Florida Bioethics Network FBN

Network News

Summer 2000 http://www.med.ufl.edu/chfm/ethics/fbn.html

Florida Partnership Awarded Grant to Improve End-of-Life Care, Education

FBN to Play Key Roles; Pain Management a Focus

By Bill Allen, J.D.
University of Florida, Gainesville

The Florida Partnership for End of Life Care has received a Robert Wood Johnson Community-State Partnership grant to improve end of life care in Florida. The four primary entities that comprise the Florida Partnership are the Florida State Department of Health, the Florida State Department of Elder Affairs, Florida Hospices and Palliative Care, and a coalition among the University of Florida Colleges of Medicine and Pharmacy and the University of Miami School of Medicine. Many other organizations in Florida, especially including the Florida Bioethics Network, have

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Inside this issue

400 Attend Conference; FBN's 10th Sets Record

FORT LAUDEDALE — In one of the largest community bioethics conferences ever, some 400 people attended the Florida Bioethics Network's 10th Annual Conference in Fort Lauderdale.

FBN's Fall Conference set for Oct. 19-20. See Page 4.

The March 10 meeting featured 26 presenters who contributed to plenary sessions, simultaneous workshops and panel discussions.

In her keynote talk, Mary Ann Hopkins, a New York surgeon and volunteer for the inernational relief organization Doctors Without

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FBN

Florida Bioethics Network

The Florida Bioethics Network is a program of

- **Medical Ethics, Law and the Humanities, University of Florida College of Medicine**
- **Forum for Bioethics and Philosophy University of Miami**
- **Division of Medical Ethics and Humanities, University of South Florida School of Medicine**

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Lauderdale Conference Draws 400

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Borders, described her work in Sri Lanka and Burundi. Her presentation, "Why Volunteer? A Surgeon's Experience with Doctors Without Borders," elicited a standing ovation from attendees in a packed hotel ballroom.

Some were so moved by the account of foreign misery, personal sacrifice and professional commitment, they wept.

More information about Doctors Without Borders is available at www.doctorswithoutborders.org/

In other highlights:

- Jim Towey of Aging With Dignity and Ken Goodman, director of the University of Miami Bioethics Program, debated the "terminal illness" condition in Chapter 765 of the Florida Statutes;
- Susan Acker of Florida's Agency for Health Care Administration, Samira Beckwith of Florida Hospices and Palliative Care and Marilyn Goldaber of the Miami Jewish Home and Hospital discussed end-of-life care in Florida.
- The program's annual session on pastoral care drew enthusiastic participation on current challenges in ethics and pastoral care and the role of clergy on ethics committees.

The conference program is still available on the Web at http://www.miami.edu/ethics. Unedited videos of the morning plenary sessions are available for $95 and complete conference syllabi for $50. For more information: ethics@miami.edu or 305-243-5723.

Sponsors

The FBN's 10th Annual Conference featured Florida Atlantic University as a special academic partner. Other sponsors: Jackson Memorial Hospital, Miami VA Hospital, Sylvester Comprehensive Cancer Center/University of Miami Hospital and Clinics, Baptist Health Systems of South Florida, Miami Jewish Home and Hospital for the Aged, VITAS Hospice Corp., KPMG Consulting, North Broward Hospital District, Miami Children's Hospital, Boca Raton Community Hospital, the Elder and Health Law Sections of the Florida Bar, the Health Council of South Florida and the Robert Wood Johnson Foundation, as part of its Community Partnerships program.

Robert Wood Johnson awards end-of-life grant to partnership; FBN in key role

Continued from page 1)

also joined in this effort.

The FBN has arranged to devote significant parts of its two annual conferences to issues in end-of-life care.

Aspects of the overall project are already well under way. For example, the Department of Health has already revised and adopted a new pre-hospital Do-Not-Resuscitate form for use by persons who do not wish to have Emergency Medical Services to administer cardiopulmonary resuscitation if someone calls 911 (see page 6). The Department is providing training for its EMS divisions around the state to implement this process. The Department has also developed a demonstration project to train EMS personnel how to respond to cases in which the family calls 911, not because they want CPR when their loved one is dying, but because they don't know what to do during the process or after the person is dead. This might be thought of as EMS palliative care, an ironic, but useful, notion.

