This issue of Community Ethics focuses on ethical issues in rehabilitation care, an area of growing interest in medical ethics. It is only natural that bioethics, having been nurtured for many years within the acute care environment, should now begin to pay more attention to the broad spectrum of healthcare including rehabilitation. As a result, more lectures, more literature, and some new networks concerned with ethics in rehabilitation care are being generated. This issue of CE samples each of these developing genres.

On a local level, the Consortium Ethics Program (CEP) boasts three rehabilitation hospitals among its membership: D.T. Watson Rehabilitation Services, Hillside Rehabilitation Hospital, and Harmarville Rehabilitation Center. Because rehabilitation ethics is a less developed field than acute care ethics, meeting the needs of these institutions has been a challenge for the CEP. However, the “consortium approach” to networking has proven its worth particularly well in this instance. The consortium approach is based on the premise that by pooling resources, we all benefit. We simply do not believe that all education must emanate from the CEP faculty.

The CEP faculty have facilitated this pooling of resources by developing bibliographies of relevant literature and doing initial talks at the rehabilitation facilities. But, the hospital representatives have generally pulled most of the load. For instance, at D.T. Watson, talks by CEP faculty have alternated with case discussions and presentations by Sarah Schlieper, L.S.W., C.C.M., and Bruce Bryce, D.Min., from the hospital. Furthermore, the CEP has sought to help bring national perspectives on rehabilitation issues to our members. Last year, we hosted James Thorabben, Ph.D., formerly of Mississippi Methodist Hospital & Rehabilitation Center (currently of Asbury Theological Seminary) and this issue recounts the visit of Giles Scofield, J.D., Director of the Health Law Program at Pace University.

The CEP is always looking for additional ways to meet the needs of our member hospitals and to contribute lessons and materials from our experience to the national dialogue. We hope that more discussions of issues and cases related to rehabilitation care will not have to wait for another special issue of CE but will be included as occasional feature articles. If you’d like to make a contribution along these lines, we’d love to hear from you.

Mark Kuczewski, Ph.D.
Editor, Community Ethics

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Giles Scofield Visits CEP to Address Issues in Rehabilitation Ethics

Giles Scofield, J.D., Director of the Health law Program at Pace University and a leading expert on rehabilitation ethics, visited the Consortium Ethics Program on March 4 & 5th, 1996. He led an advanced seminar for the CEP representatives at Warrendale and gave a lecture for hospital staff at each of the rehabilitation hospitals who are partners in the consortium.

At the Advanced Seminar:

In the advanced seminar for CEP members, Scofield gave the talk, “Ethical Issues in Rehab: Lessons for the Acute Care Hospital.” In this talk, he showed how ethical perspectives in rehabilitation care might differ from acute care and outlined what rehabilitation might contribute.

Scofield noted that rehabilitation care helps providers to deal with chronic illness and disability in the way that hospice care has helped with death and dying. However, all of this “care” talk should not mislead us. American medical ethics has been dominated by law and its rights-oriented perspective. For instance, one way to look at living will laws is that they are civil rights legislation for the dying. Similarly, the disabled have had their own rights legislation, most notably the Americans with Disabilities Act (ADA).

Scofield’s talk took an entertaining detour into an exposition on “postmodern ethics.” This digression provides a framework (or a “non-framework”) in which to cognize misgivings about the language of rights. Rights are inflexible and, in many ways, absolutist. Meanwhile, contemporary experience of moral matters suggests that there is much gray area that cannot be dismissed by elucidating the rights of the parties involved. Postmodern ethics takes this gray area as its starting point.

Because of the lack of certainty regarding the substance of decisionmaking, postmodern ethics advocates taking seriously the process of decisionmaking. Scofield compared traditional ethics to the original Star Trek show. The sense of mission, i.e., of good and evil, was clear and as a result, authoritative command structures were legitimated. In the successor show, The Next Generation, a postmodern outlook prevailed. The mission of the Enterprise was less clear and the “good guy - bad guy” mentality was often subverted in the course of an episode. The characters learned from cultural and gender differences and made most decisions collaboratively. Scofield claimed that rehabilitation ethics calls us out of the rigidity and optimism of the bioethics that evolved in acute care, and into a postmodern bioethics, i.e., into the next generation of bioethics.

