



MID-ATLANTIC ETHICS COMMITTEE

NEWSLETTER

A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
Published by the Law & Health Care Program, University of Maryland Francis King Carey
School of Law and the Maryland Health Care Ethics Committee Network

Spring 2012

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The *Mid-Atlantic Ethics Committee Newsletter* is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland Francis King Carey School of Law's Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

Diane E. Hoffmann, JD, MS
Editor

MHECN CELEBRATES 20 YEARS

It's hard to believe 20 years have passed since the first issue of this newsletter was published. There were several forces coalescing then that fostered the birth of the Maryland Health Care Ethics Committee Network (initially called the "Maryland Institutional Ethics Committee Resource Network"), and the inaugural issue of this Newsletter. The following topics included in that first issue underscore the focus on end-of-life decision-making and related legislation:

- On March 10, 1992, a Maryland Circuit Court issued the state's first judicial opinion and case involving termination of life support. The case involved whether to withdraw artificial nutrition and hydration from Ronald Mack, a 31 year-old man who had been in a persistent vegetative state for over eight years. Clear and convincing evidence was established as the appropriate evidentiary standard for terminating life support. The case was appealed to the Maryland Court of Appeals.
- The federal Patient Self Determination Act went into effect.
- Virginia passed its Health Care Decisions Act, inspired by implementation of the Patient Self-Determination Act.
- The D.C. Health Care Decisions Act was amended.
- Maryland legislation on durable powers of attorney for health care stalled in committees, but plans were underway to draft comprehensive

life-sustaining medical treatment legislation to present to the General Assembly in the 1993 session.

- A case was presented involving a 67 year old woman with nasal sinus lymphoma and encephalopathy for whom health care providers considered cardiopulmonary resuscitation attempts to be "futile."
- The Washington Metropolitan Bioethics Network discussed Do Not Resuscitate (DNR) orders in the operating room.

Back in 1992, the field of bioethics had been evolving over the prior three decades, sparked by innovations in medical technology, such as kidney dialysis, cardio-pulmonary resuscitation, organ transplantation, artificial reproductive technology, and genomics. This raised fundamental questions about life and death, quality of life, and concerns about rising health care costs and unfair allocation of health care resources. Early deliberations about the ethics of these medical innovations were dominated by physicians and scientists (Jonsen, 1993). The bioethics movement introduced the perspectives of theologians, philosophers, nurses, psychologists, social workers, lawyers, and others into these discussions to broaden the scope and depth of reflection and analysis. At times, this produced tension between clinicians who wanted answers about what the "right thing to do" was at the bedside, innovators who wanted to push the technological envelope of progress and not be hampered

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20 Years
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by “navel-gazing” philosophers or “chicken little” doom-sayers, and bioethicists who wanted to keep the forest in sight over the trees. Meanwhile, patients and family members were granted increasing autonomy to choose among a plethora of options—a pendulum swing from the paternalistic practice of physicians making medical decisions for patients to spare them the burden of choice.

While many seminal cases in biomedical ethics made their way through the courts (Poland, 1997), judges faced questions they were not formally trained to address. The idea surfaced that health care ethics committees (HCEC) were a preferable alternative to the courts for resolving disputes, particularly for decisions about end-of-life care (President’s Commission, 1983). By the late 1980’s, over half of U.S. hospitals had established an

ethics committee. However, these committees lacked legal or regulatory authority or oversight, and varied a great deal in their composition and function (Hoffmann & Tarzian, 2007). To attempt to remedy this, Maryland’s Patient Care Advisory Committee (PCAC) Act was passed in 1987, making this the first state to legally mandate that hospitals have a specially comprised committee of individuals weigh in on cases involving disputes or uncertainty about medical decision-making. However, while the Act establishes certain requirements of the committee, it does not stipulate minimum qualifications of ethics committee members.

During this time, local ethics networks began to spring up, such as the West Virginia Network of Hospital Ethics Committees, the Metropolitan Washington Bioethics Network,

The Maryland Healthcare Ethics Committee Network (MHECN) is a membership organization, established by the Law and Health Care Program at the University of Maryland Francis King Carey School of Law. The purpose of MHECN is to facilitate and enhance ethical reflection in all aspects of decision making in health care settings by supporting and providing informational and educational resources to ethics committees serving health care institutions in the state of Maryland. The Network attempts to achieve this goal by:

- Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution act consistently with its mission statement;
- Fostering communication and information sharing among Network members;
- Providing educational programs for ethics committee members, other healthcare providers, and members of the general public on ethical issues in health care; and
- Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland.

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support. Current affiliate members include the Johns Hopkins Berman Institute of Bioethics.

the Richmond Bioethics Committee Network, and the Midwest Bioethics Center (now the Center for Practical Ethics). Theologian John Fletcher, former professor emeritus of biomedical ethics in internal medicine at the University of Virginia medical school and a founder of the biomedical ethics field, was a vocal proponent of local ethics networks. He criticized seminars for not giving students a more realistic view of the complexity of human spiritual experience and moral decision-making as these unfold in real-life situations, and translated this to the field of biomedical ethics by training ethicists and health care providers at patients' bedsides. Fletcher believed that regional ethics networks could serve their communities in the following important ways:

- to educate the public and health care professionals on ethical issues and problems that arise in the clinical encounter;
- to assist health care institutions establish or strengthen their institutional ethics program through educational activities;
- to provide a vehicle for those in biomedical ethics to communicate with and support one another, to continue their education and training, and to serve others (MAEC, Spring 1992).

