakela, a recent graduate of Luther College in Iowa. Ms. Rakela is currently serving an internship with the CEP and plans to attend graduate school to study health administration. The first article was submitted for review by Robert Horn of the South Hills Health System. Please keep the articles and suggestions coming!!)


Review: This article contains an interesting insight into the health care system: the importance of enhancing the health of the elderly through "minimizing the skyrocketing costs of health care," and the relationship between these costs and the "dread misery" many suffer from not being given the choice to reject crucial life support procedures. Conard introduces the use of advance health care directives as a means of "liberation." He discusses a variety of advance directives and focuses on the importance of these directives in guaranteeing the freedom of elders to refuse unwanted procedures. These unwanted procedures often impose considerable financial burdens on the elderly patient and also drain the resources of Medicare and other insurance schemes on which the elderly rely for their health care.

Conard makes several points regarding the employment and procurement of advance directives. First, he notes that directives can be ambiguous and it may be difficult to interpret them. He argues that clearer directives may help in this matter. However, the worst clinical conflicts often result from having virtually no credible evidence of the patient's wishes. Even general directives that make reference to refusing life support can ease the potential for conflict in these situations. Second, Conard argues that elder choice can be effectively promoted with help agencies such as Medicare and Medicaid because they are already important and trusted institutions in the lives of the elderly. Thus, along with trusted health care providers, they are well-positioned to help patients match directives with the kinds of procedures they wish to receive or refuse. Although Conard is not afraid to support the use of advance directives with economic arguments, his position is ultimately that advance directives should be promoted because they provide the elderly with greater autonomy.

Review: Lidz and Arnold review various definitions or characterizations of autonomy. They review three that are prevalent in medical ethics: autonomy as total independence, autonomy as free action, and autonomy as effective deliberation. They then seek to determine whether any of these are applicable to the nursing home setting.

Lidz and Arnold analyze nursing homes in terms of "total institutions." Such institutions incorporate their "inmates" in a living and working environment that is removed from the external world. In such an environment, the three traditional notions of autonomy seem inapplicable. Lidz and Arnold introduce the notion of autonomy as consistency. That is, rather than see autonomy as uninfluenced decision making regarding a specific choice, autonomy must be seen as facilitating action that fits with the person's past activity, is consonant with current commitments and values, or is conducive to future goals. Thus, autonomy is more about the "directionality of self-direction" than discrete choices.

HIV SCREENING DURING PREGNANCY: The Views of CEP Participants

On June 15, 1994, Jack Coulehan, M.D., conducted a Series 2 class entitled, "Is an Ounce of Prevention Worth a Pound of Cure: Exploring the Ethical Basis for Health Care Reform." The Series 2 classes are conducted for hospital representatives who have completed the intensive three-year basic program of the CEP. Because of the accumulated experience of the representatives, these classes are highly interactive in nature.

Dr. Coulehan presented the following situation to a panel of participants in advance and asked them to come prepared to the class to comment upon it. It is based on a proposal that was pending before the N.Y. State legislature at that time. Below is a sample of the comments presented at the seminar. We believe it demonstrates the level of critical ethical reasoning that CEP representatives develop through their participation in the program and interaction with each other.

Case:

The State Legislature is considering a bill that would require HIV screening of pregnant women. The bill would mandate that physicians and other health care providers routinely perform a test for HIV antibodies as part of prenatal care. The Department of Health has been instrumental in developing this proposal because of new information concerning the vertical transmission of HIV and the efficacy of anti-retroviral treatment during pregnancy. Facts: (1) HIV-positive mothers transmit the virus to fetuses in 30 to 40% of cases. (2) Recent evidence indicates that treatment of the mother during pregnancy with AZT substantially reduces maternal-fetal transmission, perhaps, to less than 10%. (3) Additional new evidence confirms that HIV can also be transmitted through breast feeding. (4) Your state includes population areas with a high prevalence of HIV, as well as rural areas with a low prevalence. (5) Generally speaking, the social climate and fear of AIDS make women reluctant to agree to be screened on a voluntary basis even if their risk of infection is high.

The legislature is actually considering two versions of the bill. Both require HIV screening and counseling during pregnancy. The first bill only requires that if a woman is HIV positive, she be counseled concerning vertical transmission and the various treatment options. The second bill, however, would make medical treatment for HIV during pregnancy mandatory for HIV positive women, unless given a medical exemption.

