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

June 1995

95-3

PRESIDENT'S MESSAGE

Submitted by **Kathryn Koch, M.D., FCCP,** Associate Professor of Medicine, University of Florida, College of Medicine, Director/Critical Care Services, Chief/Division of Critical Care Medicine, Chair/Hospital Ethics Committee, University Medical Center, Jacksonville.

In September at the annual meeting, the Presidency of FBN will pass to **Hana Osman**, who is planning the meeting. During the past year, the Board has focused on extending its educational mission in specific focus areas. An *Essential Readings* list on different topics is gradually being published in the newsletter, topic by topic, by **Francille MacFarland**. At your request, a case report discussion has been initiated; the case presented in the last edition of the newsletter is being analyzed in this edition, with a letter to the editor and a response from the clinician. Your own cases are needed. **Cathy Emmett** has done yeoman's duty in editing the newsletter; submissions can be sent to her, as indicated in the *Call for Case Consults/Articles* in this newsletter.

We have developed a book of reprinted articles for Ethics Committees to help orient new members: *Orientation to Ethics Committees.* There was great demand for such a book at the 1994 annual meeting. It will be distributed to all who registered for it in Orlando last year, and will be made available to all members through FHA. The Board intends to revise this collection periodically. Work has progressed on a document, "Guidelines for Ethics Committees," spearheaded by **Glenn Singer**.

One of our focus issues this year has been Futility. A retreat to discuss that issue was held in Orlando on June 16. The results of that retreat, and the survey of current ethics committee practices in the state, will be presented at the annual meeting in Tampa in September. We have not yet made progress for the focus issue on Patient Advocacy. We welcome your ideas as to how to approach Patient Advocacy, as well as suggestions for any other focus areas. Please share your ideas with us at the upcoming annual meeting; your input will help **Hana** make the coming year even more productive than the past.

EDITORIAL

Submitted by **Kathryn Koch, M.D., FCCP**

Please be aware of revisions to Florida Statutes with respect to organ and tissue donation. Florida Statutes 320, 395, and 732 are involved. As of the date of this writing, these revisions were on their way to the Governor for signature. The high points which you need to be aware of are the following.

FS 395.2050 creates an annual death records review by each organ procurement organization for its affiliated donor hospitals. FS 732.912 indicates that an anatomical gift made by an adult that is not revoked by the donor is irrevocable, and does not require the consent or concurrence of any person after the donor's death. FS 732.915 creates an organ and tissue donor registry from such sources as a driver's license identification program. FS 732.922 requires that hospital administration access the registry to determine the existence of a donor card document, and indicates that in the absence of such a document, it should follow usual consent procedures regarding tissue and organ donation.

FS 732.917 instructs the physician to not obstruct procedures to preserve the donor's organs or tissues. It also permits the organ procurement organization to perform any invasive procedures on the deceased body in order to preserve the potential donor's organs. Those procedures do not include the surgical removal of an organ or penetration of any body cavity until a properly executed donor document is located, or until a person legally permitted to give consent for donation has been located, notified of the death, and has granted legal permission. FS 732.921 indicates that a notation on a driver's license or ID card that clearly indicates intent to donate is deemed sufficient to satisfy all requirements for consent to organ or tissue donation. FS 732.9216 creates an organ and tissue donor education panel under the Agency for Health Care Administration.

What does this mean? There is a procedure called "cold perfusion" which involves placing vascular catheters in the deceased's body and infusing cold perfusate. This has been demonstrated to be effective in preserving kidneys in situ for hours post-mortem. Under the current proposed revisions, this procedure could be performed upon death of any patient who is remotely a potential donor. Then the organs would be relatively well preserved, buying time for the institution to search for evidence in the donor registry and locate family. Technically, it appears that organ donation could proceed if evidence that the patient indicated that she was an organ donor was discovered in the registry, despite family objections. What would transpire from any annual death records review is not stated.