Inspired by Fletcher's work and the passing of Maryland's PCAC, in 1991, Diane Hoffmann formed the Maryland Institutional Ethics Committee Resource Network (later called the "Baltimore Area Ethics Network, and now the "Maryland Health Care Ethics Committee Network" [MHECN]), a project of the Law and Health Care Program at the University of Maryland School of Law. About this time, a case similar to Theresa Schiavo's in Florida came to the Maryland Court of Appeals, involving a dispute between the wife and parents of a man in a

persistent vegetative state regarding withdrawal of his enteral nutrition and hydration. The Maryland court refused to recognize a court order for guardianship that the patient's wife had obtained in Florida, where she had relocated, and held that nutrition and hydration could not be withdrawn because there was no clear and convincing evidence of the patient's wishes (Maryland Court of Appeals, 1993). Shortly after this decision, Maryland's Health Care Decisions Act (HCDA) was passed, which establishes a hierarchy of surrogate decision-makers in cases like these, and would have recognized the wife over the parents as the surrogate decision-maker authorized to withdraw enteral nutrition and hydration from the patient. The HCDA mandates involvement of the PCAC in certain situations, and provides some legal immunity for health care providers acting in good faith.

While law and ethics overlap to some extent, they are not the same. MHECN's home in the Law and Health Care Program of the University of Maryland School of Law is unique. With its close relationship with health law experts and state policy makers, MHECN serves to ensure that interpretation and application of laws like the PCAC and HCDA conform with standards in biomedical ethics.

In addition to providing resources for ethics committee members in Maryland health care facilities, MHECN has conducted surveys and held symposia to address questions such as, "Do hospital ethics committee members have sufficient competency to do ethics consultations?" (Hoffmann, Tarzian & O'Neil, 2000), "Is transferring severely chronically ill elderly from nursing homes to local hospital emergency departments ethically appropriate?" (Tarzian, Hoffmann, Volbrecht & Meyers, 2006), and "How are intensive care unit physicians, hospital attorneys, and

risk managers interpreting Maryland's Health Care Decisions Act as relates to certifications of medically ineffective treatment?"

Individual health care providers facing uncertainty or moral distress about medical decisions involving conflicting core values may look to their facility's ethics committee or ethics consultation service as a resource. MHECN has evolved as a similar resource at the state level to address ethical questions and concerns that transcend individual health care institutions, in addition to providing resources to individual ethics committee members. Since MHECN is a member-supported institution, we count on member support to continue to provide these resources. We look forward to continued opportunities to serve, and thank all of you who have supported us in our first two decades! Stay tuned for updates to our website, at www.law.umaryland.edu/mhecn.

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MHECN-SPONSORED CONFERENCES ... A LOOK BACK

Sustaining the Life of Your Ethics Committee. May, 1998, Bon Secours Spiritual Center, Marriottsville, MD

Hopkins v. Wright: A Panel Discussion. November 18, 1999, Harbor Hospital, Baltimore, MD

Healthcare Ethics in a Multicultural Society. June, 1999, Harbor Hospital, Baltimore, MD

Tailored Basic Ethics Education Courses Fall 2000, Greater Baltimore Medical Center; September 8, 2001, Shore Memorial Hospital, Easton, Maryland

Communication: The Heart of Ethics Consultation. Saturday December 2, 2000, Bon Secours Spiritual Center, Marriottsville, MD

Capacity Assessment, Tube Feeding and Other Vital Issues of Importance Before the End-of-Life. Thursday, November 15, 2001, North Arundel Hospital, Glen Burnie, Maryland

Two Topics in End-of-Life Care: African American Perspectives and Conflict Resolution. June 15, 2001, Franklin Square Hospital, Baltimore, MD

Spirituality, Healthcare and the Role of Ethics Committees. Monday October 28, 2002, Franklin Square Hospital, Baltimore, MD

Clinical Informed Consent and Capacity: Law versus Ethics. June 2, 2003, University of Maryland School of Law, Baltimore, MD

Not in My ER, Not in My Nursing Home: Regulatory, Legal, and Ethical Insights about Dying in Institutions. Friday, December 12, 2003, Franklin Square Hospital, Baltimore, MD

'Still Hazy After All These Years' – DNR Orders: Problems & Solutions. November 17, 2004, Charles-town Retirement Community, Catonsville, MD

'Healthcare Ethics in Action' – Basic Ethics Education Conference. June 28, 2005, Franklin Square Hospital Center, Baltimore, MD

Troubleshooting the Patient's Plan of Care Form. November 29, 2005, Broadmead, Cockeysville, MD

Should Conscience Be Your Guide? Exploring Conscience-based Refusals in Health Care. June 20, 2006, University of Maryland School of Law, Baltimore, MD

Money & Medicine: Bedside Ethics of the Medical Marketplace. January 30, 2007, Greater Baltimore Medical Center, Towson, MD

Ethics Committees in Action. July 26, 2007, Bon Secours Spiritual Center, Marriottsville, MD

The Ethics of Health Care Reform. April 7, 2008, University of Maryland School of Law, Baltimore, MD

Ethics Committees and Maryland Law – Time for a Change? December 3, 2008, Broadmead Continuing Care Retirement Community, Cockeysville, MD

Fine Tuning Clinical Ethics Consultation – A Workshop for Health Care Ethics Committee Members. June 8, 2009, Franklin Square Hospital, Baltimore, MD

The Ethics of Pandemic-Driven Health Care Resource Rationing. October 27, 2009, University of Maryland School of Law, Baltimore, MD

Disability, Health Care & Ethics – What Really Matters. April 28, 2010, Kennedy Krieger Institute, Baltimore, MD

Medical Futility and Maryland Law. November 30, 2010, University of Maryland Baltimore campus

Ethics Consultation & Beyond: A Primer for Health Care Ethics Committee Members. June 29, 2011, Harbor Hospital, Baltimore, MD

Medically Ineffective Treatment Under Maryland Law: A Round Table Discussion with Maryland Hospital Attorneys & Risk Managers. September 28, 2011, SMC Campus Center, Baltimore, MD

UPCOMING ...