You must now consider whether or not to support one of these bills before the state legislature.

Comments:

While this case raises many questions, my decision not to support either bill rests on the lack of a compelling need to institute restrictive public health measures to deal with this problem. In reviewing history and past cases where such measures have been taken, it seems that the goal has been to prevent more suffering than the measures create by limiting the freedom of the individual. In addition, it seems that a clear and significant danger to public health must exist to justify restrictive measures. More importantly, the measures taken should have a high probability of success. I don't believe that the measures advocated by either bill have demonstrated that they will be successful.

There are certainly conflicts of moral principles at issue in this case. However, the low probability of achieving the desired end is decisive in rejecting the proposed means. I cannot support either bill and would suggest that implementation may, in fact, deter some women from seeking prenatal care at all.

Jeanne Graff, M.S.N.
Butler Memorial Hospital
In reviewing this case, several issues are raised. In addition to questions of patient autonomy vs. institutional paternalism, the issue of the type of paternalism, pure vs. impure, should be examined. Here we have a vulnerable population, that is, pregnant women. Who, then, is exercising paternalism? Is the class whose freedom is restricted identical to those whose benefit is promoted? Or is the welfare of one class being promoted by restricting the freedom of another? I believe the latter is clearly true. The freedom of choice of one group is restricted to promote the welfare another group. If this is allowed in the case of pregnant women, why can't this principle then be extended to prisoners, those accused of sexual crimes, and even those who are victims of sexual crimes? This singling out of especially vulnerable populations for mandatory testing is one reason I had to vote against such a mandate.

Secondly, the issue of "duty to warn" could be raised. In some cases, there seems to be a duty to warn a third party when there is evidence that he or she is in danger. In this case, could "duty to warn" be expanded to include "duty to find out"? Even if we are dealing with an overwhelmingly at-risk population, do we have a duty to warn the fetus of a risk? And, if we are not sure that a risk exists, must we then exercise a "duty to find out"? I do not think this is a viable argument if the at-risk population were anyone other than a child.

Following this line of reasoning, once we find out that a risk exists, who do we then inform of that risk—the mother who didn't want to know in the first place, or does the government (i.e., the tester) then assume responsibility for the care of the child, should the mother be unable or unwilling to assume that responsibility?

In summary, my feelings were summarized nicely in the article by Gerald Dworkin: "the strongest argument against interference of the public with purely personal conduct is that when it does interfere, odds are it interferes wrongly and in the wrong place."

Susan Trapani, M.S.W.
Citizens General Hospital

The individual's right of autonomy and self-determination is the foundation of medical ethics. It also supports the right of women to be free from mandatory HIV testing. Respect for the individual and his or her right to make choices should not be overridden or disregarded in order to resolve health care issues. Individuals are generally the best judge of their own interests and values. Unless there are clear indications to the contrary, people should be presumed capable of making choices based upon their values to form a rational life-plan. Medicine has traditionally been practiced in a paternalistic fashion but this tradition is no longer acceptable in our society. A person does not lose her identity and rights as an individual by becoming pregnant. Society does have an obligation to its citizens to warn them of hazards and to provide information that will help in making educated choices regarding their welfare. Therefore, society is obligated to educate expectant mothers so that they might make informed decisions about their health care and their unborn child's care. Only the individual can identify exactly what her good is and make the particular decisions that accord with that belief.

Libby Moore, M.S.W.
Sewickley Valley Hospital

Postscript: Ethics in the Real World

About one month after our CEP class discussed the issue of mandatory testing of pregnant women for HIV, the law makers of the New York State legislature "staggered warily toward summer recess... an exhaustive negotiation and debate about the Mayerson Mandatory Notification Bill completed." This bill (which served as the basis for the CEP Case Study) would have required doctors to notify parents of the results of the HIV test that the state currently performs anonymously for tracking purposes on all newborns. Since a positive test on a newborn means that the mother is infected, mandatory notification de facto translates into mandatory HIV testing for new mothers.

The debate centered on a traditional ethical dilemma in public health: whether or not privacy rights must be compromised in order to control the AIDS epidemic. The resolution to the dilemma clearly shows how politics affects medical care. It's an election year and Governor Cuomo side-stepped taking a stand on this sensitive issue by supporting a compromise bill that requires that doctors and other health professionals counsel all pregnant women and new mothers regarding the risks and benefits of testing for HIV. The bill also requires that they offer testing. Ms. Mayerson, the Queens Democrat who sponsored the mandatory notification bill, sees this compromise as a "death sentence" because counseling warns of the possible discrimination against AIDS patients thereby encouraging mothers not to undergo the testing offered. The chairman of the New York Chapter of the American Academy of Pediatrics is more optimistic and feels the law will save lives of hundreds of infants and will improve the lives of thousands of HIV infected mothers.