Scofield referred to his position as “gloomy pragmatism.” It is gloomy because it cannot simply rely on “what works,” the traditional criterion of pragmatists. What works may be the product of oppressive power structures. Nevertheless, he embraces pragmatism since we cannot rely on the bright guiding stars of traditional ethical theory but must muddle our way through matters in a self-critical fashion. Self-criticism is all important because modern history shows that it is very easy to delude oneself regarding one’s own motives in acting. It is this self-critical element that makes Scofield’s pragmatism postmodern.

Scofield, looking through the lens of his gloomy pragmatism, identified four features of rehabilitation that are illuminating for ethicists weaned on acute care ethics. (1) Rehabilitation ethics is dominated by an educational model of informed consent. This model holds that respect for persons is often a more realistic goal than respect for patient autonomy. In respecting persons, we must work to restore patient autonomy and therefore, consent becomes an interactive and interpersonal process. (2) Rehabilitation generally takes a team approach to caregiving. This integration of caregiving facilitates respect for the patient as he or she is not fragmented into diagnostic categories and treatment patterns based upon organ systems. (3) Most of us will be disabled at some point. Thus, rehabilitation care raises important questions concerning the continuity of personal identity and invites us to revisit our cultural presuppositions about quality of life. (4) Rehabilitation brings the political dimensions of healthcare to the fore. The current trend in healthcare financing is toward managed care schemes. Managed care emphasizes outcomes and reimburses based on these. However, rehabilitation care emphasizes processes and notes that outcomes are not always clear, fixed points. As a result, rehabilitation care challenges the very presuppositions of managed care financing. Professor Scofield suggested that claims brought against insurers under the Americans with Disabilities Act might cause a rethinking of the current financing schemes.

At The CEP Hospitals:

Professor Scofield visited each of the three rehabilitation hospitals who are CEP members: D.T. Watson Rehabilitation Services, Harmarville Rehabilitation Center, and Hillside Rehabilitation Hospital. He presented the talk “The Problem of (Non-) Compliance: Is It Patients or Patience?” for the staff of those facilities.

Scofield began by asking just how reasonable our expectation of compliance is. Compliance by the patient is a kind of cooperative performance in relation to the prescribed therapy or regimen. From the perspective of the healthcare provider, compliance is a characteristic of a reasonable patient. Of course, many “normal” or “competent” people have idiosyncratic decisionmaking styles that depart substantially from the concept of reasonableness. These normal people may be perceived as noncompliant while merely exercising their autonomy, e.g., displaying their personalities.
Scofield suggested that the term 'noncompliance' is thrown around fairly easily and it is a good idea for any caregiver to question whether the patient is truly being noncompliant. He suggested that treatment teams do not always make a completely accurate diagnosis and prescribe the perfect treatment regimen. As a result, patients often engage in a kind of intelligent partial compliance. For instance, a patient who is supposed to walk two miles a day only walks one since this preserves energy that is then channeled into additional daily activities. Thus, the patient has integrated the spirit if not the letter of the regimen into his life. This example indicates that it is also important to determine how objective our assessment of the patient's noncompliance is. We may simply be dealing with a value judgment about the benefit of total compliance.

Scofield also asked whether we sufficiently scrutinize the patient's ability to comply. Is the patient physically and mentally able to comply or have we overlooked physical and mental deficits that make the regimen unrealistic at this time or in a particular way? Furthermore, unacknowledged problems such as illiteracy may undermine the transmission of what we believe to be clear instructions. This point also calls for self-scrutiny on the part of caregivers. The caregivers must be sure that they are transmitting clear and consistent information to the patient. They also must not expect more in terms of compliance than they themselves give on a daily basis. Scofield pointed to the simple example of handwashing, a well-publicized, but often unheeded, expectation of healthcare professionals.

