

COMMUNITY ETHICS

VOL. 1

The Newsletter of the Consortium Ethics Program
Addressing the Ethical Challenges Facing
Community Health Care Providers of Western Pennsylvania

NO. 2

The CEP is a cooperative effort of the University of Pittsburgh Center for Medical Ethics and the Hospital Council of Western Pennsylvania.

IN THIS ISSUE:

Welcome to the second edition of *Community Ethics*, the newsletter of the Consortium Ethics Program (CEP). The goal of the CEP is to provide its members with in-depth ethics training and consultation and also to link health care institutions in the region in an "ethics network." *Community Ethics* is the "network news."



In this issue we describe a variety of activities which the Consortium has sponsored. Also included are reviews of articles and books that provide practical guidance with problems such as setting up ethics mechanisms within a hospital (see "Truly Useful Literature"). *Community Ethics* also contains articles by local health care professionals, for the overall CEP membership. Our "Ethics Roundtable" feature concerns policies for making decisions, especially decisions to forgo life-sustaining treatment, for patients who lack decision-making capacity and have no surrogate decision maker. This is admittedly one of the most difficult dilemmas facing healthcare providers. We look forward to your comments and reactions to continue the "Roundtable" discussion.

- M. Kuczewski and R. Pinkus

THE ETHICS TASK FORCE OF THE HOSPITAL COUNCIL OF WESTERN PENNSYLVANIA: Counselor to the Consortium

By Rosa Lynn B. Pinkus, Ph.D., Director of the Consortium Ethics Program

While we describe the Consortium Ethics Program as a joint educational effort co-sponsored by the Center for Medical Ethics and the Hospital Council of Western Pennsylvania (HCWP), we rarely focus our attention on the forum that provides the working link for these two organizations: the Ethics Task Force of the Hospital Council of Western Pennsylvania.

The Ethics Task Force, a working group of the Public Affairs Committee of the Council, was created in 1985 as a forum for both hospital personnel and faculty from the Center for Medical Ethics. By providing a model of inter-institutional cooperation in ethics, it actually set the stage for the Consortium Ethics Program. The work of the Task Force has helped to alert health care professionals in western PA that medical ethics is not only abstract philosophy but also of practical import and can help to resolve a range of problems confronted in the clinic.

The Ethics Task Force was in large part successful because it was chaired, directed, and sometimes shepherded through the rocky terrain of town-gown politics by Douglas A. Clark, CEO at Latrobe Area Hospital. A graduate of Rutgers University where he

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majored in history, Doug received an M.A. in Hospital administration from the University of Minnesota. He is a former associate administrator at West Virginia University Hospital and joined Latrobe Area Hospital in 1982. One can view the success of the Ethics Task Force as largely owing to the thoughtful and pragmatic style that characterizes his work.

The Ethics Task Force serves as the link between the University of Pittsburgh and the Hospital Council. It has been most productive in this role by providing a stable source of ethics information and education for health care facilities in the region. For instance, the Task Force published a series of position papers in 1990 on various clinical ethical issues and from 1985-1992 sponsored three successful ethics workshops featuring such nationally-recognized ethicists as Dan Wikler, Ph.D.; Larry Churchill, Ph.D.; Alan Meisel, J.D.; health historian David Rothman; and Gary Edwards, President of the Ethics Resource Center, Inc. Topics ranged from end-of-life decision making to health care reform.

The Task Force has consistently served as an advisor and overseer for the Consortium Ethics Program. Current membership includes: Carol Bucci, Vice President of Operations of the Westmoreland Health System; William Cooper, M.D., from Shadyside Hospital; Elizabeth Moore, Medical Social Worker at Sewickley Valley Hospital; Mark Kuczewski, Ph.D., Community Ethicist for the Consortium Ethics Program; Rosa Lynn Pinkus, Ph.D., Director of the CEP; Margaret Potter, Associate Director of Pitt's Health Policy Institute; Laura Synnott, Assistant Executive Director of Medical Services for Forbes Regional Health Center; and Dan R. Thompson, M.D., Chief of Mercy Hospital's Division of Critical Care.