Required request laws have not been shown to significantly increase the organ donor pool. The need for organs has far outstripped the available pool, and medical criteria for potential donors have become progressively loose. There has even been a return to the practice of harvesting organs from "Non Heart Beating Cadavers Donors" (NHBCD), a practice abandoned when criteria for brain death were established. Retrieval of organs from NHBCD is performed after terminal discontinuation of life support in the OR, immediately after the patient dies. Donations from voluntary, living donors are becoming more common.

The revisions to Florida Statues discussed above were stimulated by the Organ Procurement Agencies in the state. There are a number of concerns.

First, it must be recognized that the technology of organ transplant has matured. Good functional survival of recipients has been established. The waiting list for transplants continues to grow, as the available pool has not. This has created a number of ethical concerns, particularly with the just distribution of available organs, and with issues related to conflict of interest for the institutions performing transplants. Efforts to increase the donor pool have included mandatory donation in other countries. The current legislation stops short of mandatory donation, but implements a number of new procedures to expand public knowledge. It creates a mechanism to remove the family from the decision-making process for organ donation, as family have in practice had the final say. That veto power has reduced the available donor pool, but no one is certain how much.

Second, there are some issues of respect for the dead and for grieving family which need to be addressed. In the debate regarding practicing resuscitation procedures on the newly dead in training institutions, it has recently been proposed that consent first be obtained from the family. Consent for resuscitation is publicly assumed, even though that language has been removed from FS 765. If the resuscitation fails, then the procedure of cold perfusion will now be possible without consent in the State, and without clarification of the requirement for consent for other procedures such as practice intubation which would also enable additional lives to be saved. Cold perfusion is not as deforming of the dead as practice thoracotomy, but is more deforming than the practice of intubation. The family will find their loved one quite cold upon their arrival, even if their arrival is expeditious. Their "property" rights would have been violated.

This is a conflict between personal autonomy and distributive justice, in the face of progressive blurring of the border between life and death. It is not clear what is most beneficial, and what is least harmful. If we value truth-telling, then the task of the newly created educational panel should be to create public debate and discussion about these issues. Respect for the dead requires public discussion of what should or should not be done to the body; this is clearly no longer a private and personal matter.

Meanwhile, I, who have been an organ donor and have so stated on my Florida Driver's License, will have to give careful consideration as to whether I wish to maintain that consent on my license.

CASE CONSULT AND DISCUSSION

(Editor's Note - The last issue of *Network News* contained a Case Consult submitted by **Kathryn Koch, MD**. The President's Message from Dr. Koch was included in that same article by mistake. We apologize for the error. Below is a member's response to the case, Dr. Koch's response to the letter and a review of the case.)

Dear Dr. Koch:

In regard to your case review in the April 1995 issue of *Network News*, I have a question that I have been carrying around a long time that I would like to ask of you. In your discussion of the case you mention several truths that I would like to connect and get your opinion. In one paragraph you mention to your patient that physician-assisted suicide was a felony in the state of Florida. You also mention "the nurses were horrified that we were having these discussions, incidentally." This later comment followed your discussion with your patient about refusing food and fluids.

I harken back to when the final stages of the Nancy Cruzan case were being analyzed. I recall a statement attributed to the nurses who cared for Nancy in which they allegedly said that the only thing they were upset about had to do with the mechanism of death. They reportedly did not understand why, once the decision was made, that sustenance would be withdrawn so that Nancy could die, why wasn't death mercifully hastened? Death was the desired end point in the act of starvation. I agree with them that once the decision is made that you are going to starve the patient to death then why not hasten the process and spare the patient the first 48 hours, or whatever, of possible discomfort, as well as the family having to wait 4-21 days for the death process to occur?

