In This Issue

Mark Kuczewski, Ph.D., Editor

This issue of Community Ethics examines the topic of increasing awareness of ethical issues. We usually think of increased awareness as an unequivocally positive goal. Our first feature is a report in that vein. CE reports on what one hospital did to increase staff awareness after personnel had become immune to the more conventional approaches to education. The first "Ethics Week", which was held at Butler Memorial Hospital, can serve as an exciting and innovative model to educate your hospital community.

We also present 5 contributions that discuss a gray area in the general public's ethics awareness. A recent controversial study claimed that a surprising number of nurses took part in assisting patients in dying. This study created a stir among the bioethics community not only because of its content, but also because it received a good deal of media attention. Thus, the responsibilities of the media in reporting on medical ethics is at issue. We feature a cross-section of perspectives from a nurse, a physician, an attorney, a philosopher, and a journalist.

We also introduce a new page in this issue called "And now, a word from our sponsors." This occasional feature will bring news from the Hospital Council of Western Pennsylvania and the University of Pittsburgh Center for Medical Ethics. Both institutions have collaborated to help make the CEP successful. We believe that news from these institutions will not only be of interest to readers in western Pennsylvania, but also to our national audience which might wish to draw upon this model of an ethics network.

A final note: Regular readers will note the absence of Alan Joyce's "Truly Useful Literature" column. Fans of TUL can rest assured that this popular feature will return in our next issue.
Ethics Roundtable:

Do Nurses Participate in Euthanasia and Assisted Suicide?

(Would it be a bad thing?)

A recent study in the New England Journal of Medicine by David Asch, M.D., M.B.A., [NEJM, 334 (21): 1374-1379, 1996] created a stir among healthcare professionals, patients and their families, and medical ethicists. This survey study claimed that a significant number of nurses perform active euthanasia. That is, these nurses supposedly take steps to kill some of their patients in order to relieve their pain and suffering.

We print several responses to this study below. These are indicative of the wide variety of viewpoints being expressed around the nation. Some challenge the validity of the study’s findings, others accept them and debate the morality of such actions.

Much Ado About Nothing

Scott Miller, M.D., M.A.,
Chief of Medical Ethics,
Allegheny University of the Health Sciences,
Allegheny General Hospital,
Pittsburgh, PA

A recent study in the Journal of the American Medical Association late last year (the SUPPORT study) came to the sad and disconcerting conclusion that doctors and other healthcare professionals are woefully inadequate when it comes to recognizing and treating the pain and suffering of dying patients. Earlier this year, a survey by a physician at the University of Pennsylvania, David Asch, made nationwide headlines when it reported that one out of five intensive care unit nurses has acted to hasten the death of a patient, and that some of them acted because they felt that the physician caring for the patient was ignoring their pain and suffering.

But where’s the headline news? A multitude of previous studies have shown that doctors are not well trained in recognizing and treating dying patients, and for a physician, the environment of an intensive care unit is not the ideal place for time-consuming and emotional discussions with the patient about
treatment withdrawal, advance directives, and death with dignity and without pain. For the physician, intensive care is ventilators and dialysis machines, powerful antibiotics and blood pressure medications, and long lists of laboratory evaluations.

But for the nurse, intensive care may actually mean spending an intensive amount of time with the patient and the family. They may see and hear first-hand of the patient's pain and suffering as the patients are being turned, bathed, medicated, and generally taken care of. It is likely that the nurse may be the first one to appreciate the patient's level of continuous discomfort, and also may be first to recognize an endless cycle of pain and suffering coupled with a dim hope for any meaningful recovery. As a result, nurses, often rightly so, feel that they have a greater and earlier insight into a patient's wishes concerning these difficult issues.

Therefore, at one time or another in their nursing careers, one out of five of those nurses who responded to the survey questionnaire were put in a position where a patient desperate for relief was paired with a physician unable to recognize the situation, and the nurse took matters into her own hands. But saying that one of five nurses has participated in hastening the death of a patient is not saying that the practice happens 20% of the time, as the newspaper headlines seemed to imply. In fact, the survey reported that 65% of those nurses who had "hastened death" did so three times or less, and about 93% of those were based on repeated requests by the patient or family.

Again, where's the headline news? And after all this old information is presented as front-page, bold-headline, "nurses killing patients in the ICU" stuff, it turns out the survey itself has numerous flaws on careful review, and the actual statistics are not reliable. It turns out that the survey did not do a very good job of defining the terms used, so that "hastening death" by using appropriate treatments (like adequate pain medication) could be considered similar to "hastening death" by inappropriate means (like high dose narcotics administered once for the sole purpose of killing). And one nurse's definition of "hastening death" could not be accurately compared to another's.