Navigating Communication Landmines in Ethics Consultation. June 13, 2012, Carroll Hospital Center, 200 Memorial Avenue, Westminster, MD

THE CONFLICT MATRIX MODEL: AN INNOVATION FOR CLINICAL ETHICS CONFLICT MANAGEMENT

Healthcare professionals often avoid conflict, and when they do engage with conflict, they do not always do so appropriately (Gerardi, 2004-2005). This can leave important patient care issues unresolved (Wilmot and Hocker, 2001). The Conflict Matrix Model, a tool from the conflict resolution field, may be the next step in the evolution of clinical ethics conflict management (Lederach, 1995; Thomas & Kilmann, 2003).

The Conflict Matrix Model can help both clinicians and ethics consultants understand and implement varied approaches for managing conflict in a way that is most appropriate for each conflict. It seeks to answer questions such as whether action or silence is the better option, and whether to compromise or to insist on a particular course (Lederach, 1995; Thomas & Kilmann, 2003). This model can be useful prospectively and retrospectively, helping both in the analysis of active conflict situations and in the evaluation of prior interventions.

In this Model, an individual will

assess the appropriate approach to a conflict in accordance with his or her perception of the relative importance of the issues and the relationships involved. Unlike more general situations of conflict where the importance of an issue can be highly subjective, in the clinical context, a clinician or ethics consultant must assess the importance of an issue based on the degree of ethical significance attached to a particular matter. Ethical significance can be gauged by how the issue affects the quality of clinical care, an individual's right to autonomy, or fairness. In most respects, the "importance of relationships" is straightforward, referring to the significance of one's connection with another individual or group. In the clinical setting, unlike in other settings, though, users of the Conflict Matrix must heed the special bond between health care providers and patients. As the importance of issues rises the degree of assertiveness that is appropriate also rises; as the importance of maintaining positive relationships increases, so does the importance of

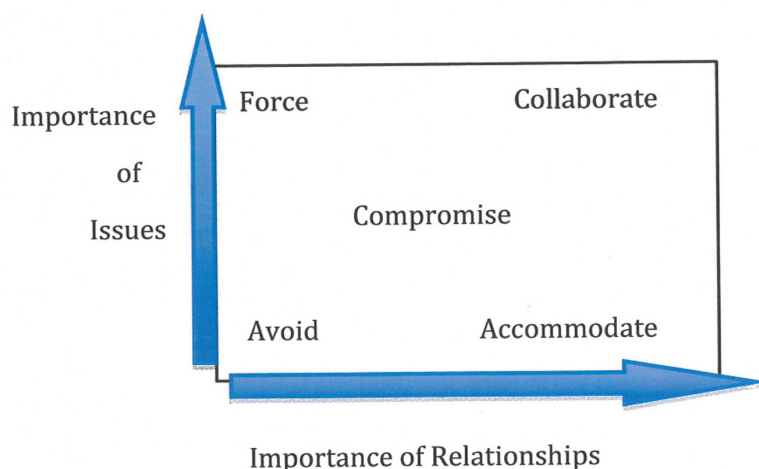
considering the needs and goals of the other stakeholders.

In the Conflict Matrix Model, there are five approaches towards conflict (Kraybill, 2000; Thomas & Kilmann, 2003).

Forcing refers to requiring a particular course of action. This approach is appropriate in an emergency or if healthcare providers are confident that a particular ethical obligation must be upheld even if doing so may strain a relationship. While it should be used with great caution, because it necessarily discounts minority viewpoints and may unfairly overpower weaker individuals, forcing an action has a role that must be recognized in the healthcare setting. For example, ethical and legal standards recognize that abiding by the health care wishes of a patient with full decision-making capacity to be of high importance. If a family member attempts to exert control over a patient's health care decisions in a way that runs counter to the patient's wishes, despite all persuasive attempts to convince the family member that this is not the appropriate thing to do, clinicians may need to force the family member to recognize standards of medical decision-making.

Forcing can be damaging to relationships because it may be disempowering and seem disrespectful to others, may reduce opportunities for learning, and may block dissident views from being voiced. However, when forcing is appropriate, shying away from it may lead to untenable delays in action or prolonged periods of indecision that cause confusion and frustration. If a clinician withholds valuable input for fear

Conflict Matrix Model



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Conflict Matrix Model

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of “forcing” a view on others, poor outcomes or ethically inappropriate actions may result. This might occur in the case of a patient who experiences a fatal stroke, after which the clinical team deems the patient to be dead, but where a family hopes for a miracle and has demanded that the patient be maintained on mechanical supports. In this situation, if the clinical team agreed to this request, an ethically problematic result would occur. The clinical team has a responsibility to provide a supportive, compassionate, and safe environment to help the family to accept the patient’s death. In this case, however, the clinical team would ultimately force an action—removing medical equipment from the body of the deceased, even if it is at odds with a family’s initial demand.