I realize I am approaching the subject which would create a lot of furor in society. However, Nancy Cruzan's nurses cared a lot for her (in both aspects of the word) and their comments should not be taken lightly. In your article, the outcome evidently was "a satisfactory adjustment to his quadriplegia." You further state "in retrospect it would have been a horrible decision to participate in his death." I would postulate that, in some cases, quite selected and totally reviewed, it may not be a "horrible decision" to participate in a patient's timely and humane death. Although at present, in Florida, I realize this would be a felony. Comments?

Sincerely,
William C. Morgan, M.D.
Q.A. Medical Advisor
Past Co-chair SMH Bioethics Committee

Response from Dr. Koch:

Thank you for your comments, Dr. Morgan. There are two points which you bring up: that although assisting suicide is a felony in the state of Florida, it might be a humane approach to consider; and that the emotional experience of the nursing staff caring for such patients is filled with conflicting values and concerns.

It was indeed this issue of the potential kindness of assisting the suicide of this gentleman that entrained me into this discussion. His life was as paralyzed as his body and his support system had totally failed him. It seemed that he could go nowhere and that every little thing he wished to do had insurmountable obstacles.

Even the issue of smoking a cigarette became a conflict. Several of the nurses caring for him would not find time to take him outside of the hospital to smoke. They did not want to contribute to his eventual death from COPD or lung cancer. His favorite time to go outside was at sunset. He would flirt with all the ladies passing by while he and I talked for hours. He was disgusted at his own smell, but in the fresh air and with a little cigarette smoke, he did not have to smell himself.

There is a huge difference between his desire to end his life at that stage of his disability and the desire of Nancy Cruzan's family to end her non-life. This man was capable of relating to people, of feeling experiences, and of enjoying life. Nancy could no longer do any of those things. It is true that neither he nor Nancy could act for themselves to end their lives, but in fact, this man was fully capable of directing his environment despite his total disability, while Nancy Cruzan was not.

If indeed we had agreed that he would end his life, we would have both preferred the mechanism of the quick and merciful death through narcotics, rather than the wasting death of starvation and dehydration preceded by a few days of discomfort. In fact, he was being maintained on more than 2 grams a day of MS Contin for pain relief at the time, under guidance from our hospice physician. It would have taken a huge dose of morphine or another agent to have enabled him to sink quietly away.

Five years later, he has been willing to be publicly interviewed about his experience. He now says that in retrospect, the decision to end his life would have been wrong for him. He expresses no regret that he did not die. He lives in a loving environment now and his independent activity is facilitated as much as possible. In contrast to the case of Dax, the young man who was horribly burned and then treated against his will, this patient does not hold me responsible for having abused him as Dax still holds his own care givers responsible.

In short, it would indeed have been a "horrible decision" to have participated in this gentleman's death. I am glad that I did not. We are still able to talk to each other, which otherwise would no longer be possible.

CASE REVIEW

Submitted by **Fred Zeller, MD,** Pulmonary/ Critical Care at the Mayo Clinic in Jacksonville.

Physician assisted suicide continues to be debated in the medical journals and lay press. Its proponents argue that it is a matter of autonomy and self determination while there are others who argue that assisted suicide is outside the spectrum of medical care or that suicide in general is inappropriate. The case study presented in the FBN April 1995 newsletter illustrates a number of points and raises several questions.

1) *Is suicide a right and, if so, is there a responsibility to carry out this option by a third party (i.e. doctors, nurses, family, etc.) for those who are physically incapable of suicide?*