The UF College of Pharmacy has begun a program that will lead to certification in pain management for health system pharmacists. The idea is that this will provide a local expert in pain management to serve as a resource for providers attempting to use the best practices in pharmacological pain control. Moreover, these local pharmacists can provide expert consultation and documentation to reduce anxiety about professional discipline, liability concerns, or other regulatory barriers to effective pain management often cited as a major reason for inadequate utilization of pain medications.

Both the University of Florida and the University of Miami ethics programs have already addressed specialty sections of the Florida Bar on how their members can provide better end of life advance care planning for their clients. So far, these meetings have included the Florida Bar Health Law Section, the Florida Bar Elder Law Section, and Bay Area Legal Services (for the Tampa Bay area). Other sessions will include the ACLU Florida Chapter as well as other legal service agencies around the state. One of the basic problems is that most attorneys who assist their clients with advance directives simply use the statutory forms, which are not especially helpful.

By making attorneys aware of other approaches, we hope to improve their service to their clients.

To improve the statutory forms themselves, the Department of Elder Affairs is developing improvements to be made in future legislative sessions. The University of Florida ethics program has collected the statutory forms from all 50 states as a way of beginning this process. But we do not plan simply to borrow other states' forms. In addition to analyzing other states' forms, we will attempt to make original improvements that will be suitable for the broadest range of consumers. As a part of this process, we need those of you who are interested to critique drafts of new forms and to test them with a focus group in your area. Please contact Ken Goodman, Ray Moseley or Bill Allen if you are interested in helping in this way.

Additional target audiences for future workshops will include clergy, who can be instrumental in earlier intervention and improved communication among family members facing end of life challenges, and journalists, who can help to improve public awareness of resources available to serve people facing end of life decisions.

The Florida Partnership's backbone is in the development of local community coalitions to facilitate public dialogue about end-of-life care and to disseminate information widely. If you are interested in being a part of the coalition in your area, please contact the Florida Partnership's statewide office in Tallahassee at 850-878-2632 or toll free at 877-783-1922.

Bill Allen is an associate professor in the Program in Medical Ethics, Law and the Humanities at the University of Florida College of Medicine.

To learn more about coalitions in your area, call the Florida Partnership statewide office in Tallahassee at 850-878-2632 or toll free at 877-783-1922.

Mark your calendar for this FBN Conference:

Law and Ethics at the End of Life

Florida Bioethics Network (FBN)
Fall Conference

Radisson Riverwalk Hotel
Jacksonville, Florida
October 19-20, 2000

Topics include:

- Update on new End of Life Legislation and Regulations, including the transportable DNR order.
- Legal and ethical issues at the End of Life with Neonatal, Pediatric and Never Competent Patients.
- Ethics Committees: Development, Function, Education and Consultation.
- Florida Bioethics Network Standards for Ethics committees.
- Advance Directives: Institutional policies, Barriers, and Patient Education
- Problems of Advance Decision-making for Alzheimer Patients.

Featured Speakers include:

Chris Hackler, Ph.D.
Director, Medical Ethics Program
University of Arkansas for the Medical Sciences

Robert Brooks, MD
Secretary of Health
Florida Department of Health

To make early room reservations:
Radisson River Riverwalk
1515 Prudential Drive
Jacksonville, FL
(904) 396-5100
(800) 333-3333
Be sure to mention the Florida Bioethics Network when making your reservation.

For more information on the conference please contact:
Ray Moseley
Phone: 352-846-1097
E-mail: fbn@chfm.health.ufl.edu
Website: www.med.ufl.edu/chfm/ethics/fbn.html

Resources

Advance Directive Kits

Bundles of 50 advance directive brochures describing the types of advance directives and answering other questions about end-of-life care are available for shipping and handling costs of $15 payable to

Jane Hendricks, J.D.
8306 Mills Drive
PMB 177
Miami, FL 33183

A package of 3 Living Will forms and 1 Health Care Surrogate Designation form is available for $90.00. Same payee and address as above.

