Health Care Law

Mid-Atlantic Ethics Committee Newsletter

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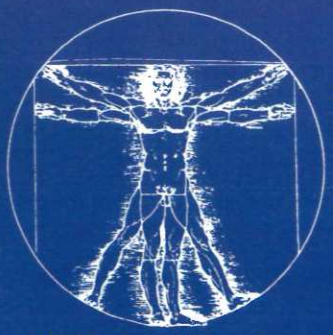

MID-ATLANTIC ETHICS COMMITTEE

N E W S L E T T E R

A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
Published by the Institutional Ethics Committee Resource Network
Law & Health Care Program
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Fall/Winter 1996

Inside this issue:

KEEPING PATIENT INFORMATION CONFIDENTIAL—THE ROLE OF ETHICS COMMITTEES

The ancient Hippocratic tradition of confidentiality, echoed in the ethical codes of all health care professionals, is crumbling under the weight of multiple pressures. Ethics committees may be the last line of defense.

Some of the assaults are results of habit and laziness, as depicted in a recent episode of the television program ER. When Dr. Weaver argued for a change in emergency room practices because the ER chalkboard violated patient confidentiality by prominently displaying patient names and presenting symptoms, she was initially rebuffed by her male colleague, Dr. Green. He reluctantly acquiesced to a change in practice, however, when she pointed out that Mr. Smith's symptoms, written clearly on the chalkboard, included "painful penile discharge." Asking Dr. Green, "[H]ow would you feel if that were your name up there?" he initially agreed to a brief experiment with an alternative system. When, however, the new system proved a bit more inconvenient than the old, he told staff to go back to the old system. So much for Hollywood's concerns for confidentiality.

Yet while intrusions into privacy because of thoughtlessness and stubborn adherence to outmoded administrative practices are frustrating, even more disturbing are the assaults

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Letter From the Editor

This issue of the newsletter focuses on the topic of confidentiality—in particular, the conflicts that arise for clinicians between the duty to keep patient information confidential and the duty to warn or disclose that information to third parties who may be at risk. Our feature article summarizes the ethical and legal dimensions of the conflict and highlights relatively recent court decisions that appear to widen the scope of the duty to warn. In addition, the case study and comments put the issue in real terms for an ethics committee that must decide whether to disclose the HIV positive status of a patient to the patient's sexual partner and caregiver. As always, we welcome your comments on any of the topics or articles in the issue.

Diane E. Hoffmann

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NETWORK NEWS

Baltimore Area Ethics Committee Network (BAECN)

The Baltimore Area Ethics Network has decided to change its meeting format in order to better serve its members. Instead of a brief meeting every other month, this year the BAECN will organize one or two meetings lasting a half or a whole day. It also hopes to provide continuing education credits for attendance at these seminars. As part of the planning process for this year's events, the Network has mailed surveys to all of its members requesting feedback on suggested meeting topics. If you did not receive a copy of the survey, please contact Jack Syme, M.D. at (410) 368-3020; completed surveys should be returned immediately.

Washington Metropolitan Bioethics Network (WMBN)

The WMBN's meeting on September 29 addressed the subject of "Mediating Ethical Disputes." It was organized by Naomi Karp of the American Bar Association's Commission on Legal Problems of the Elderly. Naomi and panelists Diane Hoffmann, Erica Wood, and Kathryn McCarty, discussed the various benefits and potential drawbacks of using mediation techniques in ethical decisionmaking. They also presented a role play involving a dispute between a nursing home resident and her daughters that was both entertaining and informational. The panelists provided excellent handouts that are available from Network Coordinator Joan Lewis at (202) 682-1581.

Evan DeRenzo, Ph.D., Senior Staff Fellow in the Clinical Bioethics Department at the National Institutes of Health, planned the October 29 program on "Ethics of Alternative Medicine." Wayne Jonas, M.D., Director of the Office of Alternative Medicine at NIH, and Andrew Sparber, R.N., Psychiatric Nurse at the National Cancer Institute, joined Evan in a discussion of the new NIH Office and presented a case study on the topic. The program took place at Care Matrix in Silver Spring, Maryland.

On Tuesday, December 3, 1996, the first "Annual Meeting of the Membership" of the Metropolitan Washington Bioethics Network will be held, from 4:30 pm to 6:30 pm, at The Washington Home, 3720 Upton Street, N.W., Washington, D.C. Following this meeting, the MWBN will be an official not-for-profit organization, with its own Board of Directors. The MWBN has been in existence for five and a half years and is now beginning to be asked to partner with other entities (other Networks, academic programs, and D.C. Superior Court, among others) to undertake a range of activities, including conference planning and the like. A Board will allow the Network to make these decisions with broader input representing the membership. The Board will also help set the overall direction of the organization for the future.