Doug Clark has recently stepped down from his chairmanship of the Task Force in order to devote more of his energies to his other professional commitments. We extend a hearty "thanks" to Doug for the time, effort, and expertise he graciously volunteered to this Task Force and to the Consortium Ethics Program. We wish him well and know he will continue to be successful in his endeavors.

Andrew Thurman, J.D., M.P.H., General Legal Council and Senior Vice President of the Forbes Health System, has succeeded Doug Clark as Chairman of the Ethics Task Force. Andy received a Bachelor of Arts degree in comparative literature and classics from Columbia University in 1976, a J.D. from the Marshall-Wythe School of Law of the College of William and Mary in 1979, and an M.P.H. in Health Administration from the University of Oklahoma in 1984. He joined Forbes Health System in 1989 and since that time has earned credentials as both a teacher and lecturer to the local community on bioethics and law. Ever seeking to deepen his understanding of the complex interrelationships between health care, ethics, and law, Andy is currently enrolled in Duquesne's M.A. program in medical ethics.

The Ethics Task Force is truly fortunate to have, and to have had, such talented leadership. In addition to talent, both Doug Clark and Andy Thurman possess a healthy sense of humor, a tolerance for impassioned discussion, and an ability to keep groups focused and get things done. As a result, the work of the Ethics Task Force of the Hospital Council of Western Pennsylvania stands as a tribute to what can be accomplished when academics and health care professionals join forces!

A FAREWELL TO AUMANN

The CEP is saddened to announce that Gretchen Aumann, R.N., B.S.N., has resigned her position as Consortium Ethicist to pursue an opportunity at the University of Texas. Gretchen has been with the Consortium since 1990 when the program kicked off its demonstration program. She has been responsible for the day-to-day running of the CEP including the nuts-and-bolts of the ethics retreats, seminar series, and on-site educational programs.

In her new position in Houston, Gretchen will continue her career as a clinical educator devoted to continuing medical education in ethics. She is also currently completing her doctoral dissertation in medical ethics at the University of Texas Medical Branch at Galveston. I believe that we speak for all Consortium participants in saying that Gretchen will be missed. The amicable style and depth of clinical experience she brought to the program will be hard to replace. We offer our best wishes for success and say, "Congratulations on a job well done!"

UPCOMING EVENTS OF NOTE

"The Spiritual Dimension of Illness, Suffering, and Dying"

A Conference for Clergy, Ethics Committees and Consultants, and Health Care Professionals

June 2-3, 1994 -- West Virginia University, Morgantown, WV

To receive a complete conference schedule and registration information, please write or call:

Alvin H. Moss, M.D., Center for Health Ethics and Law
Robert C. Byrd Health Sciences Center
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Morgantown, WV 26506-9022

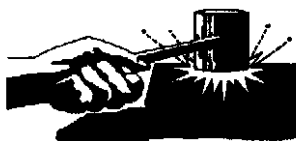
Phone (304)293-7618; Fax: (304)293-7442

CEP-2 Retreat

Hidden Valley Resort, Sept. 30 - Oct. 2

ETHICS ROUNDTABLE: Guardianship Problems and the Withdrawal of Life-Sustaining Treatment

In the last issue of *CE* we called for contributions from CEP members regarding end-of-life decision making for patients who lacked decision making capacity and had no surrogate decision maker or guardian. Hospitals are



increasingly confronted with patients who are unconscious or lack the capacity to make treatment decisions regarding the withholding or withdrawal of life-sustaining treatment. Sometimes these patients are familiar to hospital staff from prior admissions, but often they are strangers who present for the first time. Often the patient is treated aggressively at first. As the condition fails to improve, the health care team wants to know what the patient would want if he or she could speak. They find, however, that there is no clearly suitable person to exercise the patient's right of self-determination. Many of these patients have no identifiable kin or close friends. Some have distant relatives, often living in far away places, who are not willing to make decisions of such gravity for a person they

hardly know. Does this mean that the patient has no right to be free from unwanted treatment? Does the patient have to have a "full court press" until the moment of death because they lack a surrogate decision maker?

