"Ethical knowledge is practical knowledge." This is a sentence I frequently hear from my colleague, Rosa Lynn Pinkus, Ph.D. It is the ideal that has guided the Consortium Ethics Program (CEP) from its beginnings and is also the theme that permeates this issue of Community Ethics.

We have several features that will assist members in preparing for the JCAHO ethics survey, articles on practical approaches to end-of-life planning and patient care and, in place of his usual "Truly Useful Literature" column, Alan Joyce explains how to access bioethics resources on the Internet. Of course, Community Ethics also brings "the news" to CEP members. We note the recent honors accorded a CEP member and also have a list of upcoming events. (Please note: CEP members should check the revised schedule of seminars against their calendars).

We hope these articles help to meet your ethics needs. As always, we encourage contributions from our readers -- especially additional submissions concerning the JCAHO ethics survey and case submissions that contain ethical problems related to managed care. However, you need not restrict yourself to these two topics. Feel free to write to us and share any of your experiences with effective or innovative ways to address ethical issues in patient care.

-- Mark Kuczewski, Ph.D.
Editor

Goals of the CEP

Match New JCAHO Accreditation Process
by Rosa Lynn Pinkus, Ph.D., CEP Director

Every healthcare institution is familiar with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This "private, nonprofit, quasi-official group" represents five professional organizations: the AMA, the AHA, the American College of Physicians, the American College of Surgeons, and the American Dental Association. Needing certification to become eligible for reimbursement from Medicare and Medicaid, approximately 5,300 hospitals, 6,000 nursing homes, and many other facilities prepare every three years for the intense scrutiny of the Commission inspectors.1

The process has not been uniformly praised. The Commission’s only enforcement technique is the withdrawal of accreditation. Less than 1% of the 1,750 hospitals surveyed last year had accreditation withdrawn, and many of these stayed open by securing the blessing of state regulators. Dr. Jerome P. Kassirer, editor of the New England Journal of Medicine, commented on a spate of recent medical errors occurring in highly praised JCAHO facilities: "The fact is that the [Commission] does not always ask the right questions, doesn’t always look at the right information and relies on enormous mounds of paperwork that have nothing to do with anything."2 Sensitive to such criticism and to further claims that it is "incredibly elaborate and expensive..."3 the JCAHO revamped its accreditation process last year. Prior to January 1995, the checking of documentary proof provided the basis for the inspection. Now, direct measurements tied to patient outcome are the norm. Also, as of
December 1994, inspection reports are available to the public for thirty dollars. Of specific interest to us are the new ways in which patients’ rights standards are evaluated and the new standards on organizational ethics. Each plays a prominent role in the scheduled interviews with staff who are directly involved with ethics.

This year, roughly one-third of the CEP membership experienced the JCAHO’s new format. As Colleen Allison’s article indicates, CEP representatives have shouldered much of the responsibility involved in preparing the documentation and evidence of how ethics issues are addressed. Over the next three years, all CEP institutions will be surveyed. To help them prepare, we compiled a bibliography and summary of seminars held from 1990 (when the CEP began) to the present, matching seminars to the regulations they directly addressed. A typical menu of documentation is at right (Figure 1). We also sent individual institutions a list of on-site programs that directly involved with ethics. Of note is that virtually every regulation covered under the topic of "patients’ rights" has received a comparable educational approach.

What about organizational ethics? As Myra Christopher, BNS, and President of the Midwest Bioethics Center in Kansas City explains, this is not "cookbook ethics". The organizational ethics standards are to ensure that the hospital environment supports the ethical practice of the individual professionals and patients. A customized plan to meet Joint Commission Standards based hospital-specific needs is essential. This means having policies which reflect institutional goals, i.e., having mission statements that are not just "window dressing". In addition, the policies should be put to use in patient care.

Sound familiar? It should! Review the requirements for joining the Consortium (Figure 2). It is apparent that approximately three-quarters of our members satisfied the intent of the new JCAHO regulations before they became operational. Whether or not the revised accreditation process prompted our fifteen new members to join, it stands to reason that the three-year educational program and its ongoing network can serve as a national model for approaching such issues. With a commitment to attaining a solid education on both practical ethical issues in patient care and in organizational practices, our member institutions can share in the "cutting edge" approach to accreditation that is occurring. For the CEP, it is "old hat".