Virginia Bioethics Network (VBN)

In 1995, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) added a section called "Organization Ethics" to its Standards for Patient Rights and Ethics. Although this was accomplished without fanfare and with very little notice taken by the healthcare community, it has far-reaching implications for the operations of healthcare organizations (HCOs) and for their internal and

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Keeping Patient Information Confidential

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on confidentiality coming from our courts. In its wisdom, many courts have taken to heart—perhaps too intensely—the consequentialist notion of doing the greatest good for the greatest number. In attempting to balance protections for a specific individual against the need of others not to be harmed, the balance may be tipping dangerously in the wrong direction.

As a legal and public policy matter, the requirement for confidentiality is based on the two fold notion that (1) individuals will not go to a health care provider for necessary treatment if they believe the provider will disclose confidential information, and (2) persons will not reveal personally sensitive information that may be necessary for adequate treatment if they fear disclosure by treating professionals. More and more, however, there seem to be public policy pulls to require or allow for disclosure of private patient information.

The most common legislative example is reporting of child abuse. Here, society has agreed that protection of minors outweighs considerations of confidentiality. And although child abuse reporting laws can produce harms such as false charges, for the most part these laws do more good than harm. The presumption of benefits gained is not so pronounced, however, in other areas where significant inroads have been made into breaching confidentiality.

One glaring example is in the field of mental health. The mental health case known as "Tarasoff,"[1] has resulted in the so called "duty to warn" rule. The rule is based on a California case in which a male university student told his university mental health therapist that he wished to kill a coed with whom he had been infatuated. In accordance with the standard of practice, the therapist informed the proper authorities who temporarily detained the young man. Found not to be imminently dangerous, the student was released, only to subsequently kill the coed. Her parents sued and on appeal it was determined that the therapist had a responsibility to inform the intended victim to allow her to take necessary steps to protect herself. A number of other jurisdictions since have supported the ruling that mental health professionals have a duty to warn identifiable third parties who the professional believes are at imminent risk of serious bodily harm based on information provided to her/him by a patient.

> ***"In attempting to balance protections for a specific individual against the need of others not to be harmed, the balance may be tipping dangerously in the wrong direction."***

But the courts have not stopped there and the duty to warn keeps expanding.

In the AIDS arena, disclosure to third parties who might be at risk for contracting the disease is another major category of the duty to disclose confidential patient information. Unlike *Tarasoff*, however, which fundamentally altered the way in which mental health services are delivered, the breach of confidentiality in the domain of contagious disease has had a long history. Although one no longer sees signs marking houses as quarantined, the advent and spread of AIDS has rekindled the longstanding debate over public health and individual rights.

In addition to the statutes that have evolved in a number of states either requiring or making it discretionary on the part of health care providers to disclose the HIV status of a patient to a sexual or drug using partner, physicians have been held liable for "failing to warn the daughter of a patient with scarlet fever, a wife about the danger of infection from a patient's wounds, a neighbor about the patient's smallpox."[2] These cases have all been justified on the grounds that such disclosure is necessary to protect the public health. But some courts have gone even further than requiring disclosure in the case of contagious diseases. In one recent case, a physician who treated a patient with Rocky Mountain Spotted Fever[3] was held to have a duty to warn members of the patient's immediate family, "not because the disease is contagious, but because the infected ticks that transmit the disease 'cluster' increasing the risk to those likely to be exposed. Risks to family members become foreseeable risks if one family member is infected. Since early detection leads to a high cure rate, and the disease is fatal in 40% of the cases absent early detection, the risk is a substantial one."[4]

The primary ethical basis for disclosure is beneficence. By informing identifiable third parties that they are at risk, the information provided will protect the potential victim from harm and, simultaneously, protect the patient or client from committing the harm. But are these assumptions sound? Does disclosure truly protect potential victims? And if so, at what cost?

In mental health, one wonders just how many potential victims have been saved from the violent threats of

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patients and clients. Research consistently shows that mental health professionals over predict violence in their patients and clients. In the case of AIDS, by the time the health professional reports to the patient's partner(s), it is likely that these individuals have already been exposed. On the other hand, the costs of such confidentiality breaches may be great, indeed. The potential damage to the public's trust of medical and psychiatric professionals is considerable.

One final example puts a different twist on today's pressures to disclose private information. The brave new world of genetics brings the problems of protecting privacy and confidentiality to a stratospheric level. Here, boundaries between family members are all but lost in the rush to learn more about our genetic heritage in the hopes of predicting our future health. But self-knowledge in genetics is, by definition, knowledge of other family members. Boundaries of ethical responsibility for a health care professional treating several family members are almost impossible to draw. And here too, early court decisions indicate a predilection toward ever widening professional obligations along the lines of *Tarasoff*.

