The original documents are located in Box 31, folder "Bio-Medical Ethics Workshop, March 1980" of the American Citizens Concerned for Life, Inc., Records at the Gerald R. Ford Presidential Library.

ACCL copy

Minnesota Interreligious Committee for Bio-Medical Ethics

The Eye of the Needle

APRIL, 1983

For the second year in a row The Minnesota Interreligious Committee for Bio-Medical Ethics is indebted to Wilfred Bockelman for adapting an issue of his monthly newsletter, THE EYE OF THE NEEDLE, and using it to report on the annual Bio-Medical Ethics Workshop. THE EYE OF THE NEEDLE is a monthly newletter that deals regularly with ethical issues. Address and subscription price are listed below for those who may wish to read some of Mr. Bockelman's writings on other ethical issues.

Trudy Rogness Jensen, Chair,
Minn. Interreligious Committee for Bio-Medical Ethics

9th Bio-Medical Ethics Workshop

To Save or Let Die: Dilemmas Concerning Defective Newborns

\+ THE GOAL OF THIS ISSUE Although this newsletter generally deals with ethical issues as they relate to economics and politics, the annual workshop of The Minnesota Interreligious Committee for Bio-Medical Ethics touches on a subject that is very much akin to the purpose of THE EYE OF THE NEEDLE. Last year's workshop was attended by 359 clergy, physicians, judges, attorneys, nurses, social workers, hospital and home administrators, and educators. The fact that this year's workshop, held March 23 at Beth El Synagogue, Minneapolis, was attended by more than 500 says something about the importance of the subject. The subject of this year's discussion was "To Save or Let Die: Dilemmas Concerning Defective Newborns." Two case studies, Baby Doe and Missy B, set the stage for the discussions.

\+ BABY DOE Baby Doe was born on April 1, 1982 in a Bloomington, Indiana, Hospital. She had Down Syndrome and an abnormal connection between the trachea and esophagus. The parents were presented with two treatment plans: Begin intravenous feeding and prepare for corrective surgery; or do nothing, withhold feedings, administer pain relief, and allow the child to die. The parents chose the latter. Concerned about possible criminal and/or civil liability, the hospital requested that a circuit court judge review the legality of the parents' decision. The judge ruled that there was no criminal liability, but he did appoint a guardian to assure a better guarantee of the infant's rights. The guardian and the country prosecutor requested that treatment be ordered. A couple asked to adopt the child and have the surgery done but the court denied the request. It ruled that the parents had not neglected the child but had simply chosen one of two alternative forms of treatment presented to them. Baby Doe died six days after birth.

\+ MISSY B Missy B was born with a spina bifida and a protruding spinal sac. The physician gave the parents full details of the severity of the condition, which already included incontinence of bladder and bowels, and club feet. He explained the necessary treatment, costs and prognoses, and urged immediate surgery to prevent further nerve damage. He also explained that if Missy B survived the operation she would never be able to walk without the aid of braces and crutches, that she would have to undergo extensive therapy all her life, and that she would have a 90 percent chance of developing hydrocephalus ("water on the brain"). The parents decided against surgery,

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but in the next few weeks became attached to the child and reversed their decision. Surgery was performed, and although it was successful, a low-grade hydrocephalus did develop when Missy B was four months old and a shunt was inserted to drain the fluid from the brain. At six months, Missy B was able to sit up with the aid of a special splint, and her personality was emerging, although it was too soon at that time to test her mental development. The parents seem to have adjusted well to Missy B and try to treat her as much like a normal child as possible. Did doctors and parents act in Missy B's best interest?

+ WHOSE BEST INTERESTS: THE CHILD'S OR PARENTS'?

There was general agreement among virtually all workshop speakers and panelists that the Baby Doe case had been handled badly. Present at the workshop were some parents with children who had Down Syndrome, and they lamented that the Doe parents--as many parents with Down Syndrome children--are seldom told the more positive side of the story. People with Down Syndrome can lead what for them is a quality life, these parents insist. They report that often at the birth of a Down Syndrome child, the difficulty facing the parents is painted in such severe terms that they are swayed into making a decision without fully hearing the alternatives. Most participants at the workshop insisted that the Doe parents were not given two alternatives. But when one person from the audience made the comment, "You all seem to say that the choice the Does made was an immoral one, but would any of you be willing to tell the Does that they are immoral people?" Panelist Dr. James H. Burtness, professor of ethics at Luther Northwestern Theological Seminary, replied, "No, I would not tell them that they are immoral. But I probably would have told them that I would have made a different moral choice than they made."

+ A LOT OF QUESTIONS AND FEW CERTAIN ANSWERS

There are questions galore not only for the parents and attending physicians involved but for society as a whole. Two of the major questions are, "Who has the responsibility for making decisions and who has authority to intervene when an improper decision is made?" It's the old problem of balancing individual rights and the rights of society, exacerbated even more in the case of infants because they are incapable of making their own decision. How long should one prolong futile therapy? Adults have the right to refuse extra-ordinary treatment; do children have the same right? Dr. Dana E. Johnson, co-director of the Neonatal Intensive Care Unit at the University of Minnesota Hospitals and coordinator of the Metropolitan Neonatal Ethics Committee, had this to say about society: "In the best of all possible worlds all handicapped persons could be taken care of, but how about the world as it is, in the context of a society that never fully integrates the handicapped?"

+ THE "SQUEAL RULE"

To add to the complexity, on the very day the workshop was being held, the U.S. government--as a consequence of the uproar that the Baby Doe case provoked--put into effect the required posting of this notice in all hospital wards where infants and children are cared for: "Discriminatory failure to feed and care for handicapped infants in this facility is prohibited by federal law. Any person having knowledge of a handicapped infant being discriminatorily denied food or customary medical care should immediately contact the Handicapped Infant Hotline, U.S. Department of Health and Human Services, Washington, D.C." That rule has since been struck down by the courts, but at the time of this writing, the goverment is seeking to have the court's ruling overturned. Dr. Edmund C. Burke,

(continued on page 5)

1983 Bio-Medical Ethics Workshop

sponsored by

The Minnesota Interreligious Committee for Bio-Medical Ethics

Welcome - The Rev. Willis J. Merriman, Executive Director, Minnesota Council of Churches

Program Introduction and Workshop Overview
Trudy Rogness Jensen, Chair, Minnesota Interreligious Committee for Bio-Medical Ethics

Introduction of Case Studies - Dana E. Johnson, M.D., Ph. D., Co-Director, Neonatal Intensive Care Unit, Univ. of Minn. Hospitals; Asst. Prof. of Pediatrics, Univ. of Minn. Medical School

Case Study 1, Baby Doe; Case Study 2, Missy B

PERSPECTIVE FROM MEDICAL PROFESSIONALS

Norman L. Vernig, M.D., Assoc. Chief of Pediatrics and Director, Neonatal Div., St. Paul Ramsey Perintal Center; Asst. Prof. of Pediatrics and Family Practice, Univ. of Minn. Medical school.

Edmund C. Burke, M.D., Prof. of Pediatrics Mayo Medical School; Consultant in Pediatricts and Nephrology, Mayo Clinic; Dist. Chr. American Academy of Pediatrics.

Janet Weis, R.N., B.S.N., Inst. and Asst. Head Nurse, NICU and Level II Nursery, Univ. of Minn. Hospitals.

PERSPECTIVES: LEGAL-JUDICIAL PROFESSIONALS

John Diehl, J.D., Legal Counsel, Univ. of Minn. Hospitals and Clinics.

Judge Doris Ohlsen Huspeni, J.D. Fourth Judicial District - Court Decisions

INTERROGATING PANEL

Moderator: James B. Nelson, Ph.D. Prof. of Christian Ethics, United Theological Seminar of the Twin Cities

Stephen J. Boros, M.D. Dir. Neonatology and Medical Director of Respiratory Therapy, St. Paul Children's Hospital; Assoc. Professor of Pediatrics, Univ. of Minn. Medical School

Frankie M. Paulson, Ph.D., Consulting and Clinical Psychologist, Minneapolis Children's Health Center

Father Thomas J. O'Donnell, S.J., Ph. L., S.T.B.; Dir. of Medical-Moral Education, St. Francis Hospital, Tulsa, Okla.

Richard A. Dietman, Member, Ethical Issues Com., Mpls. Children's Health Center, Editor of Minn. Public Radio; Parent of high Risk Newborn

DISCUSSION -- PANEL, PRESENTERS, AUDIENCE

INTERFAITH PERSPECTIVES

CATHOLIC: Father Thomas J. O'Donnell, S.J. Ph.L., S.T.B., Medical-Moral Consultant, Diocese of Tulsa

JEWISH: Rabbi Kassel Abelson, D.H.L. Beth El Synagogue, Co-Chair

PROTESTANT: James H. Burtness, Ph.D., Prof. of Systematic Theology and Ethics, Luther Northwestern Theological Seminary, St. Paul

INTERROGATING PANEL

Moderator: Richard H. Berquist, Ph.D. Assoc. Prof. of Philosophy, College of St. Thomas

Daniel P. Kohen, M.D., Assoc. Dir. of Medical Education, Mpls. Children's Health Center; Inst., Dept. of Pediatrics and Family Practice and Community Health, Univ. of Minn. Medical School

John E. Diehl, J.D., Legal Counsel, Univ. of Minn. Hospitals and Clinics.

Konald A. Prem, M.D.Prof. and Head, Dept. of Obstetrics and Gynecology, Univ. of Minn.

Patricia H. Klauck, M.H.A., Ex. Dir. Mpls. Children's Health Center

Patricia Crisham, R.N. Ph.D. Assoc. Prof. Grad. Prog., School of Nursing, Univ. of Minn.

Closing Remarks: Father Patrick J. Ryan, S.T.D. Chair, Com. of Ecumenism and Interreligious Affairs, Archdiocese of St. Paul and Mpls.

Bio-Medical Ethics: An Interdisciplinary and Interfaith Approach

by Trudy Rogness Jensen

During the 1968 Senate hearings on the establishment of a National Advisory Commission on Health Science and Society, Geneticist Arthur Kornberg, testified that in his judgment there were no new ethical or moral problems arising from the developments in his field.

In the years since 1968, medical technology has advanced rapidly with ever more opportunity for conflict and misreading attitudes in ethical discussion making. According to ethicist James Nelson of United Theological Seminary of the Twin Cities, a great deal has happened. He says, "More people are aware that there are indeed new ethical and moral problems arising in the various bio-medical fields. Furthermore, there is an increasing recognition that nonmedical people not only have a great stake in what happens in the laboratory, the hospital and the clinic, but they also have an obligation to be informed and to enter into the process of ethical reflection on these matters. For what is at issue is not simply technical medicine, but the human dimensions and qualities of that medicine."