Elders Institute Video

A 70-minute videotape of a March 2000 Elders Institute panel on advance directives is available for $29.90 (including tax, postage and handling). Remit check or money order to

Ann Molliver Ruben, Ph.D.
4280 Galt Ocean Drive
Plaza South, Apt. 11J
Fort Lauderdale, FL 33308

Ethics Conference Video

A 3-and-a-half-hour videotape of the morning plenary session at the FBN's March 10 conference in Fort Lauderdale features a talk on health and gender, a debate on Florida's advance directive law and an inspirational presentation by a Doctors Without Borders Physician. Call 305-243-5723 for more information or remit check or money order for $95 to

University of Miami Ethics Programs
P.O. Box 016960 (M-825)
Miami, FL 33101

Florida Ethics Calendar

Please e-mail submissions to ethics@miami.edu

August 3-6, Orlando — Private Service for Public Good, Florida State Guardianship Association Annual Conference, including Aug. 5 session on "Using the Florida Bioethics Network." Information: 850-656-8848.

September 1-3, Orlando — Florida Medical Association Annual Meeting, including Sept. 2 panel, "A Forum on End-of-Life Issues." Information: 850-224-6496, www.fmaonline.org

September 8, Miami — Medical, Legal and Ethical Issues in Avoiding Blood Transfusions, sponsored by the Center for Bloodless Medicine & Surgery, Jackson Memorial Hospital. Information: 305-585-7269.

September 10-13 — On Our Own Terms: Moyers on Dying, nationally broadcast PBS special. Information: www.thirteen.org/onourownterms; and check local PBS affiliates for details.

September 19, Davie — South Florida Ethics and Health Law Working Group monthly meeting at Nova Southeastern University's Shepard Broad Law Center. Information: 954-262-6193.

September 20-22, Orlando — Explorations in Patient/Family Centered End-of-Life Care, 16th Annual Florida Hospices and Palliative Care, Inc. Symposium. Information: 850-878-2632.

September 20-23, Miami — Florida Nurses Association Annual Conference, including Sept. 20 ethics panel. Information: 407-896-3261, www.floridanurse.org

October 12-14, Miami — Extreme Ethics: Especially Difficult Challenges in Epidemiology and Human Subjects Research. Sponsored by the National Institutes of Health and the University of Miami. Information: 305-243-5723, www.miami.edu/ethics

October 16-19, Tampa Bay — Ethics in Research: Focusing on Behavioral Health Services, sponsored by National Institutes of Health and the Department of Mental Health Law & Policy Louis de la Parte Florida Mental Health Institute, University of South Florida. Information: 813-974-7623, www.fmhi.usf.edu/mhlp/ethics/ethics.html

October 19-20, Jacksonville — Law and Ethics at the End of Life. Fall Conference sponsored by the **Florida Bioethics Network**. Information: 352-846-1097, www.med.ufl.edu/chfm/ethics/fbn.html; and see notice at left.

November 8-11, Miami — American Medical Writers Association Annual Meeting, including Nov. 9 bioethics panel. Information: 301-294-5303, www.amwa.org

December 1, West Palm Beach — Vital Signs: Ethics, Aging and Dignity. Sponsored by the Palm Beach Area Agency on Aging and the **Florida Bioethics Network**. Information: 561-694-7601.

March 2, 2001, Miami — Clinical Ethics: Debates, Decisions, Solutions. **Florida Bioethics Network** Spring Conference. Information: 305-243-5723, www.miami.edu/ethics.

State's advance-directive statute amended

JANE E. HENDRICKS, J.D.

On June 15, 2000, Governor Jeb Bush signed into law CS for CS for SB 1890 modifying and expanding upon the advance-directive statute changes enacted in 1999. The 1999 amendments took effect October 1, 1999. The 2000 amendments take effect "upon becoming law," namely June 15, 2000. What follows is an itemization of the 2000 amendments.