From these considerations, Professor Scofield concluded that most individuals are better at being persons than patients. As a result, expectations of compliance must be adjusted to allow for the human and personal dimension of existence. However, institutional forces work contrary to this perspective. Outcomes and results are demanded by managed care. When outcomes are not favorable and results are not produced on schedule, blame must be assigned. As a result, there is a temptation to use noncompliance as a diagnostic category to place the blame on the patient. Once the label is used on a patient, it may have a severe stigmatizing effect that limits future options. Rehabilitation ethics must expose this pernicious tendency.

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**SHHV Rehabilitation Ethics Interest Group Prepares for Cleveland**

A very exciting development in the area of rehabilitation ethics has been the creation of the Rehabilitation Ethics Interest Group of the Society for Health and Human Values (SHHV). The SHHV is the oldest and largest professional society in bioethics. The Society's interest groups bring together academics and professionals interested in a particular discipline or area of healthcare ethics. Such groups can be vital sources of knowledge and experience.

Mark Kuczewski, Ph.D., of the CEP and Ruth Bryant Purtilo, Ph.D., P.T., of Creighton University founded this group to serve as a resource to rehabilitation professionals across the nation (and in the CEP). To plan this year's program for the interest group, Mark and Ruth asked Jim Thobaben, Ph.D., of the Asbury Theological Seminary in Kentucky, to join them. Jim had started the ball rolling by organizing an informal luncheon of people interested in rehabilitation ethics at the bioethics "mega-meeting" in Pittsburgh in 1994.

The meeting of the Rehabilitation Interest Group will be held at the joint Annual Meetings of the SHHV and Society for Bioethics Consultation (SBC) in Cleveland, Ohio (Sheraton Cleveland City Centre), October 10-13, 1996. The general theme for the session will be "patient autonomy in rehabilitation care." The session will be moderated by Ruth Purtilo, and the presenters will be:

**Bruns Myers, Chaplain, Mississippi Methodist Hospital and Rehabilitation Center**

**Abstract:** Autonomy, as generally understood, is insufficient as a model of patient decision-making for persons with new and relatively new seriously disabling injuries. Care decisions are often made for these patients and, after the fact, validated through an artificial appeal to this increasingly meaningless concept. Presenting from the perspective of patient, provider, and family member, the author argues that a new, explanatory typology of autonomy is required or the word 'autonomy' should be discarded.

**Avis Hayden, Ph.D., P.T., Southeast Alaska Regional Health Consortium, "The Social Context of Rehabilitation Ethics."**

**Abstract:** This research, in the tradition of descriptive ethics, examines the kinds of situations that physical therapists described as ethical dilemmas. These empirical findings demonstrate that the social context of rehabilitation alters the ethical landscape in ways that have not been fully considered by the medical model. A rehabilitation ethics model is developed that expands the basic casuistic approach to ethics.

**Richard Allman, M.D., Albert Einstein Medical Center, Marguerita Torres, M.D., Moss Rehabilitation Hospital, "The Assault on Autonomy in Rehabilitation Medicine"**

**Abstract:** Respect for autonomy is under particular assault in the rehabilitation environment. This paper explores rehabilitation activities and patient problems which threaten autonomy. Case examples will be used to illustrate violations of patient autonomy and suggestions will be made for working with ethical problems in rehabilitation.

We invite you to join us in Cleveland for what promises to be a thought-provoking discussion. Additional information on the Annual Meeting of the SHHV can be obtained by calling Jackie Kenney at the SHHV National Office: (703) 556-9222 or e-mailing <SHHV@aol.com>.
Who's the Patient?

A CASE STUDY & COMMENTARY

by Sarah Schlieper, L.S.W., Department of Psychosocial Services, D.T. Watson Rehabilitation Services

The Problem:

J.P. is a four year old boy with spastic quadriplegia secondary to cerebral palsy (CP). He is also delayed intellectually and functions at an 18 month old level. When J.P. was six months old, his developmental pediatrician referred him to the pediatric program at St. Catherine's Rehabilitation Hospital for a comprehensive program of physical, occupational, speech and hydro therapy. J.P. is the fourth of four children. His sisters are 7, 9, and 11 years of age. There are no other significant medical issues or history in the family.