But even if the news is old, it is still important. Overall, the survey, regardless of its numeric accuracy, is yet another piece of evidence that should serve to remind us of how hard a journey we have in order to deal more effectively and compassionately with dying patients. But what the headlines don't detail is that the issue is being taken quite seriously and is being worked on across the country. Physician organizations, like the AMA and Society of Critical Care Medicine, and nursing organizations, like the American Association of Critical Care Nurses, and ethics associations, like the Society for Health and Human Values, and hospice associations, as well as the judicial system and a multitude of other small groups, are all dedicating themselves to exploring solutions and promoting the idea that we can do better when it comes to the care of the dying.


Active Aid-in-Dying:

Recognizing What Already Exists and Preventing Abuse

Alan Meisel, J.D.
The most interesting part of the Asch article was the reaction of organized medicine: indignant and shocked outrage. But this is not shocking at all. The substance of Asch’s findings merely confirm what many had suspected. What is shocking is the hypocritical disbelief and indignation of the medical profession.

Even outside the healthcare professions, there have been hints of mercy killing for years. Everyone knows that although Dr. Kevorkian may be an outlier, he is not an "n of one." Despite its formal illegality, Emanuel has documented that the covert practice of physician-assisted suicide and active euthanasia has occurred throughout history. In more recent times, besides Kevorkian we have had Dr. Quill’s confession, “It’s Over Debbie”, and an informal survey conducted by the American Society of Internal Medicine finding that one in five physicians admitted to taking deliberate actions to end the life of a terminally ill patient.

Doctors have not been alone in actively hastening death. In 1991, it came to light that nurses at a Montana hospice were stockpiling narcotics for use by patients when their needs exceeded prescribed amounts. This appeared to be so thinly-veiled an excuse for actively aiding the patients in dying that the Montana Board of Nursing brought disciplinary proceedings against them.

Most interesting of all was the 1986 front-page revelation, on the fiftieth anniversary of the death of King George V of Great Britain, who was suffering from terminal cancer, that his doctor "sped" his death by giving him more than enough morphine to ease his pain.

What Asch's findings help to underscore, along with other findings some of which he reports, is that relief from otherwise unrelievable pain and suffering is no longer (if it ever was) the sole province of royalty. What the nurses who report having provided aid-in-dying recognize - and some doctors, too, though they are loath to admit it - is that not just royalty, but many commoners, suffer when they are dying, and that it fulfills one of the highest ideals and goals of the healthcare professions to eliminate suffering even if the only means of doing so results in ending the patient's life.

The only thing I found somewhat surprising about Asch's findings is that the numbers are as low as they are. If this study and the informal study of internists are valid, nurses are providing active aid-in-dying at about the same rate as doctors. What is somewhat surprising is that nurses, trained for compassion and caring far more so than doctors, are not providing active aid-in-dying at an even greater rate than doctors. Perhaps this is because nurses have less resources to defend themselves if caught.

The debate about actively hastening death picked up tremendous momentum in 1996 with the issuance of two federal appeals’ court decisions striking down state laws prohibiting assisted suicide, at least when performed by physicians. What these opinions - both of them extremely lengthy - underscore is the point that long ago should have been obvious. What is critical is not whether the means of hastening death are labeled active or passive but whether there is consent.

Some believe that the legalization of active aid-in-dying - a term I far prefer to "assisted suicide" because the term "suicide" so prejudices the discussion that the conclusion is all but foregone - would put us on a slippery slope headed toward practices akin to the Nazis. First, it must be recognized that we are already on a slippery slope, and we have been on it for 20 years since the New Jersey Supreme Court recognized the legal right to forgo life-sustaining treatment - the polite term for passive euthanasia - in
the Quinlan case in 1976. Second, this is a complex issue which only time will answer, but it will be answered in context. I believe that the current American political and cultural context is capable of providing toeholds on the slippery slope. The Nazi euthanasia program did not make the Nazis totalitarian; it was their totalitarian political system that made the euthanasia program possible.

In one of the federal appeals court opinions striking down a law criminalizing assisted suicide, the judge termed slippery slope arguments as "nihilistic" because it can be offered against any constitutionally-protected right. He continued thus:

"Both before and after women were found to have a right to have an abortion, critics contended that legalizing that medical procedure would lead to its widespread use as a substitute for other forms of birth control or as a means of racial genocide. Inflammatory contentions regarding 831 ways in which the recognition of the right would lead to the ruination of the country did not, however, deter the Supreme Court from first recognizing and then two decades later reaffirming a constitutionally-protected liberty interest in terminating an unwanted pregnancy. In fact, the Court has never refused to recognize a substantive due process liberty right or interest merely because there were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly.2

Or, as he concluded, "Recognition of any right creates the possibility of abuse."