Two legal opinions have discussed the question of whether a physician has a "duty to warn" children of a patient with a genetic disease that they are at risk of developing the same condition. In *Pate v. Threlkel,*[5] the Florida Supreme Court held that a physician had a duty to tell his patient of the risk to his offspring of carrying the gene for his serious genetic disease and to encourage the patient to share this information with his children.

A recent opinion by the New Jersey Superior Court[6] decided July 11, 1996, however, went farther and suggested that the duty of the physician may not simply be to warn the patient, but also to warn his children, especially if the patient has not requested that the physician not disclose the circumstances of his illness to his family or if the patient has died. The New Jersey case involved a patient who allegedly suffered from a genetic form of colon cancer. She sued the estate of the physician who had treated her father for the same disease in the 1950s and 60s, alleging that the disease was hereditary and that the physician had breached a duty to inform those who were potentially at risk of developing the condition. The plaintiff was 10 years old when her father died of the disease. The question is not yet resolved in New Jersey as the issues were not fully developed at the trial court level. Nonetheless, the opinion indicates the leanings of the court for a duty to warn in such circumstances. The court analogized genetic conditions to contagious diseases in terms of foreseeable harm to third parties.

Such cases can be expected to come before ethics committees. One can envision a case involving, for example, a man with a history of the cardiac disorder, hypertrophic cardiomyopathy, in his family. He has made a decision that he does not want to know if he carries the gene and has not told his wife about his family history. He wife becomes pregnant. They both see physicians at an HMO. Should the husband's physician disclose the husband's family history to the wife? Should she be told so that she can make a decision about whether or not to have the fetus tested? If the fetus were tested it would not only provide information about the genes of the fetus but also about the genetic status of the father. Should the health care providers disregard the father's privacy rights and desire not to know this information in deciding whether to disclose this information to his wife? Or should they honor his request denying his wife information that might affect her reproductive decisions?

Professionals faced with these dilemmas will be hard pressed not to want to disclose. A judicial inclination towards warning others about genetically transmitted conditions or disease susceptibilities feeds into two deeply entrenched emotional responses on the part of health care providers, one good, one bad. The positive emotional response is that of wanting to help others by preventing or treating disease. The negative emotional response is the fear of being sued. The strength and breadth of this fear, coupled with a laudable drive to intervene to protect the health of others, set in the context of an increasingly consistent pattern of encroachment on protections of confidentiality gives one pause. Given these forces bearing down on the fragile but essential values of privacy and confidentiality, ethics committees must be vigilant in their own efforts to preserve patient confidentiality and rights of privacy, resisting any but the most meritorious arguments to disclose patient information.

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1. Tarasoff v. Regents of the University of California, 131 Cal. Rptr. 14, 551 P.2d 334 (Cal. 1976).
2. Barry R. Furrow, et al. Health Law (1995) at 152.
3. Bradshaw v. Daniel, 854 S.W.2d 865 (Tenn. 1993).
4. Furrow, supra. note 2 at 153.
5. 661 So2d 278 (1995)
6. Safer v. Pack, 291 N.J. Super. 619

Case Presentation

One of the regular features of the Newsletter is the presentation of a case considered by an ethics committee and how the committee resolved it. Individuals are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information of patients and others in the case should only be provided with the permission of the individual. Unless otherwise indicated, our policy is not to identify the submitter or institution. Cases and comments should be sent to: Editor, Mid-Atlantic Ethics Committee Newsletter, University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201-1786.

Case Study From a Hospital in the Washington, D.C. Area

The patient was a 32 year old HIV positive woman who was admitted to the hospital with uncontrollable nose bleeds, an extremely low red blood cell count and a temperature of 103°. She had been diagnosed with both HIV infection and leukemia 7 years prior, and had been hospitalized for several opportunistic infections and episodes of bleeding since that time. The patient appeared depressed and withdrawn and asked that no one be given any information about her condition.

Over the next week, the patient was transfused several times and started on a course of chemotherapy which resulted in some improvement of her overall condition. As the time approached for the patient to be discharged, her health care providers discovered that her boyfriend, who lived with her and would be her primary caregiver when she returned home, was unaware of her HIV status or her leukemia. The patient was reluctant to tell him for fear that he would be extremely upset and might leave her. The patient's doctors and nurses were concerned about this because the patient was at high risk for continued bleeding and acknowledged that she and her boyfriend were still sexual partners. Both of these factors put the boyfriend in danger of being exposed to contaminated body fluids.

When pressed, the patient said that she would tell him about her HIV infection and leukemia. However, she kept delaying and avoiding the conversation; and the more the medical team encouraged her to talk to her boyfriend, the more withdrawn she became.

The patient was now medically ready to be discharged, and the issue of disclosure became critical. Local law (DC) prevented the health care providers from revealing the patient's HIV status without her consent; however, ethically and professionally they felt obligated to warn the patient's boyfriend of the harm to which he was going to be potentially exposed.