A. FS 395.1041 extends applicability of yellow Florida DNR form from hospital emergency department to the floors and units. Provides protection from liability for all hospital personnel honoring yellow DNR form.

B. Physicians may issue their own DNR orders. [FS 395.1041 (hospitals); 400.142 (nursing homes); 400.4255 (ALFs); 400.6095 (hospice)] Yellow form is not the only option. However, if portability is the goal, use the yellow form.

C. Makes clear only one physician need sign the yellow DNR form. Also requires signature of patient or, if patient is incapacitated, the surrogate or proxy as defined in FS 765, a court-appointed guardian pursuant to FS 744, or an agent under a Durable Power Of Attorney pursuant to FS 709. The guardian or DPOA must have specific authority to make health care decisions. [FS401.45(3)(a)]

D. For biennial relicensure or recertification, professionals may substitute a course on end-of-life care and palliative care for a course on domestic violence, provided they completed a domestic violence course in the immediately preceding biennium. [FS 455.597]

E. Health care professionals should "rapidly increase their understanding of end-of-life and palliative health care." Regulatory boards are encouraged to adopt guidelines ... for training professionals in end of life care, pain management and palliative care.

F. Patient shall be given information on pain management and palliative care by the attending or treating physician or physician's designee. [FS 765.1103]

G. Health Care Surrogate (HCS) form has been modified to address organ donation. Makes clear that the HCS only has authority to donate patient's organs if patient has signed an organ donor form. [FS 765.203]

H. Clarifies that HCS can agree to a DNR order. [FS 765.205]

I. Deletes all references to "mentally and physically" when referring to incapacity or capacity. [FS 765.303, 765.305(b) & 765.306]

J. Revises and clarifies living will form [FS 765.303]

K. Revises proxy provisions to remove (a) & (b) inserted in 1999 for reasons unknown. [FS 765.401 (3)(a) &(b)]

Jane E. Hendricks is an attorney in Miami focusing her solo practice on bioethics, guardianship and probate. She serves on several facilities' ethics committees and has been dealing with bioethics issues since 1982.

New, portable state DNR forms available

TALLAHASSEE — The state's Bureau of Emergency Medical Services has completed and begun distributing the keenly anticipated revision of the "Florida Do Not Resuscitate Order" form.

Authorized by changes to section 401 of Florida Statutes, the form is designed to make DNR orders more portable. The intent is that the forms "be honored by hospital emergency services, nursing homes, assisted living facilities, home health agencies, hospices, adult family-care and emergency medical services."

The form contains a "patient's statement," a "physician's statement" and a wallet-size subform that may be detached. Emergency medical services personnel will honor the yellow form. Copies may be made, but they must be on yellow paper.

A version of the form — omitting the detachable part — is reproduced at right.

Complete copies of the new form are available by calling the Bureau of Emergency Medical Services at 850-245-4440, ext. 2742 or 2752. Institutions may request up to 10 copies. Larger institutions are making master copies and laying in stocks of yellow paper.

Facsimile of form — see article at bottom of Page 6 for ordering information.

FLORIDA
DO NOT RESUSCITATE ORDER

(Please use ink)

Patient's Full Legal Name____
(Print or Type Name) (Date)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn. **(If not signed by patient, check applicable box)**:

☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

____
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

____
(Signature of Physician) (Date) Telephone Number (Emergency)

____
(Print or Type Name) (Physician's Medical License Number)

Pursuant to s. 401.45, F.S., a copy or original of this DNRO may be honored by hospital emergency services, nursing homes, assisted living facilities, home health agencies, hospices, adult family-care and emergency medical services.

DH Form 1896, Revised February 2000

Particular Inequalities: Justice and Access to Health Care

Robin N. Fiore, Ph.D.
Florida Atlantic University, Boca Raton

This article is adapted from Dr. Fiore's presentation of the same title on March 10, 2000, at the 10th Annual Meeting of the Florida Bioethics Network in Fort Lauderdale.

