

Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 1998*

Mid-Atlantic Ethics Committee
Newsletter, Fall-Winter 1998

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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
School of Law, University of Maryland at Baltimore

Fall-Winter 1998

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IS IT TIME FOR A NEW ETHICS COMMITTEE CHAIR?

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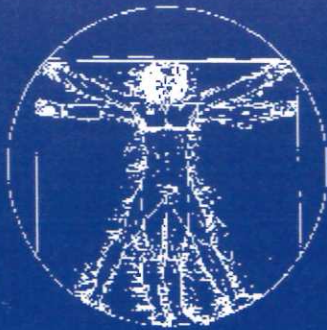
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Ethics Committee Chair

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deprives the parties involved of the benefit that can be gained from the multiple perspectives afforded by a well functioning ethics committee. When unilaterally handling a case, the ethics committee chair is more likely than not to take on the role of “expert” providing a recommendation as to the resolution of the case, rather than a facilitator taking into account the views of the multiple parties affected and seeking out the views of the different disciplines represented on the ethics committee. The final report of the Society for Health and Human Values - Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation refers to this approach as an “authoritarian” model of ethics consultation. The defining characteristic of such an approach, according to the Report, is that its emphasis is on “the consultant as the *primary moral decision-maker* at the expense of morally appropriate decision-makers.” The Report also makes the point that “ethics consultation could be authoritarian either with respect to process or outcome.” As regards outcome, a consult is authoritarian when the consultant substitutes his or her moral values for those of the relevant parties. As regards process, the consult is authoritarian when the consultant “*excludes relevant parties from moral decision-making.*” Such morally appropriate decision-makers are typically thought to include the patient, if capacitated, or his family, and the patient’s health care team. While not technically decision-makers, members of the ethics committee may help these morally relevant decision-makers better understand the issues and the normative boundaries of morally appropriate outcomes.

To the extent consensus development among committee members is important for ethics consultation, a committee chair that bypasses such opportunities may be doing a disservice to the parties, the committee and the institution. On this point, I borrow from a point made by Jonathan Moreno in his book, *Deciding Together: Bioethics and*

*Moral Consensus.*¹ Moreno states that:

[i]n the specific arena of physician-patient relations, the ethics committee movement may be understood as an attempt to promote and “troubleshoot” the new bioethical consensus that emphasizes the priority of patient self-determination while defending the continuing importance of beneficent physician behavior. The interdisciplinary membership that is usually thought to be crucial for ethics committees is thus important not only as a practical matter but also as a matter of principle, for the democratic pluralism of ethics committees itself symbolizes the democratic pluralism that conditions modern doctor-patient relations. [p.36]

The need for multidisciplinary input also underlies the notion that there is often no clear “right” answer to bioethics conflicts. Values may differ based on one’s role (physician, patient) one’s gender, cultural background, or religion. Because there is no clear right answer to many of the bioethics problems we confront, good or fair process often becomes the basis for evaluating an ethics consult. When the chair controls the process or excludes others from the process, there may be problems of fairness or at least of perceived fairness. This may be especially true when certain disciplines are not heard in the process. If the chair is a physician, for example, nurses and social workers may lose faith in the “system” if they do not feel the voice of their discipline is a part of the consultation process.

This may also be true if the chair routinely dominates discussions at meetings, whether they be in the context of retrospective case review or policy development or education. Other members, particularly those of disciplines that are not heard, may become disenfranchised and believe that their input is not valued and it is not worth their time to continue to come to ethics committee meetings. These members may also undermine the committee by telling colleagues that it is a committee run by a chair who does not allow for open discussion of the issues at stake.

To be effective, a committee chair needs to be skilled at group process, both in the context of consults as well as in the context of committee meetings and working with committee members. A good chair understands issues of group dynamics, knows how group members will respond to different proposals, knows which members do not see eye to eye on issues, knows when to encourage some members to participate, knows who will get the job done when given an assignment or who will be effective in leading a subcommittee. A chair who is insensitive to these issues probably should not be a chair.