This question is intriguing. Many people would agree that if an individual has a disease which produces intolerable physical pain or infirmity, then suicide might be reasonable and rational (although somewhat paradoxically, there may be less sympathy for autonomy of an individual with comparable mental despair and suicidal ideation in the absence of physical disease). Unless precluded by religious beliefs, the choice of suicide is within the field of options, available to all individuals. If the physical ability to commit suicide is lost, then would not a just society step forward and provide the necessary assistance to end that person's life? Inherent in this argument, however, is the assumption that there exists a physical state that reasonably precludes the individual from pursuing suicide. The refusal of nutrition and hydration, however, is an option open to all and one that does not require an executor. This option leaves the responsibility for the decision where it should be; namely, with the individual. Although, clearly not as rapid as carbon monoxide nor as painless as a barbiturate overdose, it is becoming recognized from hospice experience to be not as onerous as it might first sound. Any discomfort should be able to be palliated with conventional medication to minimize suffering. While it may be easier to have someone else kill you, does the individual not have a responsibility to protect others from the life long possibilities of self doubt and recriminations that may be incurred by an executor? In addition, there are ramifications on the societal respect for human life. It seems, at times, that we hold autonomy sacrosanct and deny the existence of any type of societal responsibility. Whether a right to suicide exists can be argued, but even if it does exist, I do not believe that there is an obligation due from others to facilitate or bring about a death.

2) *Given the finality of suicide, should we facilitate the availability or means to end one's life?*

All decisions in a rational mind hinge on a balance between positives and negatives. What constitutes a positive or negative differs from person to person, and from time to time. Autonomy is often viewed in the context of a decision at one moment in time. Even an apparently erroneous decision is "good" as long as it is made freely. Though autonomy doesn't necessarily imply perfect knowledge and insight, there is an inherent assumption that autonomy cannot be compromised by the individual himself, (i.e. that decision-making capabilities could be transiently flawed and irrational even in the context of one's own value system). Nowhere is this assumption less correct than in the individual who is depressed. A significant number of people who are suicidal are depressed and this often may be poorly recognized and go untreated. While I do believe that everyone is entitled to be on his own petard, the finality of suicide, the imperfect nature of human decision-making and lack of insight that so often accompanies physical illness opens the door slightly for a modicum of paternalism. Greasing the suicide wheel may not be in the interest of the individual or of the society.

3) *What should be the position of physicians and nurses regarding the professional's role in suicide?*

I would argue that the role of the physician and nurse should not be extended to the taking of a life either by action or assistance. To become the executioner erodes the patient/physician/nurse relationship and creates a great conflict of interest particularly as we move closer to a system of rationed health care. There is no need to compromise this relationship; it is tenuous enough as it is. Certainly we do not have a monopoly on agents that can be used to bring about death, nor is the administration of the agents so technically complex that it requires a health care worker's expertise. Options such as the refusal of nutrition and hydration are open to anyone including the most physically compromised. Palliation of pain and discomfort should be our guiding light.

4) *To whom does the responsibility for suicide fall?*

Should an individual bear responsibility for another's death or does responsibility reside exclusively with the person who wishes to die? I would like to distinguish this question from the more narrow issue of whether a health care provider should be one of the primary participants to the broader question of should **anyone**, other than the patient, be involved. Surely there are those that may step forward to offer their participation willingly, and all would agree that no one should be committed against their will to bring about another's demise. The other side of the issue is not 'could they' but rather 'should they.' Is it reasonable to request from another what you would not do for yourself; particularly when there is a substantial emotional and ethical burden that you may be imposing on another person that they must carry with them for the rest of their lives? Should you put another person in such peril? While I believe that you can expect and demand palliation from discomfort associated with disease and death, I am unconvinced that you have a right to be killed or to be assisted in your suicide.

5) *What constitutes a useful life?*

The spectrum extends from the belief that any life is good to that of man's existence is an affront to the planet. For many, life's value derives from personal relationships, religious convictions and the ability to achieve goals. It is very easy to focus exclusively on the latter and view the value of other's lives in the perspective of our own goal structure. As health care providers, we focus on limitations and disability. A patient seeks a medical opinion on what is wrong with them, not asking you to detail their positive qualities! Health care providers should be aware that their training biases them to view the quality of life for others based on physical performance measures. It is human nature to mentally focus on what disease deprives us of being able to do rather than to rejoice in the remaining possibilities. The case study shows that in the end the patient adapted to his situation. In retrospect, it would have been difficult to conclude in this case study that the patient's best interests would have been better served by assisting him to end his life. Those patients who upon deliberation and reflection decide to end their own lives are, of course, free to do so.

