

Florida Bioethics

Autumn 2001-Winter 2002

<http://www.med.ufl.edu/chfm/ethics/fbn/index.html>Email — ethics@miami.edu

BEHIND BARS

First U.S. Corrections Ethics Committee Faces Some of State's Toughest Issues

CHARLES R. MATHEWS, M.D.
Chairman, Department of Corrections
Bioethics Committee

For several decades, bioethics committees have existed in the free world, mostly in hospital settings, to address the ethical concerns involved in providing health care to their patients. Concurrently, many universities and

other educational facilities established ethics departments. However, when I first became involved with the Florida Department of Corrections in late 1989, I found no entity anywhere in the country to which I could turn to address the special ethical dilemmas involving prisoners in the fourth largest prison system in

(Continued on page 8)

In this issue

<i>State's Department of Corrections ethics committee a U.S. first</i>	1, 8
<i>Balance in pain management is endorsed as optimal strategy</i>	1, 10
<i>First FBN conference in Southwest Florida a success; 2nd planned</i>	3
<i>Aging With Dignity's Jim Towey to head faith-based initiative</i>	3
<i>'Doctor Deluxe' — Ethical issues in extra fees for service</i>	4-5
<i>Access to health care for hearing impaired people</i>	6-7
<i>Schiavo family mediation fails; case heads to trial</i>	11
<i>Perry Como's end-of-life care caused rift in family</i>	11

Pain Management 'Balance' Hailed at Special Workshop

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University of Florida

TALLAHASSEE — The aggressive use of high doses of opioid analgesic medications can relieve human suffering and dramatically improve patients' quality of life. On the other hand, the diversion of opioid analgesics from legitimate medical use to illicit use (through theft, fraud, and incompetence primarily) contributes to the problem of substance abuse.

Public policies and clinical practices aimed at increasing access to high doses of opioid analgesics for pain will usually have the foreseeable, but

(Continued on page 10)



Florida Bioethics Network

The Florida Bioethics Network is a program of

- Program in Bioethics, Law, and Medical Professionalism, University of Florida College of Medicine
- Bioethics Program, University of Miami
- Division of Medical Ethics and Humanities, University of South Florida School of Medicine
- Nova Southeastern University

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Florida Ethics Calendar

Please e-mail submissions to ethics@miami.edu

March 1, 2002, Fort Lauderdale/Hollywood — Clinical Ethics: Debates, Decisions, Solutions (**Florida Bioethics Network** spring conference and University of Miami 10th annual conference). Focus sessions to include a HIPAA track, including standards for staff education under HIPAA. 305-243-5723, www.miami.edu/ethics.

March 8-10, Clearwater — Bioethical Considerations in Human Subjects Research. University of South Florida and Stetson University. 800-852-5362.

October 24-26, Miami — Extreme Ethics: Unusually Difficult Challenges in Epidemiology and Human Subjects Research. University of Miami Ethics Programs. 305-243-5723, www.miami.edu/ethics.

November, Tallahassee — Florida Bioethics Network northern region conference. Watch for details!

Varia — University of South Florida Department of Mental Health Law & Policy. Baker Act workshops, a statewide series through April 23. 813-974-7623, www.fmhi.usf.edu/mhlp/bakeract.html.

Hospice Wins Home Health Award

MIAMI — Catholic Hospice of Miami has been named “Best Home Health Agency” by Florida Medical Business as part of its 13th Annual Healthcare Awards.

These are the only awards that are given to individual sectors of the health care industry. Judges evaluate each nominee using a customized set of criteria that recognizes quality of the organizations being considered.

Catholic Hospice is a not-for-profit health care organization providing end-of-life care to terminally ill patients and their families in Miami-Dade and Monroe counties. The hospice is a cooperative service of the Archdiocese of Miami, Mercy Hospital and St. Francis Medical and Healthcare Services.

Success of 1st Southwest Florida Program Spurs Plans for 2nd

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PORT CHARLOTTE – More than 175 individuals attended the Florida Bioethics Network's first Southwest Florida Regional Conference in August. Success of this initial effort has led to plans for a second conference, next summer.

The audience consisted of nurses, physicians, lawyers, clergy, social service counselors and pharmacists. Hospitals, ALF's, ECF's, hospices, senior service organizations, faith communities and home health services were among the types of organizations represented.

