NETWORK NEWS

The newsletter of the Florida Bioethics Network

a Health Service Group of the Florida Hospital Association - P.O. Box 531107 - Orlando, Florida 32853-1107 - 407-841-6230

January 1995 **94-5**

PRESIDENT'S MESSAGE TO FBN

Submitted by **Kathryn A. Koch, M.D.,** F.C.C.P., Associate Professor of Medicine, Director, Critical Care Services, Chief, Division of Critical Care Medicine, University of Florida Health Science Center, Jacksonville.

In October 1994 the membership of FBN approved a new relationship with the FHA. Our new association will be classified as a "Health Service Group." In this new relationship, FHA will continue to serve as the focal point for all administrative activities, and the FBN will be able to broaden the membership base.

This means that FBN is now able to invite membership and recruit Board Members from all interested individuals involved in health care ethics without requiring institutional membership in FHA. In addition, FBN is now able to set the same annual membership fee for every member of FBN. This also allows additional independence for FBN, which is required to minimize any conflicts of interest which might develop in FBN's work. I applaud the spirit of collaboration and the recognition of mutual goals that has enabled FHA and FBN to agree on this new relationship.

At our most recent board meeting, the board determined several areas of focus for the coming year. Glenn Singer will continue with his working group to develop "Guidelines for Ethics Committees." Ray Moseley, Ken Goodman, and Jerry Griffin, as well as others, are working with Glenn. Ray Moseley and Francille MacFarland will begin work on developing "Essential Readings for Ethics Committees."

Two other focus areas also have been identified: "Futility" and "Patient Advocacy." I will be working on "Futility" with Cathy Emmett and Susan Marr, and Hana Osman, Jim Wagner, and Judy Gygi will be working on "Patient Advocacy." These two groups will recruit participation from FBN members to participate in research into current practice in the state and possibly develop recommendations for practice or new legislation. Chairs of the focus groups are invited to participate in board functions as ex-officio members of the board for the period of time their group is in effect. Interested parties please contact one of the named board members if you wish to collaborate in one of these efforts.

THE OREGON LEGISLATION ON PHYSICIAN ASSISTED SUICIDE

Submitted by Susan Marr, Director of Medical Staff Relations, Lakeland Regional Medical Center, Lakeland.

In the general election held on November 8, 1994, the voters of Oregon passed "Measure 16," which is the initiative allowing physicians to prescribe medication to terminally ill patients with full knowledge that the patient intends to use the medication to end his or her life. This is the first such legislation to be passed in the United States, and indeed the world. (While the practice of "physician assisted suicide" occurs in the Netherlands, there are no laws specifically permitting this activity.) The measure is called the "Oregon Death with Dignity Act" and the provisions are summarized as follows:

What: A patient who is terminally ill may request from his/her physician medication which is expressly for the purpose of ending his or her life.

Who: Individuals who make this request must meet the following:

- The patient must be a resident of Oregon.
- The patient must be capable of making and communicating health care decisions, as determined either by a court or by the attending or consulting physician.
- The patient must be terminally ill, as determined by the attending physician and a consultant, such that within reasonable medical judgement death is expected to occur within six months.

How: Requests for medication under this law must be accomplished per the following:

- An oral request must be made to the physician.
- A repeat oral request must be made no less than 15 days after the first oral request.
- A written request must be made on the prescribed form, signed and dated by the patient and witnessed by two individuals, who attest that to the best of their knowledge the patient is capable of making health care decisions, is acting voluntarily and is not being coerced to sign. The following restrictions apply:

  * One of the witnesses is someone who is NOT:
    - related by blood, marriage, or adoption.
    - entitled to any portion of the estate of the patient.
    - an owner or operator of a health care facility where the patient is receiving care.

  * The attending physician is NOT a witness.

  * If the patient is in a long term care facility, one witness must be a person who has the qualifications stipulated by rule of the state agency overseeing this law.

SAFEGUARDS

1. Physician must inform patient of diagnosis, prognosis, risks associated with medication, probable outcome of medication, feasible alternatives, and document.

2. Physician must refer patient to a consulting physician for confirmation of the diagnosis and patient ability to make decisions. Findings should be documented in writing.

3. Attending physician or consulting physician must refer the patient for counseling if it is felt the patient may be suffering from a psychiatric or psychological disorder or depression which impairs judgement. No prescription for medication is written until the counselor determines the patient's judgement is not impaired.

