

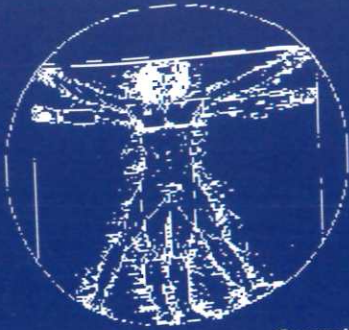
Health Care Law

Mid-Atlantic Ethics Committee Newsletter

University of Maryland Francis King Carey School of Law *Year 1999*

Mid-Atlantic Ethics Committee
Newsletter, Summer 1999

This paper is posted at DigitalCommons@UM Carey Law.
<http://digitalcommons.law.umaryland.edu/maecnewsletter/47>



MID-ATLANTIC ETHICS COMMITTEE

NEWSLETTER

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

Summer 1999

Inside this issue:

What's an Error and What's a Judgement Call	1
Network News	2
Palliative Care Pain Hotline	3
UVA To Offer Graduate Course in Clinical Ethics	3
In the Courts: Wright v. Johns Hopkins Hospital	4
Case Presentation	5
Case Discussion: Comments From a Nurse/Attorney	7
Letters to the Editor	8
Journalism Places Spotlight on Wrong Problem	9
Websites for Bioethics	9
Calendar of Events	10

WHAT'S AN ERROR AND WHAT'S A JUDGEMENT CALL?

In the last issue of the Mid-Atlantic Ethics Committee Newsletter, we reprinted an excerpt from a piece that appeared in the ASBH Exchange earlier in the year.* The errors were:

1. Allowing risk managers, lawyers, administrators, or others to do the ethics committee's job.
2. Appointing ineffective community members.
3. Establishing the ethics committee as a medical staff committee having no reporting relationship to the institution's governing body.
4. Failing to construct an annual work plan or line-item budget.
5. Being content with committee status and failing to offer education, policy studies or consultation services.
6. Being morally proactive in consultations, and trying to engineer the "right outcome".
7. Failing to adopt a policy of open access to consultation or a policy against intimidation of anyone who requests ethics consultations (e.g., nurses).

The Mid-Atlantic Ethics Committee Newsletter is a publication of the University of Maryland School of Law's Law & Health Care Program and is distributed in cooperation with the Maryland Health Care Ethics Committee Network. The Newsletter combines educational articles with timely information about bioethics activities in Maryland, D.C., and Virginia. Each issue includes a feature article, "Network News," a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing and related disciplines.

8. Failing to notify patients or surrogates before a consultation occurs.
9. Failing to document consultations in patient charts.
10. Failing to evaluate consultations or offer a process for complaints.
11. Failure to initiate policy studies.
12. Failure to examine organizational ethics.

IN THE COURTS

WRIGHT V. JOHNS HOPKINS HOSPITAL

Will Maryland Recognize Liability for Failing to Follow a Patient's Advance Directive?—A View from the Defendant's Attorney

In the Spring 1999 Newsletter, counsel for the plaintiffs in this case set forth his reasoning why the Court of Appeals should answer affirmatively the question posed above. As urged by plaintiffs, the Court did indeed answer the question affirmatively. In an opinion filed April 20, 1999, Judge Rodowsky, writing for a unanimous Court, assumed that the answer to the question was yes, but then went on to answer a second question adversely to the plaintiffs. That second question was whether the plaintiff set forth sufficient facts to state causes of action for negligence, wrongful death, battery, and lack of informed consent. Judge Rodowsky answered the question with a resounding no and affirmed the judgment of the Circuit Court for Baltimore City in favor of The Johns Hopkins Hospital ("Hopkins").

Plaintiffs had appealed from a summary judgment entered against them by Judge John Carroll Byrnes for the Circuit Court for Baltimore City in an action brought on behalf of the estate of their deceased son. They had alleged that Hopkins had wrongfully resuscitated their son who suffered from AIDS and who had arrested while receiving a transfusion just prior to his planned discharge. Their son, they contended, had signed a living will which mandated that the medical personnel at Hopkins refrain from intubating him or performing CPR. After his resuscitation, Hopkins removed him from the ventilator at the request of his mother, who was his health care surrogate decision maker. He died ten days after his transfusion reaction.