Case Discussion: Comments From a JD RN

In this case study a patient has been diagnosed with a highly communicable and deadly disease, there is a demonstrably high risk of exposure to her caregiver/sexual partner and foreseeable exposure to others if it is determined that the relationship is not monogamous. But, the social stigma attached to this patient's disease presents ethical and professional dilemmas that might not otherwise arise. The healthcare providers must balance the patient's legal right to privacy and confidentiality of her medical condition and their legal and ethical duties to warn individuals who may be harmed by her condition in light of the public health considerations caused by the AIDS epidemic.

Patient's Privacy Rights and Constraints on Disclosure of Medical Records

Statutory considerations

In this case, the healthcare providers' perception was that local law prevented them from revealing the patient's HIV status without her consent. Thus, an examination of relevant District of Columbia Code provisions and regulations is instructive.

The D.C. Code and regulations include AIDS in the list of communicable diseases that must be reported to the Administrator of Public Health. However, HIV positivity is not included in the list of reportable diseases[1] and therefore is subject to the general requirement that medical information obtained about a patient must be kept confidential.

The provisions of the Preventive Health Services Amendments Act of 1985 are often cited regarding the confidentiality of medical records and information on persons with AIDS.[2] Also, § 6-117 allows for the creation of a list of reportable communicable diseases and conditions, the establishment of reporting procedures and requirements for restriction of movement, isolation, and quarantine. Confidentiality is protected in a provision permitting the disclosure of records "only when essential to safeguard the physical health of others."[3] Regulations permit the Administrator of Public Health to investigate communicable diseases, collect data, including the names, addresses and other vital information

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Case Discussion

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about infected individuals. Such data may be used for specific purposes including determining the source of infection.[4] The Administrator may not disclose the identity of any person with AIDS without the written permission of the person,[5] except that the Administrator may disclose such information when it is essential to safeguard the physical health of others.[6] Note that these provisions are limited to disclosure of reported information by a public official, not by attending healthcare providers and would apply only to individuals with AIDS, not to those who are HIV positive.

The City Council has recognized certain compelling "state" interests which allow mandatory HIV testing and disclosure of results. Although not applicable to this case, under the *HIV Testing of Certain Criminal Offenders Act of 1995*, upon the request of the victim, the Court may order an offender (an individual convicted of an offense, adjudicated as a juvenile or who has offered a plea of guilty or nolo contendere) to furnish a blood sample to be tested for the presence of HIV.[7] An offense is defined as a prohibited activity involving a sexual act. Both the victim and the offender are notified of the result. The victim may disclose the results of the HIV test to any other individual to protect the health and safety of the victim, the victim's sexual partners or the victim's family.[8]

Unlike the legislators in our neighboring jurisdictions, the D.C. Council has not found a compelling interest in providing for similar disclosure for protection of healthcare providers or for the protection of innocent third parties in a non-criminal context. Virginia provides for statutory deemed consent of the patient for HIV testing where healthcare providers have sustained a significant blood or body fluid exposure.[9] And Maryland law provides that a physician may disclose a patient's HIV status to the individual's sexual and needle sharing partners if the patient refuses to do so.[10]

Physician-patient privilege considerations

In this case, it is possible that the healthcare providers believe that the patient's HIV status is protected by the physician-patient privilege. In D.C. and other jurisdictions, however, such privilege is limited to testimony in Court. Physicians and mental health providers may not be permitted without the consent of the person affected to disclose any information, confidential in its nature, that has been acquired in attending a client in a professional capacity and that was necessary to enable the provider to act in that capacity.

Tort liability considerations

Finally, many healthcare providers are concerned that the disclosure of medical information may subject them to liability on the basis of various tort theories including negligence and intentional or negligent infliction of emotional distress. In their codes of professional ethics, the AMA and many other professional organizations have recognized the provider's duty to maintain confidentiality of patients' information. Disclosure of confidential information may give rise to a claim of liability for a negligent or intentional breach of this legal duty.

The Duty to Warn

Despite their concerns about the liability for disclosure of the patient's HIV positive status, the healthcare workers in this case have expressed a concern regarding their ethical and professional duty to warn the patient's boyfriend. The patient's nosebleeds will likely expose him to significant blood body fluid contacts in the course of his care giving. The couple's continued sexual relations also subject the boyfriend to risk of HIV infection.

Arguably, these concerns could be met by teaching the boyfriend the concepts and practices of Universal Precautions and safe sex. After all, healthcare providers who are also at high risk for exposures to blood and body fluids are not privy to the HIV status of all of their patients. If this couple is truly monogamous, a generic discussion of past sexual practices and the need for "safe sex" may be sufficient to offer the boyfriend protection without disclosure.