As health care professionals become more comfortable with the idea that treatment is not always a benefit to a patient, they have searched for ways to handle these cases so that the patient neither receives burdensome and futile treatment nor is undertreated. We profile two responses to this issue below. These show the diversity and creativity of different efforts to deal with these clinical quandaries. They are not meant to be the "right" solution to the problems. By sharing this kind of information, we hope that each hospital and health care institution can arrive at solutions that are right for their situations and meet the needs of their patients. If these responses provoke a comment (pro or con) or prompt you to describe how your hospital handles these kinds of cases, contact Mark Kuczewski, Ph.D. and we will feature your responses in our next edition.

Response 1: "The Guardianship Dilemma: Rural Community Hospitals-- Limited Resources/Increased Demands"

(by Joyce Wright, M.S.W., L.S.W., Armstrong County Memorial Hospital)

Current ethical, legal, and medical dilemmas have done much to change the complexion of the simple guardianship procedure. With the advent of the state guardianship law, passed in conjunction with the living will law of 1992 (Pennsylvania Advance Directive for Health Care Act), requirements such as scheduled court hearings, legal representation of the patient, physician attestations, and the time limitation constraints of emergency guardianship procedures have placed multiple burdens on the rural community hospital. A lack of community resources and support networks in rural areas are common problems that serve to compound the guardianship dilemma. Armstrong County Memorial Hospital is a 217 bed rural referral center located in the heart of the county. Like many other areas of western Pennsylvania, the county has been devastated by the recent loss of a small, but once vital, manufacturing base. The hospital is the single largest employer and provides a large volume of free care to the community.

In the midst of this emotional and economic crisis, the hospital is forced to depend on internal resources to address guardianship issues. The hospital, as an institution with strong and well-established community ties, feels a moral imperative to use its influence to bring about even small positive changes in the social and bureaucratic climate. Guardianship law has resulted in increased paperwork and cost for the

proceedings. Prior to enactment of the new law, the typical guardianship proceedings cost the hospital approximately \$300. At that time, guardianship was most often sought for the purpose of arranging of services after discharge from the hospital. Subsequent to the law, the average cost for guardianship proceedings has tripled to \$900. Perhaps more alarming, the number of requests for emergency guardianship proceedings have also tripled within the past two years. This dramatic increase reflects the fact that, within the current climate, physicians have become more reluctant to treat mentally incapacitated patients without appointment of a legal surrogate. The hospital must meet the demands for this service and absorb the costs.

The hospital had historically developed the practice of assigning a social worker from its staff to serve as the patient's surrogate and thereby avoid the need for formal court proceedings. Predictably, this practice has become a major focus of hospital Ethics Committee meetings. Strong feelings regarding the appropriateness of naming a hospital employee to act in the patient's interests were expressed. Discussions with hospital administration ensued. The hospital then made a decision to turn to the community for help and support with this problem. Perhaps local agencies or community organizations would be willing to share the burden of decision making for these patients or to serve as advocates for these clients. Meetings were scheduled with

local agencies such as Area on Aging, Mental Health, Children and Youth Services, members of the Bar and ministerial associations, as well as area nursing homes and institutions for the mentally handicapped. Although many of these agencies and groups had dealt with similar problems arising within their own client base, none were willing to directly assist the hospital with particular patients on an ongoing basis. Nevertheless, a kind of progress followed from these efforts.

Some individual employees of community agencies volunteered to serve as surrogate guardians for appropriate hospital cases. These surrogate guardians have worked well in several particularly troublesome situations when the appearance of a conflict of interest was especially important to avoid. In addition, the hospital held a meeting with the two senior county judges to discuss the new guardianship law and procedures for implementing it. Representatives of the hospital were able to bring the urgency and complexities of this problem to the attention of the courts. As a result of this meeting, both judges volunteered their

personal time and assistance during off hours to facilitate emergency guardianship procedures whenever necessary. This helped to alleviate the problem of court access that is common in rural areas.

In sum, most cases in which the patient lacks decision-making capacity and has no surrogate are still handled internally by the hospital social work department in concert with the ethics committee, pastoral care, and other interested parties. However, the process of community involvement with this problem has helped to reassure the hospital staff that they are acting with the blessing of their local peers. Instead of feeling like "lone rangers," the hospital staff are supported by the knowledge that they are working within a consensus achieved through community deliberations. They know that when a case presents problems beyond the norm, there are educated support systems that can be tapped. Armstrong County Memorial Hospital continues to seek more complete and innovative approaches to this problem and encourages other CEP hospitals to consider sharing their experiences in this column.