The Minnesota Interreligious Committee for Bio-Medical Ethics originated in 1976 to speak to that obligation. The committee includes numerous disciplines, profesions, faiths and groups. Under the advisorship of H. Mead Cavert, M.D., Associate Dean of the University of Minnesota Medical School, the committee's thesis was formed. No one discipline, faith, profession or group can or should attempt to give final isolated answers to the many profound human, ethical and social questions posed by current advances in biology and medicine.

Committee members represent ecumenical and interreligious councils of the Protestant, Jewish and Catholic communities of the state. Ethicists, physicians, clergy, lawyers, judges, nurses and social workers work together in programing. Continuing education accreditation is granted by these professions. The laity is also invited.

Annual workshops have dealt with such topics as "Death, Dying and the Termination of Care," "Allocation of Scarce Medical Resources," "Human Experimentation and Informed Consent," "Genetics and Ethics," "Artificial Insemination and In Vitro Fertilization: Interfaith Perspectives," "Intending Death: Where Faiths Agree and Why They Differ," and "Hospital Bio-Medical Ethics Committees: Philosophy and Practice."

For information about the 1984 Bio-Medical Ethics Workshop, contact: Trudy Rogness Jensen, Chairperson, 4420 Philbrook Lane, Minneapolis, MN 55424 or call (612)922-3537

MEMBERS OF THE MINNESOTA INTERRELIGIOUS COMMITTEE FOR BIO-MEDICAL ETHICS

Trudy Rogness Jensen, chair
Rabbi Kassel Abelson, Co-Chair
Sister Agnes Ward, Co-Chair and Registrar
Richard H. Berquist, Ph.D., Prof. of Philosophy, College of St. Thomas
Ronald E. Cranford, M.D. Assoc. Physician in Neurology, Hennepin Medical Center
Rev. Willis J. Merriman, Executive Director, Minnesota Council of Churches
James Nelson, Ph.D., Prof. of Christian Ethics, United Theological Seminary
Konald A. Prem, M.D. Prof. and Head, Dept. of Obstetrics and Gynecology, Univ. of Minn. Medical School
Father Patrick Ryan, Chair, Archdiocesan Commission on Ecumenics and Interreligious Affairs
Paul O. Sand, Regional Director, National Conference of Christians and Jews
Samuel Schwartz, M.D., Research Professor, Dept. of Medicine, Univ. of Minn. Medical School

ADVISORY COMMITTEE

Minn. Supreme Court Justice Rosalie E. Wahl
Judge Patrick Fitzgerald
Judge Robert Levy
John Kenefick, J.D., Briggs and Morgan
Stephen B. Swartz, J.D. Legal Counsel, Mt. Sinai Hospital
Howard J. Vogel, J.D. Prof., Hamline Univ.
James H. Burtness, Ph.D. Prof. of Ethics Luther Northwestern Theo. Seminary
Patricia Crisham, Ph.D., R.N., Prof. Grad. School of Nursing, Univ. of Minn.
Shirley Zimmerman, Ph.D., A.C.S.W, Assoc. Dir. Cont. Ed. for Social Workers, U. of Minn.
Stuart V. Thorson, M.D. President, Minnesota Academy of Family Physicians

(continued from page 3) pediatrics professor at Mayo Medical School, denounced the regulation--referred to as the "squeal rule"-- as government intrusion into medicine. Pediatricians consider themselves advocates for children, are dedicated to saving lives of infants and children and object to anonymous telephone reporting and to encouraging a type of "government cop" in complicated medical problems, Dr. Burke said.

\+ THE RELIGIOUS FACTOR One of the strengths of the Minnesota Interreligious Committee on Bio-Medical Ethics is the fact that it is inter-disciplinary. It brings together specialists in the fields of medicine, law, and theology to view the various aspects of the issue. In the area of theology, representatives from the Protestant, Catholic and Jewish faiths each address the problem. Giving the Jewish view of the situation was Rabbi Kassel Abelson: "The basic principle from which all else flows is the assumption that life is good. However, while life is good, it is not absolute good. Life is only the condition by which other goods and values can be achieved....The meaning and substance of life is to be found in human relationships in the qualities of justice and compassion, respect and concern that climax in the love of neighbor." Father Thomas J. O'Donnell, director of Medical-Moral Education at St. Francis Hospital, Tulsa, Okla., gave the Catholic view. He said that American culture is losing the element of transcendence. Therapy should not be continued in questionable cases, he said, unless the burden is not worth the effort for what it is going to accomplish. He said "quality of life is a dangerous term, unless a distinction is made between operational quality of life and essential quality of life. Simply because it is human life, it has a quality."

\+ ASSIST IN THE STRUGGLE Anyone who came to the workshop in search of easy answers went away disappointed. And there were those who were disappointed. The comment often overheard was, "But they still aren't giving us any answers." In presenting the Protestant view, Dr. Burtness said that human life must never be absolutized. "The finite must never be treated as though it is infinite," he said. "There is an essential corporateness in life. Problems belong in the hands of believers. This means that not all decisions must be made by one person. We need to struggle together to find answers. Our help comes from others who assist us in the struggle." Mistakes will indeed be made at times. That's because we are finite. The best assurance for having found a satisfactory answer may be that it was arrived at through consultation with others, with doctors, with clergy, with members of the family. The difficulty of coming with answers, particularly easy answers, was well understood by the planners of the workshop. That's undoubtedly why they described their purpose as an interdisciplinary and interfaith discussion of moral choices, and listed these threefold objectives: To share the importance of interdisciplinary and interfaith approaches to bio-medical ethics....To become better informed about one another's faith stance in moral decisions regarding defective newborns....To clarify and discuss issues in the care of the newborn with birth defects and the resultant practical implications. As far as is known, this annual workshop is the only one of its kind in the country that puts such emphasis on interdisciplinary as well as interfaith cooperation. The roster of participants includes some of the highest ranking people in their profession. All give their time gratis. Attendance at the workshop is recognized for continuing education accreditation for physicians, clergy, lawyers, judges, social workers, and nurses. The workshop received excellent coverage in the media--radio, television, and national press.

+ ANNOUNCEMENTS FROM THE CHAIRPERSONS: It is with deep appreciation that we make these acknowledgments:

+ To the National Conference of Christians and Jews for its support in providing partial funding for the workshop.

+ To the Minnesota Council of Churches for scholarship aid.

+ To the Minnesota Interreligious Committee for Bio-Medical Ethics and its Advisory Committee for their dedicated participation.

+ To the Continuing Education directors in the granting of accreditation to physicians, clergy, lawyers, judges, social workers, and nurses.

+ To our speakers, presenters, panelists, and moderators (see page 3), who shared their expertise gratis.

+ To Neil Newman, Cantor of Beth El Synagogue for providing Jewish Folk Music.

+ To Beth El Synagogue, Rabbi Kassel Abelson, Phyllis Harris and the Women of the Synagogue.

+ To the Bibliography Committee for an outstanding piece of work. (Dr. Richard H. Berquist, Dr. Samuel Schwartz, Dr. Walter W. Benjamin, Dr. Ronald E. Cranford, Paul O. Sand, Dr. Mila Ann Aroskor, and Prof. M. Kathleen Price.)

+ To Wilfred Bockelman for reporting proceedings in THE EYE OF THE NEEDLE

Tapes of the workshop presentations are available from the National Conference of Christians and Jews, Paul O. Sand, Executive Director. 63 South First St., Minneapolis, MN 55401. Telephone: (612) 333-5365

A selected annotated Bibliography in Bio-Medical Ethics, "To Save or Let Die: Dilemmas Concerning Defective Newborns" is available for $3.00. Send requests to Trudy Rogness Jensen, 4420 Philbrook Lane, Minneapolis, MN 55424, or call 922-3537

THE MINNESOTA INTERRELIGIOUS
COMMITTEE FOR BIO-MEDICAL ETHICS
MINNESOTA COUNCIL OF CHURCHES
122 West Franklin Avenue
Minneapolis, Minnesota 55404

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Bio-Medical Ethics
Workshop

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MINNEAPOLIS MN 55416

THE MINNESOTA INTERRELIGIOUS
COMMITTEE FOR BIO-MEDICAL ETHICS
MINNESOTA COUNCIL OF CHURCHES
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Bio-Medical Ethics Workshop

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Continuing Education Bio-Medical Ethics Workshop

presented by

The Minnesota Interreligious Committee for Bio-Medical Ethics

Registration 8:30 - 9:00 a.m.
Wednesday, March 5, 1980
Fairview-Southdale Hospital
6401 France Avenue South
Minneapolis, Minnesota 55435
Trudy Rogness Jensen, Chairperson (922-3537)

1. Physicians:
   As an organization accredited for CME, the University of Minnesota certifies that this Continuing Education Activity meets the criteria for 8 credit hours in Category I of the physician's recognition award of the AMA. Physicians may also claim 8 hours of elective credit, AAFP.
   —University of Minnesota Medical School, Office of Continuing Education, Dr. Douglas Fenderson, Director (373-8012)
2. Clergy:
   —United Theological Seminary of the Twin Cities grants (.8 CEU) Continuing Education Unit to clergy (633-4311)
   —Approved: Luther-Northwestern Theological Seminaries Continuation Studies Office (641-3203)
   —Approved: Continuing Education for Priests Father Robert Schwartz, Director (646-4720)
3. Nurses:
   This seminar is designed to meet the requirements of Continuing Education Units as established by the Minnesota Nurse Practice Act. Upon completion, certificates for 7 contact hours (.7 CEU) will be awarded by
   —The Department of Nursing Education Abbott-Northwestern Hospital Corporation Yvonne Gorecki, R.N., M.P.H., Director (874-4307)
4. Social Workers:
   This seminar qualifies for (.8 CEU) Continuing Education Unit for social workers.
   —Department of Social Work, College of St. Catherine and St. Thomas.
   Judith A. Miller, A.C.S.W., Chairperson

The Minnesota Interreligious Committee for Bio-Medical Ethics

presents

Bio-Medical Ethics Workshop

Wednesday, March 5, 1980, 8:30 a.m. - 4:30 p.m.
Fairview-Southdale Hospital
6401 France Avenue South
Minneapolis, Minnesota

Hospital Bio-Medical Ethics Committees: Philosophy and Practice

- **to share the importance of interdisciplinary and interfaith approaches to bio-medical ethics**
- **to explore varied philosophies of hospital bio-medical ethics committees**
- **to examine actual and potential functions of such committees, such as: education, formulation of guidelines for ethics-related issues in the hospital setting, and consultations on specific cases.**

The Minnesota Interreligious Committee for Bio-Medical Ethics

***Trudy Rogness Jensen, Chairperson**
***Rabbi Kassel Abelson and *Sister Agnes Ward, Co-Chairpersons**
Dr. Richard H. Berquist, Ronald E. Cranford, M.D., Rabbi Arnold M. Goodman, *Rev. Monroe Bell, Dr. James B. Nelson, Konald A. Prem, M.D., *Father Patrick J. Ryan, *Paul O. Sand, Samuel Schwartz, M.D.