However, asking a chair to step down is not an easy task. Committee members who complain about their chairs must be willing to take action to make changes. Short of replacing the chair, there may be other strategies a committee can pursue to alleviate some of the problems mentioned. These might include:

1) appointing a co-chair, perhaps of a different discipline than the chair. This individual may be more responsive to concerns of disciplines other than that of the chair. With co-chairs, the time and effort associated with running the committee might also be shared, alleviating some of the burden for a single individual.

2) reviewing the committee’s consultation process. If the chair is involved in every consult, perhaps a new consult process should be established. Also, to the extent a chair or any other committee member unilaterally consults on a case, a process for reporting the substance and process of the consult to the committee should be established.

3) providing training in ethics consultation for the chair and other committee members. There are programs in the area that offer courses or seminars on consultation skills.

But, in some cases, these approaches may not be effective and appointing a new chair may be the only way to get out from under an existing chair’s authoritarian approach. If this is necessary, political alliances are surely necessary and committee members must

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Ethics Committee Chair

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work with the power brokers within their institution to see that changes are made. In this process, the committee may wish to re-evaluate or establish the process by which a chair of the committee is chosen as well as develop a clear policy on chair term and rotation.

Diane E. Hoffmann, JD, MS
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¹New York: Oxford University Press, 1995.

METROPOLITAN DC NETWORK PANEL: ETHICS AT THE PHARMACY

Today's pharmacy is a busy place, but not necessarily an ethically comfortable one. On October 19, the Metropolitan Washington Bioethics Network hosted a panel discussion examining moral conflicts facing pharmacists and others responsible for decisions about the marketing and dispensing of prescription drugs. Panelists were Marion Torchia, pharmaceutical industry analyst and student in bioethics at the University of Maryland; Dan English, M.D., primary care physician and instructor in health care ethics; and pharmacist-ethicist Michael Manolakis, Pharm.D., Ph.D.

The panelists speculated that some of the ethical conflicts facing pharmacists are a result of rapid changes in the organization of pharmacy services. Trends such as the increasing dominance of chain pharmacies, modern standardized packaging, and most importantly, managed care, have disturbed traditional relationships among physician, pharmacist, and patient. Mutual expectations are unsettled.

Managed care has sharpened the conflict between the commercial aspect of pharmacy service and its health care focus. Drug costs are rising, and cost containment efforts are relentless. Caught in the middle, working both as retailers and as health professionals, pharmacists must try to serve several masters: the insurer, their employer, the physician, and the patient.

No longer do physicians have unquestioned prescribing authority. They must choose from a managed care plan's formulary (limited drug list), jump through "prior authorization" hoops, and expect their prescribing profiles to be scrutinized. Drug Utilization Review (DUR) systems, originally designed to prevent mistaken or clinically inappropriate prescribing, sometimes focus on drug costs rather than the quality of care.

No longer do pharmacists compound their own medicines, except in very limited circumstances. Often they are not even responsible for counting the medicines into containers. Their quality-assurance role as dispensers of drugs remains important. However, they are seeking to transform the profession, taking on a new clinical role as providers of "pharmaceutical care."

Legislation is being introduced throughout the country to revise state pharmacy practice acts accordingly. In several states, pharmacists already have limited prescribing authority and manage patients' drug therapy under physician-signed protocols. These new activities entail new ethical responsibilities.

Confidentiality of prescription information is no longer protected by physicians' illegible handwriting. Where state law permits, prescriptions can now be transmitted to the pharmacy electronically. From there, information about the patient is forwarded to the payor or the payor's agent, where it can be linked to other personal health care information. These sophisticated data bases are necessary for managed care operations; they are also useful for research, for patient education, and, potentially, for marketing. Managed care companies and their agents bear a heavy responsi-

bility to hold them in confidence.

Dr. Manolakis, whose doctoral dissertation explored questions of conflict of interest in pharmacy services, talked about the importance of maintaining trust in the patient-pharmacist relationship. The possibility that a conflict of interest will generate harm to a patient is real in the current practice environment, and a variety of actions beyond traditional disclosure and consent should be undertaken to prevent such harms.