Response 2: The University of Pittsburgh Medical Center Guidelines on Forgoing Life-Sustaining Treatment

[Policy: 4007; Copyright University of Pittsburgh 1992]

Provisions to cover cases involving patients who cannot make decisions for themselves and lack an identifiable surrogate are included in the University of Pittsburgh Medical Center (UPMC) policy on forgoing life-sustaining treatment. The evolution of this policy has been driven by the desire to balance respect for patient self-determination with the principle of nonmaleficence. That is, the university hospitals wish to base withdrawal of treatment on a clear expression of the patient's wishes or the surrogate's decision. When such clarity is not possible, however, the decision should be made by weighing the benefits and burdens of continued treatment, not driven by legalisms regarding the appointment of a surrogate. Hence, the UPMC hospitals use in-house mechanisms of decision making as the primary mode of handling these cases.

When a patient lacks a surrogate decision maker, the Ethics Committee and hospital legal counsel are usually contacted. These bodies and the attending physician together determine whether judicial appointment of a surrogate is appropriate. When judicial appointment does not seem warranted, "forgoing life-sustaining treatment is ethically acceptable if each of the following conditions is satisfied.

- (a) Reasonable efforts have been made to identify an appropriate person (e.g., a family member or a friend) to serve as a surrogate, and those efforts have been unsuccessful.
- (b) There is consensus among physicians involved with the case that there is not significant chance of meaningful recovery and life-sustaining treatment is of no expected benefit to the patient.
- (c) Conditions (a) and (b) are clearly documented in the patient's chart." (Policy 4007: 9-10)

Additionally, the Ethics Committee reviews the case to be sure that conditions a-c have been met, with particular attention to verifying that all pertinent members of the health care team have had a chance to voice any ethical concerns regarding the forgoing of treatment in the case at hand. Because there is usually scant evidence regarding the patient's wishes, the Ethics Committee tries to view the patient's situation from the perspective of a hypothetical "reasonable person." The criterion for forgoing treatment is whether "a reasonable person would conclude that life sustaining treatment is of no expected benefit and therefore not want it." (Policy 4007: 10)

Three points are worth noting about this policy:

- The policy rests on the thesis that a consensus in clinical judgment among the members of the team caring for a patient is as good as or better than the judgment of a newly-introduced third party who would have to learn the history of the case from the beginning. Such a newly-appointed guardian probably would begin with a strong bias toward continued treatment. The caregivers began with such a presupposition but have moved away from it through experience with the case. To introduce the new surrogate is simply to re-double the process while continuing to submit the patient to the burdens of treatment.

- Although the policy embraces a "reasonable person" standard of judgment and therefore seeks to determine what is objectively in the patient's best interest, the search for a surrogate often turns up clues to

the patient's values and personal identity. The values can be of help in determining what the patient would want in the current situation. Thus, this kind of decision making, in practice, often combines objective best interests with some subjective values to reach the appropriate decision.

- This process is largely conducted by the health care team (steps a-c) with the review of the Ethics Committee and legal counsel serving as a kind of double check prior to the forgoing of treatment. This double check is helpful because it is important to have a process in which everyone "steps back" and is given an opportunity to voice concerns or second thoughts that they may not have expressed within the more urgent clinical environment. In this way, such policies and processes serve to help meet the needs of both caregiver and patient.

CEP PROGRAMMING CONFRONTS PROBLEMS IN PATIENT TRANSFER: Butler Forum Serves As Pilot for Upcoming Teleconference

On March 2, 1994, Butler Memorial Hospital hosted the outreach program "Ethics In Transition." This in-service day addressed the ethical problems that arise in patient transfer. The program was open to representatives of nursing homes that work with Butler Memorial. It renewed dialogue among these institutions on ways to foster patient autonomy and to deal with specific ethical issues such as the use of advance directives.

The Butler program consisted of a morning session featuring talks by Bob Arnold, M.D., on "Autonomy, Consent & Nursing Homes," Alan Steinberg, J.D., on "Legal Aspects of End-of-Life Decision Making," and Mark Kuczewski, Ph.D., who presented "Interpreting Advance Directives: Case Illustrations." An afternoon session followed in which personnel from Butler Memorial Hospital discussed specific problems in patient transfer and also provided information on geriatric and laboratory services available to these local nursing homes.