Avoidance means ignoring the conflict. This is only appropriate when neither issues nor relationships are important, such as when a patient’s visitor is visibly upset at the bedside, but where the patient seems at ease and has not volunteered information about the visitor’s distress.

Inappropriately avoiding conflicts may lead to conflicts persisting and becoming more destructive over time. Avoidance may become “contagious” as multiple participants ignore a conflict, creating stressful silence. Decisions may be made by default rather than through deliberation, which may disenfranchise or harm those affected. Poor clinical or ethics outcomes may also result when the signs of conflict are ignored. If, for example, each time the topic of discharge is raised, a patient says that she does not want to talk about it and becomes very anxious or withdrawn. Avoiding the patient has the potential to result in an unsafe discharge, whether because each healthcare team member feels that it is someone else’s responsibility

to address the patient’s concern, or because each team member feels it is unnecessary for anyone to delve into the patient’s anxiety. On the contrary, when individuals involve themselves in any apparent conflict without regard to whether it should simply be avoided, this may seem like nosiness or bullying.

Accommodation refers to forgoing one’s own goals in order to pursue another person’s goals. This approach is useful when the relationship is of high importance and the other party’s request does not infringe on one’s core values or concerns. Accepting the other party’s request can foster goodwill, preserve harmony, and empower the individual making the request. Backing down from a position may also demonstrate that you are reasonable and fair. In a situation where a visitor is violating a visiting hours policy to stay at the bedside of an ill loved one who has been very anxious about being alone in the hospital, making an exception to the policy may be sensible.

Accommodating others too frequently may lead them to ignore your needs and concerns, fostering the impression that you do not have any ideas or that you lack the willpower to stand up for them. This can damage your credibility. Accommodation may also contribute to “group think” if a suboptimal course of action is accepted without dissent. On the opposite extreme, persistently refusing to accede to others’ requests may signal that you lack the discretion and big-picture thinking necessary to do the right thing.

Compromise refers to reaching a decision that is part way between the goals of each side. This approach is useful when both relationships and ideas are of some importance, but neither is of utmost importance, and when a solution is better than a

stalemate, even if it does not fully satisfy each individual or group. For instance, when a physician feels that it is clinically inappropriate to maintain a dying patient on a ventilator but the family wants the ventilator to be continued, the family and doctor might agree to maintain the ventilator until the following afternoon so that out-of-town family could say goodbye. The relationship with the family and the timing of the ventilator removal were important, but a compromise was possible, which upheld each party’s main values with some concessions from their original positions.

Compromise may sacrifice long-term goals in order to quickly resolve the immediate issues or it may lead to the cynical perception that any decision is negotiable. On the opposite extreme, frequent unwillingness to compromise may allow conflicts to escalate and become destructive as unimportant issues are blown out of proportion.

Collaboration refers to identifying underlying concerns and searching for a solution that is mutually agreeable and fully satisfies everyone’s core needs. It may involve working with a broader group of relevant parties to expand the range of ideas. This approach is called for when both relationships and ideas are of high importance, and is advisable when an innovative solution to a complex problem is needed. Collaboration may also be useful where “buy-in” to a course of action will increase the chance of success, since people tend to support solutions that they helped create. An example would be a patient who refuses a blood transfusion due to religious beliefs. Deliberations with the core stakeholders (e.g., the patient, her family, the patient’s hospitalist, the family’s religious minister, the patient’s primary care physician, and the hospital chaplain) expand the range of

available clinical options to include a new synthetic blood product, which may fulfill the immediate clinical need and even offer long-term benefit. The collaborative solution upholds the patient's and clinical team's core objectives, offers the possibility of long-term therapeutic advantage, and strengthens the relationship between the patient and clinical team.

Collaboration can lead to overthinking trivial matters, causing participants to become frustrated and divert attention from important issues. Since collaboration is time intensive, participants may become less effective because they are spread too thin. Collaboration may also lead people to avoid taking ownership over a decision since the risks of accepting a course of action and responsibilities involved in upholding it, are diffused amongst the stakeholders. On the contrary, collaborating too little can deprive an organization of mutually

beneficial solutions, since quick fixes often fail to address root causes, foster creativity, or encourage individuals to challenge the status quo.

Conclusion

The Conflict Matrix Model is a tool to develop skills in effective conflict management in clinical settings. It teaches that there is no one-size-fits-all approach that will be useful in all conflicts. Clinicians require nuanced conflict management skills, and this model can help clinicians acquire these skills. In complex health care encounters, individual conflict situations warrant individualized approaches. The Conflict Matrix provides a framework to clarify thinking and guide action.

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MHECN Advisory Board member Brian Childs, PhD is the new President-Elect for the College of Pastoral Supervision and Psychotherapy. Dr. Childs is currently Director of Ethics at Shore Health System, University of Maryland Medical System, and a member of the Chesapeake Chapter. A certified Diplomat in Pastoral Supervision and Psychotherapy, Dr. Childs is a minister in the United Presbyterian Church, Presbytery of Baltimore. Previously, Dr. Childs held a chair as Professor of Pastoral Theology at Columbia Theological Seminary. He received his PhD from Princeton, a protégé of Seward Hiltner and Paul Ramsey. Dr. Childs also serves on the Clinical Ethics Consultation Affairs standing committee of the American Society for Bioethics and Humanities.