FBN 5TH ANNUAL CONFERENCE

End of Life Decisions: The Medical Ethics Debate is the topic of the fifth annual conference of the FBN which will be held at the Wyndham Harbour Island Hotel in Tampa on September 21-23, 1995. **Terry Perlin, Ph.D.** Scripps Gerontology Center/School of Interdisciplinary Studies, Miami University (Ohio), Department of Family Medicine, University of Cincinnati College of Medicine, is among a distinguished faculty of speakers, offering the keynote address opening the Thursday sessions.

More information about the conference is forthcoming, please mark your calendars and plan to attend.

ADVANCE DIRECTIVES AND PSYCHIATRIC ILLNESS: A CASE REVIEW

Submitted by **Hana Osman, LCSW,** Manager/ Social Work Department, Tampa General Hospital, Tampa. Commentary by **Terry Perlin, Ph.D.**

The right of psychiatric patients to execute advance directives and to have them respected by the medical team is featured in the following case of Mr. A; Dr. Perlin offers commentary.

Mr A is a 60-year old married male admitted to the hospital with a self inflicted gun shot wound to the head. Three years prior to this incident, the patient suffered a CVA which left him with physical deficits as well as progressive depression. The patient had executed a standard living will five years prior to the stroke. Two months after the initial stroke he designated his wife as his surrogate decision maker in a detailed, seemingly well thought out, document. Several months later, he attempted suicide and was briefly committed, under the Florida Baker Act, to a mental health facility for psychiatric treatment. Outpatient treatment followed for a few months.

The patient had been married several times, the current marriage was of 20-year duration. No children resulted from this marriage, however the patient had several children from other marriages. Mr. A is said to have been physically and sexually abusive to his children; they chose not to have any contact with him for at least 15 years. The patient's parents and siblings reside within a 50 mile radius of the patient's home; however, his relationships with his blood relatives have been fraught with problems. Also, the relationship between the patient and his wife has been strained throughout the marriage, and the pressures of the physical illness have compounded the marital stresses.

Most recently, after several weeks of verbally abusing his wife, Mr. A attempted suicide by pointing a gun to his head and discharging it. His medical condition continued to deteriorate after admission. He suffered a second CVA while in the hospital, he was in respiratory failure and he was unresponsive due to metabolic encephalopathy. The patient's condition was determined to be terminal.

Questions posed by the medical team:

- Is a Do Not Resuscitate (DNR) order appropriate?
- Is the wife (the patient-appointed surrogate) the appropriate decision maker?
- Since the injury is self-inflicted (a suicide attempt), is it appropriate for physicians to carry through a suicide attempt and allow death to occur?
- How is this scenario (honoring a suicidal patient's living will) different from physician-assisted suicide?

Commentary on Case of Mr. A is presented by Dr. Perlin

It is quite easy to think of Mr. A as a mentally ill person. His family life appears to have been chaotic; he has been ill, abusive, and often depressed. He has made two very serious suicide attempts. Mentally ill persons are, by definition, different from "us" in fundamental ways. That is why we have devised coercive ways of handling them, involuntary civil commitment for example. But, as Robert Burt reminded us half a generation ago (in TAKING CARE OF STRANGERS, 1979), "handling" a disturbed, suicidal "problem case" may evoke in caregivers a common, though often unconscious response. These patients make us feel crazy and we want to ease their suffering in order to restore ourselves to sanity. In a word, we often exclude truly strange persons from our moral community without acknowledging this exclusion. We do so on the grounds of providing "care," including terminal care. To confront this tendency to paternalize a situation, we must account for our reasons and emotions systematically. One way is to separate the non-issues from the issues. At this point in the case there are several non-issues.