Program evaluations were overwhelmingly positive. Ninety-nine percent of the participants stated that the conference met or exceeded their expectations. Many said that it was their first ethics conference. Although all the presentations were well received, the discussion on advance directives received the most interest and was the one presentation that we had to cut short.

There were also many requests for more networking time. Attendees heard about the conference primarily through direct mail, followed closely by brochure shared by colleague (who probably got it through direct mail!). Several also heard through newspaper (a Bon Secours St. Joseph Hospital ad) and notices in *Nursing Spectrum*, *Clinician Reviews* and on the FBN Web page.

We had the opportunity to profile the efforts of the Florida Partnership for End-of-Life Care and had information tables from the Coalitions out of Ft. Myers, Sarasota and Port Charlotte.

There were many comments that the conference was held in a good location and that it should be repeated on an annual basis. Based on this, plans have been made for a 2002 regional FBN Conference. That program has been set for Aug. 23, again in Port Charlotte.

Overall, the first effort appears to have been a success. Many thanks to the presenters and the planners: Father Art, Jerry Griffin, and Gordon Postill!

President Bush names Jim Towey to head 'Faith-Based' Initiative

Aging With Dignity Founder and former Florida health secretary Jim Towey has been appointed by President Bush to lead a White House effort to give federal money to religious charities.

Mr. Towey, who participated in a statewide effort to reform Florida's advance directive statute is also associated with the "Five Wishes Living Will," an advance directive developed with support from the Robert Wood Johnson Foundation.

Versions of the living will will also featured photos of Mr. Towey with Mother Teresa, for whom he was legal counsel for 12 years. Some suggested the photos constituted an inappropriate attempt to interject religion into an important effort to improve advance directives.

According to the Aging With Dignity Website (www.agingwithdignity.org), the organization "has become a leading advocate for the elderly and those who care for them. The group has hosted several forums and candidate debates on elder issues, and in

December 1999, convened the first-ever 'Summit of Faith,' in which Florida's leading Christian, Jewish and Muslim leaders joined Gov. Jeb Bush in focusing on the importance of faith in daily life."

Towey, a Democrat, served under Florida Gov. Lawton Chiles, also a Democrat, and is a friend of Republican Gov. Bush.

He takes over the Office of Faith-Based and Community Initiatives at a time of increased interest in and controversy surrounding such efforts and the appropriateness of using tax dollars to support them.

FBN members may remember Mr. Towey's participation in the 2000 Spring Conference, at which he joined in a debate over Florida's living-will statute. Mr. Towey opposed eliminating the "terminal condition test" that patients must pass before their living wills can be honored. His influence with Gov. Bush apparently led to a 1999 threat to veto legislation that would have eliminated the test; the threat effectively thwarted a bipartisan reform attempt.

Doctor Deluxe

Self interest and 'enclaving' in the practice of medicine

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Florida Atlantic University

Many of us have been thinking about the ethics of "deluxe" medical practices, that is, doctors who limit their practice to affluent, subscription-paying members. Critics deride them as "concierge medicine" or "spa medicine" for their attention to amenities that have no therapeutic justification, such as monogrammed robes, heated towel racks and escorts to specialists. Defenders hail them as a return to the personalized medicine that became a casualty of managed care, albeit limited to the well heeled, and in some plans, to the younger moneyed set. I want to discuss two specific ethical concerns — self-interest and enclaving — and argue that deluxe practice cannot be considered a moral practice of medicine.

The moral hazard of self-interest is an enduring concern in professional ethics. The idea that fee-for-service medicine encourages economically self-serving practice patterns was one of the chief rationales for managed care. In response, many established doctors stopped accepting insurance plan limits on their fees, turning to balance billing where permitted in order to satisfy their income needs. Of necessity, their practices consist of patients who can pay higher out-of-pocket costs. Deluxe practices take this a step further, by charging subscriptions ranging from \$1,500 to \$20,000 annually just in order to have exclusive access to their doctors; the cost of services actually rendered is extra.

Various responses to the ethical issues raised by deluxe medicine are available, depending on how we understand behavior and how we conceive of the practice of medicine itself. Professional medical ethics has, for the most part, been treated as a matter of individual ethical conduct. For example, Dr. Edmund Pellegrino, physician and medical ethicist, maintains that deficiencies in physicians' professional morality are deficiencies in character and virtue. On this understanding, attention to matters of character becomes a central focus of physician training and the management of medical ethics.