Judge Byrnes agreed with Hopkins that Wright's living will did not dictate that Hopkins refrain from resuscitating Wright. His living will provided:

"If at any time I should have any incurable injury, disease or illness certified to be a terminal condition by two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, and the physicians have determined that my death is imminent and will occur whether or not life-sustaining procedures are utilized and where the application of such procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally. . ."

No physician ever certified that Wright was in a terminal condition and that his death was imminent. Therefore, the living will never became operative.

Even though the living will was clearly not operative at the time of Wright's arrest, plaintiffs tried to convince the Court that statements reportedly made by Wright to various health care providers (not his attending physician) during his emergency room visits and admissions at Hopkins constituted an oral advance directive that he did not want to be resuscitated. The Health Care Decisions Act, set out as sections 5-601 through 5-618 of the Health General Article of the Annotated Code of Maryland (the "Act"), clearly provides that an oral advance directive must be made to an attending physician and one witness and must be documented in the patient's chart. Section 5-602 (d). There was no such oral directive documented in Wright's medical record, so the Court had no trouble dispensing with this contention.

Plaintiffs also argued that Wright's oral statements about not wanting to be resuscitated somehow constituted a do not resuscitate order ("DNR"). There was no DNR order written in Wright's chart nor did the circumstances alleged by plaintiffs give rise to an action for failure to enter such an order in the chart.

To give proper and appropriate effect to an advance directive, a DNR order must also be entered into that patient's chart. The terms of advanced directives can vary considerably, so it is incumbent upon a patient's attending physician to place a DNR order in the chart when an advance directive could come into play during a patient's admission. This alerts the remaining health care providers that they are to honor the patient's careful plans for end-of-life care which have been thoroughly discussed, carefully considered and specifically detailed. Without a DNR order on the chart, health care providers other than the attending physician would be left guessing at end-of-life situations if the advance directive applies to the circumstances confronting them. Health care providers simply do not have the time to debate the applicability of an advance directive while responding to a "code".

The Court upheld the actions of the Hopkins staff who in an emergency situation resuscitated a patient whose death, prior to the emergency, was not imminent.

What the Court of Appeals has made clear is that in an action for failure to honor an advance directive, the terms of the directive must be carefully scrutinized and strictly construed. The directive must conform exactly to the provisions of the Act. Only where a health care provider disregards a directive whose terms are specifically and precisely met could a plaintiff begin to state a cause of action.

Left unanswered is whether a cause of action exists: (1) when a health care provider disregards an applicable advance directive and DNR order; or (2) if an attending physician fails to document an oral advance directive; or (3) if an attending physician fails to write a DNR order despite receiving an advance directive (oral or written) which does meet the requirements of the Act.

Also uncertain is the extent of the immunity granted to health care providers in Section 5-609 of the Act. That section renders immune from civil liability health care providers who in good faith provide, withhold or with-

draw life sustaining procedures “under authorization obtained under this subtitle.” Thus, a patient should never recover damages for being wrongfully resuscitated absent proof by a preponderance of the evidence that a health care provider’s actions in resuscitating him or her were done in bad faith. Only a health care provider with actual knowledge of an advance directive and DNR order who disregards them should be subject to a wrongful resuscitation lawsuit. Mere negligence should not be enough to permit recovery against a health care provider, who without knowledge of an advance directive and DNR order responds to an emergency situation and helps resuscitate a patient. While this may limit the effectiveness of a patient’s advance directive, the legislature has wisely decided to shield health care providers acting in good faith who must make split second decisions in life or death situations. When even momentary inaction can make the difference between life and death, health care providers who react by resuscitating a patient ought not be penalized for doing so.

This would not completely eliminate liability for health care providers in end of life situations. For example, health care providers would be liable for resuscitating a patient who is in imminent danger of death, who has discussed his or her desire not to be resuscitated or intubated with his team of health care providers and who has a DNR/DNI (Do Not Intubate) order on his or her chart. An attending physician could be subject to suit when a patient is resuscitated contrary to terms of an advance directive for having failed to enter a DNR order in the chart to effectuate the directive. Where objective evidence demonstrates that a patient has given an oral directive to an attending physician and witness, and the attending failed to record the oral advance directive in the chart (or having recorded it failed to enter a DNR order), then, too, could a wrongful resuscitation suit be filed.