But the patient's uncooperative behavior does not suggest that this approach would offer sufficient protection. One might also question the capacity of the boyfriend who now plans to care for someone following chemotherapy and has not actively sought out information regarding his girlfriend's conditions!

The Tarasoff[11] case is sometimes cited as imposing a duty on healthcare providers to warn third parties of potential harm which may be inflicted by patients who are, for whatever reason, "dangerous persons." Using this case, some would argue that the healthcare providers have a legal duty to warn the boyfriend of the foreseeable harm of caring for and having sex with the HIV positive patient. Such a simplistic analysis ignores the underlying Restatement of Torts (Second) Section 315 (1965) which states that "There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless (a) a special relationship exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct or (b) a special relation exists between the actor and the other which gives to the other a right of protection." Although the Restatement is not a source of law itself it is a widely recognized

summary of existing common law and reflects the law in many, if not most, jurisdictions.

While a provider-patient relationship might qualify as "special," in these circumstances, the providers cannot reasonably take control of the patient's actions to prevent the harm to the boyfriend. Consider, however, whether a special relationship exists between the healthcare providers and the boyfriend which gives rise to a duty to warn. Clearly, the providers have assumed a duty to teach him the necessary skills and concepts to enable him to properly care for the patient following discharge. Adequate teaching must include some discussion with the boyfriend of the patient's immunosuppressed conditions and the precautions necessary to safeguard her health.[12] Without discussion of both her leukemia and HIV positive status, adequate teaching might be impossible.

In sum, there is no law in D.C. that explicitly authorizes or sanctions disclosure of a patient's HIV status to a patient's sexual partner. As a legal matter, the situation changes when the patient is diagnosed with AIDS. At that point, the patient's diagnosis must be reported to the Administrator of Public Health who, in turn, may disclose the patient's diagnosis if there is clear evidence that such disclosure would safeguard the physical health of others.

In this case, one feature that arguably makes the grounds for disclosure stronger than it might be in cases where the person "at risk" is the patient's sexual partner is that the person "at risk" is also the patient's caregiver who has voluntarily (but without complete information) assumed responsibility for the patient's care. While this may be a more compelling argument for disclosure, D.C. law apparently has not yet recognized even this as a grounds for disclosure to an "at risk" third party and continues to hold the patient's right to confidentiality paramount to the potential benefit of others.

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1. See 22 D.C.M.R. §201 et seq.
2. D.C.Code Ann. §6-2805. See also, 22 D.C.M.R. §206.1 et seq. and 32 D.C.R. 7276
3. D.C. Code Ann. §6-117(b)(1)
4. See 22 D.C.M.R. §206.1 et seq. See also, 32 D.C.R. 7276.
5. 22 D.C.M.R. § 206.5
6. 32 D.C.R. 7276.
7. D.C. Code Ann. §24-491 et seq.
8. D.C. Code Amm. §24-492(d)
9. See, e.g. VA Code Ann.§ 1-37.2.
10. Md. Health Gen. Code Ann. Sec. 18-337
11. Tarasoff v. California Board of Regents, 551 P.2d 334 (1976).
12. Compare this relationship with In re Sealed Case, 67 F.3d 965 (D.C.Cir. 1995) in which the Court found that a consultant physician, hired to provide quality control services, who had knowledge of a husband's HIV positive status, had no derivative duty to disclose this information to the wife.

Case Discussion: Comments From a Bioethics Coordinator

Conflicts which arise between ethical and legal obligations are always particularly difficult. For many, such situations raise an even more complicated ethical concern, namely, the extent of the obligation to obey the law. Thus, in a case such as the one presented in which the law seems to directly contradict one's moral duty, the ethical obligations must be clearly distinguished from the legal. Once a determination has been made regarding how to proceed ***ethically***, a separate analysis can be made regarding how to best address the legal conflict.

This case presents a number of ethical issues and concerns. There is the patient's *prima facie* "right" to have her private information maintained in a confidential manner and, as a capable autonomous adult, to make decisions regarding her health care. All things being equal, the decision of whether or not to tell her boyfriend that she has leukemia and is HIV positive should be hers to make as she sees fit. Furthermore, confidentiality is generally held to be a binding obligation on the part of health care providers (HCPs). Virtually all professional codes of ethics indicate the importance of keeping private information private in terms of both maintaining a bond of trust between patient and provider and respecting the patient's autonomy.

Conflicting with the patient's legitimate *prima facie* entitlement to confidentially is the real and significant chance of harm to her boyfriend if he is not made aware of the reality of her illness. Although it might be possible to simply inform him of the need to use universal precautions whenever caring for the patient, this would most likely not be sufficient to remove the threat of danger to this "innocent third party." It is an unfortunate reality that persons often do not take the need to use universal precautions seriously UNLESS they understand why it is important.