***Executive Committee, Minnesota Church Center, 122 West Franklin, Minneapolis, Minnesota 55404.**

funded by
The National Conference of Christians and Jews

Bio-Medical Ethics: Workshop

The International Room
Lower Level
Fairview-Southdale Hospital

8:30 Registration
Registrar - Sister Agnes Ward, Co-Chairperson
Coffee and rolls

9:00 **Welcomes:**
—The Rev. Monroe Bell, Interim Executive Director, Minnesota Council of Churches
—Mr. Kirby J. Erickson, Administrator Fairview-Southdale Hospital
—Introductory Remarks - Father Patrick J. Ryan, Chairman, Commission for Ecumenism and Interreligious Affairs, Archdiocese of St. Paul and Minneapolis

Program Introduction —
Trudy Rogness Jensen, Chairperson
Minnesota Interreligious Committee for Bio-Medical Ethics

9:15 **BIO-MEDICAL ETHICS COMMITTEES: AN OVERVIEW**
Ronald E. Cranford, M.D.
Associate Physician in Neurology
Hennepin County Medical Center

10:10 Discussion — Commentator-Moderator
Mr. John Kenefick, Attorney
Briggs and Morgan, St. Paul

10:30 Coffee

BIO-MEDICAL ETHICS COMMITTEES: THE EXPERIENCES OF THREE HOSPITALS

10:45 **Mt. Sinai Hospital** — Arnold P. Kaplan M.D.
Care and Crisis Committee

11:00 **University of Minnesota Hospitals** —
Yang Wang, M.D., Professor of Medicine
Chairman, Thanatology Committee

11:15 **Hennepin County Medical Center** —
Ronald E. Cranford, M.D.
Chairman, Bio-Medical Ethics Committee

11:30 Audience Response — Rabbi Kassel Abelson
Commentator-Moderator

11:50 Presentation of Bibliography and Resource Personnel in Bio-Medical Ethics in Minnesota —
Paul O. Sand, Regional Director, National Conference of Christians and Jews

12:00 Noon Luncheon - Disciplinary Groups

12:15 **Luncheon Discussions in International Room**
Moderators:
1. Physicians
—Konald A. Prem, M.D., Professor and Head, Department of Obstetrics and Gynecology, University of Minnesota Medical School and Hospitals
—Samuel Schwartz, M.D., Research Professor, Department of Medicine, University of Minnesota
2. Lawyers
—Joseph Hamilton, Past President Minnesota Society of Hospital Attorneys
3. Clergy
—Chaplain Russell E. Comnick, Director of Pastoral Care, Fairview-Southdale Hospital
4. Hospital Administrators
—Mr. Stephen Rogness, President Minnesota Hospital Association
5. Social Workers
—Judith A. Miller, A.C.S.W., Chairperson Department of Social Work Colleges of St. Catherine and St. Thomas
6. Nurses
—Yvonne Gorecki, R.N., M.P.H., Director of Nursing Education, Abbott-Northwestern Hospital Corporation

BIO-MEDICAL ETHICS COMMITTEES: THE INTERDISCIPLINARY CONTRIBUTION

1:15 Stephen B. Swartz, Legal Counsel, Mt. Sinai Hospital, Attorney, Maslon, Kaplan, Edelman, Borman, Brand and McNulty

1:30 Paul A. Goldstein, M.S.W.
Senior Clinical Social Worker
Hennepin County Medical Center

1:45 Patricia Crisham, Ph.D., R.N.
Assistant Professor of Nursing
University of Minnesota Graduate School of Nursing

2:00 Richard Berquist, Ph.D.
Associate Professor of Philosophy
College of St. Thomas

2:15 Discussion
Commentator-Moderator
Chaplain Arne K. Jessen, Director, Clinical Chaplaincy Department, St. Luke's Hospital, Duluth

2:30 Coffee - International Room

FUNCTIONS OF HOSPITAL BIO-MEDICAL ETHICS COMMITTEES

2:45 **Education**

Presentors

—Allen E. Buchanan, Ph.D. Associate Professor of Philosophy, University of Minnesota

—Daniel J. McInerney, Jr. Attorney, Minnesota Department of Health

3:15 **Guidelines**

Presentors

—Cecil C. Schmidt, Attorney Merchant, Gould, Smith, Edell, Welter and Schmidt

—Robert F. Donley, M.D. Neurosurgeon Duluth Clinic

3:45 **Consultation**

Presentors

—James B. Nelson, Ph.D. Professor of Christian Ethics, United Theological Seminary

—Ronald E. Cranford, M.D. Associate Physician in Neurology, Hennepin County Medical Center

4:15 **Summary** — Rev. James B. Nelson, Chairman Bibliography Committee

4:30 Closing Remarks — Rabbi Kassel Abelson, Co-Chairperson

We acknowledge with sincere gratitude the expertise of our speakers, presentors, commentators and moderators shared with us, gratis.

Bio-Medical Ethics Workshop

REGISTRATION FORM

Bio-Medical Ethics Workshop
Wednesday, March 5, 8:30 a.m. - 4:30 p.m.
Fairview-Southdale Hospital
6401 France Avenue South, Minneapolis, MN 55435

Enclosed is a check for $10.00 for the registration fee (includes coffee and rolls, noon luncheon, workshop, a post-seminar summary, and continuing education accreditation.)

Name ______________________

Profession ______________ Position ______________

Address ______________________

City ________ State ________ Zip Code ________ Phone ________

Please make check payable to: The Minnesota Interreligious Committee for Bio-Medical Ethics. Mail to: Trudy Rogness Jensen, Chairperson, 4420 Philbrook Lane, Minneapolis, MN 55424. Limited registration. Registration must be PREPAID. Refunds only for cancellation by 2-20-80.

Area parking.

The Bio-Medical Ethics Newsletter

The Minnesota Interreligious Committee for Bio-Medical Ethics

*Trudy Rogness Jensen, Chairperson (922-3537)
*Rabbi Kassel Abelson and *Sister Agnes Ward,
Co-Chairpersons
Dr. Richard H. Berquist, Ronald E. Cranford, M.D.,
Rabbi Arnold M. Goodman, *Rev. Albert C. Lehman,
Dr. James B. Nelson, Konald A. Prem, M.D., *Father
Patrick J. Ryan, *Paul O. Sand, Samuel Schwartz, M.D.

*Executive Committee

Minnesota Church Center, 122
West Franklin, Minneapolis, Minnesota 55404

Funded By

The National Conference of Christians and Jews
542 Syndicate Building
Minneapolis, Minnesota 55402
336-5365

Bio-Medical Ethics Workshop

Wednesday, March 21, 1979, 8:30 a.m.-4:30 p.m.
Minnesota Church Center
122 West Franklin Avenue
Minneapolis, Minnesota

Bio-Medical Ethics: An Interreligious and Interdisciplinary Dialogue

- to explore our interfaith and interdisciplinary concerns in bio-medical ethics
- to discuss bio-medical ethics as a discipline and its recurring themes
- to demonstrate the case-based approach to medical ethics
- to bring together persons of all disciplines and faiths with a commitment and involvement in bio-medical ethics to share perspectives and resources.

News Summary by Trudy Rogness Jensen, Chairperson

PROGRAM — The 1979 Bio-Medical Ethics Workshop was considered a unique success in bringing together persons of numerous professions, groups and disciplines of the Jewish, Catholic and Protestant communities, with an interest and involvement in bio-medical ethics. The focus was on:

BIO-MEDICAL ETHICS AS A DISCIPLINE AND ITS RECURRING THEMES; AND THE CASE-BASED APPROACH TO MEDICAL ETHICS

PARTICIPANTS — 110 invited participants representing the entire State of Minnesota registered with 22 physicians, 25 clergy, 14 lawyers, 5 hospital administrators, 7 professors of philosophy, 14 nurses, 4 biology professors, 7 social workers, and 12 professors and representatives of boards and organizations participating.

CONTINUING EDUCATION — Continuing education accreditation was offered to physicians through the University of Minnesota Medical School Continuing Medical Education; to nurses, through the Department of Nursing at Abbott-Northwestern Hospitals; to clergy, through United Theological Seminary of the Twin Cities and approved by Luther-Northwestern Seminaries and Continuing Education for Priests. Recommended for study: The 100 cases with commentary in "Cases in Medical Ethics" by Dr. Robert Veatch, Hastings Institute.

BIBLIOGRAPHY — Available upon request at $1.00 per copy (call 922-3537 or write to Trudy Jensen, 4420 Philbrook Lane, Mpls., MN 55424) "Selected Bibliography in Bio-Medical Ethics": a current, annotated bibliography of 100 works edited by Dr. James B. Nelson of United Theological Seminary, Dr. Richard Berquist of The College of St. Thomas and Rabbi Arnold Goodman of Adath Jeshurun Synagogue.

PRESENTATIONS — BIO MEDICAL ETHICS AS A DISCIPLINE AND ITS RECURRING THEMES

"Basic Models for Decision-Making"

Dr. James H. Burtness, Professor of Ethics
Luther-Northwestern Seminaries

Summary by
Dr. James B. Nelson

"Basic Models for Decision-Making" was the title of the presentation by Dr. James H. Burtness, Professor of Systematic Theology and Ethics at Luther-Northwestern Theological Seminaries. Dr. Burtness outlined three basic models: deontology, situationism, and teleology.

Deontology is an obedience-centered method which emphasizes the intrinsic right-making features of moral actions, independent of thier consequences. Following Immanuel Kant, the deontologist stresses the universalizability of the principles of action, the importance of behavioral rules, and the centrality of the will. In bio-medical issues deontologists typically defend the sanctity of life principle.

Situationism, according to Burtness, is highly existential and feeling oriented. Following Soren Kierkegaard, the situationist emphasizes the radical particularity or uniqueness of each decisional situation, asking the question of appropriateness or fittingness of each action to the situation. Religiously, the situationist seeks freshly the will of God in each event, often relying for clues to that will upon parables and stories which depict understandings of divine activity. In medical situations, patients' needs are frequently a focus.

The third method, with which Burtness identified himself most closely, is teleology. A method centering upon goals and visions of the good, it takes its clue philosophically from Aristotle and the Utilitarians. Relying heavily upon reason in the moral decision, the teleologist seeks to maximize the good in each situation - either through direct reference to the final telos or end, or by following these rules which reasonably promise the greatest utility in producing movement toward the desired end. If the religious deontologist seeks God's will through commandments, the teleologist finds God's will in some final vision of the ultimate good. In medical situations, this frequently means an emphasis upon the principle of the quality of life rather than the sanctity of life.