While the above scenarios might subject health care providers to a lawsuit, plaintiffs still face the hurdle of convincing the Court that the continuing life of someone “wrongfully” resusci-

tated is a compensable injury. Is continued life in any condition, when the alternative is death, compensable at all? Is this a decision the Court or legislature should make? If and when the decision is made, are only economic expenses incurred for medical care recoverable? Should such costs be offset by noneconomic intangibles, especially where the patient is able to spend time with or interact with family or other loved ones? The Court of Appeals did not have to deal with these difficult questions in the Wright case, but seeking an answer to them makes any attempt to allege and to prove a case of wrongful resuscitation quite problematic.

Richard P. Kidwell, JD
Managing Attorney,
Claims and Litigation
Johns Hopkins Health System

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 Hospital

The following discussion departs from our normal practice of presenting a clinical case study. The issue addressed here falls more under the heading of

hospital policy and the role of ethics committees’ approaches to policy development, review, and implementation.

Confidentiality of Patient Information

Confidentiality is a growing issue of concern in all our healthcare institutions. As we move further into the electronic age, where transmission of patient information is harder to control, old and new problems of confidentiality continue to surface. This “case,” from a Virginia hospital, points out the problems inherent in attempting to protect a patient’s right to have his or her medical record kept in confidence, available only to those designated as having a need for access to this information.

The Issues

Hospital employees, both clinical and non-clinical, can sometimes find themselves in vulnerable positions because they have access to sensitive patient information. This is especially true in smaller community hospitals where staff, patients, and families may have common ties in the community.

When the patient is a family member or fellow employee, this creates an even more delicate situation. The premise of health care supports the easing of mental and physical anguish. As a staff member it is difficult to stand by and watch another suffer when the cause is misinformation or lack of information to which the staff member has access to and may not share with others.

Professional codes of ethics, as well as our facility’s Patients Rights Policy (PRP), address such communication. Our PRP states: “The patient has the right to expect all communications and other records pertaining to his care, including the source of payment for treatment, to be treated as confidential.” This should, of course, include information transmitted to the patient or his/her family by hospital personnel who are not authorized to view or share this information.

Recently two instances at our hospital highlighted the inherent difficulties in maintaining patient confidentiality. In

Cont. on page 6

Case Study

Cont. from page 5

the first instance the uncle of one of our housekeeping staff was admitted to the hospital for a diagnostic work-up. His nephew, Jim (all names are pseudonyms) asked a nurse he knew to find out the results of his uncle's MRI test. The results were available through the hospital computer. When Jim obtained this information he went to his uncle's room and informed him that the MRI showed he had an abdominal tumor. As a result, the uncle had his first discussion of his test results with an employee/family member rather than with his primary physician. Although no apparent harm seemed to have occurred, the break in confidentiality was certainly against hospital policy and any professional ethical codes and is most worrisome to hospital administration.

In the second instance, Nadine, a respiratory therapist, was very concerned that her mother's physician was not taking care of her mother properly. She obtained her mother's hospital chart and consulted with a second physician regarding her mother's treatment during her hospital stay. Her mother had not authorized her to seek another physician's opinion.

In both instances, an ethics consultation was initiated to work through the ethical issues involved and all the employees implicated were counseled on the importance of maintaining patient confidentiality. However, the ethics committee is now debating the broader question of: What must be done in the hospital as a whole to establish the ethical importance of patient confidentiality and to heighten compliance with hospital policy?

Comments from a Nurse/Attorney

Virginia law expressly recognizes a right of privacy in the content of the patient's medical record.

VA Code Ann. §32.1-127.1:03 clearly states that, with certain limited exceptions, "no provider, or other

person working in a health care setting, may disclose the records of a patient." Re-disclosure of the records of a patient requires the patient's specific consent.

Patient includes a person currently receiving services from a provider or one who has previously received such services. Health services include examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation, or rehabilitation and mental health therapy of any kind. Patient records include written, printed or electronically recorded material maintained by a health care provider. Confidential records also include the substance of any communication made by the patient to a provider in confidence or acquired by the provider about the patient during the course of treatment. The law applies to both adult and minor patients.