It is up to us - both as healthcare professionals and as citizens - to see both that the right is maintained but not abused. This can be done by insisting on informed consent.

1. Ezekiel Emanuel, "Euthanasia - Historical, Ethical, and Empiric Perspectives, Archives of Internal Medicine, 154: 1890, 1994.


A Nurse's Response
The Role of Critical Care Nurses in Euthanasia and Assisted Suicide

Sandra Thorpe, R.N., B.S.N.
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The Uniontown Hospital

The article by David Asch has created an unnecessary level of fear and anxiety in patients in Intensive Care Units and their families. The article and related television and newspaper reports have painted a false picture of critical care nurses and their role in caring for patients who are terminally ill and nearing the end of life.

The survey Dr. Asch distributed was meant to determine the practices of ICU nurses caring for these patients but the instrument he created failed to do so. The questionnaire was eight pages long and designed to take 10 minutes to complete with 'yes' and 'no' answers. No reliability or validity tests were done. As complicated as these two ethical issues are (euthanasia and assisted suicide), can they be clearly determined in this manner? The sample size is yet another issue that causes concern regarding how the interpretation has been presented. While 1600 surveys were sent, only 129 respondents reported engaging in any of these practices. Of those, only 74 stated a description which would indicate that the questions were understood. The survey instrument and questions were open to individual interpretation.

Although it is stated in the article that the results of this study are not meant to suggest that patients or the public should fear or distrust critical care nurses, a local newspaper headline exclaimed, "SURVEY FINDS 1 IN 5 INTENSIVE CARE NURSES AIDED PATIENT'S DEATH!" How could this information not create concern, especially when the patients and/or families are in the process of making end-of-life decisions or are considering creating advance directives?

Nevertheless, it is still disturbing that, perhaps, some nurses may be engaging in unlawful practices. Critical care nurses frequently care for patients who are near death and who may wish to die, but as the American Association of Critical Care Nurses states, "nurses do not kill the patients entrusted to their care." As several of the other authors in this roundtable also note, the survey did not make clear the distinction between euthanasia (which is illegal) and the forgoing of life-sustaining treatment (which is a patient's right). As was pointed out in the NEJM article, the most common method of hastening death reported by the nurses was administering a high dose of morphine. This was reportedly done on occasions when life-support was being weaned. This practice is a humane way to alleviate suffering of oxygen "hunger"; it is not euthanasia.

The NEJM article has successfully created confusion about end-of-life care and compassionate care of patients by critical care nurses. This confusion will affect patients and their families for some time to come. Nevertheless, nurses will continue to be true patient advocates. Nurses will continue to provide care that is humane, compassionate, and within the standards of professional practice in spite of such unfounded conclusions and media reports.

Many available resources are open to patients to insure that their wishes are carried out and their rights are respected. Patients and families who are concerned by such matters should seek the assistance and advice of hospital ethics committees, patient advocacy programs, hospice programs, and information on the creation of advance medical directives.

"Sexy" Medical Ethics:
Who’s Responsible?

Mark Kuczewski, Ph.D.
Associate Director,
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On May 23, 1996, the Pittsburgh Post-Gazette, the "paper of record" in this city, ran a front page article with a large-type bold-print headline, "Hastening death’s hand."1 There was nothing singular about this article. Indeed, many papers across the nation were running similar features. They were reporting on the results of the Asch study. The public attention that such issues command make medical ethicists the envy of many of our academic colleagues. But, public attention is not necessarily a good thing. In this particular case, it was clearly a bad thing.

In the weeks immediately following the appearance of this article, I received several phone calls from CEP members in community hospitals who wished to know if there are good methods for dispelling the misunderstandings created by this publicity. These healthcare professionals are often involved in discussing the forgoing of life-sustaining treatment with patients or their family members. After holding long discussions in which they explained the patient's rights, reviewed the patient's medical history and prognosis, and found that the family believed the patient would not wish his or her dying process prolonged, they were sometimes confronted with questions such as, "You're not going to kill my mother like those nurses I read about?" Even more sadly, one professional reported that a patient's daughter stayed at her unconscious mother's bedside for several days before the nurse discovered that this vigil was motivated by fear that someone might kill the patient. I'm not going to be as reserved about this as some of the other discussants in this roundtable. That this happened is just plain wrong and, I believe, there are people responsible for this situation whose actions are blameworthy.