In bioethics, as in much of Western philosophy, the ideal moral standpoint has traditionally been taken to be one of impartiality - "the view from nowhere." This epistemic standard distorts moral analysis about practical matters in a number of important ways. Specifically, attention to particular facts about human beings — for example, that human beings are gendered — is thought to be irrelevant at best, and at worst, a source of error. The standard methods of bioethics tend to obscure what I call "particular inequalities" — disadvantages that are attributable to patterns of stereotyping and prejudice embedded in particular social facts such as race, gender, class, age, ability, sexual orientation, etc.

Neither public policy nor mainstream bioethics has attended to the fact that women and men are biologically and socially dissimilar in important ways such that they are differently situated with respect to the health care system. Much of public policy discourse about "securing equal access to health care" focuses on budgets, financing and political considerations, as if the notion of just health care is satisfied by something like universal health insurance or a national health service. Leading philosophical accounts of just health care offer only the most abstract specifications of what is to be equally available to all — for example, "fair equality of opportunity" and "a decent basic minimum" (Daniels 1985). Given the particularities of gender, the difference gender makes in terms of differences in family roles, economic status and patterns of illness and health care utilization, identical health insurance coverage — even identical provision of health services — is unlikely to serve both men and women well. More importantly, the prevailing focus on questions of when access is equal or equitable ignores important moral questions about the practices and social conventions that constitute "health care" in the United States and the differential economic and social power relations that shape health policy. Consequently, a crucial form of injustice – the systematic advantage of some social groups compared to other social groups to define health care needs and have them met – is absent in mainstream discussions about access to health care.

Space does not permit an analysis here, but an abundance of data demonstrates that women are harmed by a medical system that takes the white male as the model for research and insurance coverage and that health care and science policy have consistently failed to attend to the health interests and experiences of women (Faden, Kass et al. 1996). Outcomes for many health conditions are poorer for women than for men, with those for minority women worse than for white women. Women are further disadvantaged in terms of access to private insurance, reflecting their lower pay and lower work status. In addition, women are less well protected by health insurance, both public and private. Medicare and private health insurance better fit men's needs, providing more comprehensive coverage for acute conditions than for chronic diseases or mental health care, services utilized more by women. (Goff et al 1997a, b). It is estimated that women of reproductive age pay 68% more in out-of-pocket health care expenses than men; a significant percentage of women's cost differential is attributable directly and indirectly to the management of reproduction.

I contend that women's particular inequalities are not fundamentally a distributive problem.

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That is to say, women's disadvantage will continue to persist even if their access to the set of social arrangements we call health care /health insurance is on par with men's because the system itself is normatively male. It neglects women's needs, proceeds without women's own interpretation of their needs, and not infrequently against women's health interests when those conflict with or compete with men's interests. A major reason for women's lack of success in changing the system, in my view, is that women's particular inequalities are obscured under prevailing notions of equality or equity as sameness in some sense. Thus, claims of gender bias are only recognizable when they can be framed as a failure of equal treatment – for example, women's exclusion from clinical research trials – compared to that which is available to men. What I call "Viagra Logic" illustrates why these sorts of equality arguments are ultimately self-defeating.

Recently, Japan's Ministry of Health and Welfare took less than six months to approve the sale of the drug Viagra. This is regarded as noteworthy because Japan, citing safety concerns, is the only industrialized nation that has not approved the low-dose birth control pill more than ten years after application. Japanese women's groups have exploited the gender bias evident in the "tale of two pills" and news reports indicate approval of the pill may be hastened by public reaction.

Analogously, 97% of U.S. employer-sponsored health plans for groups with 100 or more employees pay for prescription drugs but only one-third cover oral contraceptives. Publicity surrounding health insurance reimbursement for Viagra, but not for birth control pills, has generated similarly reasoned demands for gender equity.