Congratulations to our friend and colleague!



CASE PRESENTATION

One of the regular features of this Newsletter is the presentation of a case considered by an ethics committee and an analysis of the ethical issues involved. Readers 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 about patients and others in the case should only be provided with the permission of the patient. Unless otherwise indicated, our policy is not to identify the submitter or institution. We may also change facts to protect confidentiality. Cases and comments should be sent to MHECN@law.umaryland.edu, or MHECN, Law & Health Care Program, University of Maryland Francis King Carey School of Law, 500 W. Baltimore St., Baltimore, MD 21201.

The following case study and commentaries are from White, Becky Cox; Zimelman, Joel, Moral Dilemmas in Community Health Care: Cases and Commentaries, 1st Edition, ©2005, Reprinted by permission of Pearson Education, Inc., Upper Saddle River, NJ.

CASE STUDY FROM A RURAL CLINIC

Mr. I is a family nurse practitioner in a frontier town of 2000 in a western state. He is in practice with Dr. R, a general practitioner who has been a physician in town for 35 years and will be retiring soon. After seven years in his position, Mr. I is liked and respected by the population. He, his wife, and their two young sons are immersed in and enjoy their life in this community.

Mrs. M, a 26-year-old wife of a local rancher, has been Mr. I's patient since he began his practice. She has been in excellent health, requiring only routine care (e.g., pap smears, flu shots). When Mrs. M arrived for her annual pelvic exam and pap smear, Mr. I was shocked to see that this normally vivacious, energetic, petite woman had lost nearly 20 pounds and looked as if she had aged as many years. With compassionate encouragement from Mr. I, Mrs. M tells the following story:

Three months ago her car broke down several miles from town as she was returning home from Wednesday night choir practice. She began to walk the several miles to the family ranch

and counted herself fortunate when her pastor came along and picked her up. To her horror, the pastor drove to a deserted area and raped her. She still has trouble believing the rape actually took place, and keeps hoping this is a bad dream from which she will awaken. Since the rape Mrs. M has had difficulty sleeping, eating, concentrating, and completing her normal tasks (common experiences for rape victims). Her husband, whom she loves dearly, is deeply concerned about her and repeatedly asks if anything is wrong. Nonetheless, she has been unable to bring herself to tell her husband—or anyone else—about the rape. The pastor and her husband are lifelong friends, hunting and fishing buddies, and confidants. She fears her husband will not believe her or, if he does, will take some violent revenge on his friend. She worries, too, that he will ultimately come to resent her for the loss of the friendship. She also worries that she may now be pregnant.

Mr. I performs a pelvic exam and is relieved to note the absence of any sign of trauma or pregnancy. Nonetheless, he advises that Mrs. M be tested for pregnancy and for several sexually transmitted diseases. Mrs. M absolutely refuses. She indicates that she would never have told anyone about the rape had her husband not been so worried about her health. She certainly is not about to have Mr. I's office assistant fill out forms requesting these tests. ("God knows who she would tell!") When Mr. I assures her

that he will fill out the forms himself, Mrs. M still refuses, crying that she doesn't even want the test results in her medical record. And what if the office assistant opened the mail when the results returned?

Mr. I's more pressing concern is how to manage Mrs. M's profound depression. He advises an antidepressant which she rejects, fearing that the local pharmacy could not guarantee confidentiality or that her husband would discover the pills and insist on an explanation. Mr. I suggests counseling, but the nearest family counselor and nearest psychiatrist are about three hours away. Mrs. M insists that she could not travel so far on a regular basis without raising suspicions. She pleads with Mr. I to serve as her counselor. Mr. I reluctantly begins to see Mrs. M twice weekly. He believes he is her only option, though is keenly aware that his counseling skills are meager. Telephone consultations with colleagues specializing in psychotherapy and rape counseling provide minimal guidance. Mr. I asks Mrs. M at each visit to reconsider seeing a qualified counselor; but she is steadfast in her refusal.

Six weeks later Mrs. M has made no apparent progress; she is still depressed and has lost seven more pounds. Mr. M has called several times, frantic about his wife's condition and asking if he can or should do anything to help her. Further, Mr. I is himself becoming depressed. He has

stopped going to church, long his most important source of psychological support, because he and Mrs. M. attend the same church and, thus, have the same pastor. Mr. I cannot bear to listen to the sermons or interact with the man he knows has committed a deep moral evil. What is Mr. I's moral obligation to Mrs. M now?

RESPONSE FROM A LAWYER & A PHILOSOPHER

This case raises far too many issues for a single comment. But cases in real life often raise multiple issues, particularly in a small community where the practitioner plays many roles and faces difficult ethical issues regarding the boundaries of professional and personal relationships.

This is a case of alleged rape. We say "alleged" advisedly, because no matter how clear the case seems, the alleged perpetrator has not been convicted of the offense and will be entitled to all due process protections. We also say "rape" advisedly, because the case describes what happened as "rape." Rape, however, is a notoriously difficult offense to prove. Under a typical statute the prosecution would need to prove beyond a reasonable doubt that the defendant had sexual intercourse with the victim against the victim's will. With the time that has passed, there is no physical evidence of the alleged intercourse. Moreover, in some states proof that the intercourse was against the victim's will requires evidence of violence or other duress. In addition to the personal pain and perhaps shame that victims may experience in reporting an alleged rape, these difficulties in prosecution must always remain in the background (Estrich, 1987).