One caveat: while the goals and intent of the CEP educational program in ethics and the new JCAHO accreditation process are amazingly similar, we differ in at least two major areas. Clearly, we are not involved in accreditation. Our educational process is both specific and general and is meant to serve as an ongoing basis for resolving ethics dilemmas as they arise. Also, our participation fee is no match for the cost of preparing for a JCAHO site visit!

References
2. ibid.
3. ibid.

Figure 1

Figure 2
The New, Anxiety-Producing Ethics Interview!
(One Hospital’s Experience with the 1995 JCAHO Survey)

By Colleen C. Allison, M.S., Vice President, The Washington Hospital (Washington, PA)

The Washington Hospital was recently one of the first hospitals in Western Pennsylvania to undergo a 1995 JCAHO Survey. As part of preparation for the Ethics Interview, which gauges compliance with the Patient Rights and Organizational Ethics Standards, the hospital developed an Organizational Ethics Statement. This included such information as the Board’s recognition of the basic principles guiding ethical behavior, and its responsibility to serve the patient, staff, physician, and the community in an ethical manner. Statements on respect for the patient, marketing practices, billing practices, resolution of conflicts, recognition of potential conflicts of interest, and patient confidentiality were documented. Listed at the end of the Statement were related references to other hospital policies such as non-discrimination, informed consent, organ donation, charity care, advance directives, Institutional Review Board, etc.

Actual interviewees could include anyone involved in ethics activities at the hospital. The hospital chose to have their Consortium representatives (Mark Trombetta, M.D., and myself) interviewed by the surveyor. In the interview, we covered a variety of topics. To show the careful consideration that our hospital has given to ethical issues, we described our participation in the Consortium Ethics Program. The surveyor seemed to be quite interested by the model. He then reviewed the composition of the hospital’s ethics committee, and was glad to see that community representatives from the local clergy and nearby Washington and Jefferson College were members. He saw them as patient representatives, as they had no vested interest in the hospital. Most ethics committees, he noted, are facilitators working with families, patients, and physicians in order to achieve consensus on treatment.

Although the Joint Commission recognizes a policy review role, the surveyor was more interested in education in current ethical topics. Some of his other concerns included how the committee can be accessed and whether patients and families were able to ask for a consultation. He also asked what the representatives saw the Committee doing in five years.

The surveyor seemed to be very pleased with the interview. The hospital will not receive any recommendations in the areas of Patient Rights and Organizational Ethics.

A Life-Context Approach For Developing End-of-Life Decisions

By Rev. George A. Burn, Director of Pastoral Care, Centre Community Hospital, State College, PA

Over the last several decades, there has been a rapid increase in patients’ control over end-of-life decisions related to medical care. Patients now are empowered with rights to refuse treatment, withdraw life support, and remove artificial hydration and nutrition. Organ procurement agencies routinely offer the opportunity for donation and proxy decisions authorized via advance medical directives are part of our daily clinical experience. Each of these options has developed as the result of a dialectic between technological advances and personal and societal values and they have often required legal articulation and interpretation.

Although the federal Patient Self-Determination Act requires that patients be asked about advance directives, many decisions about complicated medical interventions are hastily made by patients and families in the midst of inquiry when one applies for a driver’s license, e.g., organ donor stickers. Speculation about patient values is often the best information we have to go on.

In the crucible of hospitalization, families sometimes become embroiled in conflict which produces a significant cost in time, resources, and money while treatment decisions are delayed. We would all agree, I’m sure, that patients and families who have a concept of their values prior to hospitalization make care-giving easier for all involved.

Unfortunately, before the onset of a crisis, few forums are readily available for individuals to discuss with their families the values that should guide their end-of-life decisions. More importantly, I have felt that all end-of-life decisions, from medical choices to funeral arrangements, would make more sense if they were grouped together and discussed in the context of “Life-Values”.
Over the past several years I have begun to work with local clergy, congregations, and community agencies to approach choices from this perspective. I give a presentation entitled, "Ethical, Psychological, and Spiritual Reflections Influencing End-of-Life Decisions". The best format for this has been a series of three or four evenings or Sunday mornings in small groups. It takes several hours of work before people truly enter the dialogue from a position of openness. While wrestling, sometimes painfully, with the core issues, people become aware of the extraordinary psychological, familial, and spiritual issues which may influence their choices.