There is also the issue of the boyfriend's autonomy to be considered. He cannot make an informed decision about taking on the care of the patient unless (or until) he is aware of all that this will entail. If he does not know the truth about her medical condition, he may not be as careful as he should when treating her (e.g., he might not practice infection control measures as effectively as he would if he was aware of catastrophic nature of infection to someone with these diagnoses). Moreover, and perhaps even more importantly, he would also be prevented from making a **voluntary** choice to assume responsibility for the patient's care since he would not know the risks involved.

In determining the ethically appro-

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Case Discussion

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priate course of action, the HCPs' responsibilities to tell the truth and/or keep promises must also be accounted for. Do the HCPs have a duty to disclose the truth (for the reasons noted above) or is the obligation to maintain confidentiality stronger in this situation? Have they implicitly "promised," in virtue of their professional roles, to keep the truth from those who the patient directs should not have access to it, even when not knowing the truth may place another in significant danger? Is the potential for harm greater to the patient (if her boyfriend leaves her and she has no one to care for her) than to her boyfriend? Even if it is not, does he have a "right to know" the truth since it affects him directly? This may be especially relevant considering that the patient was diagnosed as HIV positive seven years ago and has continued a sexual relationship with her boyfriend since that time.

In this case, it would appear that there is a reasonably strong argument for informing the boyfriend of the patient's medical condition in light of his significant risk of potential harm and despite the concern about the patient's rights and her desire not to have the information shared. However, there is the legal requirement NOT to disclose to consider. Even assuming that one can ethically support overriding the patient's wishes and telling the boyfriend, there remains the concern of violating the law by doing so. Certainly one may argue that the law is inappropriate and even that it should be changed; however, this does not remove the immediate problem of how to proceed in this situation.

Basically, there appear to be two options: (1) adhere to the law and violate one's ethical obligations; (2) violate the law and adhere to one's ethical obligations. The decision is a difficult one because while one's conscience may strongly urge option (2), one's pragmatic self may point out the more concrete risks involved in violating the law (e.g., expensive lawsuit, loss of license, etc.). For many, it is this question which is more ethically challenging as it forces the individual to directly confront his beliefs about the moral legitimacy of the law. In the end, the decision to tell or not tell in a case of this nature may depend upon what the individual perceives as his potential for incurring harm as a result of breaking the law and/or his potential to do good by challenging an inappropriate law.[1]

Of course, it may be possible to come to some sort of compromise which results in the patient either disclosing the truth to her boyfriend herself or allowing someone else to do so (with the provision of appropriate support) thus removing the need to actually violate the law. The importance of revealing this information could be re-emphasized to the patient adding that if she chooses not to reveal her HIV status to her boyfriend, arrangements will have to be made to discharge her to an alternate care facility (instead of home to be cared for by her boyfriend). This, it should be explained, is not intended to be a punishment or a threat but, rather, is the only available alternative to protect her boyfriend's safety. If this is ineffective, the HCPs are left with the same ethical dilemma. However, if it is successful, then the best interests of all parties are served.

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[1] *It is worth noting that the AMA Council on Ethical and Judicial Affairs' Code of Medical Ethics (1996-97 edition) states that: "In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations." (p. 1)*

NEW EDUCATIONAL OPPORTUNITIES

University of Virginia Program in Education and Training in Clinical Ethics

John Fletcher, Director of the Center for Biomedical Ethics at the University of Virginia, is planning to establish an "off grounds" (i.e., outside of Charlottesville) Certificate Program and Master's Program in Clinical Ethics for members of ethics committees in Southwestern Virginia and the Washington, D.C. metropolitan area. The Program would fill a gap in the educational opportunities in those areas for members of ethics committees who are looking for more than a theoretical grounding in ethics. A unique feature of the program will be a focus on the practical aspects of doing case consults and establishing an ethics program in an existing health care institution.

The proposed Program is modeled after the existing Clinical Ethics Program that has been in operation at the University of Virginia for several years. It includes three components: (1) an introductory course of study for ethics committee members; (2) a clinical ethics certificate program, awarded by the University's Division of Continuing Education; and (3) a Master of Arts in Clinical Ethics.

The introductory program consists of two three credit courses: an "Introduction to Clinical Ethics" and "Principles and Practice of Clinical Ethics Services." Requirements for satisfaction of the Certificate Program require completion of 12 - 15 credits of coursework in bioethics plus a summer residency (one week in Charlottesville, VA). Requirements for receipt of the Master of Arts include 24 credits of coursework in bioethics, satisfactory completion of two comprehensive exams, a research

project and two summer residencies (one of which would be the one week program in Charlottesville.)