The law contains a number of specific exceptions, notably, disclosure with the express consent of the patient, written or oral, and disclosure in emergency situations. Disclosure may be required by law in such instances as by subpoena or court order, for reporting of infectious diseases, suspected child or adult abuse or other public safety provisions. Patients may waive the right to privacy in medical records. Other notable exceptions include permitted disclosure to third party payors for purposes of reimbursement, disclosure in support of receipt of health care benefits from a governmental agency, and disclosure to communicate a patient's specific and immediate threat to cause serious bodily injury or death to an identifiable party.

VA Code Ann. §32.1-36.1 permits the disclosure of HIV test results to health care providers for the purposes of consultation, providing care and treatment to the person who was the subject of the test or providing care to the child of a woman who was HIV-positive at the time of the child's birth. The parents or other legal custodian of a minor child and the spouse of the subject of an HIV test can also obtain release of the results of the test. This section of the Code provides for penalties up to \$5,000.00 if the Court finds that a person has willfully or through gross negligence made an

unauthorized disclosure in violation. The person who was the subject of the unauthorized disclosure may also initiate civil action to recover actual damages or \$100.00, whichever is greater, plus costs and attorneys' fees.

What must be done in the hospital as a whole to establish the ethical importance of patient confidentiality and to heighten compliance with hospital policy?

The Virginia Legislature has expressed a clear mandate for the confidentiality of patient medical records as cited in the above laws. All health care providers, regardless of size have an affirmative legal and ethical duty to educate their employees of the specifics of the law. A detailed policy setting out *restricted, permissive* and *mandatory* disclosures under Virginia and Federal law must be written and distributed to all employees. Such policy should contain reasonable disciplinary measures in the event of violation. Key departments, such as Medical Records and Patient Accounts should have clear policies and procedures in place for document release. Reasonable security safeguards must be in place for all information computerized or otherwise electronically stored. In addition, because of the re-disclosure provisions, non-employed staff and all contractors should also be bound by agreement to the institutional policy.

Recent Cases

Ultimately, however, regardless of the policies, procedures and safeguards in place, as the cases illustrate, each individual with access to confidential patient information has to recognize and comply with his or her legal duty to maintain patient confidentiality.

A Tidewater, Virginia area hospital recently fired two nurses for breach of confidentiality. Both were nurses in good standing with over twenty years combined service to the hospital and no prior disciplinary actions. A former co-worker came in for surgery and these two nurses accessed the patient's medical records to learn about her condition. They were motivated only by concern and they did not re-disclose beyond the department where she had

previously worked. Because they were not providing care to this patient, these nurses had no reason to access the confidential medical records. When the patient learned of the disclosure, she gave "after-the-fact" consent and was not angry with her former colleagues. The physicians in the department were supportive of the two nurses and wrote letters protesting the firing as too severe a punishment under the circumstances. At this time, the hospital has not reversed its position, and may be using these nurses as an example, and a *very effective* one, to other employees of the institution's serious intent to enforce patient's privacy rights.

In addition to termination from their jobs, the nurses may face action under an administrative proceeding by the Virginia Board of Nursing for unprofessional behavior. Reprimand, suspension, monetary penalty or even loss of license could result.

The Supreme Court of Virginia weighed in on the disclosure issue in *Fairfax Hospital v. Curtis*, 254 Va. 437; 1997 VA. LEXIS 122; 492 S.E. 2d 642. Patricia Curtis delivered a baby, Jesse, at Fairfax Hospital. During the course of her care, she disclosed to her providers confidential and very personal information about her medical history before and during the pregnancy and this information became part of her medical record. The baby died and Curtis filed an action against the hospital. Her medical condition was not at issue in the case. In the course of defending this action, the hospital conceded that it had disclosed Ms. Curtis' confidential medical records to an attorney and a nurse without the requisite consent from the patient or determination from a judicial officer permitting disclosure.

The court held that "in the absence of a statutory command to the contrary or absent a serious danger to the patient or others, a health care provider owes a duty to the patient not to disclose information gained from the patient during the course of treatment without the patient's authorization." Furthermore, this court held that "violation of this duty gives rise to an action in tort."

In Summary

Job termination, civil penalties, licensure actions and even civil suits are very real and very serious consequences of violation of patient's privacy rights in Virginia. If employees are not persuaded of the ethical importance of patient confidentiality, *per se*, knowledge of these consequences may help with compliance.