Each of the three methods, Burtness noted, is not without its characteristic problems and weaknesses. But clarity about the method upon which one is principally relying, he argued, can bring clarity to bio-medical decision-making.

"Fundamental Issues in Death and Dying"

Dr. Richard H. Berquist, Professor of Philosophy,
St. Thomas College

Summary by Paul O. Sand

Dr. Richard Berquist, Professor of Philosophy at St. Thomas College in St. Paul spoke on the "Fundamental Issues in Death and Dying." In his address, Dr. Berquist distinguished various positions on the ethical questions involved in abortion, infanticide and euthanasia. Each position, he noted, differ by the way they approach the traditional moral law: Do not kill innocent human beings. The two basic positions analyzed were: the Utilitarian positions, and the Deontological positions. He noted that these ethical orientations do not lead to legal solutions nor do they dictate what law is.

According to Dr. Berquist, the Utilitarian position holds that it is not wrong in principle to kill an innocent human being. In making a moral evaluation, however, the Utilitarian must consider the consequences of killing vs. not killing of others besides the person being killed. The decision should be based on the principle of the greatest good for the greatest number. There is also a cautious Utilitarian position which focuses on the so-called wedge argument-that being-once the idea of killing innocent human beings becomes acceptable, it will spread beyond desirable limits. This argument would necessitate an analysis of each step of the argument in terms of casual relationships. For example, will step A actually cause step B given what we know about social change? And is not step B often the result of multiple casual factors, making the role of A highly ambiguous? Dr. Berquist also noted that within the Utilitarian position there is what is called the Radical Utilitarian position which views human nature and human perfectibility in optimistic terms. This radical position wants ethical rules to be more flexible and focuses primarily on immediate consequences. Killing for merciful reasons, they feel, will not likely lead to other kinds of killings. Abortion on demand also appears safe. However, this position is cautious about involuntary euthanasia, since here the dangers of undesirable consequences are more apparent.

Dr. Berquist then critically probed the second ethical position of Deontology. Essentially Deontologists hold that killing an innocent human being for the greatest good of the greatest number is wrong in principle. In their view, each individual is independently valuable, and therefore all attempts to promote the common good must be consistent with respect for the inviolable and inalienable individual rights. Within the Deontological position, there is also the individualistic position which begins with the principle of individual dignity coupled with the idea of self-ownership. For the individualists, the main question is not what is decided but **who** decides. They are disposed to favor abortion on the grounds of the right-to-privacy, so long as they are convinced of the non-personhood of the fetus. And lastly, there is the non-individualistic Deontological position which adheres to the principle of human dignity: that each individual is naturally ordained to his own good and to the common good. In addition they feel killing an innocent person is inconsistent with his or her objective value and hence is wrong in principle. They do not accept either active or passive euthanasia or infanticide. However, they generally allow the withholding of excessively burdensome life sustaining measures (extraordinary means) on the ground that our obligations to help others are not unlimited. On abortion, they tend to feel that any doubts on the personhood of the fetus should be resolved in favor of the fetus.

"Rights and Responsibilities"

Rabbi Kassel E. Abelson, Co-Chairperson
Beth El Synagogue

Summary by
Sister Agnes Ward C.S.J.

Rabbi Kassel Abelson, Beth El Synagogue, and Co-Chairperson of the Minnesota Interreligious Committee for Bio-Medical Ethics, spoke on the "Rights and Responsibilities" of the patient and the doctor. Rabbi Abelson began by noting that physical health cannot be separated from spiritual and social health. Health is a relational term in that the doctor is viewed as the **I** to the patient's **Thou.** I and Thou relationship, he noted, must never become an I and It relationship where the patient is treated merely as an object. The Thou (patient) must have his or her dignity preserved and the right to make his or her own decision concerning treatment and care.

Concerning the problem of whether or not the doctor should tell his patients the truth about a serious illness such as cancer, Rabbi Abelson pointed out that the patient does have a right-to-know. However, he cautioned, how much to tell and when to tell it must be seriously considered; for a sudden disclosure of terminal illness could hurt another member of the family. Hence, the decision must be weighed carefully concerning the consequences, and must use language in such a manner that the patient responds with some hope.

Concerning the right of the patient to participate in treatment decisions, Rabbi Abelson noted, that this right does not release the doctor from the responsibility of presenting choices to the patient. For the doctor has the responsibility of emphasizing life-affirming decisions. Also, he noted, that the state has the responsibility to save a patient's life when refusal of treatment (blood transfusions) could lead to an unnecessary death.

Rabbi Abelson also examined the right-to-die with dignity issue. He noted that today's medical technology could keep an individual biologically alive indefinitely in time and space. He also pointed out that the right-to-die with dignity principle could ultimately lead to the right-to-suicide.

In conclusion, Rabbi Abelson noted that when examining the rights and the responsibilities of the doctor and the patient, it is very important to move from personal objectivity to personal involvement in answering these complex problems. During the discussion moderated by Dr. Walter Benjamin, following his presentation, Rabbi Abelson added that it is the responsibility of the doctor to challenge the opinion of the patient who has rejected the life-affirming ethic and opted for death. This problem arises where the doctor and the patient have different schools of thought concerning life-ethics. He noted that it was also very important that the patient, family, and the doctor all be involved in the discussions concerning treatment and care. One question was raised concerning the use of placebos, and whether or not this was a breakdown between the I and Thou relationship. Also the question was raised whether or not it was good to always tell the patient the truth.

CASE STUDY METHOD IN BIO-MEDICAL ETHICS

Presentation of Clinical Summary

Ronald E. Cranford, M.D.

Associate Professor of Neurology, University of Minnesota
Associate Physician in Neurology and Director, Neurological Intensive Care Unit,
Hennepin County Medical Center

Evaluation of Clinical Summary and Case-based Approach to Medical Ethics

Dr. James B. Nelson, Professor of Ethics,
United Theological Seminary of the Twin Cities

Summary by
Dr. Richard Berquist

The afternoon session began with the presentation by Dr. Ronald Cranford of a serious ethical dilemma which confronted the staff at Hennepin County Medical Center. It concerned a forty-year old woman, essentially bedridden and quadriplegic from age twenty, who was hospitalized for respiratory insufficiency. She required a tracheotomy and respiratory support soon after admission. Attempts over a two-month period to wean her from the respirator were unsuccessful and the neurology service concluded that, because of her progressive neurological disease (syringomelia), she would never again be able to support herself without the respirator. After having been so informed, the woman requested that the use of the apparatus to be discontinued and that she be allowed to die. Various factual aspects of this case were brought out in a lively question and answer session with Dr. Cranford.

Workshop participants considered the case in small interdisciplinary groups moderated by Konald A. Prem, M.D., Samuel Schwartz, M.D., Rabbi Arnold M. Goodman and Attorney, Daniel McInerney. They then reassembled in a general session with Dr. James B. Nelson as moderator. Each group presented a brief summary of its discussions. The most serious question brought out in these summaries was whether the woman wished to commit suicide or whether she merely wished to avoid the burdens imposed by the medical treatment necessary to keep her alive. After these reports, Dr. Nelson gave the participants an opportunity to express their individual opinions on what the medical staff should have done. No consensus emerged, although a majority favored discontinuing the use of the respirator. Dr. Cranford stated that this is, in fact, what was decided and that the woman died a short time later.

Dr. Nelson explained some of the advantages (and disadvantages) of the case study methods in bio-medical ethics which he and Dr. Cranford have been using successfully for some time. The session concluded with a general discussion of activities in various parts of the state related to the concerns of bio-medical ethics.

CURRENT COMMITTEES AND ACTIVITIES IN THE STATE —

1. In addition to the state and county medical and legal committees, the interdisciplinary committees at work in their areas are:
- Committee on Medicine and Religious, Zumbro Valley Medical Society
- North Memorial Hospital Thanatology Committee
- Mt. Sinai Hospital Committee on Death and Dying
- Ad Hoc Committee on Resuscitation of Patients, St. Paul Ramsey Hospitals
- Hennepin County Medical Center Thanatology Committee
- Children's Health Center Ethics Committee
- University of Minnesota Hospital Thanatology Committee

(To our readers: Please inform us if you know of committees to be added to this list.)

2. Courses and Conferences
- University of Minnesota Medical School Medical Ethics Course
- Mayo Medical School: Medical Ethics Course
- Minnesota Interreligious Committee for Bio-Medical Ethics: Resource Center; Resource Personnel Listings; Consulting Services; Bibliographies; Workshops; Conferences
- Conferences in individual hospitals, colleges, churches and synagogues
- Duluth: Monthly panels on bio-medical ethics issues

EVALUATION FOR OUR FUTURE WORK — As a result of the decision of the Massachusetts Supreme Judicial Court re: The Joseph Saikewicz Case, there has been a great deal of confusion. "Time has come," Dr. Cranford stated "to approach these problems by an interdisciplinary approach. We should help hospitals set up ethics committees and formulate ethical guidelines by interfaith and interdisciplinary cooperation. Models and guidelines are needed."

NEEDS:

- Formulation of Ethics Committees
- Ethical guidelines for decision-making for hospitals from an interdisciplinary approach
- Workshops to deal with ethical guidelines and priorities in decisions
- Consultants from theology, humanities and social sciences in hospitals and medical centers
- Educational ventures toward relieving concerns of consumer of medical care

THE MINNESOTA INTERRELIGIOUS COMMITTEE FOR BIO-MEDICAL ETHICS WAS URGED TO:

- to give help in forming ethics committees for hospitals
- to act in an informative, consultative role in an interfaith and interdisciplinary capacity
- to further evaluate rights and needs of patient, family, physicians, hospital staff, and society toward priorities of each and their relationships, as in The Quinlan Case (who decides?).
- to give help in formulating ethical guidelines by interfaith and interdisciplinary exchange

1980
TO BE PUBLICLY ANNOUNCED: SEMINARS TO PROVIDE GUIDANCE AND ASSISTANCE IN FORMING HOSPITAL ETHICS COMMITTEES

Hospital Ethics Committee speak to a broader scale of ethical and legal dilemmas within medical practice. They are not limited to the concern of death and dying as are the Thanatology Committees. Included seminar topics: Decision-making process, and ethical guidelines e.g. Brain Death and DNR Guidelines written by The Ad Hoc Committee on Death, Minnesota Medical Association, Ronald E. Cranford, M.D., Chr.

Ethics committees can become catalysts bringing different faiths and disciplines together. The Minnesota Interreligious Committee for Bio-Medical Ethics becomes a clearing house for what is occurring on the interdisciplinary scene with responsibility toward building ethical guidelines and setting up channels of information.