The media, the journal in which this study appeared, and the investigator who authored the study, together produced the kind of mental suffering that is apparent in the aforementioned anecdotes. They probably did not intend to produce it; they merely accepted it as a by-product of acting in their own interests. Let us see how this works, one party at a time.

(1) The media - People buy reputable newspapers because they believe these sources will tell them the truth regarding issues of general interest and, as far as possible, will avoid misinforming them. It would seem the paper has a good-faith obligation to live up to these expectations. Furthermore, a reporter has the same basic moral obligation to avoid harming his neighbor that everyone else has. In this case, both obligations were infringed upon in many places around the nation.

The Asch study purports to establish that nurses actively kill patients or assist them in suicides. However, as several of my peers have pointed out, there are good reasons to doubt this. There is much confusion about the distinction between forgoing life-sustaining treatment, which is legal, and actively euthanizing a patient, which is illegal. Because Asch's survey has not been proven to be able to sort out confused responses, it is difficult to know if the nurses who reported killing patients understood what they were being asked. But how should a reporter, one who is not a healthcare professional or a medical ethicist, know such subtle criticisms? The answer is simple: the study was accompanied by an editorial in the NEJM that made these points.2 So, those who filed lopsided stories on this study must have done so for a reason. Perhaps, to emphasize the weak points of the study would make the newspaper story less intriguing and less worthy of a headline. The New York Times article on the study did take the critical editorial very seriously, citing it the second paragraph of the story. As a result, this newspaper article appeared on page A8.3
(2) The journal - Of course, if the reporters who wrote about the study should have known about the very serious questions concerning the conclusions of the study, certainly the editors of the prestigious New England Journal of Medicine should have. And, of course, they did. They printed a critical editorial that raised pointed questions about the study and so, can claim balance in their approach to these sensitive matters. Nevertheless, the editors certainly sought the publicity for this study. Assuming that medical journals serve the cause of science and the interest of the public, seeking media attention, attention that is sure to be sensationalistic in many corners, is wrong in a case where the conclusions are dubious and potentially harmful. Furthermore, it is very likely that because a prestigious publication is "trumpeting" the conclusions of a study, newspaper reporters feel confident in reporting the results as if they are facts.

(3) The investigator - The researcher, Dr. Asch, would seem to have the best prima facie case for being blameless. After all, research is research and investigators aren't responsible for what people make of their results, right? Furthermore, he is putting forth what he believes to be the "truth." If he is wrong, by publishing his study and his conclusions, others will be able to show where he has gone wrong. There is some merit to this line of argumentation and it is the rationale behind peer-reviewed research and publication. But, does an investigator have a duty to try to avoid publicity until he has fairly good evidence or, is it O.K. to disturb the public with troubling findings that are less than well-established? Of course, if his data from the present study are shown to be faulty, there will be no headlines for that follow-up story. It's just not as "sexy" as his initial conclusions.

One final note: some bioethicists, including some of my distinguished colleagues, believe that the distinction between forgoing treatment and killing a patient should be abolished because it is a distinction without a difference. However, the difference seems to be important to those families in the anecdotes that CEP members related to me. They believed their loved ones would not want their suffering prolonged by aggressive treatment when there was no hope. But, they clearly thought it would be wrong if someone walked into the room and killed the patient. This does not prove that there is a difference between forgoing treatment and killing patients. But, I believe it's a very important moral datum which we academics should not simply dismiss.


**Media and Medical Ethics:**

**The View from the Trenches**

Byron Spice

Science editor,

Pittsburgh Post-Gazette

It began with a call from a local hospital's public relations department. Would I be interested in talking with the hospital's ICU chief? Seems the doctor, who is head of the Society of Critical Care Medicine,
was concerned about the Asch study, which was to be published that week in NEJM.

Well, sure, I said, thumbing through my advance copy of NEJM. Always looking for an angle.

As I read the study, the accompanying editorial and other information gleaned from my computer, the story seemed intriguing: a significant number of critical care nurses had on at least one occasion helped a patient die. Yes, the study had some problems, but not enough to keep it from passing muster with the NEJM editors. The findings were strong enough to convince the SCCM president to call a special conference to address the issue.

Few people would be so naive as to believe that no doctor or nurse has ever hastened the death of a terminal patient. Many, in fact, take comfort in believing such an option would be available to them. But most discussions of the issue have focused on the physician, not the nurse. And this study suggested that it was neither a common nor a rare practice. It seemed to me - and obviously to many of my colleagues at the PG and other newspapers across the country - an opportunity to again address an end-of-life issue that touches many of our readers.