We begin with the most fundamental issue, namely the acceptance of one's own mortality. As people "feel" their way into their own death they begin to move from an understanding of their own mortality from a rational "head level" to a "gut level". To assist in this process, there are a number of questions that may be asked: What does it feel like for you to think about not being here? ("I worry about my family!") What is the worst thing about your death that you can imagine? ("Not being able to say good-bye, or dying in pain") What do you fear the most? ("Pain," "Loss of control," "Not being remembered") Under what conditions would life be tolerable or intolerable (loss of limb, sight, mental faculties, ability to communicate), and why? If you had a choice, how would you like for your life to end: slowly, so that you would be able to tie up loose ends, or suddenly, to avoid the pain? Who would you trust to handle your affairs after death, and how would you let them know your preferences? How are funerals traditionally practiced in your family, or do you desire something different? How important is it to you or to your loved ones that your body be whole? (Some people maintain beliefs about a bodily resurrection which may cause them to rule out organ donation, cremation, or autopsy). What, if any, is your concept of an afterlife?

One psychological component of end-of-life decisions involves the capacity to trust. Advance directives, usually thought of as vehicles for exerting control over our choices, require the ability to place trust in others to comply with our wishes. Each of us has a capacity to trust others based upon our experience with the world around us. For some the world is a place in which the significant people in our life have been trustworthy. For others, relationships have brought a series of disappointments, thereby impairing the capacity to trust others. A need to "control" one's own life is sometimes inversely related to the capacity to trust. Key questions from a spiritual perspective are, "In what or whom do you have the capacity to trust?...yourself, others, God, medicine?" If being in control is an issue, and there are few others you can trust to know your desire, perhaps an instructional directive such as a living will can provide you with a way to maintain control even if you are incapacitated.

Other values regarding money and the ethics of allocating scarce resources can enter into choices. How much money are you willing to spend in order to remain alive? (This is especially true for families without healthcare insurance). Would you rather this be spent in other ways? For some people who have filled their lives with service to others, the concept of organ donation continues to affirm a message about what gave meaning to them. The words of Christ, "This is my body broke for you" which is used during the communion service, offers some a new perspective upon organ donation.

The response to these efforts has been most heartening. Some people have begun to develop "Life Crisis Files" containing their wills, advance directives, and pre-paid funeral arrangements including information about how, where, and by whom they wish their funerals to be conducted. Some have designed their own funeral services. Copies have been sent to family members, clergy, significant others. Many have affirmed that grouping all End-of-Life Decisions is a way of putting a "parenthesis" around the end of their lives (or adding exclamation points!!!), and leaving a commentary on the values under which they conducted their daily affairs.

This approach is not for everyone and requires, at the very least, a willingness to look seriously at mortality issues. As you might expect, it is especially welcomed in the geriatric population. It has also been well received in religious communities because these congregations, at their best, are focused upon the meaning of life and death. Furthermore, these communities are most likely the place in which the members' funerals will take place.

Producing this kind of public service program for the community has — beyond the obvious public relations implications — significant benefits for patients and their families, their religious communities, and ultimately, the hospitals and nursing homes who will be asking questions surrounding these choices upon admission. Decisions to terminate care can effect a reduction of life-prolonging treatment, which may in turn produce cost savings for the hospitals. Those of us who support families in the heartbreaking moments near death may feel more assured that decisions to terminate care have integrity and reflect some anticipatory thought. Most importantly, our patients may experience a much more peaceful resolution to their final moments.
A UNIVERSITY HOSPITAL PALLIATIVE CARE SERVICE

By John L. Coulehan, MD, MPH, & Maureen Haralabatos, RN, CNP
State University of New York at Stony Brook

Hopelessly ill and dying patients are among the most underserved groups in our health care system. Patients who are no longer candidates for curative measures ought to receive aggressive palliative measures to reduce their symptoms and provide emotional support. Yet, while much lip service is paid in our hospitals to symptomatic treatment for dying patients, a large gap often exists between the idea of "comfort care" and the reality. Thus, even though we now routinely respect the wishes of patients who elect to forgo life-sustaining therapy, we are frequently unsure of what to do next. Comfort care becomes more a negative process of deleting orders, rather than a positive treatment plan. This report describes an attempt to address the needs of acutely dying patients (like DNR orders) by developing an inpatient Palliative Care Service.