Andrea J. Sloan, RN, JD
McLean, VA.

LETTERS TO THE EDITOR

To the Editor:

The case presentation in your last issue raised provocative issues about the care of a very low-weight infant. Briefly, the central dilemma concerned the mother's insistence that the infant remain in an acute care facility well beyond the time that the medical staff deemed necessary for the infant's care. The staff was convinced that the infant's needs could be met in a chronic pediatric hospital, but their efforts to gain the mother's agreement for a transfer were rebuffed.

I limit my comments to one aspect of the case: the potential impact of the Maryland Health Care Decisions Act. The Act provides that nothing in it "may be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be ethically inappropriate" or "to require a physician to prescribe or render medically ineffective treatment." Ann. Code MD HG §5-611(a) and (b)(1). One commentator, an attorney/ethics committee chair, observed that the "medically ineffective" language probably did not apply, because the treatment at the acute care facility was effective, albeit more than was necessary. The commentator went on to suggest that this provision "provides no shield against liability in the event that the provider actually chooses to withhold 'ineffective' care . . ."

Perhaps the commentator's analysis of this issue was foreshortened by space

constraints, but two points merit clarification: First, this provision in the Act applies to both "medically ineffective" and "ethically inappropriate" treatments. Even if the "medically ineffective" language does not fit this case, a court might well decide that the open-ended provision of a scarce resource, acute neonatal care, can reasonably be thought "ethically inappropriate" when that level of care is not needed and care that meets the patient's needs is available elsewhere. Second, if a health care provider withholds or withdraws a treatment in the reasonable belief that the treatment is "medically ineffective" (as properly documented) or "ethically inappropriate," the Act does provide a shield against liability. Under §5-609(a), a health care provider is not subject to criminal, civil, or disciplinary liability "as a result of withholding or withdrawing any health care under authorization obtained in accordance with this [Act]." Although this immunity provision may have been aimed chiefly at decisions made under the auspices of an advance directive or by a surrogate, the immunity extends to a provider's good-faith decision, as authorized by the Act, to withhold or withdraw a treatment as "medically ineffective" or "ethically inappropriate."

Jack Schwartz, JD
Assistant Attorney General
Director, Health Policy Development
Maryland Attorney General's Office

To the Editor:

In the Spring 1999 issue of the Mid-Atlantic Ethics Committee Newsletter, Dr. Evan DeRenzo surmises that offering or providing certain healthcare technologies (e.g., allowing a mother to harvest her dead son's sperm, facilitating the birth of octuplets, or allowing a father to donate his only remaining kidney to his daughter) is morally unjustifiable. She advocates identifying boundaries of moral permissibility that limit provision of certain healthcare technologies, acknowledging that

Cont. on page 8

Letters to the Editor

Cont. from page 7

“respect for persons is not defined as supporting every human whim.”

On one hand, I say “Hooray!” that a bioethicist is willing to advocate setting limits on certain healthcare technologies. However, Dr. DeRenzo focuses more on the issue of setting limits of moral permissibility than on the justifications for those limits. It is true that reluctance to make judgments about what is right and wrong and distortion of ethical norms (such as the principle of respect for persons) has led to situations in which individuals demand and receive medical interventions that are, in the opinion of many, morally unacceptable. Yet what Dr. DeRenzo never clearly states is *why* such interventions are ethically unjustifiable. In order to identify the boundaries of moral permissibility and avoid the moral paralysis that Dr. DeRenzo observes is rampant in today’s technology-driven and cure-oriented healthcare system, we must be able to articulate what makes an action or decision ethically justifiable or unjustifiable.

Dr. DeRenzo gives three examples of situations in which medical technology exists but should not be made available to the public. Two involve artificial reproductive technology (ART)—the creation of octuplets, and harvesting the sperm from a 65-year-old woman’s dead son. I agree that we should draw lines here, but the justifications for where and when we draw these lines are important. For example, in the case of the McCaughey septuplets, no discussion between Mrs. McCaughey and her physician apparently had taken place ahead of time related to the possibility of selectively aborting implanted embryos. Confronted with the decision whether to selectively abort after the seven embryos had implanted, Mrs. McCaughey made a decision not to do so. This decision was consistent with her moral beliefs, which were based on her understanding of the Christian mandate not to kill and to trust in God’s greater plan. Thus, even though she put herself and all of the fetuses in danger