Was it old news? Perhaps to people in the medical ethics arena; most of my readers could only guess what the dimensions of the practice might be. Would it upset some ICU patients and their families? Certainly, just as stories about airline safety can upset the flying public, or stories about potential dangers of calcium blockers can upset millions of hypotensive people. That doesn't mean many of those people wouldn't want to know. Would it result in more questions, more discussions between patients and nurses, families and doctors? Probably. Would that be a bad thing?

The story struck a responsive chord with my superiors. Photos and graphics were assigned as it became clear the story would be a front page "focus." A second story, an interview with a critical care nurse, was assigned to a second reporter.

In the main story, I addressed the shortcomings of the study, alluding to some disbelief among the intensivists in the third paragraph and referring to flaws in the study design in the fourth. The critical editorial was quoted, as were nursing leaders. Local doctors expressed skepticism about the size of the numbers and noted how practices at local hospitals helped safeguard against abuses. But the story also noted acknowledged problems in the care of the terminally ill that might explain the study results.

Of course, I cannot ensure that all readers will read all of my story. As a writer, I know that many people will judge my work in the light of the few words I don't write: the headline, written by a copyeditor. The PG's copydesk settled on "Hastening death's hand," along with a long overline summarizing the story above the headline. Other papers were variations on a theme.

- **The New York Times**: 1 in 5 Nurses Tell Survey They Helped Patients Die.
- **Chicago Tribune**: Some nurses put very ill out of misery; Compassion guided their actions, poll finds.
- **Los Angeles Times**: 20% of ICU nurses have aided deaths, survey finds; Some say they acted without permission of patient or doctor. Critics call the study erroneous.
- **Miami Herald**: Compassion or complicity? Nurses admit aiding death.
- **USA Today**: 1 in 5 nurses help patients die.

Can headlines be misleading? Sure they can. Just try summarizing such a complicated story in 10 words as the New York Times did. Did any of those headlines say 1 in 5 ICU patients are killed by nurses? No. To suggest that any of them imply the same is a stretch.
If reporting on this story caused unnecessary pain among families and patients, I and my colleagues certainly regret it. If there were errors or omissions in my story that contributed to that pain, nobody has bothered to pick up a phone or a pencil and tell me.

I'm tempted to suggest it is poor communication between patient and caregivers - not a newspaper headline - that is most responsible for any panic among patients and families. But, that's a cheap shot coming from a layman. I can't comprehend the difficulties that must surround interactions at such a sensitive time. Yet I can't help but think that end-of-life issues will not get the public scrutiny they deserve if this type of information isn't shared with the public. And it will never be shared if we must first wait for all of the ICUs to empty.
The Latest Thing:

Butler Memorial Hospital Pioneers "Ethics Week"

It is a perennial challenge for hospital ethics committee members to educate and re-educate themselves and their colleagues. Nevertheless, everyone realizes this challenge must be answered. Committee members must avail themselves of recent developments in medical ethics and cannot ignore the need to educate new hospital staff. In general, the mission of an ethics committee is to raise the level of ethical awareness and dialogue on the "shop floor" on a continuous basis.

The long-term member institutions of the CEP, such as Butler Memorial Hospital (BMH), have been through the initial process of educating two representatives in medical ethics, forming an ethics committee, and reaching out to do staff and community education. After several years, these educational efforts must be reinvigorated since the typical educational activities may no longer excite widespread interest. The challenge is to do ethics education in a way that rekindles excitement. In response to this challenge, the Consortium Ethics Program collaborated with the ethics committee of Butler Memorial Hospital to design the first "Ethics Week."

Ethics Week, sometimes called Ethics Education Week or Ethics Awareness Week, is a high-profile series of educational activities in medical ethics designed to be sure that every member of the hospital staff is aware of the hospital's ethics program and that each person has an opportunity to attend some function. For this purpose, the BMH ethics committee convened a task force under the coordination of Tom Sobieralski, M.A., the Director of Social Work and Discharge Planning. This task force comprised not only various members of the ethics committee, but included a representative of the public relations department, the coordinator of the medical staff office, and the director of the senior citizen outreach division ("Priority Care"). These persons were essential in insuring that the events reached a number of target audiences and also spilled out beyond the walls of the hospital into the local community.