We are at work to serve you. Send your requests, suggestions and all new information to:

Trudy Rogness Jensen, Chairperson
Minnesota Interreligious Committee for Bio-Medical Ethics
4420 Philbrook Lane
Minneapolis, Minnesota 55424 (612-922-3537)

MINNESOTA COUNCIL OF CHURCHES
THE MINNESOTA INTERRELIGIOUS COMMITTEE FOR BIO-MEDICAL ETHICS
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BIO-MEDICAL ETHICS NEWSLETTER

INSTITUTE OF
SOCIETY, ETHICS AND
THE LIFE
SCIENCES

THE HASTINGS CENTER

Back in the late 60s "the biological revolution" seemed more science fiction than reality. It was true that heart transplants were being attempted, and also true that a handful of scientists were learning how to control behavior by direct electrical impulses to the brain. But science was nowhere near what came to be called "genetic engineering," and the art of prenatal diagnosis was still in its infancy.

Yet the biological revolution had begun, and in 1969, The Hastings Center, Institute of Society, Ethics and the Life Sciences, was founded to meet its challenges in a scholarly and systematic way. The organizers were convinced that the central problems posed by rapid advances in the biological, medical, and behavioral sciences are ethical. They were also convinced that it is possible to make progress on disputed ethical issues, that insight, reason and careful inquiry are still the most valid means of confronting even the newest and most vexing moral dilemmas.

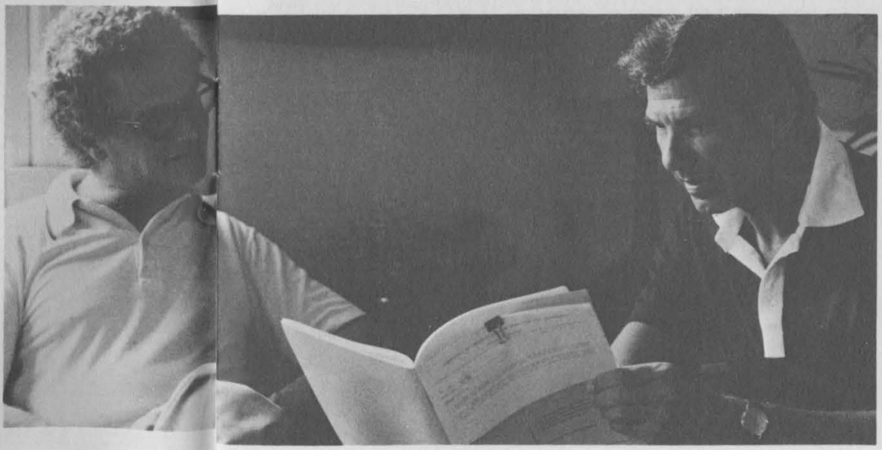
The organizers of The Hastings Center were also convinced of something else. The ethical problems of modern technology require for their solution an unprecedented interdisciplinary effort and a fresh attempt to reunite the sciences and humanities. Whether the issue is the termination of treatment on a dying patient, or psychosurgery, it transcends the skills and methodologies of any one discipline: law, science, medicine, philosophy, history, and the social sciences must all come into play. No less importantly, while biology, medicine, and the behavioral sciences may generate the problems, they soon cease to be scientific problems alone—they raise fundamental normative issues, thus demanding a place for the humanities and concerted attention to the professions and public policy.

The Hastings Center has three goals:

- *First,* to make a sober and nonpartisan contribution toward a solution of the ethical problems of biology, medicine, and the behavioral sciences.
- *Second,* to assist universities and professional schools in the development of courses and programs designed to introduce ethics in a serious way into the curriculum.
- *Third,* when requested, to assist legislators, administrators, and public officials in coping with normative issues of public policy, law, and decision making.

This work is carried out by a staff of 25, by 111 elected non-resident Fellows, and by invited researchers and consultants. Most of the research is done by standing interdisciplinary groups of 12 to 15 people, who work together, often for a period of years, and draw upon their varied disciplines, experience, and perspectives. Twenty or so conferences a year are held at The Hastings Center, which is located in Hastings-on-Hudson, New York, about 20 miles north of New York City. The Center does not take official positions on the issues it deals with and works hard to bring a wide range of viewpoints to bear on its work.

The budget of The Hastings Center is slightly over $1 million a year, with a third of that amount coming from its membership program, assorted service projects, and individual contributions from the "Friends of The Center" program. The remainder of its income comes from grants from private foundations and the federal government and from corporate support.



Daniel Callahan (left), director, and Willard Gaylin, president of The Hastings Center

Ten Years of Inquiry and Service

In the ten years since its foundation, the Center has seen a dramatic increase in public and professional awareness of ethical issues. It was hardly the case, a decade ago, that problems of morality were being neglected. But it was surely the case that the concern was limited to a comparatively few interested philosophers, scientists, legal scholars and others. Since then, however, moral dilemmas have become too obvious and important to escape the public eye. Whether in the fields of biomedicine, law, journalism or government, common pressures have become manifest—individual good versus common good, rights and duties, justice, and the ethics of professionals.

The Hastings Center has tried to anticipate the problems when possible, to respond quickly to those already present, and to serve individuals, universities and professional schools, legislators and policy-making bodies.

In the field of education, the Center has been a major stimulus in the development of courses in ethics at the undergraduate and professional school level. Its bibliographies and reading packets have served hundreds of teachers and thousands of students. Over 900 educators and others have passed through its intensive summer workshops.

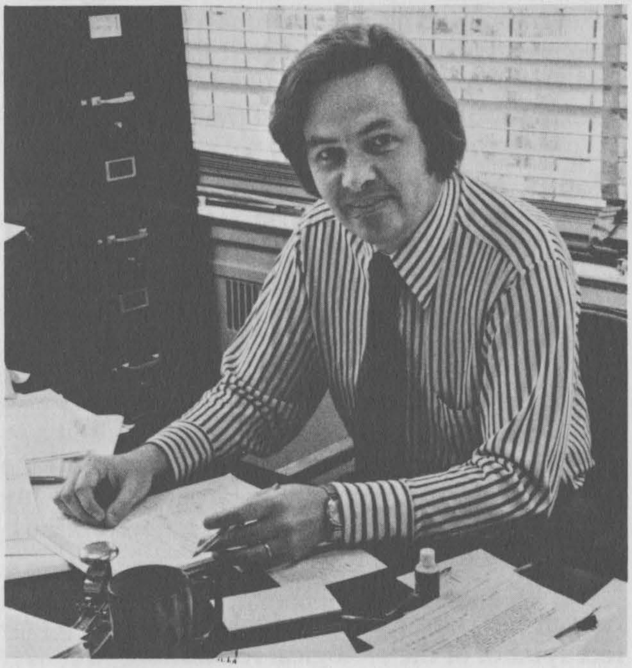
In the area of public policy, the Center has considered questions of cost-containment, the ethics of allocating scarce medical resources, the relationship of expert and lay views in biomedical research policy, the economics of care for the chronically ill and the terminally ill, and the relationship between law and morality. Its staff members and elected Fellows have testified on numerous occasions before state and federal legislatures. A model bill on the definition of death developed by one of its research groups has been adopted in eight states, and its guidelines on mass genetic screening have been widely influential in medical practice.

Over 90 students, including undergraduates and graduate students in fields such as medicine and law, have spent time in intensive study at the Center. Seventeen post-doctoral fellows have spent a year each at the Center, drawn from a wide variety of fields.

In addition to articles that have appeared in *The Hastings Center Report,* articles by its staff and Fellows have appeared in the *New England Journal of Medicine,* the *University of Pennsylvania Law Review, New York Times Magazine, Atlantic Monthly, Commonweal,* and the *Journal of the American Medical Association,* among others. The Center has also published over 25 books.

In sum, the Center has been highly productive. It has tried to approach the issues both with intensity and soberness. It does not claim to have solved any of the troubling issues it has confronted. It can only claim that it has become a major resource for those who want to get to the bottom of some of the most troublesome questions of our times.

Robert M. Veatch, Senior Associate at The Hastings Center



Projects and Programs

The Hastings Center has ongoing research projects in seven areas:

1 Death and Dying

Beginning in 1970, the Research Group on Death and Dying has systematically examined a number of moral, social, and legal issues engendered by medical advances: organ transplantation and the definition of death; the termination of treatment on dying patients; the allocation of scarce resources to the dying; the relationship between the forestalling of death and the relief of suffering as sometimes competitive, and sometimes complementary, goals of medicine.

Death raises profound philosophical and theological issues. The fact that most people now die in the context of advanced medical technology raises vexing legal and policy dilemmas. In that respect, then, the work of the Research Group on Death and Dying is forced to deal with both the oldest of human problems and some of the newest.

2 Behavior Control

In *Brave New World,* Aldous Huxley apocalyptically explored the possibilities for the control, by scientific and medical means, of the human mind and emotions. It was a chilling prospect, and perhaps all the more so since the medical and behavioral sciences have in fact made such enormous contributions to human welfare by their ability to directly modify the emotions and behavior of the mentally ill, the mentally retarded, and many others who had for so long been ignored or stigmatized by society.

Yet the power to modify, shape, or even coerce human behavior by technological means is a perfect symbol of the biological revolution—a power for enormous good combined with a power for considerable harm. The Behavior Control Research Group has in that context examined the use of psychosurgery, psychotropic drugs, and psychological and psychoanalytic techniques for modifying behavior. It has also inquired into the use of such techniques in institutions.

Under a grant from the National Science Foundation, the Research Group is now examining a series of case studies of research on the control of violence. It is looking not only at the legitimacy of the use of scientific knowledge for the understanding and control of violence, but also at the social, ethical, and political problems which such use unavoidably raises.

3 Genetics

For many, the biological revolution means one thing—the potential power of science, through an understanding of the human genetic makeup, to remake human beings altogether. That has not happened and probably will not, but there can be little doubt that the discovery by Watson and Crick of the structure of the DNA molecule and the development of recombinant DNA technology represent remarkable and unsettling advances.

While our Genetics Research Group has focused a considerable part of its effort on genetic engineering, it has also devoted its attention to genetic counseling and screening and, most recently, to the ethical, social, and legal problems raised by the rapidly developing science of prenatal diagnosis. If the problems here seem less dramatic than those of genetic engineering, they are more immediate and personally affect many more people. A forthcoming study of genetic counseling, and another of prenatal diagnosis, both supported by the National Foundation-March of Dimes, has made clear to us, as it will to others, just how many difficult professional and personal dilemmas the new techniques for predicting or diagnosing genetic defects have created.

4 Population

Few are now prepared to deny that the world as a whole has a serious problem of an excessive population growth rate. But there is considerably less agreement about the exact nature of "the population problem," and less agreement still on the most ethically acceptable ways of coping with it. Interventions to limit population growth, or to introduce family planning programs, inevitably raise a number of difficult and delicate ethical and value problems, especially in the developing nations of the world. This has been all the more pronounced since the World Population Conference in Bucharest in 1974.