By "acutely dying" we mean those patients who are expected to die within a few days or weeks and who, therefore, will probably not survive until discharge. This includes several relatively distinct groups of patients. First, patients already known to be terminally ill who are admitted to the hospital for a palliative procedure or due to inability to be cared-for at home. Second, critically ill patients who are initially treated with aggressive curative measures, but whose condition is not responsive to treatment. Third, patients who suffer a catastrophic injury or illness, and who subsequently choose to forgo life-sustaining treatment.

In our hospital we found that palliative care for different groups of patients varied greatly in quantity and quality. On the oncology and AIDS services, patients often received good palliative care because the attending physicians and nursing staff were oriented toward symptom control, emotional support, and an interdisciplinary approach. However, the story was quite different for those who were terminally ill from cardiac or pulmonary disease. Physicians tend to think the outcome of these conditions is less predictable and, therefore, "comfort care" is considered a less appropriate medical option. In our hospital these patients are commonly treated in an intensive care setting and often maintained on a ventilator during the final days of their lives. When therapy proves to be ineffective, shared decision making frequently results in decisions to limit life-sustaining therapy and initiate "comfort care only." Comfort care, however, is variously defined by different physicians and is commonly inadequate. The ICU staff is understandably oriented toward aggressive medical intervention. The notion of purely symptomatic care introduces both cognitive and emotional dissonance. Nonetheless, many "comfort care" patients remain in the ICU because they are expected to die quickly or because they continue on mechanical ventilation, even though other treatment modalities may have been discontinued.

To meet the needs of such dying patients, we initiated a Palliative Care Service (PCS) at University Medical Center, Stony Brook. Our approach was based on the model of comprehensive supportive care developed by Carlson and his co-workers at Detroit Receiving Hospital, but modified somewhat to reflect our local conditions. The PCS provides a holistic approach aimed at achieving the best possible quality of physical, emotional and spiritual care for patients and their families. Treatment goals include maximal symptom relief and provision for the psychosocial and spiritual needs of both patients and families. Candidates for transfer to the PCS include dying patients who are both medically unstable and not expected to survive hospitalization. The PCS team consists of a physician, nurse practitioner, chaplain, social worker, and other healthcare professionals as needed. The nurse practitioner (M.H.) provides day-to-day coordination of the service, working closely with her collaborating physician (J.C.).

Our services are usually initiated when a patient's attending physician consults the PCS. The nurse practitioner then evaluates the patient and determines whether he or she meets specific admission criteria and, if so, whether the patient or surrogate desires transfer to the PCS. In addition to an existing DNR order, our operational criteria for "acutely dying" include at least one of the following:

1. ICU patients no longer requiring curative intervention because the medical condition is irreversible and they are not expected to survive more than a few days or weeks.

2. Terminally ill patients in whom the application of life sustaining measures would only serve to prolong the process of dying.

3. Patients who are comatose or in a persistent vegetative state, and who are also hemodynamically unstable and not expected to survive beyond a few days or weeks.

If a patient is eligible, the PCS may assume day-to-day management responsibility, but the patient's own physician remains in charge as the attending of record. The PCS nurse practitioner or her collaborating physician regularly review all aspects of the care plan with the attending physician. In the case of ICU patients, the plan usually involves transfer to a private room in a step-down unit that has ventilator capability. This allows for terminal weaning to take place in a private, uncluttered setting in which family members may visit at any time. If a given patient does not meet PCS criteria or does not wish to be transferred to the PCS, the nurse practitioner and collaborating physician will still provide a formal consultation, including specific "comfort
care" recommendations as appropriate.

It is important here to distinguish a PCS such as ours from hospice care. As described above, PCS patients are both hospitalized and expected to die in a very short time. In some cases they may be hospice patients who were admitted for an acute but limited intervention or, alternatively, were admitted for a terminal event. However, such patients almost by definition have a palliative care plan already in place and interdisciplinary support available through the hospice. Most of our PCS patients were not considered terminally ill prior to their present hospitalization and, therefore, had no connection with a hospice program. However, hospice becomes a focal point of the discharge plan for PCS patients who survive their hospital stay. Moreover, in developing protocols for palliative care at Stony Brook, we have learned a great deal from hospice management. For example, we have relied greatly on hospice-oriented materials, especially Peter Kaye's immensely useful book, Notes on Symptom Control in Hospice and Palliative Care (Hospice Education Center, Essex, Connecticut, 1990).