4. Physician must inform the patient the request may be rescinded at any time in any way.

5. At the end of the 15 day waiting period, the physician must offer the patient the opportunity to rescind the request.

6. The physician must assure that all the steps have occurred and the necessary documentation is achieved.

OTHER

1. The patient is encouraged to notify family of the decision, but the patient request is not denied if he/she declines to do so.

2. This action has no impact on wills, contracts, insurance.

3. Immunity is provided for health care providers and others who participate, including those present when the patient takes the medication.

4. The State will collect data regarding cases, the information is not to be made public except in a statistical report compiled annually.

CASE CONSULT AND DISCUSSION: DISCONTINUATION OF NUTRITION & HYDRATION

Submitted by Kathryn A. Koch, M.D.

A 42 year old man was riding his bicycle when he was struck by a garbage truck. He suffered multiple injuries, including a depressed skull fracture. After a six week ICU stay, he was transferred to the floor. When he failed to recover further, the neurosurgeon met with the family to inform them that their son had persistent vegetative state. A DNR decision was made.

Subsequent efforts to identify a nursing home willing to take this patient were unsuccessful. He had no rehabilitation potential and no funding other than Medicaid. Approximately one month later the family met with the trauma surgeon and requested that nutrition and hydration be discontinued, as they saw no future for him. The surgeon agreed. Tube feeding was discontinued and the patient was started on a long-acting enteral narcotic. Seven days later, the narcotic dose was doubled. Three days later, the nurse manager of the floor called for an Ethics Consult.

Several nurses had tried to discuss their concerns with the surgeons without a response that was satisfactory to them.

The nurse manager had talked to the trauma surgeon and was also unsuccessful. The nursing staff was deeply worried that they were killing this patient and had great difficulty going into the room to administer narcotics with no feedings. Several of the nurses were very uncomfortable during routine bedside nursing care.

The patient had been moderately mentally retarded prior to the accident. He had never held a job, and was still living with his parents. However, he had never been declared incompetent. His parents were elderly and lived on fixed incomes. His two siblings lived in other states and had families of their own.

The parents were deeply saddened by the situation, and felt their son was dying a long, drawn out death. In fact, they felt like he had died on the day of the accident. As both of them were infirm, they had been unable to visit him regularly, and were unable to care for him in their home. His siblings had rarely seen him since they had left home and felt that their parents should make decisions regarding level of care.

Prior to his injuries, the patient had functioned at the level of an eight year old child; able to manage basic activities of daily life, able to ride his bike, but unable to cook for himself or to read. The parents did not want to prolong a miserable situation. They felt he was not aware of his environment and would be better off "all the way dead." They had not discussed the issue of comfort medications with the physicians.

The physicians were unanimous in their assessment that the patient had no chance for recovery, and in their diagnosis of persistent vegetative state. In their discussions with the patient's parents, they had not involved the nursing staff. After the decision to withdraw artificial feeding and fluid, they had started narcotics "just in case he was more aware than he appears to be." They had escalated the dose at one week because of the known physiologic tolerance that rapidly develops to narcotics. The decisions to start narcotics and to escalate the dosage had not been discussed in the medical record and were reflected only in physician's orders.

Discussion Case 1
There are several dilemmas in this case.

<u>Number One:</u> Who should decide?
The patient was technically competent. His level of mental functioning prior to the injury was child-like. He had never discussed medical care with his family or friends, nor did he produce a living will. Could it then be assumed that his parents were appropriate surrogates for a decision at this level? Taking the overall family situation into account, could the parents be permitted to make a "best interests" decision for him in view of their inability to care for him and his lack of potential for recovery? For a child, such a decision might be examined by HRS, but the patient's age excluded him from such review.

Good faith on the part of the physicians should have included an independent third party review, such as by the Ethics Committee or the legal system, prior to implementing what appeared to be an appropriate medical decision. The Ethics Committee might have strongly recommended a judicial determination on the patient's competence and assignment of guardianship, if they had been called during an earlier stage of the process. To call for judicial review at this stage of the situation, however, would have put the family and the medical staff through a painful process for what appeared to be an appropriate family and medical decision.

<u>Number Two:</u> Nursing discomfort
The nurses were very uncomfortable with the situation. They had not been involved in the decision-making process, as the nurse in the "Barber" case had not, yet they had been asked to implement the decision. They were watching this patient waste away day by

day. Every dose of narcotic they administered produced serious conflict as to whether they were contributing to his death. They wanted to know why the family did not take their son home in order to care for him if they were going to care for him in this way. They had been unsuccessful in their requests for clarification from the physicians.