In this case, the nurse practitioner, Mr. I, sees Mrs. M for a regular visit.

Her appearance is disturbing and, on inquiry, he is told that she was raped three months ago. Mrs. M requests Mr. I to keep the rape confidential and refuses to allow Mr. I to perform procedures that are standard to protect the health of rape victims (a pregnancy test and tests for sexually transmitted diseases [STDs]). Mr. I acquiesces and agrees to try to help Mrs. M deal with the rape through counseling, although Mr. I has no special training in psychiatric nurse practice (American Psychiatric Nurses Association, 2003). At the time of these decisions, Mr. I fails to serve Mrs. M's health-related interests. He does not determine whether she is pregnant, which might affect medical management. Indeed, he offers antidepressants without knowing whether she is pregnant. He does not determine whether she has contracted a STD, which again might affect medical management. Furthermore, this failure risks Mrs. M's husband if she is an unwitting vector of disease transmission. Finally, he agrees to counsel Mrs. M, possibly outside the scope of his practice. He makes each judgment in response to Mrs. M's earnest requests, perhaps reasoning that Mrs. M's autonomous choices should outweigh her health-related interests. There are of course deep ethical conflicts about whether and why patient autonomy should outweigh patient interests, and when health care providers should act in accord with patient choice.

In this case, however, criticism of Mr. I's actions can avoid these deep conflicts and provide direction for future action. First, Mr. I acquiesced in Mrs. M's choices hastily at best. No evidence from the case suggests he took care to explain to Mrs. M the significant risks of her decisions or to ensure that she understood them rather than reacting from distress. Did Mr. I explore risks to her and to

a fetus if she were pregnant and did not receive adequate prenatal care or indicated treatment for any STD? Did he discuss health risks to her husband? Did he explain his own lack of counseling expertise? When patients make decisions against their health-related interests, they should do so with clear understanding; Mrs. M's refusals here were not appropriately informed. Second, no evidence indicates that Mr. I ascertained his legal obligations or explained them to Mrs. M. Depending on the law of his state, Mr. I might be required to report evidence of a crime. Third, Mr. I might have sought the advice of other practitioners in this difficult situation. The case is silent about any practice agreement between Mr. I and Dr. R, another alternative left unexplored.

What should Mr. I do now, when counseling has not helped Mrs. M and when the situation has burdened Mr. I as well? Difficult as it may seem, he should do what he should have done in the first place. He should work with Mrs. M to be sure she understands all the risks of her current choices, including their effects on her own health, on that of her husband, and on her marriage. He should explain why, as a responsible practitioner, he can no longer counsel her. He should explore with her possible alternatives, their risks and benefits, including telling her husband and seeking alternative sources of care. He should be prepared with a referral. He should consult his lawyer, to understand his legal obligations, within the practice and with respect to state reporting requirements. Throughout, he should offer to support her in these choices and to continue to provide her with health care within his scope of practice. The most difficult situation for him would arise if she refuses to take any action. She is depressed and he may not be trained

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to recognize whether she presents a risk to herself of suicide. Under such circumstances, he should tell her that it is his professional obligation to take steps to protect her, including violating her confidentiality, unless she takes steps to protect herself through a referral. Psychologists and psychiatrists have a professional duty to maintain patient confidentiality, unless certain circumstances obtain, including, though not limited to, the patient's being a threat to self or others (APA, 2002).^{*} Although he is a nurse practitioner (NP), he is acting as a mental health professional; these would be his obligations as a mental health care provider, acting in Mrs. M's interests and attempting to further her well-reasoned choices.

In sum, this is a case in which Mr. I has confused being nice and trying to help with principled practice. He has done so because Mrs. M is deeply upset and because he wants to try to help her. But the result, unfortunately and all too predictably, is not a success. Moreover, helping Mrs. M take steps now is also likely to be beneficial to the community as a whole; if the pastor really is a rapist, Mrs. M is all too likely not to be his only victim.

*Leslie Francis, PhD, JD,
and Diana Buccafurni, PhD(c)*

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^{*}*The American Medical Association (AMA) also endorses the violation of patient confidentiality privilege in cases where the patient is a threat to self or others, though the AMA does not describe such action as a professional obligation: "Psychiatrists at times may find it necessary, in order to protect the patient or community from imminent danger, to reveal confidential information disclosed by the patient" (American Psychiatric Association, "Code of Ethics with Annotations Especially Applicable to Psychiatry" [1998 ed.]: § 4, no. 8). See also American Psychiatric Association, "Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry: Opinion 4E," 2001 Ed. These materials can be found on the Web site of the American Psychiatric Association, <http://www.psych.org>.*

RESPONSE FROM A NURSE ETHICIST

The nurse practitioner (NP) is in the type of impossible situation common to nurses. What Mr. I ought to do in this particular situation is unclear. His actions are constrained by competing moral claims, social and professional role expectations, and binding ethical guidelines (American Nurses Association, 2001; International Council of Nurses, 2000). For the most part, nursing codes of ethics are based on deontic ethical theories. These theories determine the rightness or wrongness of an act in terms of the nature of the act and an imperative of duty. Within this tradition, nurses are expected to fulfill duties and uphold inflexible principles.

As Mr. I weighs good and harm, he considers the following moral principles.

Autonomy: Western health care ethics presupposes a strong commitment to patient autonomy. If Mrs. M has decision-making capacity, the

principle of autonomy leads Mr. I to respect her wishes, even if they cause her harm.