In the first six months of operation, we averaged about two formal referrals to the PCS each week, in addition to frequent informal consultations by medical and nursing staff. The program is slowly growing as physicians throughout the hospital become aware of its services. At this point much of the nurse practitioner's time is devoted to various educational programs for nursing and medical staff regarding symptom management and palliative care. We hope in this way to utilize the PCS as a catalyst to enhance the knowledge and practice of palliative care throughout the hospital. For more information about Stony Brook's PCS, contact Maureen Harnabatos, Department of Nursing, Stony Brook University Medical Center, Stony Brook, NY 11794-8033.

REFERENCES

If the Policy Fits-- Snare It! If the Policy Fits-- Declare it! (The Eight Fold Path to Reviewing Policies)

By Alan Steinberg, Esq., Horty, Springer & Mattern, P.C.

What's the best way to review an advance directive policy? To size up a forgoing treatment protocol? To examine an AIDS testing procedure?

Well, there is no actual best way, nor any magic to the process. But, there are a number of things I look for in a policy, when I am asked to review one. Revealed now for the first time to the general public, these are the eight steps to follow or questions to ask when reviewing a policy:

(1) Does the policy satisfy legal requirements? Well, I bet there is a check to see whether it satisfies the pertinent legal requirements. Some of this is straightforward—if it is an advance directive policy, is it a second, consulting physician required as per the State law? Some is more interpretational—when the Patient Self Determination Act first came out, just where “in the admission process” did materials have to be given to the patient?

But the legal requirements review is not always the most important element, as oftentimes the remaining questions are just as important to making the policy work. So, take the next step...

(2) Does the policy work operationally? Are the right people involved in each step? Is the approach too bureaucratic; not bureaucratic enough? From a common sense, operational point of view, does this work? Is there any way it could work better?

(3) Is the policy understandable? Is the writing clear? Is it too jargonistic (an ironic comment coming from an attorney.) A policy is most effective when it is written in simple English, and provides clear directions in a step by step manner.

(4) Is the policy the right length? All right, this may sound a bit silly, but every policy has a correct length. Too long, and nobody will read it. Too short, and chances are you don't have sufficient detail or direction.

What is the right length? This is one of those “know it when you see it” things. And the right length for a nurse may not be the right length for a physician and may not be the right length for social services...

(5) Does the policy work well with other related policies? Does the existing DNR policy appropriately reference the new advance directive policy? Do their concepts work well together? Are there any other policies that should be thought through?

(6) Does the policy address all the different groups of practitioners involved? Depending upon the policy, different departments of the hospital may be involved. Does the policy give clear directions for the different people involved? Even where only a finite treatment team is involved, does the policy address the different roles of those practitioners? Or, is that handled by separate policies (nursing and medical staff each have their own DNR policy)?

(continued on next page)
Sandra Janaszek Named "Woman of the Year"

On May 16, 1995, the Meadville YWCA recognized seven women “who excel in their areas of expertise and make the community a better place.” In the area of health care/human services, the winner was Sandra Janaszek, R.N., M.S.N., C.D.E., of Meadville Medical Center’s Department of Education. She received the award for her role in the success of the diabetes outpatient education program at the medical center and for her work as a community educator in medical ethics and end-of-life decision making.

Sandy has been one of Meadville Medical Center’s representatives to the Consortium Ethics Program since 1990. A natural educator, she teaches community education classes on living and coping with diabetes. Her experience with the CEP has also assisted her in providing education on advance directives and other end-of-life concerns. Some of her presentations on medical ethics have led her to local churches, service organizations, and radio stations in addition to the health care facilities of her community. She has also been the “behind-the-scenes” force in organizing the ethics committee at Meadville Area Hospital.

All of us in the CEP have come to know Sandy as an extremely dedicated and tireless educator. She is also well-known for her humility. When notified of the award, she stated, “Knowing some of the people who have won in the past, you’re in pretty good company. I was surprised and honored.”

(7) Have the peculiarities of the subject matter, and perhaps of the hospital, been thought through? For example, there are no laws or rules as to a required composition for an ethics committee. But, an ethics committee works best when it is made up of more than physicians. If the proposed composition of the committee is purely of the medical staff, are the decision-makers aware of the value of an inter-disciplinary approach? They may well be; perhaps in this hospital the only way to give the new ethics committee credibility is to begin it solely as a medical staff committee.