They were worried about the lack of artificial nutrition and hydration. There was an impulse to provide surreptitious feedings every time they went into the room. They were even more worried about the narcotic administration.

This kind of nurse-physician conflict is a reflection of the nurse's perceptions of her professional obligations in conflict with an inability to meet the physician's power on equal terms. Some physicians do not adequately respect the nurse's professional commitments or her responsibility under the Nurse Practice Act. If the nurse is unable to personally mount a challenge to the decision, or if she is unable to garner sufficient peer support to the challenge, she is unable to challenge a decision she is being asked to implement; she is left "holding the bag." Again, there are strong similarities to the "Barber" case.

There are two issues of concern here. One is lack of the team approach in the decision-making process. This sort of conflict may be avoided by involving the nursing staff in the decision-making process, as a function of respect both for the nurse's professional responsibility and for her special knowledge of the situation at the bedside. There must be recognition of the fact that she will have to implement any decision that is made and it must make sense to her. The second is one of conscientious objection. If the nurse finds that she is being asked to do something against her values and commitments, must she be required to participate? The nurse is not empowered to object in the formal hierarchy of many institutions, nor in her personal working relationships with many physicians.

Whenever a decision of such difficulty is made, there should be ongoing support provided to the staff implementing this decision, rather than a blatant ignorance of their concerns. There is considerable potential liability for the physician and the institution whenever such a dynamic develops.

<u>Number Three:</u> Comfort Care in Persistent Vegetative State

It can strongly be argued that patients in a persistent vegetative state are aware of no pain or discomfort or they would not have received this diagnosis. Recent review of this syndrome in the NEJM, points out that there is occasionally a patient who experiences delayed awakening, particularly trauma patients. Does this mean that there is a period prior to recognizable awakening when the patient might be more aware than the staff or family can appreciate?

This possibility raises the possible appropriateness of the physician's actions of the narcotic administration. This particular aspect of the patient's management is the most troublesome. If the principle of double effect is to be invoked in the medical decision-making process (i.e. narcotics are to be administered in order to ensure comfort with the recognized possibility that they may secondarily shorten the patient's dying process, but without primary intent to promote the patient's dying), then that aspect of the decision MUST be consciously recognized, appropriately documented, and explained to all involved.

There are two cases in the literature of Minnesota physicians having been held liable for homicide by a determination by a medical examiner of very high levels of narcotic in the patient's body. The issue was inadequate documentation in the medical record of the physician's intent in the

provision of the narcotics. Intent to provide comfort MUST be clearly documented. In this particular case, the physicians appeared to have appropriate concerns for the patient's comfort on one hand, but on the other hand, appeared to be attempting to hasten the patient's death.

What Was Done?

There were both strong ethical concerns and strong potential legal liability active in this situation. The physicians had not called for an Ethics Consult, and the nursing staff had built up major concerns and resentments by the time this came to consultation.

The first question in the Ethics Consult intervention frequently raised by Ethics Committees is how to handle the situation when the physician does not request the consult. Some institutions handle this by technically restricting access to the committee to physicians only. As can be seen by this situation, however, many potential problems can be raised and can also be solved by such a policy.

In our consultation process, we violated the informed consent process, that should have taken place with the family prior to starting our evaluation, by talking to the nurses, reviewing the chart, and then calling the senior physician. We argued among ourselves that although the physician might have some right to approve this consult, he had no more right than any other staff person. If we found what amounted to violations of due process in the medical decision-making, then it would have been in no one's best interest to withhold our consultation. We hoped that our documented and well-recognized reputation would get us through a politically sensitive situation for integrity.

Before calling the senior physician, the consult team called in an additional physician to review/discuss the case, so that there were two physicians who had not previously cared for the patient participating in the consultation. The rationale was that additional peer pressure could be added to the consultation when it came to a discussion with the senior physician. The senior physician was then called and informed that an ethics consultation was taking place, and that it had been requested by "nursing" who had several concerns. To protect the nursing staff from any potential liability as whistle blowers, the name of the actual nurse involved was withheld from the physician. In fact, he did not request it; he promptly accepted the consultation without argument.