Beneficence: This principle requires one to "do good" and prevent harm, insofar as it is reasonable. The NP must determine what is "good" (not an easy task) and follow through. In this case, he decides that beneficent actions should include reporting the crime, doing further tests, prescribing antidepressants, and referring Mrs. M. for counseling.

Nonmaleficence: This principle requires Mr. I to avoid actively harming Mrs. M. Unavoidable harm that occurs during a beneficent act must be weighed against the benefit.

Confidentiality: Professional codes of ethics require absolute confidentiality for autonomous patients (Burkhardt & Nathaniel, 2002). Mr. I. is compelled to maintain confidentiality, even if a crime was committed and Mrs. M's husband is frantic about her deteriorating condition.

Fidelity: The principle of fidelity is related to faithfulness and promise keeping. Society grants NPs the right to practice nursing through the processes of licensure and certification. Fidelity, in turn, requires that nurses uphold professional codes of ethics, practice within the established scope of practice, remain competent, and keep promises to patients (Burkhardt & Nathaniel, 2002). Mr. I balances the concern that he exceeds his scope of practice against the prospect of abandoning Mrs. M.

Mr. I valiantly attempts to uphold the traditional ethical principles while simultaneously recognizing the professional and legal implications of his actions. Unfortunately certain moral claims in this case are mutually exclusive and are complicated by social and

professional role expectations. For example, Mrs. M rejects antidepressant medications, testing for sexually transmitted diseases (STDs), and professional counseling that the NP recommends. Mr. I feels compelled to follow Mrs. M's autonomous wishes. Even though he lacks the requisite skills, he caves in to Mrs. M's insistence that he counsel her—after all, he reasons, some "good" is better than none. He may worry that she will become suicidal if he abandons her. Although Mr. I is uncomfortable in the role of counselor, some forms of counseling are not entirely outside the domain of primary care NP practice (especially in a frontier clinic).

As Mrs. M's condition deteriorates and she continues to refuse professional counseling, Mr. I questions the moral valence of his actions. Gender and social expectations aside, he tries to do what is "right" in a case in which there are no easy answers. Experiencing both physical and emotional problems, Mr. I begins to suffer from moral distress.

Moral distress is defined as the pain or anguish affecting the mind, body, or relationships resulting from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action—yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner perceived by the nurse to be morally wrong (Jameton, 1984; Nathaniel, 2003; Wilkinson, 1987-88). Moral distress results from a dynamic interplay of the nurse's moral outlook, commitment to moral principles that may be either intrinsically incompatible or incompatible in specific situations, relationships with patients, role identification, and perception of power imbalances or other insti-

tutional constraints. Moral distress is a pervasive problem in nursing, contributing to loss of nurses' ethical integrity and dissatisfaction with the work of nursing. Moral distress is a major contributor to nurses leaving their work settings and even the profession (Nathaniel, 2003).

Familiarity with nurses' codes of ethics will help Mr. I make decisions, though there are no easy and valid "cookbook" solutions. Nursing codes of ethics sometimes fail to provide solutions to moral problems in complex situations such as this, in which there are divergent ethical perspectives, imbalance of power, competing needs, and privacy concerns within a small-town milieu. In the end, there is no absolute morally correct path for Mr. I. If he continues to care for Mrs. M, he is morally obligated to respect her, avoid harming her, maintain expertise in practice, remain faithful to promises, and, insofar as it is possible, adhere to other professionally sanctioned ethical principles.

Since moral claims compete in this case, Mr. I can make a valid decision by using one of two methods: lexical ordering or reliance on conscience. Lexical ordering provides a noncapricious means to prioritize competing moral principles (Nathaniel, 2003). For example, the traditional adage, "first, do no harm" assigns nonmaleficence greater weight than other principles. But Mr. I defaulted to the contemporary Western health care tradition of giving predominant weight to the principle of autonomy. Using lexical ordering, Mr. I can devise a cogent and consistent prioritized list of principles. Once the principles are ordered, Mr. I may conclude that it is more important to benefit Mrs. M and prevent her harm than to support her autonomous decision. Or, he could make the opposite judgment. Either would be valid.

The second option (the one that I would choose) is to view nursing codes of ethics as moral norms while accepting conscience as the ultimate guide for behavior (Beauchamp & Childress, 2001). Conscience serves as an internal alarm when there are threats to core beliefs. If Mr. I believes it is morally wrong to exceed his scope of practice and risk harming Mrs. M, he should refuse to counsel her. By following his conscience, Mr. I preserves his moral integrity.

One final caveat: Both ethics and law treat the suicidal patient as a special case. If Mrs. M is suicidal, she lacks decision-making capacity and therefore is not autonomous. The nurse practitioner is obligated to protect her from harm by making sure she has immediate mental health care.

Alvita Nathaniel, DSN, APRN, BC

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COMMENTS FROM A RAPE COUNSELOR

An individual's personal setting influences her response to all situations in which she finds herself; for example, being the survivor of a sexual assault. Individuals belong to a number of cultural systems in which beliefs are created and behaviors are supported. In contemporary American society these structures include positive social attitudes toward the clergy; negative social attitudes toward women who "cry rape"; a social perception that rape is the victim's fault and, hence, pressure on rape victims to keep silent and a demand that they, rather than law enforcement, produce evidence and witnesses to prove they aren't "crying rape."