The Program will initially be limited to members of ethics committees in health care organizations (HCOs), e.g., hospitals, ambulatory & outpatient, long term care, rehabilitation, home health, and hospice. In order to participate, an individual must be sponsored by a HCO that makes a financial commitment to support the individual's participation in the program (no less than 1/2 program and tuition costs) and to work with the individual in designing or improving the operations of the organization's ethics committee. The Program is designed to provide such persons with basic advanced education and training for roles in clinical ethics, e.g.:

- to be educators in clinical ethics for clinicians, patients, surrogates, and the larger community;
- to do policy studies and make recommendations for institutional and community guidelines to address various ethical issues in patient care;
- to provide a process for case consultation at the bedside or the conference room; and
- to do targeted research towards prevention of ethical problems, where possible.

While still in the planning stages, Dr. Fletcher hopes to have the Program up and running by fall of 1997. For more information about this program, contact Dr. Fletcher c/o Center for Biomedical Ethics, Box 348, Health Sciences Center, University of Virginia, Charlottesville VA 22908, telephone number (804) 924-8274, fax number (804) 982-3971, or by e-mail at jcf4x@va.edu. **Stay tuned for more on this exciting development!**

OTHER ANNOUNCEMENTS

Evan DeRenzo Named Co-Editor of Mid-Atlantic Ethics Committee Newsletter

Evan Derenzo, Senior Staff Fellow at the Department of Clinical Bioethics at the National Institutes of Health in Bethesda, has joined Diane Hoffmann as co-editor of the newsletter. In her position at NIH, Evan has served as staff to the Clinical Center Ethics Committee and has been doing clinical consultations for the past five years. In addition to her work at NIH, she is an adjunct faculty at Marymount University where she teaches ethics to graduate students in mental health counselling. She is also an adjunct at Johns Hopkins University where she teaches bioethics in the graduate program in biotechnology. Her own research interests include ethical issues in conducting research on cognitively and psychiatrically impaired persons, and ethical issues in the areas of genetics and oncology. Evan received her PhD in Human Development Geriatrics from the University of Maryland. We welcome Evan as a co-editor and look forward to working with her on future issues of the newsletter.

Advanced Clinical Ethics Course

Eastern Virginia Medical School Office of Continuing Medical Education is presenting a 16 hour biomedical ethics course September 21 through November 2, 1996. The target audience is primary care physicians, nurses, social workers, clergy, and others. Classes will meet at Chesapeake General Hospital. The cost is $125. For further information and a flier, phone (804)547-8121, Ext. 1186. Fax (804)482-6245.

external relationships with healthcare professionals, managed care organizations, and other HCOs. The Center for Biomedical Ethics at the University of Virginia has developed a two-day intensive workshop, which is being co-sponsored by the Virginia Hospital & Healthcare Association, to address this subject. The goals of the workshop are (1) to help HCOs (particularly hospitals and nursing homes) understand the new standards, and (2) to help the individual organization develop an appropriate strategy for response. This workshop will therefore not only help a HCO respond to the JCAHO at the next inspection but assist in strategic planning for the future.

The workshop, "Responding to the JCAHO Organization Ethics Standards," is scheduled to be held at the Omni Hotel in Charlottesville, Virginia, November 14 and 15, 1996. Paul Schyve, M.D., Senior Vice President for Standards at the JCAHO, will give the keynote address, "What Is The JCAHO Trying To Do?," at dinner on November 14. The program requires that two persons attend from each organization: an administrator and one other, preferably an ethics committee member. The fee for the workshop is $1,000 for two participants. Fees include all educational materials, breakfasts, lunches and breaks. Institutional members of the Virginia Bioethics Network (VBN) and Fellows (graduating participants of the Center's Developing Hospital Ethics Programs) are offered a 10% discount on the fee. Arrangements can be made for more than two persons from one institution to attend the workshop. For further information or to register, please call (804) 924-5974.

West Virginia Network of Ethics Committees (WVNEC)

On October 4, 1996, the West Virginia Network of Ethics Committees presented a day-long workshop on the subject of addressing the JCAHO's (Joint Commission on Accreditation of Healthcare Organizations) new standards on organizational ethics. The workshop was designed to identify key components of the new standards and offer practical strategies for an institutional response. Jacqueline Glover, Ph.D., new Associate Director of the Center for Health Care Ethics and Law at the Robert C. Byrd Health Sciences Center of West Virginia University, presented an ethical framework for analyzing the business dimensions of health care, while Alvin Moss, M.D., Director of the Center for Health Ethics and Law, guided participants in applying the ethical framework to the analysis of case studies. Rusti Moore-Greenlaw, RN, BSN, M.Ed., JCAHO Surveyor, described the key JCAHO standards concerning organization ethics The final session involved participants in analyzing business codes of ethics or organizational ethics policies developed by area healthcare organizations.