Dr. English reflected on his experience as a physician working under the constraints of managed care. The formulary Dr. English worked with was not unduly restrictive. Physicians had input to the selection of drugs, and off-formulary medications could be obtained if necessary, though sometimes at extra cost to the patient. However, after four years the formulary had not been updated. Whether intentionally or inadvertently, access to innovative therapy was reduced.

Dr. English warned of the tendency in today's health care environment to lose sight of the whole patient, and to use medications as a "quick fix." Often lacking the time to counsel patients extensively about their medications, he welcomes the expertise of pharmacist-educators. Pharmacists are specialists who can spot drug contraindications and potential adverse interactions, and who can encourage patients to follow their medication regimens. They should be encouraged to assume this clinical role.

However, Dr. English suggested that while pharmacists working under physician-authorized protocols can improve patient care, independent prescribing by pharmacists is likely to interfere with the continuity of an already-stressed physician patient relationship.

The panel's conclusion: that these are complex issues, important to all of us. They await rigorous ethical evaluation.

Marion Torchia
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LAST ACTS: CARE AND CARING AT THE END OF LIFE

(Excerpted from the brochure, "Last Acts," published by the Last Acts Communications Resource Committee.)

In response to the need for better end of life care as documented by the SUPPORT study,¹ the Robert Wood Johnson Foundation established the Last Acts campaign, an effort to "engage both health professionals and the public in efforts to improve care at the end of life." As part of the campaign, the foundation has brought together a coalition of over one hundred organizations with the common goals of:

- 1) improving communication between dying people and their loved ones, and between dying people, families and health professionals;
- 2) reshaping the medical care environment to better support high quality end-of-life care;
- 3) changing American culture so that people can more comfortably face death and the issues raised by care of the terminally ill.

According to materials published by the campaign, the effort "provides a unique forum for collaboration between professional groups and consumer groups—as well as individuals in both areas—to create new solutions and raise the visibility of the need for better care and caring at the end of life."

Members of the coalition share the following concerns:

- ◆ Care should be centered around the needs of patients and their families.
- ◆ Dying is more than a medical event. It has emotional and spiritual components as well.
- ◆ Improvement is needed in all the care settings where people die, including the home, hospitals, and the long-term care facilities.

- ◆ Pain and symptom control should be high priorities and could be improved starting today.
- ◆ Care giving by family members and friends is an invaluable gift not sufficiently recognized by society.
- ◆ Care for a dying loved one should not leave the family physically, emotionally and financially bankrupt.

The campaign has established six Task Forces and five Resource Committees. Task forces are in the areas of family, palliative care, institutional innovation, provider education, financing and workplace. Resource Committees work with the Task Forces to provide information on communications, diversity, spirituality, standards & guidelines, and evaluation & outcomes.

The campaign has undertaken a number of significant activities since its inception. Examples of some of these include:

Leadership conferences which brought together "top thinkers and organizations concerned with end-of-life issues to identify areas where progress is being made, to target areas for improvement, and leverage existing advances." (Proceedings available on the Last Acts Web site: <http://www.lastacts.org>.)

A television scriptwriters' conference, in Hollywood, to encourage writers for "prime-time dramas, soap operas and other entertainment formats" to explore death and dying more realistically

A television show, "Before I Die" made possible by the campaign and aired on PBS stations across the nation

A quarterly newsletter published for campaign members. These are available on the Web at www.lastacts.org.

If you are interested in more information about the Last Acts Campaign or would like to apply for membership, contact Stewart Communications at 312-642-1888

¹ *Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments, funded by the Robert Wood Johnson Foundation*

JOHNS HOPKINS AND KAISER PERMANENTE WORK TOGETHER TO IMPROVE ADVANCE CARE PLANNING

Kaiser Permanente of the Mid-Atlantic and the Johns Hopkins School of Public Health are working together on a unique collaborative project to improve advance care planning. This pilot project is part of a larger three-year initiative at the School of Public Health, funded by the Pew Charitable Trusts to: (1) develop sustainable models of preventive and population-oriented care within managed care organizations (MCOs); and (2) develop and disseminate state of the art educational and support materials to assist health professionals in applying these models.