Next we interviewed the family. In airing the issues with the family, we discovered that they appeared to have the patient's best interests at heart, and that there was no way they could adequately provide for him during extended medical support. The burden on the family seemed excessive. In fact, the issue of comfort was not relevant to the parents, who felt that he had already departed and was not aware of his environment. It was explained to the family that the doctors had some concerns in this area and had administered medication to ensure comfort. We did not, however, inform the family of the nurse-physician conflict which had developed over this issue. The family appreciated that additional review of the decision was taking place, but remained firm in their decision.

We then met with the senior physician and his residents. The concerns of the consult team were discussed with him. He had not been aware that his residents had been prescribing narcotics. The residents had been prescribing narcotics because of their own concerns about ensuring comfort in the withdrawal of nutrition and hydration, and felt that they had appropriately escalated the dosage due to the known properties of physiologic tolerance to narcotics. They had not even considered the possibility that their prescription, without accompanying documentation, might have looked like murder to an outside reviewer.

They also had not considered the nursing staff's professional responsibilities and obligations.

The senior physician was advised to consult the hospital lawyer to inform him of the decision which had been made. The consult team joined him in this discussion. The team felt that the decision to withdraw life-prolonging treatment in this patient was ethically permissible, and that the parents had been the appropriate decision-makers. To call for judicial review at this late stage in the implementation of the decision would have been unduly burdensome. Legal agreed with that assessment, agreeing that the parents were the appropriate decision-makers.

The physician staff was reminded of the full due process/consent procedure, which should have been followed in this case. They were asked to taper back the narcotics slowly, which could not be stopped because of risk of physical withdrawal symptoms which might have contributed to the patient's earlier demise. They were reminded of the appropriate documentation process that should have been followed, and that this particular case should have included independent review because of the patient's lack of apparent decision-making capacity prior to the injury.

The nursing staff was reinforced in their right to disagree with the physicians more strongly at an earlier stage in such decisions, and in their right to call a consultation if they could not resolve a situation with the responsible physicians. They were informed of the current literature that lack of nutrition and hydration is euphoric rather than uncomfortable, due to ketonemia. As long as comfort care included keeping the mouth moistened, even alert patients are more comfortable without forced feedings as death approaches. The nursing staff was supported on a daily basis during the remaining five days of the patient's life.

The family was informed that this decision seemed ethically permissible in view of the overall family situation. They seemed relieved that their decision was confirmed.

More questions are raised by this case than answered. The consultation process could have taken a number of different forms, and what was actually done could easily be criticized. We offer this difficult consult for debate and discussion.

ANA ETHICS SURVEY LOOKS AT NURSES' EXPERIENCES (SUMMARY OF ARTICLE IN THE AMERICAN NURSE BY C. SCANLON)

Submitted by Catherine P. Emmett, Manager/Gerontology, Sarasota Memorial Hospital, Sarasota.

A survey conducted at the 1994 American Nurses Association Convention revealed important information about the experiences of nurses in dealing with ethical issues. Fifty-nine percent believed that they were not sufficiently prepared to deal with ethical issues, as a result of their educational preparation. Forty-three percent stated they were confronted with ethical issues on a daily basis. Fifty-five percent worked in environments that had multi-disciplinary ethics committees. Eighty-one percent felt that the committees were available to assist them. Although only 27 percent had nursing ethics committees, out of that group 90 percent stated that the committee was available to them.

The 10 most frequently occurring ethical issues were cost containment that jeopardized patient welfare, end of life decisions, breaches of confidentiality, unethical

practices of colleagues, pain management, use of Advanced Directives, informed consent, access to healthcare, care of HIV patients, and providing futile care.

These results will be used to guide the ANA Center for Ethics and Human Rights in their programming and activities for the future.

NEW GREENWALL FELLOWSHIPS IN BIOETHICS AND HEALTH POLICY AVAILABLE FOR NEXT GENERATION OF LEADERS IN THE FIELD

Taken from a release from The Greenwall Foundation.

In search of the next generation of leadership in the field of bioethics and health policy, the Greenwall Foundation of New York City announced a $1.25 million fellowship program to train 16 distinguished scholars who will be chosen through a rigorous competitive process.

The Greenwall Fellowship Program in Bioethics and Health Policy will be jointly administered by the John Hopkins University and Georgetown University. It will be directed by Ruth Faden, Ph.D., M.P.H., Professor and Director of the Program in Law, Ethics and Health at Johns Hopkins University School of Hygiene and Public Health. Dr. Faden also holds a faculty appointment at the Kennedy Institute of Ethics at Georgetown.