The Fall 1996 issue of the *WVNEC Newsletter* reported the results of a survey of the members of the Medical Staff of the Charleston Area Medical Center regarding the topics of physician-assisted suicide and euthanasia. The survey was adapted from a study of physicians in the state of Washington, which was reported in the *New England Journal of Medicine* on July 14, 1994 (Vol. 331, No. 2:89-94). The survey distinguished between administering an overdose of medication (euthanasia) and prescribing medication to be used by the patient (physician-assisted suicide). In each of these two categories, the physicians were asked whether the practice was ethically justified, whether it should be legal, and whether the physician would personally take the action indicated. The results of the survey were reported in the *WVNEC Newsletter*, along with the data generated by the Washington state survey. For a copy of the Newsletter, contact Cindy Jamison at (304) 293-7618.

CALENDAR OF EVENTS

NOVEMBER

6 American Association of Critical-Care Nurses, *1996 Health Care Ethics Forum.* Co-sponsored by the American Society of Law, Medicine & Ethics. Keynote Address: "The Emerging Ethics to Support End-of-Life under Managed Care," Steven Miles, M.D., Center for Biomedical Ethics and Dept. of Medicine, University of Minnesota. At the Pittsburgh Hilton and Towers, Pittsburgh, PA. Registration $200 - $245. For information or to register, contact the AACN at (800) 899-AACN or (714) 362-2050, ext. 595 (tel), (714) 362-2020 (fax).

14 University of Maryland Medical System, *Medical Humanities Hour*. "Pain and Suffering in Medicine and Literature (19th century - present)," Steve Vicchio, Ph.D., Dept. of Philosophy, College of Notre Dame. 4:30 - 5:30 p.m., at the Shock Trauma Auditorium, University of Maryland Hospital, Baltimore, MD. For information, call (410) 706-6250.

14-15 University of Virginia, Center for Biomedical Ethics, *Workshop*. "Responding to the JCAHO Organization Ethics Standards," Keynote Speaker Paul M. Schyve, M.D., Senior VP for Standards, JCAHO. Co-sponsored by the Virginia Hospital & Healthcare Association, at the Omni Hotel, Charlottesville, VA. Registration $1,000 (for required two participants per institution). For information or to register, contact Ann Mills at (804) 924-5974 (tel), (804) 982-3971 (fax), amh2r@virginia.edu (email).

15-16 American Society of Law, Medicine & Ethics, *Annual Meeting*. "Maintaining Responsive Health Care in the 21st Century: Accountability, Quality, and Change in Traditional Roles and Relationships." Co-sponsored by The George Washington University Medical Center. At the Royal Sonesta Hotel, Cambridge, MA. Registration $145 - $495. For information or to register, contact the Annual Meeting Registrar at (617) 262-4990 (tel), (617) 437-7596 (fax), or aslme@bu.edu (email).

19 West Virginia Network of Ethics Committees, *Wilhelm S. Albrink Lecture in Bioethics*. "In Search of a Peaceful Death," Daniel Callahan, Ph.D., Co-Founder and Past President of The Hastings Center. 12:00 noon, at the Addition Auditorium, Robert C. Byrd Health Sciences Center, University of West Virginia, Morgantown, W.V. Free and open to the public. For information, call (304) 293-7618.

22-24 Pacific Center for Health Policy and Ethics, *Third World Congress of Bioethics*. Sponsored by the International Association of Bioethics, presented in conjunction with the Annual Meeting of the American Society of Bioethics. At the Parc 55 Hotel in San Francisco, CA. For information, contact the Pacific Center at (213) 740-2541.

DECEMBER

3 Metropolitan Washington Bioethics Network, *First Annual Meeting of the Membership*. 4:30 - 6:30 p.m., at The Washington Home, 3720 Upton Street, N.W., Washington, D.C. For information, call (202) 304-7618.

JANUARY

14 *Improved Care for the Dying: Lessons from the SUPPORT Study,* Joanne Lynn, M.D., Director, Center to Improve Care of the Dying, George Washington University Medical Center. The Georgetown Bioethics Colloquium is a lecture and discussion forum held from 5:00 - 6:45 p.m. in the Warwick Evans Room, ground floor Bldg. D of the Georgetown University Medical Center, 4000 Reservoir Road, N.W. Free and open to the public. For further information, please contact Stacy Schultz at (202) 687-1122.

18 West Virginia Network of Ethics Committees, *Biannual Forum in conjunction with the State Medical Association*. "Caring for the Chronically Ill: New Challenges Resulting from Medicine's Successes," Timothy Quill, M.D., The Genessee Hospital, Rochester, N.Y. 1 - 5 pm, at the Holiday Inn - Charleston House, Charleston, W.V., registration $35. To register, contact Cindy Jamison at (304) 293-7618.

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