Dr. Arnold's talk focused on the need to reconceptualize autonomy in the long-term care setting. He pointed out that traditional models of informed consent focus on the provision of information by a health care professional and the act of choice by a patient. While this focus may be appropriate for the

acute care setting, long-term care does not evidence such eventful and discrete choices. Instead, Dr. Arnold suggested that these settings need to see autonomy in terms of consistency. That is, the ethical focus needs to be on helping residents to retain their identity as individuals and to live in accordance with personal preferences and values that are articulated in small and continuous behaviors.

Attorney Steinberg covered the major points of the current ethical and legal consensus regarding forgoing life-sustaining treatment. He highlighted the major cases (for example: Conroy, 1985; Quinlan, 1976) that have developed the common law tradition of informed consent and showed how this line of reasoning underpins current thinking about forgoing life-sustaining treatment. Steinberg also addressed issues that arise from the federal Patient Self-Determination Act and the Pennsylvania Advance Directive For Health Care Act.

Dr. Kuczewski presented two cases which showed the difficulty of applying advance directives written in one health care setting, to situations arising after the patient has been transferred to another. Kuczewski reiterated a point made by the first two speakers: advance directives must be interpreted rather than taken literally. To do this well requires that the health care professionals interpret the specific treatments mentioned on the living will in light of the patient's treatment goals. Thus, Kuczewski concluded that the challenge to health care professionals is to find ways to transfer knowledge of the patient's treatment goals along with the transfer of the written directive.

This program was developed and conducted in collaboration with Tom Sobieralski, M.A., Director of the Department of Social Work at Butler Memorial Hospital. Tom's organizational abilities and administrative expertise were pivotal to the success of the conference. The program is part of the community outreach work that is coming to characterize this phase

of the Consortium Ethics Program (CEP-2). "Ethics In Transition" will serve as the model for a teleconference on ethical issues in geriatric care and patient transfer that the CEP is planning for November 1994 (tentative date). We will keep you posted on plans for this event as they take shape.

CENTER FOR MEDICAL ETHICS FACULTY PARTICIPATE IN SHHV CONFERENCE: CEP GETS NATIONAL RECOGNITION

By William Welton, Ph.D., Staff Ethicist, Center for Medical Ethics

Consortium faculty and others from the University of Pittsburgh Center for Medical Ethics took part in the Twenty-fourth Anniversary Annual Meeting of the Society for Health and Human Values on November 4-7 in Washington, D.C. This distinguished organization, perhaps the oldest and most prestigious bioethics organization, provided the forum for Center faculty and associates to present papers and participate in workshops and discussion groups on a variety of current issues in bioethics.

Rosa Lynn Pinkus, Gretchen Aumann, Mark Wicclair, Mark Kuczewski and Anne R. Medsger ran a pre-conference workshop entitled "Building Local and Regional Ethics Networks: The Pittsburgh Model," which described the Consortium Ethics Project and offered guidelines for the formation of similar ethics networks. This three-hour workshop was attended by approximately twenty scholars and health care professionals from around the nation. This workshop is likely to be just the beginning of the national attention that the CEP will receive as others seek to learn from our

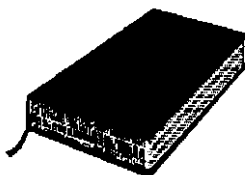
experience.

Center for Medical Ethics faculty were highly active at the conference in other ways as well. Stanley Dorst moderated a session called "Moral Reasoning and Moral Orientation: A Comparison of Physicians and Teachers of Medical Ethics," which discussed the influence of educational background on moral decision-making. Robert M. Arnold participated in a discussion on "Teaching Respect for Persons" in residency education. Presenting a paper entitled "Casuistry and its Communitarian Critics," Mark Kuczewski defended the method of case-based reasoning against its most serious challengers. Gretchen Aumann took part in a workshop on Howard Brody's book, "The Healer's Power." The SHHV Annual Meeting was presided over by current president Joel Frader, the Center's Associate Director of Consultation. Through these diverse forms of involvement, the Center for Medical Ethics made a significant contribution to this annual bioethics event.