The Greenwall Program will admit four fellows per year. Three of these fellows will be at the post-graduate level, with a graduate degree in medicine, nursing, law, philosophy, health policy, economics, health services research, theology, or the social sciences. The fourth will be a doctoral student in health policy or a JD/MPH candidate with a minimum of 3-5 years' work or academic experience in a health-related field.

Regardless of their backgrounds and specific, individualized courses of study, all fellows will participate in the following: a year-long seminar in bioethics and health policy as an overview of the field; a bimonthly colloquium series in ethics and health policy with presentations by policy makers and academics; a paid summer internship at a federal health agency, Congressional health committee or private institution involved in health policy; and a supervised research project of a quality and scope to produce at least one publishable manuscript.

Applications are due March 1. Applications are available by writing:

Ruth Faden, Ph.D., M.P.H.
Greenwall Program in Bioethics
and Health Policy
Program in Law, Ethics, and Health
School of Hygiene and Public Health
Johns Hopkins University
Hampton House, Room 511
624 North Broadway
Baltimore, MD 21205-1996

Requests also may be faxed to Dr. Faden at 410/614-9567.

Further information can be obtained from William Stubing at 212/679-7266.

The Greenwall Foundation was created in 1949 by Anna and Frank Greenwall. An independent foundation, it makes philanthropic grants primarily to support work in medical research, the arts and humanities, and education. Through its Interdisciplinary Program in bioethics, the Foundation provides funding for physicians, lawyers, philosophers, economists, theologians, and other professionals.

MEETING CALENDAR

REGIONAL MEETINGS

· **February 1-3, 1995:** Charity, Justice, and Rights: Religious and Philosophic Perspectives on Access to Health Care, Jupiter Beach Resort, contact Director, Page and William Black, Post-Graduate School-212/ 241-3757

· **February 9-10, 1995:**AIDS & Medical Futility, Tampa

· **February 9-10, 1995:**When Health Care and the Law Collide, Tampa Bay Bioethics Consortium, Tampa Marriott Westshore

· Ethical Dilemmas in Healthcare: Shared Concerns (Series) - **February 20, 1995:** Tissue, co-sponsored by USF College of Medicine and the USF Institute on Aging, University of South Florida, Theatre II, **March 2, 1995:** Medical Futility: When is Enough Enough?, Tampa Tribune Auditorium, **April 6, 1995:** Medical Ethics Across Cultures & Religions: One Decision Does Not Fit All, Tampa General Hospital, MacInnes Auditorium, **May 9, 1995:** Over My Dead Body: Understanding Your Options After Death, co-sponsored by Lifelink of Florida, University Community Hospital Auditorium, Tampa

· **March 9-10, 1995:** Geriatrics, JCAHO and the Ethics Committee, Miami, sponsored by the Forum for Bioethics & Philosophy, University of Miami

· **March 10-11, 1995:** Bioethics, Geriatrics, and Health Care Reform, University of Miami Forum for Bioethics and Philosophy, Miami, contact 305/547-6270

· **March 11, 1995:** Second Annual Pediatric Conference, Pediatric Clinical and Moral Dilemmas, sponsored by Lee Memorial Hospital, Ft. Myers, contact: Shirlee Buck, 813/598-1303

· **April 12, 1995:** Reproductive Ethics, Jacksonville, sponsored by University of Florida

NATIONAL MEETINGS

· **March 4-8, 1995:** Feminist Perspectives on Bioethics, Kennedy Institute of Ethics, Georgetown University, Washington, D.C., contact 202/687-3200

· **March 31-April 1, 1995:** Health Care Crisis: The Search for Answers, jointly sponsored by the University of Florida, the American Medical Association and the Hastings Center, Washington, D.C., contact 904/392-3143

· **June 2-3, 1995:** The Sixteenth Annual Health Law Teachers Conference, co-hosted by the Health Law Institute of DePaul University and the Institute for Health Law at Loyola University School of Law, Chicago, IL

· **June 4-10, 1995:** Intensive Bioethics Course XXI, Kennedy Institute of Ethics at Georgetown University, Washington, D.C., contact 202/687-6771

· **September 29-30, 1995:** 1995 ASLME Annual Meeting, Boston, MA

INTERNATIONAL MEETINGS

· **July 16-20, 1995:** The Fourth International Conference, Health Law and Ethics in a Global Community, Amsterdam, the Netherlands, sponsored by the American Society of Law, Medicine & Ethics and the University of Amsterdam

*Information will be updated as it becomes available. Please contact Luanne MacNeill for registration information at 407/841-6230 x106.