A variety of promotional materials that carried information of the week's events and of ethical issues were developed. A bulletin board was created in the hospital lobby that featured photos of the ethics committee members and contained information on ethical issues. Similarly, calendars were placed on the cafeteria tables to publicize events. The screen savers on the hospital's computer terminals carried an ethics message-of-the-day for staff. The public relations department created wallet-sized ID cards with basic information on advance directives and a phone number for additional information. These cards were included with other written information on patient rights and advance directives and were sent to senior citizens in a mailing done by their Priority Care program. Two members of the ethics committee, Jeanne Graff, M.S.N., and Bernie Andreyo, B.S.N., appeared on a television show on a local cable
public access channel. They toured the host of the show through the intensive care unit and discussed the process of ethical decision making.

The week was scheduled to coincide with the normal medical staff quarterly luncheon. Gary Fischer, M.D., Assistant Professor of Medicine at the University of Pittsburgh, spoke to BMH's medical staff on the topic of "Talking to Patients About Advance Directives." Mark Kuczewski, Ph.D., Associate Director of the CEP, teamed with Ira Handler, M.D., Director of BMH's Gero-Psychiatry Unit, to speak about "Death & Dying: Patients' Rights and Doctors' Responsibilities" to a breakfast meeting of clergy and medical staff and again to representatives of nearby nursing homes. Similarly members of the ethics committee conducted a number of forums at different times that were open to all members of the hospital family: case discussions over lunch, forums on organ and tissue donation, informational gatherings on patient rights and hospital policies, and repeated showings of a video of Alan Meisel's renowned lecture, "Legal Myths About Forgoing Life-Sustaining Treatment."

Responses to Ethics Week have been uniformly positive and BMH seems to have met its goal of dramatically renewing ethics awareness. CEP faculty believe this could be the prototype for many Ethics Weeks to come throughout Western Pennsylvania and Eastern Ohio.

Want to hold your own Ethics Week?

Click here.
And now, a word from our sponsor...

HCWP Ethics Committee:
Renewing and Revitalizing a Legacy of Service

It is common knowledge that the success of the Consortium Ethics Program owes much to the collaboration of several important institutions, in particular, the dual sponsorship of the Hospital Council of Western Pennsylvania and the University of Pittsburgh Center for Medical Ethics. The sponsorship of the HCWP and the guidance provided by the HCWP Ethics Committee (formerly known as the HCWP Ethics Task Force) has contributed a good deal of organizational and administrative know-how to the CEP and has made it possible for CEP faculty to serve all hospitals in the region, regardless of their administrative affiliations. Of course, like any ethics committee, the HCWP’s committee must renew and revitalize itself.

Under the direction of Chairman Andrew Thurman, Esq., Senior Vice President and General Counsel, Forbes Health System, the HCWP Ethics Committee has added members who represent additional areas of healthcare or who are affiliated with healthcare systems that have been underrepresented in the committee’s workings. Furthermore, Chairman Thurman has sought to develop ways in which the committee can serve the ethics needs of the western Pennsylvania healthcare community.

As a result, several important new members have been added: Michael DeVita, M.D., of the UPMC. Andrew Krouskop, M.D., of Harmarville Rehabilitation Center. Beaufort Longest, Jr., Ph.D., of the Health Policy Institute (University of Pittsburgh). D. Scott Miller, M.D., of Allegheny General Hospital. Adrianna Selvaggio, M.D., of Shadyside Hospital. William Stewart, M.D., of Mercy Hospital, and Judith Wohnseidler, N.H.A., of Redstone Highlands Healthcare Center. They join William Cooper, M.D., of Shadyside Hospital. William Horvath of the Hospital Council. Mark Kuczewski, Ph.D., of the CEP. Rosa Lynn Pinkus, Ph.D., of the CEP. and Dan Thompson, M.D., of Mercy Hospital to make the committee’s membership a well-rounded one.

The HCWP Ethics Committee will, of course, continue to serve as an advisor to the CEP, helping to give direction and guidance. But, the committee is also considering areas that it should address directly. In particular, the committee has recruited collaborators to review what steps can be taken to facilitate more effective implementation of advance directives and DNR orders during emergency transfer of patients between home or a long-term care facility and the acute care hospital. This kind of project requires the skills and knowledge of a variety of kinds of healthcare providers including EMS personnel. Community Ethics will keep you posted as more details become available about this exciting project.
Simply the Best:

A Preview of the CEP's 1996-97 Line-Up

In keeping with the theme of spreading ethics awareness, we wish to highlight the large variety of programming that the CEP has prepared for the upcoming academic cycle. Somehow, it seems that we are always tossing around superlatives such as "this is our best calendar of programs yet." Nevertheless, we beg the reader's indulgence while we do this once more. We are compelled to speak in this manner because, each year, these superlatives ring true.