Much of the focus of previous end-of-life care planning research has focused on hospital and nursing home-based interventions. This project seeks to intervene with relatively healthy HMO members who are age 65 or older and are visiting their primary care provider for a health maintenance visit. Baseline data revealed that few patient charts contained a copy of an advance directive, although anecdotal evidence suggested that many patients might have such documents at home, though have never shared them with health care providers.

The goal of the initial phase of the project is to increase the proportion of medical charts that contain an advance directive. Provider and staff training, systems changes, support materials and patient preparation in the form of a pre-visit letter, facilitates a provider-initiated conversation about advance directives at periodic health maintenance visits of members age 65 and older. The pilot project developed a simple, two-sided advance directive form that the Maryland Attorney General's office subsequently approved. This new form offers patients and providers an alternative, easy way to document durable powers of attorney for health care.

Even if the first phase of the project is successful in increasing the proportion of patients whose medical charts contain an

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advance directive, actual care provided will not change without ensuring that these forms are available at the time they are needed and that the statements appropriately guide decision-making. Kaiser has implemented system-wide changes so that when hospital-based providers call to admit a member, Kaiser staff will fax a scanned image of the member's advance directive to the hospital. Next steps in the project may include monitoring the use of these documents in the hospital and other care facilities, and expanding the program to other Kaiser regions, including network providers. A "pre/post" evaluation of the effectiveness of the first phase interventions is slated for 1999.

Benefits of partnership

Kaiser selected this topic as the focus of the partnership with the Johns Hopkins School of Public Health not only because of the school's expertise in ethics issues, but in part because of the sensitive nature of end of life care, especially if perceived by the public as a managed care cost-cutting measure. End of life decision-making is an example of a health policy issue that can be understood and addressed through collaboration between managed care and public health professionals. With a combined managed care and public health "population" perspective, patient decision-making can be seen not only as an individual health care issue, but also as a community concern. The Johns Hopkins School of Public Health offers the standing of a neutral (without any financial interest) party, a wealth of experience in ethics and patient decision-making, and a population-orientation that complements the quality improvement activities at Kaiser Permanente. At the conclusion of this project, materials developed will be disseminated widely to others interested in population-based applications in other health plan settings.

For more information contact Amy Belote, Project Coordinator at the Johns Hopkins School of Public Health, at 410-614-5809 or on the internet at abelote@hsr.jhsph.edu.

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 Virginia Hospice

Mrs. D. is a 73-year-old woman who was diagnosed with lung cancer six years ago. After numerous therapies had not succeeded in eliminating the cancer, it widely metastasized. When hospice care was first recommended to her by her oncologist, Dr. M., Mrs. D. took the information but said that neither she nor her family were "ready for that." A month later, after a rapid decline during a hospital stay, she was admitted to the hospice program, electing the Medicare Hospice Benefit. At the time she was experiencing pain and greatly increased weakness. She had signed a living will, refusing life-extending therapy if she were imminently dying or in a persistent vegetative state, and executed a durable power of attorney giving her husband authority to make health care decisions for her should she become incapacitated.

Two weeks later, her pain under control, she decided that she wanted to undergo additional therapy, even though it offered little chance of long-term

benefit. Two weeks after that, during a visit from Dr. M., she said that she "had had enough," and wanted no more curative or life-extending therapy "of any kind," including a feeding tube or antibiotics, even for uncomfortable symptoms. Dr. M. agreed with her decision, but noted that her husband expressed ambivalence about her decision and that her daughter was visibly upset. The hospice team was aware of the patient's and family's ambivalence, and was providing lengthy psychosocial support. Mrs. D.'s pastor was also supporting her in her decision.