- Mr. A's decisional capacity (competence) is irrelevant. He is not going to awaken and tell us what he wants, or wanted. Earlier, he was presumed to be competent as a matter of law and principle. Thus, we must deal directly with his prior expressions and designations. He has made adequate provision for this contingency by designating his spouse as surrogate decision-maker. Unless we have reason to think that Mrs. A is violating Mr. A's views and values, we must attend to her determinations in this matter.
- The decision to allow Mr. A to die, either via non-resuscitation, or withholding or withdrawing life-sustaining treatments (including hydration and nutrition), is important, but has nothing to do with suicide. Mr. A is terminally ill, as a result of both physical and psychological illnesses. His two prior efforts at ending his life are part of his case history.

Terminating treatment and offering only palliation at this stage is no different than what we might offer to a cancer patient in a hospice setting. Physicians and other caregivers help patients die all the time. It is estimated that 60-70% of the 2,000,000 deaths in the U.S. each year are "negotiated deaths." That is, either patients or surrogates work with physicians in determining the timing and mode of dying, usually via the termination of medical intervention. This is not suicide, no matter what the motivation or earlier actions of the patient. It is simply, when done well and for good reasons, allowing a patient to die.

- Physician assistance in suicide is no worry here. The classic scene in which the doctor tells the terminally ill patient "I am prescribing X barbiturate for you. Do not take more than N of these." is unrelated to Mr. A's situation. He is a hospital patient who is terminally ill. No caregiver, including his wife, is implicated in his effort to kill himself. Still, because his suicidal gesture resulted in this hospitalization he may provoke anxiety and concern. But his condition is comparable to any other patient who was a victim of a gunshot wound who is now in a terminal condition. It was a terrible thing, but given his present status there is nothing we can do to restore his thinking or his functioning. Thus, decisions about withholding or withdrawing treatments, such as CPR or tube feeding, should be rooted in concerns for Mr. A's pain and suffering and in recognition of his prior expressions.

Conclusion:
Hovering over this case, I believe, is a concern about the law. Physicians are notably anxious about legal issues, especially negligence and malpractice. The itchy temperament of plaintiff's attorneys is well known to doctors. But, in fact, there have been (to my knowledge) no successful lawsuits against physicians or hospitals who have withheld or withdrawn life-sustaining treatments in conformity with prior advance directives and with agreement from appropriate family members. Focussing on the legal periphery of the case diverts us from the essential decisions that must be made. Shall we give Mr. A a DNR order? Shall we withdraw hydration and nutrition from this dying patient? Shall we "let Mr. A go?" This decision must be made by Mrs. A and Mr. A's care givers. We already know what Mr. A said he wanted. I can see no reason to contravene this patient's wishes.

Outcome:
Mr. A's terminal condition qualified the implementation of his living will. The DNR order was written after discussion with his designated surrogate (his wife), and all comfort measures continued. Mr. A suffered a cardiac arrest one day later and he was allowed to die, in accordance with his living will.

Readers are encouraged to offer opposing views.

ESSENTIAL READINGS #2

Submitted by **Francille M. MacFarland, MD,** Winter Park.