Over the course of the past three and a half years, J.P. and his parents have become quite interactive with the pediatric staff. His mother and father take turns bringing him to therapy; they have never brought him together. Once, J.P.'s mother confided to the social worker that she thought their marriage was “on the rocks.” She and her husband had wanted a son desperately, and when they found out about J.P.'s developmental difficulties, things were never the same. Mrs. P. feels she has failed as a wife and sees her only role as helping J.P. to be as normal as possible. She will do whatever she feels is necessary to achieve this end. She has become active in local and state CP advocacy organizations, attends CP support groups, and is also quite active in her local school system. Mr. P. is more passive; he watches therapy and takes instructions from, but doesn’t interact with J.P. any more than is necessary. Mr. P. states he loves his family, but it's hard for him to see his boy as a “helpless cripple.”

From a therapeutic standpoint, J.P.'s parents are able to understand and carry out a stretching/range-of-motion program and have done an excellent job of maintaining this program. J.P. is able to stand with moderate assistance. He ambulates and ambulates, and sometimes takes steps unassisted. J.P. can walk on dry land, it will probably be with much assistance and not functional or safe. They have met with Mrs. P. to tell her their opinion.

Mrs. P.'s response is to state that there are several mothers in her CP organizations whose doctors said the same thing about their kids. Mrs. P. added that as long as she never gives up hope, he will walk. J.P. will be starting kindergarten in two months, where he will receive educationally based physical therapy, occupational therapy and speech therapy. The therapy team feels J.P. should be discharged from the pediatric program, except for speech therapy to monitor the swallowing situation (a medical issue) when he starts kindergarten. The team feels his other therapeutic needs will be met by his individual educational program in kindergarten. When the physiatrist discussed termination with Mrs. P., she got quite angry and threatened to sue.

Mrs. P. has stated J.P.'s developmental pediatrician thinks this recommendation is “insane” and will write orders for J.P. to continue all therapies, especially the pool. Mrs. P. said that she sees progress constantly, and that what the therapists are doing helps him. She also believes that speech therapy is the least of his needs, and that he is ready to eat everything the family eats except tough meat. The therapy team discussed this informally over lunch and feels that J.P.'s mother is over-involved with him and in denial. The therapists feel compromised at the idea of being forced to continue therapy even though they see limited functional gains.

The Outcome:

This team met again with Mr. and Mrs. P. to review the recommendations and solicit their feedback. The team’s agenda focused on concern around the feeding issue, need to terminate PT, OT, and Hydro, and the switch to an educational focus. Mrs. P. seemed to focus on concerns that she and J.P. were being abandoned and being told there was no hope. The team was able to reframe some of these concerns, so that the “graduation” from the program was seen as a move forward, not backward. The team and the parents were able to contract for periodic reevaluations of J.P.’s rehabilitation status, with the understanding that when J.P. is able and ready to benefit from more intervention, he would be considered for an outpatient program.

The physiatrist asked for and received permission to reinforce this plan with the pediatrician. The team also evaluated their need setting with parents of children entering the Pediatric Program and reevaluated this aspect of the program. The social worker was able to set up a brief intervention focused on engaging Mr. P. in J.P.'s care, helping Mrs. P. come to terms with her son's differences, and reestablishing them as a couple. Once this brief intervention was completed the parents continued counseling at an outpatient mental health facility.

The Commentary:

From a medical ethics perspective, the issues in rehabilitation always seem to be a bit “grayer” than the norm. The famous four principles sometimes fit, yet more often than not, complicate matters. Most of rehabilitation focuses on living with some sort of chronic illness, not trying to fix, cure, or eradicate it. The issues are often transitional and process-oriented. Such issues seldom break into the neat dichotomies of conflicting principles and parties that acute care ethics celebrates.