We particularly wish to call attention to the fine line-up of national speakers in the advanced tier of seminars (see "Advanced Class Schedule 1996-97"). As you know, the CEP works on three-year educational cycles. For the first three years, two representatives from each hospital attend classes on the "meat and potatoes" issues of medical ethics including several classes on basic topics in the medical humanities. Those hospital representatives who continue for three additional years in the CEP's educational programming present a special challenge: we must continue to provide clinically useful yet intellectually stimulating seminars. The way we insure this objective is to feature the perspectives and insights of leading thinkers in bioethics, not only from Pittsburgh, but from around the nation.

The first speaker on the Advanced Schedule will be Laurie Zoloth-Dorfman, Ph.D. Dr. Zoloth-Dorfman is an associate professor of social ethics and Jewish studies at San Francisco State University and a founder of the ethics consulting firm, The Ethics Practice. She is well-known in the bioethics community for her vibrant speaking style and the breadth of her scholarship. She has experience as a registered nurse and a noted social critic. Much of Dr. Zoloth-Dorfman's work deals with the relationship of religion, culture, medicine, and the community. Because the subject of her lecture will be ethics consultation, this session will be a combined class for the Basic and Advanced Classes.

Rebecca Dresser, J.D., Professor of Law and Biomedical Ethics at Case Western Reserve University will be our second presenter. Professor Dresser is a leading authority on the relationship between personal identity and end-of-life decision making. She has a wide variety of research interests and her publication record includes many of the leading medical, legal, and bioethics journals. Her presentation to the CEP will focus on the women's health movement and bioethics.

Community Ethics will continue to profile many of the presenters in the Advanced Series as their seminars approach.
Community Ethics / Volume 3, Number 4
Previous Article: Issue Contents

Upcoming Events

- National
- University of Pittsburgh: Ethics Grand Rounds
- CEP: 1996-97 Classes

National

September 30, 1996
A Legacy of Horror: Fifty Years After the Nazi Doctors’ Trial
Sponsored by the Center for Bioethics, University of Pennsylvania Health System. To be held from 1-5 PM at the Penn Tower Hotel on the University of Pennsylvania Campus, 34th & Civic Center Boulevard, Philadelphia. This is a half-day conference which is free to all full-time students (ID required); $50.00 for all others. For information, e-mail: dicaprio@mail.med.upenn.edu (FAX: 215-573-3036.)

October 10-13, 1996
Health Care, Ethics and Humanities: From Our Roots to our Shoots.
The joint annual meetings of the Society for Health and Human Values (SHHV) and the Society for Bioethics Consultation (SBC). To be held at the Sheraton City Centre Hotel, Cleveland, Ohio. Keynote speaker: Albert R. Jonsen, Ph.D., "The Birth of Bioethics." For information and registration, contact: SHHV, 6728 Old McLean Village Drive, McLean, VA 22101. Phone: 703-566-9222; Fax: 703-566-8729; E-mail: SHHV@AOL.COM

November 20-22, 1996
Bioethics 1966: Comparative Perspectives
Annual Meeting of the American Association of Bioethics: To be held at the Parc Fifty Five Hotel, San Francisco, CA. Keynote and Discussion Session topics to include: Can there be a unifying theme in bioethics?; The ethics of managed care: do communitarian ethics help sort it out?; Health: Race/Ethnicity/Class; Assisted suicide; and others. The meeting is timed to coincide with the first United States meeting of the International Association of Bioethics (November 22-25, 1996). For more information, contact: The American Association of Bioethics; by Fax at 801-585-5489; E-mail: aab@cppa.utah.edu or check the AAB website at http://www.geog.utah.edu/aab/
Ethics Grand Rounds
(formerly "Ethics for Lunch")

Fall 1996 Schedule

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

AUDITORIUM 5, SCAIFE HALL, NOON - 1:00 P.M.
(All sessions are on Thursdays, except 10/4/96)

September 19, 1996
Respecting Both Adolescent Patients and Their Families
William Aiken, Ph.D.
Professor of Philosophy, Chatham College

SPECIAL FRIDAY SESSION: AUDITORIUM 6, SCAIFE HALL
October 4, 1996
Ethical Issues in Managed Care for the Elderly
Mark R. Wicclair, Ph.D.
Professor of Philosophy, West Virginia University

October 17, 1996
Palliative Care for End-Stage Dementia
Diane Meier, M.D.
Associate Professor of Geriatrics and Medicine,
Mt. Sinai School of Medicine