Cuomo's press secretary explains "It's a good step for now, but not necessarily the final answer." Will mandatory notification become a reality? We'll keep you posted.

(Quotations are from the New York Times, page 12, Sunday, July 3, 1994)

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

Valley Hospice presents:

"Caring on Both Sides of Death"  
Dr. Joyce Brothers

November 3, 1994, 7:30 p.m.  
Moon Area High School  
Beaver Grade Road, Moon Township  
Tickets are $20.00

For ticket information:  
call (412) 749-7054 or (412) 749-7100  
or write to the event's chairman,  
Chaplain Bruce Bryce,  
Coordinator of Spiritual Care  
Sewickley Valley Hospital  
720 Blackburn Road  
Sewickley, PA 15143-1498

CONSORTIUM ETHICS PROGRAM

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Connie Johnston, Administrative Assistant  
Alan Joyce, Editorial Assistant  
Connie Rakela, Intern

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 Task Force of the Hospital Council of Western Pennsylvania for the continued encouragement and guidance 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., University of Pittsburgh Center for Medical Ethics, 3400 Forbes Avenue, Suite 110, Pittsburgh, PA 15213, phone (412) 624-3486 or fax (412) 681-1261.

Consortium Ethics Program Events

(1) Annual Retreat:  
September 30 - October 2, 1994,  
Hidden Valley Resort

(2) Teleconference:  
"Ethics at the Interface,"  
November 16, 1994  
9:00 a.m. - 10:30 a.m.  
Workshop: 10:45-11:45

(3) Basic Classes  
(Education Center of the Hospital Council of Western Pennsylvania, Warrendale, PA):  
October 26, 1994 1:00 p.m. - 5:00 p.m.  
December 12, 1994 1:00 p.m. - 5:00 p.m.  
March 16, 1994 8:30 a.m. - 12:00 p.m.  
April 18, 1994 1:00 p.m. - 5:00 p.m.  
May 16, 1994 1:00 p.m. - 5:00 p.m.  
June 13, 1994 8:30 a.m. - 12:00 p.m.

(4) Advanced Classes  
(Education Center of the Hospital Council of Western Pennsylvania, Warrendale, PA):  
December 12, 1994 8:30 a.m. - 12:00 p.m.  
March 16, 1994 1:00 p.m. - 5:00 p.m.  
May 16, 1994 8:30 a.m. - 12:00 p.m.  
June 13, 1994 1:00 p.m. - 5:00 p.m.
The University of Pittsburgh Center for Medical Ethics presents:

**Ethics for Lunch**

*Fall 1994 Schedule*

A series of lunch-hour presentations dealing with ethical problems in medical practice.

**ALL SESSIONS (except 9/22/94) TAKE PLACE IN AUDITORIUM 5, SCAIFE HALL**

**NOON-1:00 P.M.**

Presentations begin promptly at noon.

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**September 22, 1994**

Auditorium 3, Scaife Hall

*Baby K and Me—Whither Futility?*

**Joel Frader, M.D.**

Associate Professor of Pediatrics,
University of Pittsburgh School of Medicine

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**October 13, 1994**

Advance Directives: A Reassessment

**Rebecca Dresser, J.D.**

Professor of Law and Biomedical Ethics
Case Western Reserve University School of Medicine

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**October 27, 1994**

Paternalism’s Tacit Dimension: History and Ethics in Neurosurgery

**Rosa Lynn Pinkus, Ph.D.**

Associate Professor of Medicine and Neurosurgery
University of Pittsburgh School of Medicine

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**November 17, 1994**

Women and Folic Acid Supplementation Recommendations: A Tough Pill to Swallow

**Rachel Ankeny Majeske**

Research Specialist
University of Pittsburgh Center for Medical Ethics

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**December 8, 1994**

The Impact of Genetic Testing

**Ellen Wright Clayton, M.D., J.D.**

Charles E. Culpeper Foundation Scholar
Department of Pediatrics
Vanderbilt University School of Medicine

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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).

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