In contrast, managed care debates recommend that we view physician conduct in a new light — as a structural problem. The structural view understands physician behavior as a rational response to the way we as a society have chosen to organize the delivery of medical care. This is not to say that such response is moral or acceptable, merely that it is explainable in terms of prudence and self-interest. If we understand the problem as

“... in responding to the ethical issues raised by deluxe medicine, it matters very much how we understand the sources of ethical and unethical behavior. It also matters how we conceive of the practice of medicine itself.”

a rational but deplorable response to the market, we can make better sense of the fact that physician self interest, whether or not it leads to professionally unethical behavior, is not an exception, not confined, say, to some few rotten apples. The recommended remedies from a structural perspective involve revising incentives in order to make unethical behavior too costly.

The point of the foregoing is that in responding to the ethical issues raised by deluxe medicine, it matters very much how we understand the sources of ethical and unethical behavior. It also matters how we conceive of the practice of medicine itself. On a Platonic view, the proper grounds for the performance of any activity are contained within the best understanding of the activity itself. That is, the idea of medicine contains within it the goal of the practice and the moral obligations of practitioners can be deduced from reflection upon that goal. Thus, the good of medicine — surcease of suffering — specifies its appropriate practice. The judgment that a practice is morally excellent then depends on its satisfying the obligations that define the practice from the inside.

We can best determine the virtues of excellence applicable to a given profession by reflecting on this “internal morality”. With respect to doctors, the fact that one is a doctor rather than some other kind of professional affects how one's actions and one's character are to be morally evaluated. It follows that professional knowledge is to be used not primarily for personal gain, but for the benefit of those who need that knowledge — *patients* — “those who suffer.” The necessary virtue then, in medicine is more than simple beneficence; it implies some degree of self-effacement

(Continued on page 5)

(Continued from page 4)
as well.

Concerns about social justice expanded the definition of medical ethics to include medical professionals' moral obligations with respect to inequalities in the distribution of social goods such as health care. Bernard Williams and other philosophers use the idea of "internal goods" to argue that the proper ground for the distribution of health care should be ill health or need, not ability to pay. Responding to Williams, the philosopher Robert Nozick argues that there could be more than one correct description of an activity. The example he offers is the imaginary activity – call it "schmoctering" – which closely resembles doctoring but which has as its primary goal earning money for the practitioner. Nozick argues that a person's particular reason for performing an activity – prestige, altruism, earning money – should take precedence over the goal/goals of the activity itself, in this case, care of the sick. For Nozick, each individual ought to be free to decide how to employ their talents and skills on the same basis as any other individual. That is, all are subject to a common morality but there is no morality specific to certain professions beyond the general rules of society. Whatever "special" characteristics we might imagine attach to, say, the practice of medicine, cannot justify infringements on the liberty of individuals who are "schmocters" with respect to their provision of services.

More recently, Arthur Applbaum considers of whether and how morality attaches to specific professional roles. He argues that moral prescriptions and the moral evaluation of acts under certain role descriptions may change as the institutional framework that structures the role changes. Thus, the new forms of non-fiduciary doctoring — "schmoctering" — that emerge in managed care medicine as a result of market and institutional pressures vary from standard doctoring. While we might be justified in criticizing "schmoctering" in terms of whether or not such practices serves a worthy goal, we are not, according to Applbaum, justified in criticizing "schmoctering" on the basis that it violates some internal goal which it does not share with doctoring.

Let us suppose for a moment with Nozick that doctors, no less than any other persons, are entitled, as a matter of personal liberty, to ply their expertise where and when they will. And let us further suppose with Applbaum that new forms of distributing the medical arts give rise to new social meanings surrounding the role of doctor. Must ethics then be silent?

There still remains the problem of enclaving. The ideal of social justice includes equal respect for persons understood to be moral equals. Segregation and exclusionary practices jeopardize that moral project. To the extent that society's practices and institutions deny or impair equal access to necessary goods such as health care, injustice is done. Inequalities of one sort — wealth — become translated into more comprehensive inequalities — health

and wealth — which are much harder to address

Moreover, when elites who have the most power in determining social arrangements, cut themselves off from contact with the less privileged they lose intimate knowledge of less privileged lives, leading to distorted understandings, loss of empathy, and the erosion of the ideal of equal respect. The possibilities for social justice are deeply diminished when powerful elites such as doctors decline to participate in the general health care system or to change it for the good of all, but rather attend exclusively to their own self interest.