Furthermore, rehabilitation care, especially rehabilitation for children, has traditionally included and considered fami-
lies and significant others as active participants and even as “patients.” Family teaching and inclusion has a long history in rehabilitation hospitals and the idea of systemic medicine has been around for some time. Nevertheless, the idea of families and significant others as a biological system and the integration of this living system into medicine and the medical subculture is still new and radical to some.

In this case the main ethical questions are: Who is the patient and who should the medical system treat in order to remediate J.P.’s medical issues? Is it J.P., his mother, his father, the family, the systems he may be integrating into (the school, the CP organization)? Does the definition of patient change as technologies, therapies, medicine or families develop and go through transitions? Where does “healthcare” (or perhaps we should consider it “sick care” or “technology care”) end and living a new and different kind of life begin? Is there a boundary between being sick and being disabled? How does the healthcare system respond? What are the roles and obligations of rehabilitation throughout this process?

The treatment team and the patient and family seemed to do well until the boundaries between illness and disability began to blur. What the healthcare team views as disability or maintenance, Mrs. P. views as treatment, remediation, and hope. I also have to wonder about J.P.’s bio-psycho-social system and the medical culture’s response to it. Might the medical/bio aspects of his recovery be improved if we changed the focus from J.P.’s muscles and bones to the muscle and bones and how they interrelate with his family system?

The case of J.P. highlights some of the everyday ethical dilemmas encountered by rehabilitation physicians and clinicians. The staff were able to come together and redefine who the patient was (the parents and the system J.P. was transitioning into). They were able to look at his physical and psychological needs in relationship to these systems and redefine a treatment plan to address these needs. This included requesting that Mr. & Mrs. P. come together to J.P.’s remaining treatment sessions so that they can be on the same page in regard to learning the “boundaries” between therapy (changing) and learning (integrating the changes).

The patients were able to accept this framework as a developmental one based on their experience with their daughters. The family needed a way to accept the educational transition without viewing it as the medical system abandoning them. The physician’s role was critical in developing this framework. The team also was able to work with the family and the school together to look at the transitional issues. Mrs. & Mr. P. together were able to look at the feeding concern from this framework and agreed with the physician recommendation that this was a “medical” need and were in agreement to addressing it with the physician and the speech pathologist. The parents also agreed that they had some work to do as parents and a couple in regard to J.P. and their marriage — they were quite accepting of a referral and ready to do some family counseling.

Rehabilitation Ethics “On the Prowl”
by Joan Nypaver, B.S.N, C.R.N., and the Ethics Committee of Hillside Rehabilitation Hospital, Warren, OH

Our ethics committee is still “getting its feet wet” when it comes to having cases referred to us for consultation. However, we recently did take the lead, in response to a situation of potential violence within our facility.

One morning, a 26 year old male began walking the hallway between Physical Therapy (PT) and Occupational Therapy (OT) at a very rapid, determined pace. At first glance, most employees did not suspect anything amiss, because outpatients often walk that hallway in a similar fashion in order to complete portions of a physical capacity test. Employees became concerned when the man began pushing away people who were in his path.

Appropriate management of the situation was implemented by Dr. Joe Pecorelli, our psychologist. Hence, this crisis did not result in anyone being physically hurt. However, it was necessary to restrain and transfer the disturbed individual, who was in our facility for vocational treatment, to an acute care psychiatric environment.

During the debriefing which followed, several concerns became apparent. One, although things went pretty well, we realized we needed a policy regarding managing potential violent situations. Two, we needed to coordinate our efforts with community resources, such as the police and rescue squad. Three, we needed to educate our staff and volunteers about a safe and confidential course of action.

In identifying and beginning to address these concerns, our first official retrospective case resolution and analysis was underway! Our committee first met with all interested or involved hospital employees, and representatives of our police and rescue squad. We spent time discussing what went right, what could be improved, and what criteria were important in the implementation of the basic guidelines for staff and volunteers in the event of a future situation.