Under a grant from the United Nations Fund for Population Activities (UNFPA) and the ARCA Foundation, The Hastings Center's Population Research Group has been examining the value congruences and differences between those agencies which provide funds for population limitation programs, and the recipient nations and peoples themselves. It is a study both in the ethics of population policy assistance programs, and in the politics of international development programs.

5 Health Policy

The four research groups already described are The Hastings Center's oldest. One of the newest groups is the Research Group on Ethics and Health Policy. While most of the Hastings Center's work moves directly into policy and legislative issues, it recently became clear that the broad area of health policy raised issues different from many other of our research programs.

In a nation that has flirted for some years with the idea of National Health Insurance, and has already supported Medicare, Medicaid, Health Maintenance Organizations, and so on, fundamental questions concerning the allocation of scarce health resources inevitably arise. No less critically, the development of a national health policy requires an examination of the concepts of health and illness, of the goals of medicine, and of the relationship between medical and other social needs. The pervasive use of cost-effectiveness and cost-benefit techniques itself raises basic ethical questions about the most appropriate means of policy-making. At present, under a grant from the National Center for Health Services Research, The Hastings Center is focusing its attention on the ethics of cost-containment.

6 Humanities

The nature of The Hastings Center's work requires an unceasing effort to move across the usual barriers separating the sciences and the humanities, and a no less diligent effort to grapple with some of the oldest of human problems. Our work in the humanities, supported by a grant from The Rockefeller Foundation, has moved in a number of complementary directions. We have tried to enrich the mix of those from the humanities working on problems of bioethics and science policy. We have also tried to confront a broad range of very old issues which, again and again, crop up in our more applied work in ethics. We have thus had papers and meetings on the concept of "rights" and of "health and illness," on the strain between individual good and common good, on the tension between need and desire, and on the vexed relationship between the "is" and the "ought."

We believe the humanities have a major contribution to make to issues of public policy. If it is impossible now to confront ethical problems in biomedicine and the behavioral sciences without the help of the humanities, it is no less impossible to think of the role of science itself without a fruitful interchange between scientists and those trained in the humanities.

7 The Foundations of Ethics

Our humanities work represents one move in a direction away from an exclusive emphasis on ap-

A meeting of the Population Research Group at The Hastings Center

plied ethics. Our program on "the foundations of ethics and its relationship to science" represents another. Both are meant to complement and strengthen our other work, the former by adding breadth and interdisciplinary richness, the latter by allowing us to look squarely at the nature and basis of ethics itself.

Conceptions of ethics, both philosophical and theological, have undergone a number of striking changes during the twentieth century. There is a fresh interest in normative ethics and vigorous efforts are underway to find methodologies in ethics capable of dealing with concrete moral dilemmas. The mutual impact of science and ethics upon each other is another unmistakable feature of our times, one central to our work.

With the support of a grant from the National Endowment for the Humanities, The Hastings Center has now published three of a projected four-volume series on the Foundations of Ethics. It has also begun work on a project to examine those scientific disputes with a major ethical component —for example, the use of Laetrile, recombinant DNA research, nuclear energy, and the IQ debate.

Exploratory Projects

Ethical problems in medicine, biology, and the behavioral sciences arise with remarkable rapidity these days. The Hastings Center cannot possibly cope with all of them. In order to help us explore possible new research directions, a Ford Foundation grant enabled us to take an intense look at some developing areas, both to be of assistance to others and to map out some otherwise unexplored territory. Among some recent ventures:

- **ethics and international health:** to examine disparities in health care between developing and developed nations, and to explore priorities in international aid programs
- **ethics and nursing:** to assist in the development both of a scholarly literature for nursing ethics and in course development in nursing schools
- **ethics and neonatal intensive care units:** to look at the special problems posed by efforts to treat critically ill infants, and to examine the proliferation of such units as a case study in the allocation of scarce resources

- **hospital ethics committees:** in the aftermath of the Karen Ann Quinlan case, to analyze the possibilities and problems of special hospital ethics committees.

Under a separate grant from the Ford Foundation, The Hastings Center also carried out a survey of *the teaching of ethics in schools of public policy*, and will cosponsor a summer workshop on that subject.

Education Programs and Research Opportunities

The Hastings Center provides a number of education programs and a variety of special opportunities for research:

Consultations. The Hastings Center staff has had considerable experience in course and curriculum development at both the undergraduate level and in professional schools. Where time and resources permit, we are happy to provide information and occasional assistance in the development of courses in ethics, particularly in medical schools, nursing schools, and in undergraduate departments attempting to give ethics a more central place in the curriculum.

Reading Packets. To meet the frequently expressed need on the part of those teaching ethics for accessible and usable reading matter, The Hastings Center has developed a "Reading Packets" series, making available for student use collections of key articles and documents in a wide number of areas in bioethics.

Summer Workshops. Since 1972, The Hastings Center has organized a variety of one-week workshops in medical and biological ethics. The workshops are of two kinds. First, every summer an introductory workshop is offered, designed to give the participants a general survey of bioethics. Second, there have been a number of specialized workshops: on philosophical ethics for those in science and medicine; on clinical ethics for those who have had only a theoretical exposure to medical ethics; on human experimentation and institutional review boards; on death and dying; and on ethical issues in the care of the newborn. Since 1972, some 900 people have participated in these workshops.

Research Opportunities at The Hastings Center. There are a variety of research opportunities available at the Hastings Center:

- *Student Intern Programs.* With the support of a grant from The Commonwealth Fund, The Hastings Center is able to accept approximately 20 students a year for a stay of one to three months. While there is a preference for law and medical students, and pre-law and pre-medical candidates, applicants are welcomed from all disciplines, and may be at the undergraduate or professional school level. Some financial help is available, and students work on specific research projects with the tutorial assistance of staff members. Since 1971, 90 students have participated.

- *Post-doctoral Fellowship Program.* With the support of the National Endowment for the Humanities, The Hastings Center offers four post-doctoral fellowships a year. These fellowships provide stipends for a year in residence at The Hastings Center. Their purpose is to allow those seriously intent on a future career in bioethics to spend time in research and reading in fields other than their own. Interdisciplinarity, and the development of complementary skills, is thus a central focus of the program. Post-doctoral fellows have come from the fields of medicine, law, religion, philosophy, sociology, economics, political science, molecular biology, and neurophysiology.

- *Visiting Scholars Program.* When space is available, and when the applicant can supply his or her own financial support, The Hastings Center is prepared to accept visiting scholars for a period of a few weeks to six months. Applicants are accepted on the basis of their potential contribution to our ongoing work, and on the likelihood that their stay will be of significant scholarly benefit to them.

Special Project on the Teaching of Ethics

Under a grant from the Carnegie Corporation of New York, The Hastings Center recently began a broad study of the teaching of ethics in American higher education. This study will encompass the teaching of ethics at the undergraduate level and at the professional level in a variety of fields—medicine, law, journalism, public policy and politics, the social sciences, business, and engineering. The premise of the study is that the problems in the teaching of ethics, regardless of the field, are more common than disparate. What are the purposes in teaching ethics: moral development, the acquisition of analytical skills, or problem-solving techniques? Who should teach ethics, and where and how is it best taught? *Can* ethics be taught, especially in a pluralistic society?

Associate Member Program

While most of the direct research and educational work of The Hastings Center is carried out by its staff and elected Fellows, an Associate Member program not only creates a much larger circle of friends and concerned scholars and citizens, but also allows us to make available a number of publications and other services.

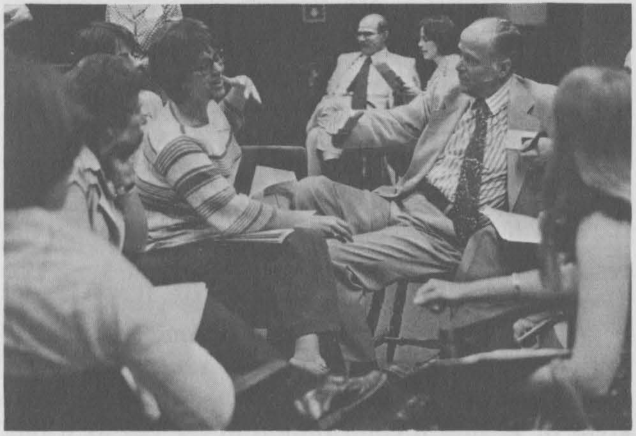
There are now 10,000 Associate Members of The Hastings Center, including 1,000 libraries, about 1,500 students, 1,800 physicians, 1,800 theologians, 1,000 philosophers, another 1,000 or so in the sciences and allied health professions, and a growing number from law. There are also legislators and administrators, historians and social workers—in all, a diverse combination of professional and lay people.

Associate Membership in The Hastings Center —$19 a year—entitles an individual to receive the bi-monthly *Hastings Center Report*. There are various discounts on other publications and early notice of workshops and open meetings.

The *Hastings Center Report* is our primary publication. Widely cited in the scholarly literature and in the general media, it attempts to speak to a wide professional and lay audience. Its contents range from a regular case study in ethics and a special feature on ethics and the law, through scholarly articles in ethics, to concrete examinations of topical moral issues in medicine, biology, and the behavioral sciences.

For the past few years, The Hastings Center has sponsored a series of informal receptions in different parts of the country for its Associate Members, has assisted in the development of some regional programs, and, each June, has organized a meeting open to its Associate Members, their friends, and colleagues.

A discussion group at an open meeting for Associate Members



Financial Support

The budget for The Hastings Center in 1979 is $1.3 million. The Center has no endowment or permanent support of any kind—and it owns no buildings or property. Instead, the Center carries out its work by means of grants from private foundations and the federal government, by the income generated by its membership program and other educational activities, by corporate contributions and by its "Friends of the Center" program.

Over the years, the Center has received grants from the National Endowment for the Humanities, the National Science Foundation, The Commonwealth Fund, the Ford Foundation, the Rockefeller Foundation and the Rockefeller Brothers Fund, the Kaiser Family Foundation, the Carnegie Corporation, and the National Center for Health Services Research, among others. Corporate contributors have included Exxon, Western Electric and IBM.

As generous and helpful as those foundations and corporations have been, however, the Center could not survive without the help of concerned and interested individuals. In 1976, the Center established a "Friends of the Center" program. There are six categories of contributors under the program: **Benefactors:** $5000 or more; **Patrons:** $1000-$5000; **Donors:** $500-$1000; **Supporters:** $100-$500; **Contributors:** $26-$100; **Friends:** $25. In 1976, the Center received $16,000 through this program; in 1977, $45,000. In 1978, 800 individuals contributed $65,000. This support is critical. The Center is prepared to provide information on the gift of securities as well as on bequests.