In my view, the honorific "physician" ought to be reserved for doctors who are committed to medicine as a moral practice. "Schmocters" who engage in the practice merely as an economic activity ought to be denied the non-economic rewards due doctors. For example, "schmocters" should not, in my opinion, receive courtesy appointments in academic institutions, especially medical schools where the virtues of profession are valued; they should not be permitted to become officers of medical societies, or be honored by such organizations. Physicians must not succumb to moral relativism in the interest of collegiality and should engage in appropriate forms of professional "shunning". As Applbaum says, "Insofar as doctors look to their colleagues for support on what counts as good professional practice — that is, insofar as those with medical training wish to subject themselves to the judgment of their peers — they will reject the label of schmocter."

Some have suggested legislation to limit or prohibit deluxe practices, or special licensing fees. Enacting medical ethics into law can make certain issues matters of public policy and collective deliberation. However, external regulation cannot replace a strong professional ethos. All who care about medicine as a moral practice must work to inspire medical students and physicians beginning their professional lives to commit to that ideal of doctoring.

Notes

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Access to Health Care for the Hearing-Impaired Individual

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Hearing-impaired individuals often encounter obstacles to access to medical care. The following are true stories: Ella Olson and her husband, James Olson, a hearing-impaired couple, received a letter from their physician of 20 years that he was terminating their physician-patient relationship because he refused to pay for a sign language interpreter. The sign language interpreter cost the doctor more than he charged the couple for an office visit.

Dina Freydel, a deaf Russian immigrant, had a heart attack and was taken to New York Hospital. While there, she requested a Russian sign language interpreter. Nevertheless, during her first week of hospitalization, she was required to rely on family members and her ability to lipread the comments of a Russian-speaking doctor for communication.

Candi Daviton-Sciandra brought her mother, Jeanette Daviton, to the emergency room because her mother was suffering from severe abdominal pain. Both are deaf. They requested a professional sign language interpreter. The emergency room refused to authorize payment for a professional sign language interpreter to assist in Mrs. Daviton's communication needs. Instead she had to rely on a staff member who was not qualified to interpret.

These stories are playing out in hospitals, clinics and doctor's offices across the country. Such scenarios affect quality of care, access to medical services, individualized participation in the decision-making process and the health/life of these hearing-impaired individuals.

The Hearing-Impaired Patient

More than 28 million Americans have hearing losses that can hinder daily communication. Sixty percent of people with hearing loss are between the ages of 21 and 65 (working age). By age 65, one out of three people have a hearing loss. Thirty out of 1,000 school age children have a hearing loss.

Among the 28 million Americans with hearing losses, there are different levels of hearing impairments such as mild, moderate, severe, and profound deafness. Within the deaf groups, there are three levels of deafness that exist: persons who are born deaf, persons who lost hearing after speech was acquired, and persons with sudden deafness. The varying levels are part of the reason that communication with hearing-impaired individuals is so difficult.

A person's hearing impairment affects everyone — his or her family, friends, co-workers, health care providers, and strangers. If a hearing-impaired individual cannot communicate with others, he or she cannot establish a dialogue.

This article is the first in a three-part series on access to medical care for the hearing-impaired individual. Part one provides a snapshot of the importance of the issue and discuss the legal rights of hearing-impaired individuals. Part two will cover the hearing-impaired individual's responsibilities in ensuring that he or she gets quality medical care for him or herself and his or her family. Part three will cover hospitals' and doctors' responsibilities to their hearing-impaired patients.

Dialogue is an essential ingredient in the exchange of words or ideas that makes communication effective.

Each deaf individual has a preferred and unique form of communication. Among the forms of communication they may choose are speechreading, American Sign Language (ASL), English Sign Language or another visual method. Speechreading or lipreading involves looking at the speaker's face and watching the mouth movements that form speech. ASL and English Sign Language use finger/hand movements as well as facial expressions to form words. The difference between ASL and English sign language is the linguistic of the language. For example, in saying, "Are you going home?" when using English sign language, it is signed exactly as it is spoken. But when using ASL, the signer signs, "Home You?" Other visual methods may include anything ranging from the exchange of written notes to use of another type of sign language originating from the person's home land, such as Dutch, French or Japanese sign language. All hearing-impaired individuals have legal rights regarding their unique communication needs.