of death or severe morbidity, her actions were morally justifiable (i.e., she acted consistently with her deeply held moral convictions). It would have been different if Mrs. McCaughey had been informed ahead of time of the harms she would expose herself and her fetuses to if she decided to carry more than three implanted embryos to term—had she known, she could have decided not to take the ovarian stimulant medication. I believe it’s wrong to offer ART that fails to minimize or prevent the possibility of 4+ births.¹ Justifications for limiting the number of implanted embryos include avoiding the potential harms to the mother and surviving children of a 4+ multiple gestation/birth (nonmaleficence) and the financial costs to society (distributive justice). As Dr. DeRenzo implies, an infertile woman who has moral objections to embryo reduction is not entitled to ART on her terms simply because she wants her own biological child and the technology exists to provide her with one (or eight).

Likewise, merely because a woman requests the harvesting of her dead son’s sperm and we have the technology to do so doesn’t obligate us to comply. Dr. DeRenzo pointed out that some health care providers mistakenly interpret the principle of respect for persons as obligating them to comply with nearly any patient’s or family member’s request. While her point is valid that a physician may not be obligated to comply with a mother’s request to harvest her dead son’s sperm, it doesn’t explain *why* a line of moral unjustifiability should be drawn there. Is it because the son has not given permission to have his sperm harvested? Is it because the son’s sperm might be used to create a child, which he may not have wanted? Is it because the act of harvesting the sperm may represent the mother’s attempt to minimize the loss of the dead son, in the process using the child (or potential child) merely as a means to assuage her grief? I admit that, if faced with the mother’s request that she be inseminated with her dead son’s sperm, something deep inside me would scream “NO!” But this gut-level response is not enough to

justify placing global limits on access to such healthcare treatments. High-tech healthcare options contribute to increasingly complex moral decision-making. While such decision-making is certainly informed by gut reactions, it also needs to be enlightened by conscious reflection on our values and priorities and those of the culture in which we live. Conscious reflection can then lead to public discourse in which values and priorities are discussed. Limit setting can then take place within a democratic process. We will only be able to provide optimal healthcare for all when we are able to communicate with each other and set priorities on moral values (e.g., autonomy versus distributive justice) and goals or ideals (e.g., lives saved versus *quality* of lives saved). Although I agree that offering a platter of choices to patients without providing advice on the pros and cons of each option is an example of physicians abdicating their duty to assist patients in avoiding unwise decisions, it isn’t enough to state that certain healthcare decisions or actions are just plain wrong. If we are going to draw lines (and I think we need to!), we have to be able to justify where and how these lines are drawn. This is a prerequisite for personal reflection *and* for public dialogue. Both are sorely needed, particularly when it comes to a discussion of limit setting with cutting-edge healthcare technologies.

Anita J. Tarzian, PhD, RN
Research Associate
Maryland Healthcare Ethics
Committee Network

¹Ways of minimizing or preventing the possibility of 4+ multiple gestations/births include: (1) regulating ovulatory activity for women taking ovulatory stimulant medications and advising couples not to engage in sexual intercourse if too many of the woman’s eggs are released in a given cycle; and (2) implanting 3 or fewer embryos in the IVF procedure; and (3) selectively aborting implanted embryos so that no more than three implanted embryos remain in the woman’s uterus. One could add: abstaining from ART.

JOURNALISM PLACES SPOTLIGHT ON WRONG PROBLEM

Hospice and palliative care proponents were outraged by a story that aired on "60 Minutes II" recently in which it was strongly implied that a hospice murdered between 15 to 20 patients with overdoses of morphine. Patients with terminal illnesses who experience "crescendo" symptoms in the last days of life often do not receive optimal treatment from health care providers, who fear they will cause the patient's death if they give too much pain medication. Providers of hospice and palliative care have worked hard to educate health care providers on the difference between aggressive symptom management at the end of life and euthanasia. Yet, proponents of legalized physician-assisted suicide are quick to name individuals who died a horrible, painful death as justification for passing assisted suicide legislation. Before such legislation is pushed forward, access to aggressive palliative care to relieve symptoms such as intense pain and breathlessness before death should be available to all those in need. One of the main barriers to the availability of such care is the fear that health care providers will be accused of killing their patients. The 60 Minutes II story has likely fueled such fears. The credibility of the report is highly questionable. The choice to target such an investigation was clearly irresponsible. As Brad Stuart, medical director of the Hospice of Northern California, exclaimed, "shouldn't 60 Minutes be investigating and raising hackles over the rampant and often willful undertreatment of pain at the end of life?" Feel free to send comments to the 60 Minutes II crew at 6011@cbsnews.com.