The role of an independent non-profit organization devoted to the central moral problems of our times is, we believe, crucial. The Center cherishes its independence, its nonpartisan stance toward the issues, and its work in providing help and resources to all sectors of American society. Though already ten years old, its work is just beginning. The decade ahead promises to be a critical one for ethics in American life. With continuing support, the Center will be able to make as great or greater a contribution in the 80s as it did in the 70s.

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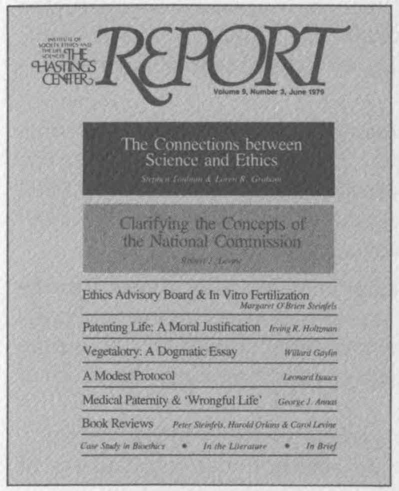

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Volume 9, Number 3, June 1979

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Clarifying the Concepts of the National Commission

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In 1969, when the Hastings Center first began, the social dilemmas posed by advances in medicine and biology seemed a matter of science fiction or futurology to most Americans. The situation has changed dramatically since then. Issues once considered to be purely speculative are realities—psychosurgery, mass genetic screening, a new definition of death, radical forms of genetic engineering, and coercive population control policies.

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The Minnesota Interreligious Committee
for Bio-Medical Ethics

Minnesota Church Center
122 West Franklin Avenue, Room 230
Minneapolis, Minnesota 55404
(612) 870-3605

To: American Citizens Concerned
For Life Inc.

Enclosed is a registration packet including our Bibliography and existing Guidelines for Hospital Bio-Medical Ethics Committees in the State of Minnesota.

Let us know if we may be of more help, Beverly.

Trudy Jensen, Ch.
4420 Philbrook Lane
Mpls Mn 55424

CARDIOPULMONARY RESUSCITATION

When cardiopulmonary resuscitation should not be used, it should be indicated in the patient's progress notes by the responsible physician. The note should include the reasons for the medical judgment that resuscitation efforts are inappropriate and should indicate that the decision had been discussed with the patient's family. Either of the following orders on the patient's chart may be used to convey this decision: "Do Not Attempt to Resuscitate" or "Supportive Care Only."

Current University of Minnesota Hospitals policies on resuscitation of patients suffering a cardiopulmonary arrest, and on the meaning of orders for supportive care only are as follows:

Resuscitation of Patients: When an arrest occurs, nursing personnel will initiate resuscitation measures (triple page the appropriate physicians, support circulatory and respiratory function by mechanical ventilation and external cardiac massage, have medication and supportive equipment available for the physician's arrival). This will be begun on every patient unless a medical directive for "supportive care only" or "do not resuscitate" is written on the doctor's order sheet. If the order not to resuscitate is given verbally, it will be treated as any other verbal order and transcribed by the nursing staff onto the doctor's order sheet. Resuscitation will be initiated until verbal orders are countersigned.

Definition of Supportive Care Only: Defines the level of care that should be provided in those cases where it has been medically determined that there is no possibility of recovery. The practice associated with the terms SCO shall include all services ordered by members of the medical team; however, no efforts shall be taken to resuscitate the patient if an arrest occurs.

BRAIN DEATH NOTIFICATION PROCEDURE

Death is traditionally defined as the time when the heart has stopped beating and the patient has stopped breathing. The physician so pronounces and the patient is considered dead. The legal profession is solely dependent upon the medical profession for the determination of time of death. It is an expert opinion.

The determination of brain death is the responsibility of the attending staff physician. We realize that this is a serious matter from moral and religious points of view. The attending physician shall, therefore, obtain consultations and employ diagnostic methods to assist in making such a decision. (A good article on this topic is: "Brain Death, A Clinical and Pathological Study," *Journal of Neurosurgery* 1971, Vol. 35, No. 22, pp. 211-218.)

The family and nursing staff shall be fully informed of the situation and appropriate steps taken to secure both an autopsy permit and donation of organs.

Mechanical supportive measures can be discontinued only after death is pronounced.

The responsibility for obtaining a signed autopsy permit and the organ donation release form belongs to the attending physician because of the existing relationship the physician has with the family. If donation of organ or organs for transplantation is secured, the transplantation services shall be informed at once, and these services shall then be the responsible party in the care of the body.

CRITERIA FOR THE DETERMINATION OF BRAIN DEATH, RECOMMENDATIONS OF THE AD HOC COMMITTEE ON DEATH, MINNESOTA STATE MEDICAL ASSOCIATION

The following current criteria for the determination of brain death are recommendations of the Ad Hoc Committee on Death of the Minnesota State Medical Association and are intended to provide consistency and guidance in the pronouncement of brain death by physicians throughout the state of Minnesota. The final responsibility regarding pronouncement of death and termination of treatment and support rests with the attending physician; nevertheless, in the opinion of the Ad Hoc Committee, the criteria listed below (items 1 - 5) are the necessary and essential criteria that should be satisfied in all cases of brain death. These essential criteria conform to the concept of brain death, that is, irreversible cessation of total brain function determined by clinical examination; if these criteria are satisfied, the physician can be assured that there is a permanent, nonfunctioning brain without any reasonable chance of survival or resumption of brain functioning.

1. Cerebral Unresponsivity

   Deep coma with total unawareness and unresponsiveness is present. Intense stimulation evokes no verbal or motor responses. No spontaneous movements nor involuntary posturing (except purely spinal segmental responses) are present.

2. Apnea

   The patient is observed for spontaneous respiratory movements for a minimum of three minutes without respirator support.

3. Absent Brain Stem Reflexes

   Pupils are fixed and mid-position (greater than 5.0 mm. in diameter). All brain stem reflexes are absent, including oculocephalic, oculovestibular, corneal, gag, cough, swallowing, decorticate or decerebrate posturing.

   Spinal segmental reflexes, such as deep tendon reflexes and triple flexion responses, may be present, since these are only indicative of a viable spinal cord and are not incompatible with irreversible cessation of brain function.

4. Period of Observation - 12 Hours

   There should be at least two separate clinical examinations of the patient with a minimum of 12 hours between the first and second examinations.

5. Irreversibility

   Any reasonable possibility of a reversible CNS dysfunction should be excluded, specifically, hypothermia (temperature below 90 degrees F, 32.2 degrees C) or intoxications.

6. Confirmatory Tests

Confirmatory tests, such as EEG and cerebral angiography, may provide supportive data in the diagnosis of brain death, but are not essential. When the etiology of the cerebral insult is known and there is a gross structural lesion of the brain, the clinical findings of cerebral unresponsivity, apnea, and absent brain stem reflexes, establish that brain death is present. When the etiology is known but there is no gross structural lesion of the brain or when the etiology is unknown (provided intoxications and hypothermia have been excluded), electrocerebral silence, according to the standards of the American EEG Society, is of confirmatory value and provides objective documentation. Cerebral angiography and other techniques to demonstrate absence of cerebral blood flow may also be of confirmatory value in selected cases. The decision to use the EEG and/or other confirmatory tests should be made by the attending physician.

PROCEDURAL GUIDELINES

Once the determination has been made by the attending physician that the patient has satisfied the medical criteria for brain death, the following procedural guidelines are recommended.

The physician is legally obligated, by proposed statutory legislation, to pronounce the patient dead once the medical criteria have been satisfied. Consent of the family is not legally required; however, the family should be kept informed of the condition and prognosis of the patient and of pertinent facts relating to brain death so that the family can fully understand what is being done.

The patient is pronounced dead, and then the respirator is discontinued. The reason the respirator is discontinued is not because it has been considered an extraordinary means of support, but because the patient is now medically and legally dead.

Consideration of transplantation should have no influence on the criteria for brain death nor the time of death. The criteria remain the same in all cases, whether or not transplantation is contemplated. The determination and pronouncement of brain death should be made by physicians who are not involved in the transplantation.

Although the patient is not pronounced dead until all criteria, including the period of observation to verify irreversibility, have been satisfied, the time of death occurred when the irreversible cessation of brain function was first noted.

There should be adequate documentation in the medical records to substantiate that the criteria for brain death were fulfilled and that the patient was pronounced brain dead. All other pertinent issues and facts relating to the case should be documented in all medical records.

From the medical, moral, and legal standpoint it is absolutely essential to separate the issues of when a person should be pronounced dead from when a person should be allowed to die. These recommendations are not intended to provide any operational guidelines to decide when extraordinary means of support should be discontinued in a patient who, although severely and irreversibly brain damaged, fails to satisfy all the criteria for irreversible cessation of functioning of the brain.

REC/mmf
10/12/76

EXTRAORDINARY TREATMENT MEANS TO PROLONG LIFE

Metropolitan Medical Center

GENERAL STATEMENT

The purpose of this document is to state the guidelines of the Metropolitan Medical Center with regard to the use of ordinary and extraordinary means to prolong life. While it is recognized that the protection and preservation of life and health is the essence of MMC's existence, it must also be recognized that the use of extraordinary means (those which involve a detriment to meaningful human life, excessive pain, expense, or other inconvenience which, if used, would not offer a reasonable hope of benefit) to prolong life is neither required nor reasonable in all cases. In determining when and to what extent extraordinary means are to be used, it is preferred that the patient should make the decisions with direction from the physician regarding the consequences of the various treatment alternatives. MMC recognizes the right of the patient to refuse treatment under certain circumstances. If the patient is not legally competent to make such decisions, the physician must look to other sources that could most accurately indicate the best interests of the patient.

At no time does this guideline allow or suggest that the physician withhold ordinary and reasonable treatment unless it is knowingly refused.

DO NOT RESUSCITATE (DNR)

The use of cardiopulmonary resuscitative measures are not appropriate for all events of acute cardiac or respiratory arrest. The individual physician must determine in each situation whether CPR is not necessarily an appropriate treatment. The physician must consider the total medical condition of the patient in concert with the desires and best interests of the patient and to avoid an unnecessary abuse of the patient's presumed reliance on the physician and hospital for continued life supporting care. If the competent patient, one who understands the relevant risks and alternatives of treatment or withholding treatment, chooses for or against the DNR alternative it may not be overridden by contrary views of family members. It is recognized, however, that it may be inappropriate to introduce the subject of DNR to certain competent patients when, in the physician's judgment, the patient will probably be unable to cope with its psychologically, or it may be deemed medically inappropriate. Appropriate individuals should be so informed, and the physician should explain the course that will thus follow in the event of sudden cessation of the patient's vital functions.