October 31, 1996
Health Insurance Choices, Challenges and Changes for Families On Medicaid
Kelly Kelleher, M.D., M.P.H.
Staunton Professor of Pediatrics & Psychiatry,
University of Pittsburgh

November 14, 1996
Rabbinical Perspectives on Brain Death*
Rabbi Daniel Schiff
Temple B'naï Israel (McKeesport)
Rabbi Stephen Steindel
Congregation Beth Shalom (Squirrel Hill)
Rabbi Joseph Weiss
Congregation B'naï Emunoh (Squirrel Hill)
*This session is co-sponsored by the "Jewish Responses to Clinical Perspectives" series,
Rabbi Larry Heimer, Course Director.

December 5, 1996
Religious Belief as Ethical Distraction and Decoy in Medical Treatment Disputes
Lawrence J. Nelson, Ph.D., J.D.
Adjunct Lecturer, Department of Philosophy  
Associate, Markkula Center for Applied Ethics,  
Santa Clara University

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

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

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

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**Consortium Ethics Program**  
1996-97 Class Series

**Basic Class Schedule**

October 10, 1996 / 9:00 am - 12:00 p.m.  
"Case Consultation: A Methodology that Works"  
Laurie Zoloth-Dorfman, Ph.D.  
Bioethics Consultation Group, Berkeley, CA

November 4, 1996 / 9:00 am - 12:00 p.m.  
"Managed Care and the Elderly"  
Mark Wicclair, Ph.D.  
Professor of Philosophy, West Virginia University

December 2, 1996 / 1:00 p.m. - 5:00 p.m.  
"The Role of Law in Bioethical Decision-Making"  
Andy Thurman, J.D., M.P.H.  
Senior Vice President & General Counsel, Forbes Health System  
Bioethicist, Forbes Health System

March 13, 1997 / 1:00 p.m. - 5:00 p.m.  
"Spirituality, Faith Development, and Ethical Thinking"  
Patrick McCruden, M.T.S.  
Marian Health Center, Sioux City, Iowa

April 1, 1997 / 9:00 am - 12:00 p.m.  
"Ethics Consultation: Policy and Practice"
David Kelly, Ph.D.
Professor of Theology, Duquesne University

May 5, 1997 / 9:00 am - 12:00 p.m.
"The Consensus on Forgoing Treatment: It's Status and Prospects"
Alan Meisel, J.D.
Dickie, McCamey, & Chilcote Professor of Bioethics
Director, Center for Medical Ethics
University of Pittsburgh

June 9, 1997 / 9:00 am - 12:00 p.m.
"Confidentiality and Truth-telling: People Say the Darnedest Things"
Robert Arnold, M.D.
Associate Professor of Medicine, University of Pittsburgh

Advanced Class Schedule

October 10, 1996 / 9:00 am - 12:00 p.m.
"Case Consultation: A Methodology That Works"
Laurie Zoloth-Dorfman, Ph.D.
Bioethics Consultation Group, Berkeley, CA

November 12, 1996 / 1:00 p.m. - 5:00 p.m.
"What Bioethics Can Learn From the Women's Health Movement"
Rebecca Dresser, J.D., M.S.
Law School, Case Western Reserve University

December 2, 1996 / 9:00 am - 12:00 p.m.
"Use of Restraints in the Acute vs. Long Term Care Setting"
Mary Colburn, M.D.
Medical Director,
Joseph L. Morse Geriatric Center,
West Palm Beach, Fl

March 27, 1997 / 9:00 am - 12:00 p.m.
"Issues of Personal Responsibility in Managed Care"
Peter French, Ph.D.
Cole Chair in Ethics and Professor of Philosophy,
University of South Florida

April 8, 1997 / 9:00 am - 12:00 pm
"Stories, Dreams, and Visions of the Future of Medicine"
John Lantos, M.D.
Associate Professor of Pediatrics
Associate Director, Center for Clinical Medical Ethics,
University of Chicago

May 19, 1997 / 1:00 pm - 5:00 pm
"The Changing Meanings of Death: From the Fear of Premature Burial to the Debate over Brain Death"
Martin Pernick, Ph.D.
Professor of History, University of Michigan

June 9, 1997 / 1:00 pm - 5:00 pm
"Ethical Issues in Pediatric Care"
Joel Frader, M.D.
Associate Professor, Pediatrics
Associate Professor, Anesthesiology & Critical Care Medicine
University of Pittsburgh

Previous Article: Issue Contents