WEBSITES FOR BIOETHICS

The following list of websites may be helpful for ethics committees looking for resources in bioethics.

American Society for Bioethics & Humanities www.asbh.org

American Society for Law, Medicine & Ethics www.aslme.org

Center for Bioethics - University of Minnesota (also contains links to CNN - Ethics Matters)
www.med.umn.edu/bioethics

Center for Bioethics - University of Pennsylvania
www.med.upenn.edu/bioethic
or www.bioethics.org
links to Biobookstore and MSNBC - Breaking Bioethics.

Center for Bioethics and Health Law
www.pitt.edu/bioethic/

Expert Panel Report to the National Institutes of Health Research Involving Individuals with Questionable Capacity to Consent: Ethical Issues and Practical Considerations for Institutional Review Boards (IRBs)
www.nih.gov/sigs/bioethics/reports/index.htm

International Calender of Bioethics Events www2.umdj.edu/ethicweb/upcome.htm

Medical College of Wisconsin Bioethics Home Page www.mcw.edu/bioethics

Midwest Bioethics Center
www.midbio.org/toc.htm

National Bioethics Advisory Commission www.bioethics.gov

National Human Genome Research Institute
www.nhgri.nih.gov/Policy_and_public_affairs/Elsi

The National Reference Center for Bioethics Literature (NRCBL)
This site contains a collection of books, journals, newspaper articles, legal materials, regulations, codes, government publications, and other relevant documents concerned with issues in biomedical and professional ethics. This is a good starting point for finding "what's out there."
www.georgetown.edu/research/nrcbl

SUNY Buffalo Center for Clinical Ethics and Humanities in Health Care
www.wings.buffalo.edu/faculty/research/bioethics/index.

The Center for Biomedical Ethics – University of Virginia (This site also contains links to Health & Living Page of ABC-NEWS.com with Jonathan Moreno's regular bioethics column "Judgement Call.")
www.virginia.edu/bioethics

West Virginia Bioethics Network (Cindy Jamison is the contact person at West Virginia University and is more than willing to help you with this site if you have problems. She's also good at sending back a rapid response to your e-mail inquiries. cjamison@wvu.edu)
www.hsc.wvu.edu.

CALENDAR OF EVENTS

September

- 16-17 *Ethics in Healthcare Institutions: New Issues, Controversies and Practical Considerations*, sponsored by the Center for Biomedical Ethics (UVA) and the Virginia Healthcare Ethics Network (VHEN) in cooperation with Continuing Medical Education (UVA). This year's focus: race in healthcare, stem cell therapy, and the Hugh Finn case. Omni Hotel, Charlottesville, \$150 (\$125 members). Contact Ann Mills 804-928-3978 or e-mail amh2r@virginia.edu.
- 17-18 *American Society of Law, Medicine & Ethics 1999 Annual Meeting: Discontented Physicians: Changing Roles in Health Care*. Cambridge, Mass. For information, call 617-262-4990, or visit www.aslme.org.
- 23 *Ethical Managed Care: Is it an Oxymoron?* Ezekiel J. Emanuel, MD, PhD, Director, Department of Clinical Bioethics, National Institutes of Health, Medical Humanities Hour lecture at UMMS, Shock Trauma Auditorium, Baltimore, MD, 3:30 - 4:30 p.m. Light refreshments will be served.
- 24-25 *Doctors, Death, & Dignity, II: Regaining Lost Ground*, sponsored by The Hamot Second Century Fund and The Center for Hospice and Palliative Care. Chautauqua Institution, Chautauqua, NY, \$100-250. For information, call 800-352-2553.
- 30 *The Richmond Bioethics Consortium's Annual Meeting*, featured speaker **Eric Cassell**, MD, "Why Do We Fail to Attend to Suffering?" Members, guests, and interested public welcome, no charge. Chippenham Medical Center's Kraus Auditorium, Richmond, VA, 7:00 p.m. For more information call the RBC voice mail at 804-287-7450. RSVP to voice mail by September 16.