If the patient is incompetent, he should not be denied the evaluation described above. The basis for a final decision for DNR must be concern from the patient's point of view, not that of some other person who may represent what he regards as sufficient reasons for not resuscitating the patient. A proposal for DNR may be initiated by family members, but it is essential to recognize that a family member's instructions not to resuscitate are not necessarily to be viewed as a choice of the patient. An essential condition for the issuance of DNR for an incompetent patient is approval of at least the same family members who are required to consent to postmortem examination. DNR orders must be reviewed on a regular basis and may be rescinded at any time. A DNR order should not be construed to mean or refer to the withholding of ordinary or reasonable methods used to maintain life or health.

A. Definition of DNR Orders

In the event of a circulatory or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated.

B. Medical Assessment

When it appears that a patient is irreversibly and irreparably ill, the question of the appropriateness of cardiopulmonary resuscitation in the event of sudden cessation of vital functions may be considered by the patient's physician. Preliminary medical judgment on such questions should be made by the primarily responsible physician after discussion and consultation with members of the health care team, consisting of the other physicians attending the patient and the nurses and others directly involved in the care of the patient. The final decision regarding the decision to initiate the order of DNR resides with the primary care physician. This final decision will be reached after the opinions of the health care team are elicited, and their considerations and concerns are incorporated into the final decision-making process.

C. Documentation

All orders not to resuscitate a patient or to otherwise withhold extraordinary care must be written and signed by the member of the medical staff attending the patient on the Physician's Order Sheet in the patient's medical record. In the event of such an order given by telephone, two parties must take the order, with it being signed by the medical staff member as soon as possible. Failure to write such an order in the medical record will result in the initiation of resuscitative measures.

Documentation should be existing in the medical record to justify a DNR order. It is recommended that a summary of the medical justification be included when such justification is not apparent on the face of the record as well as an indication of concurrence from either the patient or the family when available.

REFUSAL OF TREATMENT

MMC recognizes the patient's right to refuse medical treatment if he/she has been fully informed of his condition, of the possible consequences if treatment is refused, and if the patient is determined to be competent and reasonable. The only situation that would alter this situation is where public policy interests, as determined by the courts, would outweigh the patient's rights. Special consideration must be given in situations involving minors. Any refusal of ordinary and reasonable treatment can only be made after the patient has been fully informed of the reasonably foreseeable consequences of such decision. Failure to obtain such consent shall require that all ordinary and reasonable treatment be continued.

INFORMED CONSENT

Consent must be obtained from the patient if he/she is legally competent. Legal competence is determined by medical opinion as to whether the patient understands the consequences of his actions. In the event that the patient is not competent to give an informed consent, the physician must refer to other persons that are deemed to be best able to act in the patient's behalf. This would usually be the immediate family or a court appointed guardian. A Living Will, if one exists, should also be given consideration during this process.

If there is significant disagreement between the parties with regard to the appropriateness of a certain treatment or if the physician believes these individuals are not acting with the best interests of the patient in mind, reasonable and ordinary care, as determined by the physician, must be continued.

Any refusal of treatment by a minor (a person under 18 years of age who is not "emancipated") or by a parent or guardian in the minor's behalf that could have life threatening consequences to the minor, should be immediately reviewed by legal counsel prior to any response or compliance by the physician, other than to render emergency care that would be deemed ordinary and reasonable. Treatment with extraordinary means will not be required.

LIVING WILLS

The Living Will is a statement that has been formally executed by the patient which indicates to the physician that in the event the patient cannot participate in the planning of his patient care treatment, he specifies what limitations should be made with regard to the treatment rendered or appoints an individual to make these decisions in his behalf.

Such Wills are not recognized as binding in Minnesota, but they can provide assistance to the family and the physician with regard to determining the wishes of the patient.

This does <u>not</u> provide for affirmative acts that would relatively painlessly put persons to death when they are suffering from incurable diseases or conditions.

A Living Will shall only be used in cases where the physician is confident that the present problem was similar to that type of situation the Living Will was executed to prevent. If there is strong resistance from family members, the validity of the Living Will must diminish.

Therefore, the Living Will is not conclusive but rather of partial assistance in determining what type of care should be given.

8/28/79
/mjd

SAMPLE

LIVING WILL

TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN, MY LAWYER --

If the time comes when I can no longer actively take part in decisions for my own future, I wish this statement to stand as the testament of my wishes. If there is no reasonable expectation of my recovery from physical or mental and spiritual disability, I, ______________, request that I be allowed to die and not be kept alive by artificical means or heroic measures. I ask also that drugs be mercifully administered to me for terminal suffering even if in relieving pain they may hasten the moment of death. I value life and the dignity of life, so that I am not asking that my life be directly taken, but that my dying not be unreasonably prolonged nor the dignity of life be destroyed.

This request is made, after careful reflection, while I am in good health and spirits. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to take it into account. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing this responsibility that this statement is made.

8/28/79
/mjd

MOUNT SINAI HOSPITAL

CARE IN CRISIS COMMITTEE

The present Care in Crisis Program at Mount Sinai Hospital had its origins in January 1975, when a group of concerned staff members organized the Committee on Death & Dying (later the name was changed to the Care in Crisis Committee).

Presently, the Care in Crisis Program is a division of the Human Services Department of Mount Sinai. The program is staffed by a coordinator, nurse specialist and trained volunteers. Since Mount Sinai has recognized that people experiencing significant personal loss do not always have the personal and social resources necessary for adequately dealing with such life-disrupting events, we have created the Care in Crisis Program to address the issues and needs of these people.

The broad goals of the program are:

1. To assist people to die in a way that is meaningful to them.
2. To assist survivors (or potential survivors) through preparation as well as facilitating their grieving.
3. To confront and deal with ethical issues related to patients' rights, when to treat or not treat, use of limited resources, etc., and to establish guidelines for other helping professions.

The present services offered by the Care in Crisis Program are:

A. Care in Crisis Committee
B. Chemotherapy administration and training
C. Home/Hospital care by professionals
D. Home/Hospital care by trained volunteers
E. Patient/Family share group
F. Grief Share Group
G. Adolescent Share Group
H. Staff Share Groups
I. Informational Sessions (Mini-Series)
J. Educational Resource Center
K. Speaker's Bureau for public gatherings
L. Volunteer training
M. Volunteer supervision and support
N. Staff training and education
O. Staff support services
P. Individual counseling (by professionals)
Q. Family counseling (by professionals)
R. "I Can Cope" education series

The philosophy of the committee coincides with that of the overall program. Its purpose also agrees with that of the program and its specific contributions to the broad goals delineated. The specific contributions that the Care in Crisis Committee makes to the program and the hospital are:

(over)

1. Consultation - to Coordinator, In-house Staff, Medical Staff and individuals or groups outside of Mount Sinai
   - this would involve programatic as well as issue-oriented concerns
   - the whole committee, a subcommittee and/or individual members may provide this consultative service

   This means that as members of the committee you agree to be available as a consultative resource individually and/or within the larger group.

2. Case Presentation - from within Mount Sinai as well as from health care institutions other than Mount Sinai Hospital
   - may be actual cases or hypothetical cases representative of some problem or issue

   This means that as members of the committee you agree to be available to review cases, examine the issues and make recommendations.

3. Forum for discussion of medical/social/ethical issues -

   This means that as members of the committee you agree to consider these issues, contribute your personal and professional opinions and perhaps be involved in action taken. This should be done on an on-going basis. An on-going policy formation task force is a subcommittee of the large committee and makes recommendations on ethical issues i.e.: DNR guidelines.

4. Active involvement in the community - with agencies or groups concerned with death, dying and grief

   This means that as a member of the committee you would be available to consider involvement in outside community groups should the committee deem it appropriate. In such cases the member would not only represent him/herself and Mount Sinai but also the committee. If a member is already involved in such a group he/she should inform the coordinator.

5. Promotion - this involves further education of the community, in-house staff and others outside of Mount Sinai as to our existence, services, philosophy and dreams

   This means that as a member of the committee you would be available to represent the committee and give a presentation of its services to others.

6. Recommend policy and appropriate use of program resources -

   This means that as a member of the committee you would be involved in an evaluation process out of which policy recommendations and appropriate use of program resources would be made to administration.

7. Forum for program evaluation - check various elements of program to see if we're meeting the overall goals
   - make recommendations concerning program development
   - keep ourselves informed on progress of program

7. Forum for program evaluation (Cont'd)

   This means that as a member of the committee you will be involved in assessing our effectiveness and making appropriate recommendations.

8. Serve as a model of interdisciplinary work -
   - continue to function as an interdisciplinary committee
   - evaluate that functioning occasionally
   - promote the concept to other appropriate programs in Mount Sinai Hospital

Generally, the committee deals with philosophy, purpose, goals, objectives, ethical issues, case consultation, action-issues within hospital and in the community when appropriate while the coordinator and staff work to carry out the tasks and methods as defined. The committee is a primary resource to the coordinator and administration in decision-making authority and is intimately involved in program direction and development. The committee is inter-disciplinary, has 30 members and meets twice a month with invited guests attending each meeting. Attendance and participation by all staff members is encouraged. The Care in Crisis Coordinator is chairperson of the committee and a volunteer in the program is secretary, assuring continuity and follow-through. The committee is viewed as an educational forum for the entire staff at Mount Sinai Hospital

August 29, 1978

DRAFT **

DNR GUIDELINES

It is widely recognized that, under certain clinical circumstances, the initiation of potentially life-prolonging therapy may be inappropriate when such therapy would not serve the best interests of the patient. These guidelines are intended to clarify one specific aspect of these life-prolonging therapies, i.e. DNR (Do Not Resuscitate).

DEFINITION

DNR - In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated.

CONSIDERATIONS

1. An adequate period of observation and appropriate diagnostic evaluation are necessary before consideration of a DNR order.

2. The concept of DNR is compatible with maximal therapeutic care. The patient may be receiving vigorous support in all therapeutic modalities and yet justifiably be considered DNR.

3. The conditions under which the DNR order may be applicable should be left to the judgment of the responsible physician.

4. When the patient is competent, the DNR decision will be reached consensually by the patient and physician. If the patient is incompetent, this decision will be reached consensually by the family and physician.

   If a competent patient disagrees, or, in cases of incompetency, the family disagrees, the DNR order will not be implemented.

   The principles of self-determination and informed consent apply to the DNR decision-making process. However, in some situations, the attending physician may decide that consultation with the patient is medically inadvisable and not in the best interests of the patient.

IMPLEMENTATION

1. Once the DNR decision has been made, this directive should be written as an order by the housestaff physician on the order sheet. Senior staff consultation and concurrence with this order shall be documented in the patient's chart.

2. All facts and considerations pertinent to this decision should be documented in the progress notes.

3. The DNR order should be subject to review on a regular basis and may be rescinded at any time.

**Draft guidelines formulated by the Ad Hoc Committee on Death of the Minnesota Medical Association; as of August 1979, these guidelines have not been formally adopted by either the Ad Hoc Committee or the Minnesota Medical Association.