Several days later on a Friday, the family called to report that Mrs. D. was running a high fever with cough, sputum production and increasing confusion. A nurse visited and assessed the patient for probable pneumonia. A social work visit was offered but refused. The nurse did remind the family of the patient's choice to refuse antibiotics for infections. On Saturday, the on-call nurse, Ms. S., received a call from a family physician, Dr. A., who had been a long-time friend of the family but who was not in the hospice records as the patient's oncologist or internist. Dr. A. was demanding that Ms. S. send someone out to the house to provide antibiotics for the patient's pneumonia. The on-call nurse told Dr. A. of the patient's decision to refuse antibiotics then called the family. Mr. D. reported that Mrs. D. was confused, delirious, and refusing to eat because she thought that her family was trying to poison her; that this was very upsetting to her adult children, two of whom had just arrived from out of state; and that he wanted her to have the antibiotic "so that she could clear up and tell us herself that she doesn't want it." Mr. D. had called Dr. A. because Dr. M., the oncologist, had left town on vacation; his covering partner, who did not know the details of the case, advised Ms. S. to follow Dr. A.'s order.

After a brief discussion with the hospice medical director, Ms. S. requested a consultation from the hospice ethics committee.

Comments from a Hospice Nurse/Bioethicist

This case provides a poignant example of the complexities of deferring to advance directives in end-of-life decision-making. Mrs. D. has what many consider the “gold standard” of advance directives—both a written living will and a designated durable power of attorney for health care (DPAHC). As Mrs. D.’s agent under her DPAHC, Mr. D. is charged with making a “substituted judgment” decision regarding his wife’s course of treatment in light of her confusion and delirium. What is it that *she* would want? Although her written living will may not explicitly define what she considered “life-extending therapy” or “imminently dying,” Mrs. D. was clear in a recent discussion with her physician that she considered antibiotics to be life-extending therapy. Yet, her husband ultimately requests that the staff “put on hold” Mrs. D.’s stated wishes not to receive antibiotics. How would you proceed if you were a member of the hospice ethics committee that was consulted?

Many would view carrying out Mrs. D.’s wishes not to receive antibiotics as a paramount responsibility because this advances her autonomous choice. Autonomy is foundational in bioethics not just because it commands respect for persons as ends in themselves, but because it is the cornerstone of moral development upon which bioethics is derived. Each one of us acts and thinks within the context of a code of moral behavior promulgated by the culture or society in which we live. Ideally, we progress from following customs and laws out of a fear of punishment or public scorn, to actively thinking about, reflecting on, justifying, and consciously adopting what we believe to be morally “right” and “wrong.” This process of *self-determination* is what helps maintain our faith that Nazism and other forms of blind obedience to rules will be held in check. It is out of a recognition of the primacy of autonomy

that advocates for the ill, disabled, and dying speak out against overt paternalism in the physician-patient relationship. Thus, it is not misguided that Western bioethics has focused so heavily on autonomy.

However, respecting the autonomy of a person who is made vulnerable by serious illness does not mean complying with any choice made by that person—only choices made truly autonomously (e.g., without coercion or out of ignorance or despair). To fully respect and enable her autonomy, one must take into account Mrs. D.’s increased *dependence*, which has fluctuated during the progression of her lung cancer. At present, Mrs. D. is completely dependent on others to make a decision regarding her treatment regimen. In attempting to make this substituted judgment decision, one tries to determine what Mrs. D. would want were she able to voice a preference. The crux of the dilemma is not “would it be in her best interests to have antibiotics?” but “would she again decide against the antibiotics based on her present situation?” We know that at one point Mrs. D. opted for more aggressive therapy in the hopes of curing her lung cancer or prolonging her life. We also know that she judged the burdens of this therapy as outweighing its benefits, opted to discontinue it, and refused initiation of any other means of curative or life-extending therapy. The question remains, had she known when she spoke with Dr. M. earlier in the week that her decision not to receive antibiotics would result in her death within one to two weeks, would she have made the same decision?