(8) Be aware of the hard work that has already gone in to creating the policy. By the time a policy gets to me for review, chances are that anywhere from one to a number of people have worked hard on it. My job is not to critique the policy: it is to try to improve it and to check to see if what I identify as key issues have been thought through. If this has all been accomplished, and there’s nothing else to add, that’s it, we’re done.

And so is this article!

Ethics Online

by Alan Joyce

As the CEP’s resident "computer guru", I’ve been asked to provide some basic information about bioethics resources available on the Internet to the readers of Community Ethics. Those of you who already know the basics of telecommunication should skip to the good stuff at the end of this article: information on bioethics listservers and on-line databases, including the CEP’s own World Wide Web home page (created and maintained by yours truly). For those of you who haven’t yet explored the Internet, read on.

Basic Equipment

If you have a home or office computer and a modem (the device that allows you to send and receive computer data via telephone), gaining access to the Internet should be a snap. If your institution has its own computer network that allows you to send e-mail and exchange information, you may also be able to access more of the Internet -- contact your network administrator for details. Otherwise, you can get access through various commercial organizations, including America Online, a national telecommunication service (call 1-800-827-3338 for membership information) and Telerama, a service for the Pittsburgh region (call 412-481-3505 for information).

Most university and college computing services departments provide computer and Internet access to their students, and may be able to direct you to other local providers. In addition, a number of libraries and photocopying stores (like Kinko’s) have begun to offer computer/Internet access at hourly rates. If you don’t have a computer of your own, these are inexpensive ways to see what you may be missing.

The Good Stuff

Bioethics Listservers

Anyone who can send or receive e-mail can subscribe to a listserv. Listservers are large (national, or even world-wide) e-mail discussion groups devoted to specific subjects. One subscribes to a list and joins a conversation with hundreds of other people with the same interest. A listserv, or simply "list", is much like a conference call: a copy of each e-mail message sent to the list is forwarded to every list subscriber. For bioethics, there are two dominant lists:

BioMed-L: this is open to anyone who requests a subscription. Each day, most subscribers receive the previous day’s messages in one ledger-like e-mail message. To subscribe, send an e-mail message to listserv@vm1.nodak.edu. In the body of the message, type subscribe biomed-l <your full name>. You will receive confirmation within a day or two.

...
PLEASE NOTE: One of the reasons for keeping this article short is that we don't know how many CEP members or administrators will approve or deny your membership. To subscribe, send an e-mail message to listproc@lists.mcw.edu. In the body of the message, type subscribe mcw-bioethics <your full name>. The list administrators will send you further information about the list and will ask for a brief explanation of your interest in it.

Other Bioethics Resources

Check with your local network administrator or access provider to find out about Web browsers that you can use with their service. These are software programs that allow you to view documents, or "pages", on the World Wide Web, a kind of subset of the Internet on which people post pages of information written in Hyper-Text Markup Language (HTML). Lynx is a simple browser that allows you to view text-only pages on the Web; Netscape is a popular program that allows you to view pages that contain not only text, but also graphic images and brief sound and video clips.

You can view the CEP's own Web pages using these and other Web browsers. Press "G" in Lynx or the "Go To" button in Netscape (or use the equivalent command in your browser), and type the address for our page: http://www.pitt.edu/~caj3/CEP.html. You can currently view back issues of Community Ethics and the CEP prospectus, or you can view the home pages of other bioethics centers by selecting them from our "Other On-Line Ethics Resources" menu.

Upcoming National Events

September 29-30, 1995. "Ethics, Medicine and Health Care: An Appraisal of the Thought of H. Tristram Engelhardt." To be held at Youngstown State University, Youngstown, Ohio. The conference is convened in recognition of the Second Edition of Engelhardt's The Foundations of Bioethics. For information, contact: James E. Reagan, Ph.D., Center for Ethics, St. Elizabeth Hospital Medical Center 1044 Belmont Avenue, Youngstown, OH 44501-1790. Phone: 216-480-2265; Fax: 216-480-2957.


October 12-15, 1995. Annual Meeting of the Society for Health and Human Values (SHHV). To be held in San Diego, CA. Theme: "Values of Health Care: Diverse Perspectives." For information, contact the SHHV National Office, 6728 Old McLean Drive, McLean, VA 22101; Phone: (703) 556-9222; FAX: (703) 556-8729, E-mail: SHHV@AOL.COM.