Although Viagra is not a contraceptive it has enough similarities with oral contraceptives – available only by prescription, pill-form, necessarily connected with sex – that the two pills have become proxies for comparing the way men's interests are privileged and women's interests are erased or trivialized in medicine and science. However, Viagra Logic illustrates the paradox of attempts to remedy certain types of gender imparity by recourse to an understanding of equality as treating like cases alike. It may, as in the case of Viagra/birth control pills, offer women the opportunity to force recognition of their claims as a matter of justice, but only those claims that by chance can be assimilated to claims that men have justified or want to justify for themselves. While this opportunistic strategy has achieved desirable practical benefits for women, we should not ignore the ways in which such a strategy affirms rather than challenges the metric — male needs and interests as normative — that underlies women's particular inequalities.

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Check Out FBN Online, Send E-mail

The Florida Bioethics Network is on the Web at http://www.med.ufl.edu/chfm/ethics/fbn.html. Please have a look at the network's Web site and send suggestions about features, content, etc. to

fbn@chfm.health.ufl.edu

Also, we're compiling a list of members' e-mail addresses. This will improve efficiency and let us send special news items, Florida ethics updates, the newsletter and other material. So, please send your email address to

ethics@miami.edu

Ethical issues in pain and palliative care

CATHERINE EMMETT, ARNP, CS
Hospice of Southwest Florida, Sarasota

One of the most disturbing facts about End of Life care in the United States today is that many patients are in pain during these last days, weeks and months. Studies published in the *New England Journal of Medicine* (Cleeland 1994), and the *Journal of the American Medical Association* (Support Study 1995, Bernabei 1998) have identified patients with unrelieved pain in outpatient settings, hospitals and extended care facilities. Experts in End of Life care have pointed out that we have the resources to provide good clinical care to people in their final weeks and months, but too often patients do not receive comfort care for pain, anxiety or dyspnea. One of these experts, Ira Byock, M.D., states that, "no patient needs to die in pain," while Joanne Lynn, M.D., (founder of Americans for Better Care of the Dying) has said, "Everyone should be able to expect good care at the end of life."

Many who provide care routinely at the end of life have observed that adequate pain management remains one of the toughest hurdles towards providing this "good care." Many healthcare professionals did not receive much (if any) education in management of terminal pain. The education that has been given has often focused on the perils of drug addiction and identifying drug-seeking behaviors, rather than on the alleviation of pain. Many myths abound regarding sedation, addiction, the amounts of opioids that can safely be used and how to assess a patient's pain.

In order to treat pain effectively, we must first ask patients if they are experiencing pain. This may seem like a rudimentary question, but in fact, most patients are not routinely asked this question. Several organizations are now calling for healthcare professionals to add assessment of pain as a "fifth vital sign." We should be asking patients where their pain is located, and to rate it on some type of consistent scale. The most frequently used tool asks patients to rate their pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain. We should always accept and record the patient's report of their pain, not impose our own opinions or judgments. Different individuals respond differently to pain. Our goal should be to relieve the pain to the level that the patient would find acceptable.

Although opioids have been shown to be both safe and effective for pain control when ordered in appropriate dose schedules, many healthcare professionals, families and patients are reluctant to use them, based on myths and misinformation. For many types of terminal pain, opioids remain the drugs of choice. For example, with NSAIDS medications, there is eventually a ceiling in terms of the amount of medication that can be given. With opioids, there is no ceiling; the amount necessary to relieve the patient's pain can be given as required with no maximum limit.

The amount of opioid medications that terminally ill patients may require at the end of life can be frightening to those who are not familiar with administering them. A frequent concern is that the patient will become overly sedated or that respiratory depression will occur and the administering nurse may "hasten" the patient's death. Respiratory depression and sedation can be avoided in the opioid naïve patient if these medications are given in small doses initially, and gradually titrated as needed over several days. Accommodation to these drugs usually develops within 72 hours, without adverse respiratory and CNS effects.