Next, as a result of the meeting a task force of individuals representative of the response team and developed team functions. We recognized the importance of de-escalating an agitated person before a situation escalates into physical violence, thereby recognizing the value of an individual retaining his or her autonomy by regaining self-control. We also developed educational plans for staff and volunteers, in order that all would be aware of the steps to take to secure the environment, in the event of an incident, thereby allowing the team to interact with the agitated person. This strategy would eliminate voyeurism, recognizing the dignity of the agitated person even in their compromised position.

Unfortunately, we were unable to de-escalate this individual’s behavior and had to use physical restraints. However, we were able to provide some direction for his mother who felt trapped by the fact that although chronologically an adult, her son is not mentally competent at all times. We advised her of resources for evaluating his competency and encouraged her to share personal observations with any treatment teams, e.g., the fact that he “was agitated yesterday and this morning before leaving home” and “I tried to get him help yesterday, but his doctor would not listen to me.” Thus, through the retrospective review we were able to recognize ways for handling this sort of situation to be avoided in the future.

We are excited about the commitment and prompt response of our ethics committee to this case. Since all departments have received the HRH Administrative Policy for “Code Red — Unruly person — potential violence” authored by the ethics committee, we expect an increasing number of case referrals. Within our rehabilitation environment, currently feeling the crunch of managed care upon length of stay and reimbursement, we are sure that the future will keep our ethics committee busy.
Is Rehabilitation Ethics So Different?
by Mark Kuczewski, Ph.D., Associate Director,
Consortium Ethics Program

One of the recurrent themes of this issue has been the difference between traditional medical ethics which was developed mainly in the acute care hospital, and rehabilitation ethics. But, are these two so different?

We have heard that rehabilitation ethics calls our attention to (1) respect for persons rather than patient autonomy, (2) an educational or process model of informed consent over a contractual or event model, and (3) an intimate role for the family that occasionally blurs the distinction between the family and patient. Nevertheless, careful students of acute care medical ethics will not be strangers to any of these notions. All of these points of emphasis of rehabilitation ethics are represented in the acute care literature. I must conclude that we are, in fact, dealing with differences in emphases, not in kind.

Are there genuine qualitative differences in the approaches of rehabilitation ethics and acute care ethics? We could continue down the road of looking for additional concepts on which the two types of ethics differ. Clearly the concept of the healthcare team is more pronounced in rehabilitation and there is far greater honesty regarding the quality of life judgments that are a part of rehabilitation care. Again, we are dealing with emphasis, not kind. But, when we look at the cases that Joan Nypaver and Sarah Schlieper shared with us, we “acute care ethicists” are struck by their novelty. Perhaps it is not primarily in the principles that we find differences in applied ethics, it is in the cases.

Medical ethicists refer to case-based ethics as “casuistry.” Casuists claim that ethics is primarily a matter of attention to the details or circumstances of the case. It is the details that dictate solutions. The ethics committee at Hillside Rehabilitation Hospital showed themselves to be good casuists. They were called to review a case and they teased out the relevant considerations. They looked at what went right and what could be improved. They developed certain priorities for similar situations, e.g., de-escalating the potentially-violent patient, and developed criteria concerning when stronger measures are needed. They framed generalizations about these criteria and encoded them in guidelines. Thus, they drew distinctions between cases that can be handled in one manner and other cases that demand different steps. They also noted certain considerations relevant to all these cases, e.g., avoidance of voyeurism, and took steps to educate staff concerning them. These casuists have clearly done an exemplary job.

What initially causes a particular clinical case to be labeled as an ethics case is often somewhat mysterious. But, once it is identified in this way, a chain of events begins. This case was referred to the Hillside Rehabilitation Hospital ethics committee because someone thought it contained ethical issues. From now on, this kind of scenario is an “ethics case” at this facility. Furthermore, new members of this ethics committee will probably be educated by the incumbent members regarding these types of cases. Such cases become a part of the “institutional conscience.”