Cross Cultural Issues

1. Veatch, R.M. Cross Cultural Perspectives in Medical Ethics: Readings. Boston: Jones and Bartlett Publishers, Inc. 1989.
2. Pellegrino, E. Intersections of Western Biomedical Ethics and World Culture; Problematics and Possibility. Cambridge Quarterly of Healthcare Ethics 1992 Summer; 1 (3):191-196.
3. Pellegrino, E., et al. Transcultural Dimensions in Medical Ethics. Frederick, Maryland: University Publishing Group, 1992.
4. Special Section: Cultural Differences in Bioethics. The Journal of Clinical Ethics 1993 Summer; 4 (2).
5. Patcher, Lee M. Culture and Clinical Care: Folk Illness Belief and Behaviors and Their Implications for Health Care Delivery. JAMA 1994 271:690-694.
6. Kopelman, Loretta M. Female Circumcision, Genital Mutilation and Ethical Relativism. Second Opinion 1994; 20 (2); 55-71.
7. Bishop, L.J., et al. Scope Note 25: Religious Perspectives on Bioethics Part 1. Kennedy Institute of Ethics Journal 1994; 4 (3):155-183.
8. Bishop, L.J., et al. Scope Note 26: Religious Perspectives on Bioethics Part 2. Kennedy Institute of Ethics Journal 1994; 4 (4):357-386.
9. Jecker, N.S., et al. Caring for Patients in Cross-Cultural Settings. Hastings Center Report 1995; 25 (1):6-14.
10. May, Larry. Challenging Medical Authority - The Refusal of Treatment by Christian Scientists. Hastings Center Report 1995; 25 (1):15-21.
11. Orr, Robert D., et al. Cross-Cultural Considerations in Clinical Ethics Consultations. Archives Family Medicine 1995; 4:159-164.

Current References

Dresser, R., Advance Directives: Implications for Policy. Hastings Center Report, special suppl. 1994; 25 (6):S2-S5.

Rosner, F., Do Not Resuscitate Orders in the Operating Room. Mount Sinai Journal of Medicine 1994; 61 (6):493.

Loewy, E.H., Institutional Morality, Authority, and Ethics Committees: How Far Should Respect for Institutional Morality Go? Cambridge Quarterly of Healthcare Ethics 1994; 3:578-84.

Pellegrino, E.D., Allocation of Resources at the Bedside: The Intersection of Economics, Law, and Ethics. Kennedy Institute of Ethics Journal 1994;4 (4):309-17.

Piper, A., Truce on the Battlefield: A Proposal for a Different Approach to Medical Informed Consent. Journal of Law, Medicine & Ethics 1994; 22 (4):301-13.

Emanuel, E.J., Institutional Conflict of Interest. New England Journal of Medicine 1995; 333 (4):262-67.

NETWORK NEWS READERSHIP SURVEY

Submitted by **Cathy Emmett, RN, MSN,** Manager/Gerontology, Sarasota Memorial Hospital, Sarasota.

The results are in! Twenty-seven readers responded to the *Network News* survey which was included in the last issue. The results indicate that you agree/strongly agree that *Network News* contains current information and that it is useful and interesting. While you like the format of *Network News* and the majority felt the writing style was clear and concise, a few of you felt we could do better. Perhaps most gratifying was the response that the majority of readers share their issue with their colleagues. The topics you were most interested in were trends, new problems and changes in bioethics as well as pending legislation and new regulations. Editorial articles were of least interest.

Thank you so much for your response. We will do our best to keep *Network News* interesting and up-to-date!

REPORT OF COMMITTEE ON GUIDELINES FOR BIOETHICS COMMITTEES

Submitted by **Glenn Singer, MD, FACP, FCCP,** Chairman, Bioethics Committee, Broward General Medical Center, Ft. Lauderdale.

A preliminary draft of Guidelines for Ethics Committees: Practice and Theory was presented at the last board meeting of the Florida Bioethics Network. These guidelines evolved from a perceived need to help nascent committees with the many challenges that ethics committees face.

Bioethics Committees were once uncommon in the hospital. The well known Karen Quinlan case led the New Jersey Supreme Court to recommend hospital committees be formed to help with end of life decisions. In 1991, the Joint Commission on Accreditation of Healthcare Organization stated that institutions should have a mechanism for the resolution of ethical problems and for the education of its staff. Finally, hospitals needed to have policies to deal with a public that has become more informed and has greater knowledge on advanced directives such as living wills or do not resuscitate orders.

The guidelines will cover mission statement, committee composition and terms, procedural issues, education and training of committee members, institutional policy making and education, consultation, and remuneration for ethics committees members.

Final draft with bibliography will hopefully be available this fall.