February 29 - March 2, 1996. Fifth Annual Meeting of the Association for Practical and Professional Ethics (APPE). To be held at the Stouffer Renaissance Hotel, Saint Louis, Missouri. For reservations, call 314/429-1100 or FAX: 314/429-3625. For more information, contact the Association for Practical and Professional Ethics, 410 North Park Avenue, Bloomington, IN 47405, Phone: 812/855-6450; FAX: 812/855-3315, E-mail: APPE@INDIANA.EDU.
Upcoming Events in Western PA

CEP Retreat—Hidden Valley Resort
September 29 - October 1, 1995

Consortium Ethics Program
Series One (Basic) Class Schedule
1995 - 1996

Tuesday, November 14, 1995
1:00 pm - 5:00 pm
"Ethical Theory and Models of the Physician-Patient Relationship"
Mark Kuczewski, Ph.D.

Friday, December 16, 1995
9:00 am - 12:00 pm
"Informed Consent & Competence"
Robert Arnold, M.D.

Tuesday, March 5, 1996
1:00 pm - 5:00 pm
"Surrogate Decision Making, Advance Directives, & DNR Orders"
Rose Lynn Pinkus, Ph.D. and Alan Stanberg, Esquire

Tuesday, April 2, 1996
9:00 am - 12:00 pm
"Death and The Ethics Committee; Stopping, Starting, and Getting Out Alive"
George Annas, J.D.

Wednesday, May 8, 1996
8:30 am - 5:00 pm
Duquesne Conference, "The Ethics of Managed Care?" (This conference will be held at Duquesne University)

Thursday, June 6, 1996
1:00 pm - 5:00 pm
"Forgoing Life-Sustaining Treatment: Politics, Ethics and the JCAHO"
Mark Wicclair, Ph.D.

Tuesday, December 19, 1995
1:00 pm - 5:00 pm
"It Ain't Necessarily So: Clinicians, Bioethics, and Religion"
Dana Davis, J.D., Ph.D.

Tuesday, March 6, 1996
9:00 am - 12:00 pm
"Ethical Issues in Rehabilitation: Lessons for the Acute Care Hospital"
Giles Scafield, J.D.

*Tuesday, April 2, 1996
2:00 pm - 4:00 pm
Special Class Session, location TBA
4:30 pm - 6:00 pm
"Life, Liberty, and the Pursuit of Death: American Culture and Choice at the End of Life"
George Annas, J.D.
(To be held in the Members Lounge of the University Club at the University of Pittsburgh)

*Wednesday, May 8, 1996
8:30 am - 5:00 pm
Duquesne Conference, "The Ethics of Managed Care" (This conference will be held at Duquesne University)

Thursday, June 6, 1996
9:00 am - 12:00 pm
"The Black Stork: Eugenics in History and Human Genetics Today"
Martin Parnick, Ph.D.

*All CEP classes except those marked with * are held at the Education Center of the Hospital Council of Western Pennsylvania, Warradale, PA.

Ethics for Lunch Fall 1995 Schedule

ALL SESSIONS TAKE PLACE IN AUDITORIUM 5, SCAIFE HALL (University of Pittsburgh). NOON - 1:00 P.M.

October 5, 1995
They Took the Moral High Road to Death
Reverend George Exoo
Chaplain, Hemlock Society of Western Pennsylvania

October 19, 1995
Ethical Issues in Sharing Statistical Data in the Biomedical and Health Sciences
Stephanie E. Fienberg, Ph.D.
Maurice Falk Prof. of Statistics and Social Science, Carnegie Mellon University

November 2, 1995
From Professional Ethics to Business Ethics in Health Care: A Paradigm Shift?
Jacqueline J. Glavas, Ph.D.
Associate Professor of Health Care Science & Pediatrics
Adjunct Assistant Professor of Philosophy
George Washington University

November 19, 1995
The Lie That Heals: The Use of Placebos in Clinical Practice
Stanley K. Darer, M.D.
Assistant Professor of Family Medicine and Clinical Epidemiology
University of Pittsburgh

November 26, 1995
The Physician as "Gatekeeper"
Gail Fower, M.D., M.P.H.
Professor of Medicine and Health Care Sciences
George Washington University

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