Legal Rights

Some state and local laws impact the rights of the hearing-impaired, but the major protections for this class of patients arise from federal law. Under federal law, both the Americans with Disabilities Act of 1990 (the ADA) and the Rehabilitation Act of 1973 (the Rehabilitation Act) prohibit discrimination against people with disabilities that affect at least one major life activity, such as hearing.

Regulations promulgated under the Rehabilitation Act require recipients of federal funds that employ fifteen or more persons in the provision of health, welfare, and other social services to provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills where necessary to afford such persons an equal opportunity to benefit from the services in question. The regulations ex-

(Continued on page 7)

(Continued from page 6)

plain that auxiliary aids may include interpreters.

While there is no *per se* rule that sign language interpreters are necessary in hospital settings, violations of §504 of the Rehabilitation Act may be found where hearing-impaired patients have been denied access to sign language interpreters. The test, a factual one, is whether an interpreter is necessary to provide the hearing-impaired individual with an opportunity to benefit from the services provided equal to the opportunity enjoyed by patients who do not suffer from hearing impairments.

Similar to but broader than the Rehabilitation Act, which only reaches programs and activities receiving federal money (such as Medicare payments), the ADA prohibits discrimination by any person who owns, leases, or operates a place of public accommodation. There is no requirement that federal money be involved to trigger regulation under the ADA.

When Congress enacted the ADA in 1990, it specifically found that American society has "tended to isolate and segregate" persons with disabilities, and that this societal practice constitutes a "serious and pervasive social problem." Among the various forms of discrimination that people with disabilities frequently encounter, Congress specifically recognized the "communication barriers" suffered by deaf persons. Thus, when Congress enacted the ADA to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," it clearly contemplated discrimination against deaf persons.

Public accommodations include hospitals, pharmacies, physician offices, dentist offices, mental health counselors and those places that affect commerce. The ADA defines discrimination as the failure to take necessary steps to ensure that no individual with a disability is "excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids or services."

A decade after the ADA's enactment, health care remains a critical area of need for persons with disabilities. Although disabled individuals as a group may be better protected from having the door to a doctor's office, a dentist's office or the hospital shut in their faces, individual people with disabilities still face substantial barriers to health care access.

Looking Forward

Even with all these federal laws in place, the system still displays weaknesses. Federal laws have made some improvements in the lives of disabled individuals in the area of deaf awareness, but society as a whole must be willing to make some changes along with the input from disabled individuals. The next two articles in this series will examine the duties of both patients and providers in this regard.

Notes

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2. *Freydel v. New York Hosp.*, No. 97 Civ.7926, 2000 U.S. Dist. LEXIS 9, at *2 (S.D.N.Y. Jan. 4, 2000).
3. *Daviton v. Columbia/HCA Healthcare Corp.*, No. 98-16698, 2001 U.S. App. LEXIS 2969, at *6 (9th Cir. Cal. March 1, 2001).
4. Self Help For Hard of Hearing People, (visited March 31, 2001) <<http://www.shhh.org/NewWeb/Memb/membinf.html>>.
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7. 42 U.S.C.S. § 12101-12213 (LEXIS Law Publishing 2001).
8. 29 U.S.C.S. § 794 (LEXIS Law Publishing 2001).
9. 29 U.S.C.S. § 701 (LEXIS Law Publishing 2001).
10. 45 C.F.R. § 84.52(d)(1) (2001).
11. 45 C.F.R. § 84.52(d)(3) (2001).
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14. *Falls v. Prince George's Hosp. Ctr.*, Civil No. DKC 97-1545, slip op. at 20 (D. Md. March 16, 1999).
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16. 29 U.S.C.S. § 794(a) (LEXIS Law Publishing 2001).
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18. 42 U.S.C.S. § 12101(a)(2) (LEXIS Law Publishing 2001).
19. 42 U.S.C.S. § 12101(a)(5) (LEXIS Law Publishing 2001).
20. 42 U.S.C.S. § 12102(2)(A) (LEXIS Law Publishing 2001). The ADA defines disability as "a physical or mental impairment that substantially limits one or more of the major life activities of an individual." Clearly individuals with hearing impairments, including the profoundly deaf, are protected by the Act.
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22. 42 U.S.C. §12182(b)(2)(A)(iii) (LEXIS Law Publishing 2001).
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Prison Dilemmas: Corrections Committee Faces Tough Cases

(Continued from page 1)

the country.