CALL FOR CASE CONSULTS/ARTICLES

Submitted by **Cathy Emmett, RN, MSN**

Do you have an interesting case to share? Is there a bioethics issue for which you have done a presentation and/or article? Consider submitting it for the next issue of *Network News*. Submissions should be sent to: **Cathy Emmett**, Gerontology Dept., Sarasota Memorial Hospital, 1700 South Tamiami Trail, Sarasota, FL 34239; or faxed to: 941/917-2169 or E-mailed to: Cathy-emmett @ smh.com.

AGING ISSUES

(Source: FHA *Legisletter* March 20, 1995.)

The House Aging and Human Services Committee reported favorably proposed committee bill PCB-6. The bill permits the Long Term Care Ombudsman to have access to all records of a long-term care facility resident, including medical, social, clinical, and financial records as well as access to the records of the facility, including staffing, personnel business, and fiscal records. It amends the nursing home and ACLF laws to allow the resident's personal representative to sue for all violations of the resident's rights, whether or not the licensee's behavior resulted in death, injury, or a simple deprivation of the resident's rights. The bill would require each nursing home to retain records of accidents or incidents involving residents or staff members which caused injuries, or had the potential to cause injuries, to any person within the facility. It would allow certain persons to copy the records for a fee which may not exceed 25 cents per page for each page requested by the resident or the resident's representative. **(Linda Brainard)**

WELCOME NEW MEMBERS!

The Florida Bioethics welcomes **Mario Ceballos,** Chaplain, Florida Hospital, Orlando, FL ~ 407/897-1553; **Artrema Green,** Bioethics Committee, Jacksonville, FL ~ 904/388-8070; **Carol Kunau,** Vice President, Florida Hospital, Orlando, FL ~ 407/897-1844.

ORGAN AND TISSUE DONATIONS

(Source: FHA *Legisletter* March 20, 1995.)

A bill to clarify processes by which individuals or their families can make organ and tissue donations was reported favorably by the full *House Health Care Committee*. Proposed committee bill PCB-3 requires the AHCA and the Department of Highway Safety and Motor Vehicles to establish a central donor registry and information bank. Revenues from a voluntary one dollar contribution collected when driving licenses are issued will be used to fund organ and tissue donor public education activities. **The FHA has worked with the bill's sponsors, the Health Care Committee staff, and the AHCA to refine the bill and to clarify provisions relating to the responsibilities of hospital personnel. The FHA supports the bill. (Lester Abberger)**

POSITION OPEN . . .

Creighton University is currently seeking applicants for the position of Director of the Center for Health Policy and Ethics. Anyone interested in either applying for the position or nominating a colleague, contact **Victoria F. Roche, Ph.D.**, Chair, Search Committee, Director of the Center for Health Policy and Ethics at 402/280-2950.

MEETING CALENDAR

Regional Meetings

- **September 20-22, 1995**: FBN Annual Meeting: Focus on Futility, Wyndham Harbour Island Hotel, Tampa, FL, contact Hana Osman at 813/251-7043.

- **December 15-18, 1995**: Ethical Issues in the Care of Terminally Ill and Dying Patients, Rolling Hills Hotel & Golf Resort, Ft. Lauderdale, FL, contact Dr. Jos V.M. Welie, CEREC Center, P.O. Box 292932, Ft. Lauderdale, FL 33329. Tel./Fax: 305/424-9304. E-mail: jewlie@bcfreenet.seflin.lib.fl.us.

- **April 26-28, 1996**: Ethical Issues in Renal Dialysis and Kidney Transplantation, Rolling Hills Hotel & Golf Resort, Ft. Lauderdale, FL, contact Dr. Jos V.M. Welie, CEREC Center, P.O. Box 292932, Ft. Lauderdale, FL 33329. Tel./Fax: 305/424-9304. E-mail: jewlie@bcfreenet.seflin.lib.fl.us.

National Meetings

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

*Information will be updated as it becomes available.