Mr. D. may be unconvinced that his wife didn’t intend foregoing antibiotics at some later date when death was “more imminent.” In the absence of the oncologist’s perspective, the ethics committee is left with the perceptions of the members of the hospice team and Mrs. D.’s family as to what Mrs. D.’s frame of mind was when she spoke with her oncologist about foregoing all life-extending therapies. Did it matter to her that her husband was ambivalent and her daughter upset about the decisions she made? Did she talk about seeing

her other children (who lived out of state) before she died? We are told Mrs. D.’s pastor supported her decision. Does this mean Mrs. D. was prepared emotionally and spiritually for her death? Would it make a difference if Mrs. D. was not prepared to die? What if all indications were that Mrs. D. *was* ready to die as soon as she made the decision to forego life-extending therapy, regardless of her family members’ readiness? Should we ever put family members’ needs or desires alongside or above the patient’s?

The job of the ethics committee is to speak on behalf of Mrs. D. recognizing that she is a unique individual within the context of her family and supportive others. The hospice team has a primary responsibility to Mrs. D. to minimize her suffering and provide as smooth a transition to death as possible in accordance with her wishes. However, it is a rare individual whose needs and desires are unaffected by relationships with family members or intimate friends. The process of self-determination is anything but what the name suggests. It is situated within the context of family, culture, and human relationships. The hospice team is committed to the patient but also to the needs of those who support the patient through the dying process. That commitment extends beyond the patient’s death into the bereavement period, with the goal being to minimize regrets and if possible, allow for positive recollections of the patient’s dying and death by the bereaved. Barring evidence to the contrary, one could assume that Mrs. D. would consider minimizing the regrets of her family members in relation to her physical decline and death as of value to her. *How* she would weigh the emotional well-being of her family against her own needs and desires related to end-of-life care is not known. It might be helpful to gather information about what kind of person Mrs. D. was, and whether her choices seemed consistent with “who she was.” While some would argue that others’ end-of-life choices are not held to such scrutiny before they

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Case Comments

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person stops eating and drinking even though this is a normal process when the body starts shutting down and preparing for death. The children who have recently arrived also need to be shown their mother's living will and to be told of her wishes.

Since Dr. M. is unavailable, the hospice should contact Mrs. D.'s pastor since he or she appears to have been involved with Mrs. D.'s illness and dying, and has been supporting her in her decision to forgo life extending treatment. The pastor could be an ideal mediator in this situation since he or she is uninvolved in the immediate conflict, likely to be familiar with the family, and is aware and supportive of the terms of Mrs. D.'s living will.

Although Dr. M. is out of town, the hospice may also want to try and contact him and urge him to at least talk with Mr. D., or help his covering partner understand the situation enough to play a meaningful role. At the very least, the hospice medical director should contact the covering partner, explain Mrs. D.'s condition and the terms of her living will and ask him to speak with Mr. D. and/or Dr. A. The hospice medical director also may be able to intervene with Dr. A., who may simply be responding to Mr. D.'s panic without understanding Mrs. D.'s condition and her expressed wishes.

In summary, deaths often give rise to ethical conflicts for families, and the only way to avoid them is to have the time and make the effort to talk things out in advance and put as much in writing as possible. Unfortunately, this often doesn't happen. In this case, the hospice is under the gun to try and help this family come to terms with their wife and mother's wishes and grant her the death she wanted, and there is no guaranteed shortcut to help them feel ready to let go.

Network News

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On January 7, 1999, the WMBN will sponsor a session on "Organizational Ethics: What Does it Mean? What is the Scope?" The session is being organized by Evan DeRenzo, Ph.D., and Diane Hoffmann, J.D. The program will address the growing interest in organizational ethics and its relationship to legal compliance. (See Dr. DeRenzo's article and Ms. Hoffmann's commentary in the summer 1998 issue of the *Mid-Atlantic Ethics Committee Newsletter*.)

Virginia Center for Biomedical Ethics (VCBE)

The Virginia Center for Biomedical Ethics is focusing attention on the issue of organizational ethics. In September, the Center held a highly successful national conference on this topic. At the conference, there was a concern ex-

pressed about the lack of literature available to professionals regarding the role and scope of health care organization ethics. As a result, the Center is on the lookout for cases dealing with organizational ethics issues that can be used as learning tools for those involved in building organization ethics programs within their institution. (See Call for Cases below.)