TRULY USEFUL LITERATURE: Ethics Consultation

by William Welton, Ph.D., Staff Ethicist,
Center for Medical Ethics, & Mark
Kuczewski, Ph.D.

(Editor's Note: We print abstracts or reviews of both theoretical and practical articles and books concerned with common ethical problems in your hospital.)



(1) Theoretical

Richard M. Zaner, "Voices and Time: The Venture of Clinical Ethics," *Journal of Medicine and Philosophy*, 18:9-31, 1993.

Review: This article examines four models of clinical ethics. Zaner investigates whether the ethicist should be thought of as a moral expert or a kind of

negotiator/facilitator, whether the ethicist requires clinical experience and training, and whether the ethicist is analogous to the various kinds of medical specialists that may be called upon to consult on a case. The author examines and rejects the view of the ethicist as a moral expert who has a single body of knowledge to transmit. He finds this view problematic because it suggests that the ethicist can function in isolation, apart from involvement in the specific case and decision-making process. He goes on to examine the concepts of the ethicist as "casuist" (case-based reasoner) and the ethicist as facilitator. These two views move ethics consultation away from the individual expert model associated with medical consultations and toward the view of the ethicist as someone engaged in dialogue with the diversity of points of view of those involved in the clinical situation. Zaner uses these models to advocate a view of ethical

decision making as a community enterprise; the ethicist's role is to promote discussion aimed at identifying the relevant information for understanding the issues at hand and making recommendations.

(2) Overview of Problems

Joel E. Frader, "Political and Interpersonal Aspects of Ethics Consultation," *Theoretical Medicine*, 13:31-44, 1992. Review: In this article Frader deals with the political and interpersonal aspects of ethics consultation, pointing out that the literature leaves out important considerations regarding the political context in which consultations transpire. In particular, he examines the issues connected with the origination of consultation, the problem of nonconsultation, whistleblowing, and the content, conduct, and conclusion of the ethics consultation process. Frader notes that who can and will request an ethics consultation varies from institution to institution and discusses some of the political barriers that may inhibit consultation, as well as some strategies for dealing with them. He discusses several problems involved in the issue of "whistleblowing," i.e. the consultant's obligation to report the unethical conduct of others, and considers the reasons why it should be done, its limitations, and various obstacles the consultant may encounter in this role. He raises questions about the ways consultation may be conducted and the possible conflicts of interest that the consultant may face. Frader makes the point that many perceived moral problems resolve themselves into problems of communication and suggests that improving the communication process requires dealing with the power differentials that exist between doctors, nurses, social workers, various therapists, and the users of medical services.

(3) Specific Problem

POINT AND COUNTERPOINT, "Should Concurrent Case Review Recommendations Always Be Recorded in Each Patient's Records?" *HEC Forum*, 5(6): 374-376, 1993.

YES: Paul J. Reitemeier

Review: Reitemeier explains that in normal clinical consultations, a record of the request for consultation, the consultant's recommendations, and any actions taken are typically entered and kept in the patient's chart. Reitemeier asks whether ethics consultation should be an exception to this general rule. Typical exceptions to the rule of completeness in chart records include sensitive psychiatric information and patient care errors such as medication mistakes. Such information is often stored separately and special requests for it must be made. This prevents the casual observer from accessing this information.

Reitemeier argues that ethics consultants often arrive at conclusions that all caregivers must know, e.g., that all information on the patient's condition should be channeled through a specific family member. Creating access problems to such information will only compound current difficulties. He goes on to suggest certain guidelines for chart entries, e.g., avoiding placing blame on specific actors, writing in a way that is pedagogical in style, etc., that will make the chart entries helpful and reduce the desire to hide them.

No: Mark H. Waymack

Review: Waymack claims that there may be reasons to occasionally write in the patient's chart, i.e., if information important to the patient's continuity of care is involved. However, he points out that most ethics consultations result in clearing up misinformation and miscommunication. Hence, there is no point to narrating the story of this misinformation in the patient's chart. Waymack argues that to insist ethics consultants always make chart entries only fosters the misimpressions that ethics consultants are moral experts or "ethics police." Hence to routinely make chart entries will only discourage health care professionals from taking advantage of the "constructive forum for discussion" that an ethics consultation can provide.