October

- 1 *Connecting Ethics and Health Policy*, presented by Department of Clinical Bioethics National Institutes of Health, The Robert Wood Johnson Foundation and the Center for Outcomes and Effectiveness Research at the Agency for Health Care Policy and Research, Bethesda Marriott, Bethesda, MD, 8:00 a.m. - 5:00 p.m. Enrollment limited. \$99 before 9/1/99 and \$125 thereafter. For more information call Center for Bio-Medical Communication at 201-342-5300.

- 8 *19th Annual Sr. Margaret James Lecture*, featured speaker **Tristan Engelhardt**, MD, PhD, "Christian Bioethics in a Post-Christian Age." Public welcome, no charge. Wine and cheese reception follows. St. Agnes Hospital, Leashur Auditorium, Baltimore, MD, 4:00 p.m.
- 10- 11 *Jewish Bioethics in the 21st Century, The Second Annual International Conference*, Boston University, Boston, Mass. The only annual interdenominational Jewish bioethics conference in the U.S. Contact Lisa Gibalerio at lisa@apfmed.org.
- 19 **Metropolitan Washington, DC Bioethics Network Meeting**, Georgetown University. 4:00 p.m. For more information call Valerie Parker at 202-682-1581.
- 21 *End of Life Care: What Does the Public Want?* Beverly A. Tyler, American Health Decisions, Atlanta, Georgia. Medical Humanities Hour lecture at UMMS, Shock Trauma Auditorium, Baltimore, MD, 4:00 p.m. - 5:00 p.m. Light refreshments will be served.
- 28-Nov. 1 *American Society for Bioethics & Humanities Annual Conference*, Philadelphia, PA. Get more information at www.asbh.org.

November

- 10-12 *Complementary and Alternative Therapies in the Academic Medical Center: Issues in Ethics and Policy*, sponsored by the University of Pennsylvania School of Medicine & The National Institutes of Health. Targeted for decision-makers in medical schools and teaching hospitals, physician executives, managed care executives and others concerned with how to relate to unconventional therapies. Wyndham Franklin Plaza, Philadelphia, \$395. Call Office of Continuing Medical Education University of Pennsylvania School of Medicine 215-898-6400 for more information. Contact Marti Patchell 202-687-8999 or e-mail patchelm@gunet.georgetown.edu.
- 11-13 *Organizational Ethics*, sponsored by The Center for Clinical Bioethics at Georgetown University. Targeted for ethics committee members. Holiday Inn-Georgetown, \$450. Contact Marti Patchell (202) 687-8999 or e-mail patchelm@gunet.georgetown.edu.
- 18-19 *Healthcare Organization Ethics*, sponsored by the Center for Biomedical Ethics (UVA) and the Darden Graduate School of Business (UVA) and the Virginia Healthcare Ethics Network. Targeted for board members and top level executives and healthcare professionals working within HCOs. Jordan Hall, University of Virginia in Charlottesville, \$650. Contact Ann Mills 804-928-3978 or e-mail amh2r@virginia.edu.

**SUBSCRIPTION ORDER FORM
THE MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER**

NAME _____

ORGANIZATION _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE/FAX NOS. _____

E-MAIL _____

No. of Subscriptions Requested:

_____ **Individual Subscriptions**
@ \$35/yr.

_____ **Institutional Subscriptions**
@ \$90/yr. (up to 20 copies)

Please make checks payable to: The University of Maryland

**and mail to: The University of Maryland School of Law
Maryland Health Care Ethics Committee Network
Law & Health Care Program
515 West Lombard Street
Baltimore, MD 21201**

All correspondence
including articles, cases,
events, letters should be
sent to:

Diane E. Hoffmann,
Editor

**The Mid-Atlantic Ethics
Committee Newsletter
Maryland Health Care
Ethics Committee
Network**

**University of Maryland
School of Law
515 West Lombard
Street**

**Baltimore, MD 21201
E-mail: dhoffman@
law.umaryland.edu**

**The Maryland Health Care Ethics
Committee Network**

Law & Health Care Program

University of Maryland School of Law

515 West Lombard Street

Baltimore, MD 21201