AV LIBRARY ADDITIONS

	Catalog #	Format	Year
A FRIEND OF THE FAMILY	**VT-251**	**1/2" video**	**1993**

Nobody likes to give bad news . . . But as a medical care provider you are, and will continue to be, called upon to do so. Physicians especially find themselves in this situation. Little attention has been given in medical schools on how to communicate or convey difficult messages to patients. Learning various techniques to communicate "bad" news can be beneficial in at least three ways: First, it benefits the physicians and health care providers by allowing them to take on an extremely delicate mission with confidence and honesty. Secondly, it allows the patient to hear the truth in an atmosphere that is designed to maximize hope and minimize despair. And finally, if these techniques are skillfully practiced, it can allow the patient to be freed from panic, permitting him or her to constructively respond to the situation.

This program presents three office visits in which physicians are confronted with some of the following challenges:

*Inform a patient that he or she has a life-threatening disease.
*Discuss with a patient issues related to creating a Living Will.
*Encourage a patient to express his or her wishes concerning Do Not Resuscitate (DNR) orders.
*Advise a patient that it is time to consider an extended care facility.

Produced by Baxley Media Group. (40 minutes)

DOCTOR DEATH: MEDICAL ETHICS AND DOCTOR **VT-222** **1/2" video** **1994**
This video is a Phil Donahue show about individuals with chronic degenerative diseases. They want to manage their own death. Dr. Jack Kevorkian, M.D., is present to present his philosophy and justification for doctor assisted suicide. Donahue fields questions from the audience and phone calls. A film clip of individuals interviewed before their assisted suicide is also shown. The program is provocative and can be used to assist discussions concerning assisted suicide. (35 minutes).

HEALTHCARE ADVANCED DIRECTIVES **VT-247** **1/2" video** **1994**
L.W. Blake Hospital, Bradenton, produced a videotape, "Healthcare Advanced Directives," that clearly features the decisions to be made by individuals while competent and the importance of informing physicians, family and health care institutions of these decisions prior to admission. The videotape meets all the requirements of the Federal Self Determination Act of 1990 and Florida Healthcare Advanced Directives Law. This videotape will help patients answer the common questions about Advance Directives, Living Wills and Healthcare Surrogates in a short eight minute format. It is designed for use in admitting areas, physicians' offices, in-house circuit television patient education and community education forums, as well as for staff development functions. (8 minutes)

NURSING, ETHICS AND THE LAW **VT-258** **1/2" video** **1993**
This videotape tackles a very pressing subject facing all health care workers: understanding what ethical decisions are, how a nurse makes an effective decision, and the legal implications of ethical issues for nursing. Nursing faculty, inservice educators, and other health care instructors must be well versed in the terminology, basic philosophies, and legal tenets related to ethics in order to prepare students and staff for the extraordinary demands of today's high tech medical environment. In Part I, points of interest to faculty are discussed -- what issues are most important to consider for inclusion in nursing curricula; how ethical issues are best introduced to students; and how students or staff might develop the skills necessary for applying the content in nursing practice.

After this discussion, the title of the show with "Part II" will appear. Following that is the case study, documentary-style portion of the program, which is ideally suited for student viewing. Areas covered in this Study Guide include the ethical and legal dilemmas posed by:

·Overview of Philosophical Ethics
·Discontinuance of Life Support
·Transplants
·Premature Infant
·AIDS

Produced by National League for Nursing. (33 minutes)

If you are interested in viewing any of the above videos, or would like further information, please contact Amy Barnhill, FHA, 407/841-6230 x123.

WELCOME NEW MEMBERS!

The Florida Bioethics Network welcomes **Dr. Virgil Dawson,** Medical Doctor, South Seminole Hospital, Longwood--407/834-4200; **Dr. Barbara Frye,** Prof. Clinical Ethics, Florida State University School of Nursing, Tallahassee--904/893-1238; **Dr. Bruce McIntosh,** Chairman, Ethics Committee, St. Vincent's Medical Center, Jacksonville--904/387-7374; **Ms. Cynthia Shimizu,** Social Worker, Tampa General Hospital, Tampa; **Ms. Kay Sweeney,** Chaplain, Lee Memorial Hospital, Ft. Myers--813/432-3263.