For pain medication to be effective for chronic terminal pain, it needs to be administered around the clock, not on a PRN basis. PRN doses of medication should be reserved and used for breakthrough pain. The patient should be constantly reassessed to determine if more medication is needed. Another frequently expressed concerned is that the patient will become a drug addict. Studies have demonstrated that physiological tolerance occurs in less than 1% of patients using opioids for pain relief.

We all must unite to do all that we can to relieve pain at the end of life. We should be assessing patients for pain and advocating for appropriate medications and treatments to alleviate their pain. We must help in educating our peers, other healthcare professionals, patients and their families about pain management. In the field of bioethics we frequently find ourselves confronted with ethical dilemmas; in this case there is no dilemma, only an ethical imperative to *do the right thing!* Together, we *can* improve care at the end of life.

References and Readings

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Catherine Emmett, a gerontological nurse practitioner, is Education Liaison at Hospice of Southwest Florida.

'High tech' indigent care: In search of a model

Rev. Jerry J. Griffin, BCC
Lee Memorial Health System, Fort Myers

The cost of care is a dynamic presence in healthcare delivery today. In FY 1999, our health system spent $20 million on uncovered health care. A great portion of those costs was from high cost, high technology procedures.

This fact alone has caused our leadership to wonder about establishing a process model that will serve to contain the loss through the allocation of a certain amount of money for a specified number and types of procedures. A process of screening "applications" from physicians requesting the procedures would be created. The appropriate criteria would be identified. The panel would address the potential for indicators of successful and positive outcomes based on patterns of life change, other existing medical conditions and increasing quality of life.

Conceivably , a specific number of dollars would be allocated for the four or five most frequently done procedures for which reimbursement or payment has not been received. On the basis of cost, a limited number of procedures in a category would be set. If that number was reached in a given year, there would be no more consideration given to those cases until the next allocation year.

This concept has grown out of the pursuit of maximizing dollars and benefits to persons/patients in a day of dwindling resources: natural, human and financial. It is recognized that this concept has many, many implications ethically.

We are wondering ... are there others "out there" who are thinking like this? Is there a model that is being considered or practiced anywhere? What are the critical issues: legally, ethically, morally and interpersonally that need to be addressed?

We know this is a potentially "electric" subject. But, our ethics forum wants to investigate this concept. We welcome your suggestions, responses, cautions, and experiences. Please e-mail us:

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Jerry Griffin is System Director of Spiritual Services and Chair of the Ethics Council for Lee Memorial Health System in Fort Myers.

Baptist System Awarded Grant

MIAMI — Baptist Health Systems of South Florida has been awarded a $75,000 grant from the Open Society Institute as part of its Project on Death in America's Community Grief and Bereavement program. The grant will be used to establish a referral network of bereavement training and support groups.

The grant is the only one awarded in Florida and one of seven nationwide.

"The establishment of a network of bereavement support groups in diverse faith communities will be a valuable service," said Chaplain Dale Young, director of the Congregational Health Ministry Alliance Program, a Baptist system pastoral care service that is overseeing the two-year grant.

"The bereavement program will build upon the partnerships already in place with area churches and synagogues who are actively engaged in health ministry in their congregations," Chaplain Young said.

For more information about the program, call the Baptist Pastoral Care office at 305-596-6577.

FBN Member Co-authors Key Text

DAVIE — FBN member Kathy L. Cerminara has signed on to co-author the legal treatise *The Right to Die*. Cerminara, an assistant professor at Nova Southeastern University's Shepard Broad Law Center, is working on the 2001 cumulative supplement to the second edition of the book and will continue as co-author when the book goes into its third edition.

Cerminara's co-author is Professor Alan Meisel from the University of Pittsburgh School of Law, who published the first edition of *The Right to Die* in 1989. Cerminara was a research assistant for Meisel in law school on the first edition of the book. She was the first research assistant he hired at that time, in 1985, to begin work on the book, and thus she was involved in its initial planning and creation.

The first edition of *The Right to Die* was named the most outstanding book in the legal and accounting practice category for 1989 by the Association of American Publishers.

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