In November, the Center held a Conference on: "Ethics in Health Care Institutions: New Issues, Controversies, and Practical Considerations." Topics addressed included: the Role of Consensus in Clinical Ethics, the Virginia Supreme Court case of *Curtis v. Fairfax Hospital* and its implications for Virginia ethics committees, the SHHV-SBC Report on Ethics Consultation, Developing a Plan to Address Organization Ethics, Mediation and Ethics Consultation, and the Effects of Social Relationships on Practical Ethical Discussions.

Call for Cases

The Center for Biomedical Ethics at the University of Virginia is calling for organizational ethics cases. These are cases that include such issues as contracts, mergers, outsourcing committees like Institutional Review Boards, and discussions of either discontinuing or adding new services which may have an impact on the community served by the healthcare organization. In addition, the Center is interested in cases in which various functions of healthcare provider services are involved as well as cases that document the development of healthcare organization ethics programs. The cases will be compiled and used for teaching purposes. If you have cases please send them to Ann Mills, Editor, Bioethics Matters, Box 348, HSC, Charlottesville, VA 22908 or for more information, call Ann at 804-982-3978.

CALENDAR OF EVENTS

DECEMBER

- 2 "Ethical Issues in the Use of Restraints," presented by The Metropolitan Washington Bioethics Network at George Washington University Medical Center. Organized by Vera Mayer. The program will highlight successful restraint reduction efforts and the ethical, medical and legal issues surrounding use of restraints in hospitals and nursing homes. 4:00 - 6:00 pm. For more information contact Joan Lewis at 202-682-1581.
- 3 University of Maryland Medical System Medical Humanities Hour. Marion Danis, MD, Senior Staff Bioethicist, National Institutes of Health will provide an update on advance directives. 4:30 - 5:30 pm. Shock Trauma Auditorium. For information call 410-706-6250.
- 11 "Caring for the Dying: Reexamining Our Approach," sponsored by the University of Maryland Law & Health Care Program. Westminster Hall, University of Maryland School of Law. 8:00 am - 4:00 pm. Symposium fee: \$70 (\$56 for members of the Maryland Healthcare Ethics Committee Network.) For information contact the Law & Health Care Program at 410-706-3378 or 410-706-7239.
- 14 Medical Center Ethics Grand Rounds: Case Presentation - Cardiac Surgery Department. Podium A Conference Room, Lombardi Hall, Georgetown University Medical Center. For information contact the Center for Clinical Bioethics at 202-687-8999.

JANUARY

- 7 "Organizations Ethics: What Does It Mean? What is the Scope?" presented by The Metropolitan Washington Bioethics Network. Organized by Evan DeRenzo, Ph.D. Speakers will include DeRenzo and Diane Hoffmann, J.D. Location TBA. 4:00 - 6:00 pm. For information contact Joan Lewis at 202-682-1581.

MARCH

- 15 - 20 "Developing Healthcare Ethics Programs," a course for healthcare professionals from hospitals and other healthcare institutions, presented by the Center for Biomedical Ethics at the University of Virginia. Designed to facilitate or strengthen the implementation of an ethics program within these institutions. Carries both CHE and CME credit hours. For information contact Ann E. Mills at 804-982-3978 or e-mail amh2r@virginia.edu.
- 26 "Beyond Autonomy: Issues in Pediatric Ethics and Diverse Cultures," Winter Forum presented by the West Virginia Network of Ethics Committees. Days Inn Conference Center, Flatwoods, WV. For more information email Cindy Jamison at cjamison@wvuvphs1.hsc.wvu.edu.
- 26-27 "Transitioning from a Clinical Ethics Program to an Institutional Ethics Program," a conference on organizational ethics presented by the Center for Clinical Bioethics at Georgetown University, Washington, D.C. For information contact Marti Patchell, Assistant to the Director, Center for Clinical Bioethics at 202-687-8999, or e-mail at patchelm@gunet.georgetown.edu.