(4) Combination

Judith Wilson Ross, John W. Glaser, et. al., *Health Care Ethics Committees: The Next Generation*, American Hospital Association, 1993.

[This book, as well as its predecessor volume, *Handbook for Hospital Ethics Committees*, can be ordered by calling 1-800-242-2626. We recommend these highly to anyone seeking to organize an ethics committee]

Review: Chapter 7 of this book discusses both the theory and practice of ethics case consultation. It begins, like Zaner's article, by considering models of the consultation process (medical, legal, educational). The chapter explores the strengths and weaknesses of each model and counsels that committees be very clear in stating what model they are employing and what those seeking consultation can expect as a result. The chapter also explores types and methods of case review, discusses practical problems such as documentation and patient access to consultation information, and offers helpful exercises and role play scenarios.

(The articles in our next issue of Truly Useful Literature will be provided by Robert Horn and summarized by us. If you have materials you find to be valuable in guiding your ethics deliberations, send them our way...Thanks Bob!)

CEP MAKES PLANS TO ADDRESS ETHICAL ISSUES RELATED TO AIDS/HIV

The faculty of the Consortium Ethics Program are currently making preparations to help member hospitals and local physicians address ethical issues related to treating AIDS patients. The CEP has received a grant from the Jewish Health Care Foundation (JHCF) to provide educational support to frontline clinicians in the community who care for AIDS patients. The JHCF has taken a proactive stance toward the AIDS crisis and contacted Rosa Lynn Pinkus to see how we might address this issue.

As is the way of the consortium, Dr. Pinkus pulled together core faculty from the CEP and Center for Medical Ethics such as Bob Arnold, M.D., and Mark Kuczewski, Ph.D., and invited other experts, such as Susan Hunt, M.D., medical director of the Pittsburgh AIDS Center for Treatment (PACT), and Linda Frank, Ph.D., M.S.N., of PA AIDS ETC, to brainstorm regarding the approach to take. Bob Arnold suggested that local physicians who treat AIDS patients might welcome the opportunity to come together for an evening workshop to discuss the problems they encounter and share ideas and support with each other. Thus, the workshop, "AIDS and the Local Physician," was born. It is, of course, sponsored by the Consortium Ethics Program (CEP), PA AIDS ETC, and the Jewish Health Care Foundation.

"AIDS and the Local Physician" will take place

on May 5, 1994. It will be attended by approximately 15 physicians who have been invited because of their commitment to treating AIDS patients. To moderate this forum, we have enlisted the services of Karen A. Porter, J.D., a postdoctoral fellow in bioethics at the Albert Einstein College of Medicine and former senior policy analyst for the National Commission on AIDS. As is usually the case with CEP activities, this workshop is not an end-in-itself but is meant to provide a beginning for wider community education. Following the workshop, Mark Kuczewski, Ph.D., with direction from Dr. Pinkus, will compile teaching materials to address the specific needs identified by these local physicians. We hope to generate a videotape and a set of accompanying readings to be used to educate other health care professionals. These materials will be made available to CEP-member hospitals in Fall '94.

Consortium hospital representatives will be contacted to serve as facilitators both within their institution and in their communities to discuss ethical dilemmas posed by the AIDS pandemic. Underpinning the program is a commitment to be "tough on problems but gentle on people." Together, the CEP members can approach what sometimes may seem as overwhelming dilemmas in a thoughtful, educated, and compassionate manner. Our thanks to the JHCF for enabling us to begin this dialogue.

CONSORTIUM ETHICS PROGRAM

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We also extend a special word of thanks to the Vira I. Heinz Endowment for its continued support of the Consortium Ethics Program and to the Ethics Task Force of the Hospital Council of Western Pennsylvania which advises the CEP faculty.

If you have any suggestions or questions regarding the Consortium Ethics Program, wish to submit information for an upcoming edition of *Community Ethics*, or are not a member of the CEP but wish to receive this newsletter, contact Mark Kuczewski, University of Pittsburgh Center for Medical Ethics, 3400 Forbes Avenue, Suite 110, Pittsburgh PA, 15213 or phone (412) 624-3486.