When sexual assault occurs, social structures reinforce the survivor's keeping the trauma, the crime, and the whole of the experience contained within her inner world. Without intentionally minimizing the trauma of a sexual assault in an urban setting, we note that a small, rural community can enhance the pressures that keep survivors quiet. In this setting, Mrs. M has a number of things working against her that make her situation more difficult to resolve: confidentiality is not guaranteed; her assailant is not only an acquaintance, but also a respected person with authority in her community; her health care professional (HCP) has experienced a significant change in his world and

support system that may set up a conflict between his own interests and those of Mrs. M; and the community as a whole may be threatened by public knowledge of the sexual assault.

One can presume, in part, that the pastor was able to commit the crime as a result of his social status—one that confers distinct advantages. He has an established level of trust, respect, and authority. He is a "lifelong" friend of Mrs. M's husband. Both these factors reinforce Mrs. M's reluctance to make the rape public. Doing so would disturb numerous personal and social relationships in her town. As a result, Mrs. M will quite likely be seen as a trouble maker if she makes his behavior known.

Nonetheless, the pastor's advantages, if protected by secrecy, will allow him to continue his life—at great expense to Mrs. M—as it was before the sexual assault. At the very least, secrecy deprives Mrs. M of access to local resources that may help her to cope with and recover from this assault on her physical and emotional well-being.

We must also wonder if the community contains other victims. How many other times has the pastor sexually assaulted members of this rural community? We are assuming that Mrs. M is the only victim, but the social pressure to silence survivors may have hidden a serious and ongoing threat to the town. Secrecy gives a perpetrator numerous advantages, including the opportunity to continue illegal and immoral actions. Unless communities force perpetrators to stop, they will continue to rape. The community, and its individual citizens, must dissolve the conditions of secrecy that protect the perpetrator.

One cannot blame Mrs. M for not wanting to report the sexual assault. Sometimes keeping the assault secret is safer for the victim, especially in small communities. But to address the problem of sexual assault, communities must educate their members on the topic. It is also critical to go beyond education to intervention and prevention. A national survey studied sexual assault and domestic violence programs in rural areas (Walker, Edmunds & Wallace, 2000). The survey, which both documented the problem of sexual assault in rural areas and posited useful responses, found that "43% [of the towns] have Community Awareness programs," and that "78% also provided training for other community or criminal justice agencies." One way in which Mr. I might reduce the threat to his community would be to initiate a program to bring this information to the community. Ongoing commitment to prevention and intervention can decrease the occurrence of sexual assault, as well as increase survivor safety, reporting, and treatment—all of which make the community safer.

In addition to concerns about Mrs. M's welfare, the community's welfare is threatened because Mr. I's professional, emotional, and spiritual welfare are at risk. Are there moral obligations to take care of the caregiver? Mr. I's knowledge of this crime and his efforts to care for Mrs. M may have serious negative effects on him. These effects, if not addressed, can have an adverse effect on his ability to practice. If he cannot survive in this environment, he may be forced to relocate, depriving this small town of access to qualified health care. Although the moral obligation of

beneficence may suggest that Mr. I continue his support of Mrs. M, this can have devastating effects for both individuals if he is not aware of his own boundaries. Mrs. M is experiencing long-term effects, the treatment of which is beyond his capabilities. He can continue to be a support system for her short-term effects—being scared, feeling anxious, withdrawing/isolating herself, self-blame, etc. But more intensive therapy is also warranted. Referral to a specialist will be better for both Mrs. M and Mr. I.

Mrs. M is justifiably concerned about the distress she will cause on an interpersonal level. Her relationship to the pastor/perpetrator has been damaged, and there are several ways she may internalize this. She may also have concerns that her marriage will be destroyed. Her husband's obvious and ongoing concern suggest that he cares deeply about her; however, one cannot necessarily predict how family members will react to a sexual assault.

Finally, on a purely personal level, Mrs. M may have concerns about being believed; however the mere fact that Mr. I believes her creates some assurance in this regard. Also, her previous trusting relationship with her pastor, both in his role as spiritual

advisor and as a friend, should lend credence to her charge and suggest that it is not one she would make lightly. Finally, Mrs. M is also justifiably concerned about her emotional, intellectual, physical, and spiritual safety. However her safety seems to be endangered rather than protected by her insistence on secrecy—especially since secrecy obstructs her opportunities for identifying or establishing local support systems and for healing.

Although the case suggests few resources are available to Mrs. M and Mr. I, the survey cited earlier demonstrated that: (1) 50 percent of the programs provided outreach services to victims living in isolated jurisdictions; (2) 53 percent had satellite offices open at least on a part-time basis; and (3) 63 percent had inter-agency task forces in their community (Walker, Edmunds & Wallace, 2000). This information dispels the myth that adequate resources do not exist in rural communities. Accessing these services may sometimes require travel; however, most programs have a 24-hour hotline number. National hotlines can also be utilized as an outreach and support system. The Internet is also becoming a widely used resource by survivors; Web sites that

offer education, general information, and support are frequently available in libraries, churches, and schools. Mr. I, like other HCPs, could install Internet access in his office.

In conclusion, the largest problem for all involved in the sexual assault is that the perpetrator's actions create secrecy, which has devastating and immediate effects of this secrecy on individuals. Seeking out resources and implementing change are critical for all concerned. If necessary resources truly do not exist within the immediate area, they must be brought in. Like anyone who offers support to a survivor, Mr. I has a moral obligation to not only support the survivor but to also improve the community in which the rape occurred.

Tiffany Eskelson

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