Conscience is a good thing. In the modern era, conscience has come to be thought of as a private matter that is beyond the judgment of others. However, in its original meaning, conscience meant “knowing with” and was a public matter. This would seem to be closer to what we are considering when we speak of an institutional conscience. Institutional memory must be open to public scrutiny and refinement. It would seem that each rehabilitation facility would benefit from exposure to the case studies of other institutions. Through this process, each committee would become sensitive to a greater variety of situations and would be less likely to develop its institutional conscience in an idiosyncratic manner.

In acute care ethics, the bioethics community has become a repository of relevant scenarios through casebooks, case studies in prominent journals, and commentaries on important court cases. This has not yet happened in rehabilitation ethics. What is needed in rehabilitation ethics is the sharing of more cases. Bioethicists, while acknowledging our general lack of attention to rehabilitation care, nevertheless often succumb to the temptation to generate literature that takes the form of conceptual generalizations and fails to link these generalities to observations from rehabilitation care. The challenge for bioethicists is once again to leave the philosophical armchair and to watch rehabilitation professionals in the same way they observed acute care professionals 20 years ago. Listening to their case reports will be more important to the ethicist than her philosophical repository will be to the rehabilitation professionals.
Before the mid 1980's, there were few published articles that focused specifically on the place of biomedical ethics in the field of rehabilitation medicine. One of the first major efforts to correct this situation was a Hastings Center project that produced the article, "Ethical & Policy Issues in Rehabilitation Medicine," by Arthur Caplan, Daniel Callahan, and Janet Haas (Hastings Center Report Special Supplement, August 1987, pp. 1-20) and a casebook, *Case Studies in Ethics and Medical Rehabilitation* (The Hastings Center, 1988).

The authors provide a basic introduction to rehabilitation medicine and note the ways in which it differs from acute care, many of which are noted elsewhere in this newsletter. These differences seem to mandate a different approach to "doing" medical ethics. For example: in contrast to a typical model of acute care in which treatment is directed by a single physician, rehabilitation care is based on a "team approach" in which a variety of specialists work together, with a great deal of patient input, to determine and work towards certain physical, mental, and social rehabilitative goals. In many cases, this means that rehabilitation medicine is necessarily more respectful of patient autonomy and informed consent than the familiar acute care model. However, many rehabilitation patients are, at least initially, demoralized by their disability and will refuse to participate in any treatment program. These patients may still be "competent" according to the definitions common in acute care, yet care providers will often override their stated wishes -- how can this fit with our notions of respect for patient autonomy?

In response to these and other ethical dilemmas particular to rehabilitation medicine, the authors propose an *educational model* of the physician/patient relationship. This model is an "evolving relationship between providers and patients," in which the providers may initially assume a more paternalistic role -- but only towards the end of restoring autonomy in patients who may be traumatized by sudden and permanent disability. Once patients come to terms with their situation and are helped to understand the benefits of rehabilitative services, then they can assume their role as equal and autonomous members of the care team. The authors examine these and other issues, including confidentiality, family duties, and resource allocation, and the casebook provides more graphic illustration of these issues via ten cases with extensive commentary.

Also of interest is a relatively recent issue of *Healthcare Ethics Committee Forum* (March-May 1995, vol. 7 nos. 2-3) focusing on ethics in rehabilitation medicine; this issue includes Giles Scofield's "The Problem of (Non-) compliance: Is it Patients or Patience?" in addition to articles on topics such as suicide by disabled persons and disability rights. In addition, *The American Journal of Physical Medicine and Rehabilitation* ran a medical ethics series throughout 1993 and 1994 (volumes 72 and 73), with articles such as "Allocating Health Care Resources: The Vexing Case of Rehabilitation" (Daniel Callahan, vol. 72 no. 2); "Healing the Self: The Moral Meaning of Relationships in Rehabilitation" (Bruce Jennings, vol. 72 no. 6); and "Ethical Issues of Treating Patients with AIDS in a Rehabilitation Setting" (Thomas E. Strax, vol 73 no. 4).

*[Case Studies in Ethics and Medical Rehabilitation is available, for a small fee, from the Hastings Center. For more information, contact their publications department at 255 Elm Road, Briarcliff Manor, New York 10510-9974.]
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 <mgk@med.pitt.edu>.

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