I had prior experience with bioethics committees, having been a founding member of Sarasota Memorial Hospital's committee in 1983. As was typical of most hospital-based committees, there were monthly meetings to discuss ethical problems related to that hospital's patients, to consider and recommend policies, and to provide consultations as needed.

The prison system was a stark and massive contrast to the hospital environment. Sarasota Memorial was an 800-bed community hospital, serving a small part of the state. In contrast, the Florida state correctional system prisons held 38,000 prisoners when I became its medical director in late 1989; it has since grown to the current count of 72,000 incarcerated in the major institutions (these numbers do not include federal prisons nor county jails in Florida). These prisons are located all over the state, from the Keys to the remote end of the Panhandle.

The inmates of our prison systems are disproportionately from minority groups, from the socioeconomically lower strata, the undereducated. These offenders enter the prisons with higher proportions of health problems than in the free world, both physical health and mental health disorders.

The federal courts had decreed that the incarcerated have a constitutional right to health care, with specific reference to the Florida system. However, it seemed to me that the ethical considerations were more important than the courts' mandates. How much health should the state be providing our inmate patients? How to assure the quality of that care?

To assist our health care providers and the Department in identifying and addressing ethical issues, the Corrections Bioethics Committee was organized in 1993, with its initial meeting in 1994. It was the first of its kind in the nation, and is apparently still unique. We were fortunate in having the enthusiastic participating by outstanding ethicists from outside the corrections system, Dr. Ken-

Florida's Department of Corrections Ethics Committee has looked at capital punishment, human subjects research and prison policy.

neth Goodman from the University of Miami and Dr. Ray Moseley from the University of Florida were founding members, and still give of their time and expertise to the committee. By design, a majority of its members are from outside the correctional systems.

The Mission of the Bioethics Committee are these:

1. Identify and analyze ethical issues, and provide practical approaches to resolving those issues.
2. Provide educational services to appropriate entities within the department.
3. Review and advise on policies.
4. Conduct research on issues affecting correctional health care.

In addition to these functions, the committee provides consultations when requested by health care providers within the system.

With its members scattered throughout the state, monthly meetings in one set location were impractical. The committee meets quarterly, usually in one of the major institutions. It communicates mostly by E-mail, for consultations and other issues.

The Bioethics Committee has been of major help to the Department in many ways, especially by being available for consultation, by assisting in the development of policies and by participating in educational workshops.

Among the ethical issues addressed by the Committee are these:

1. **Inclusion of prisoners in investigational drug**

(Continued on page 9)

Ethics Committees as Sources of Educational Opportunity

JASON BORENSTEIN, PH.D.

For approximately three years, while completing my doctoral degree in philosophy, I participated as a supervised observer at various ethics committee meetings within the University of Miami's medical community. Being a part of these meetings significantly enhanced my appreciation for ethical issues in the clinical environment, which leads me to believe that allowing other students in the future to observe ethics committee meetings could be a potentially rewarding educational opportunity. Up until now, it is an opportunity that has been largely untapped.

Attending ethics committee meetings enabled me to see how professionals from fields such as medicine, nursing, social work, psychology, and law work together to respond to concerns about patient care, hospital policies and practices. For example, questions were raised during an ethics meeting about why a patient's family disagrees with the medical staff's treatment recommendation. Committee members analyzed the situation from various different perspectives and offered suggestions about how to improve the situation. Suggestions included making sure that the patient adequately understands the benefits and drawbacks

to the recommended medical procedures and that the medical staff takes more time communicating with the patient's family about treatment options.

My education at the ethics meetings consisted of learning about concepts such as autonomy, beneficence, privacy, justice and valid consent, while gaining an appreciation for how these concepts apply to clinical practice. At times, it was difficult for committee members to figure out how ethical standards and principles should best be applied in a particular case, such as when parents do not want their child to be informed about his/her diagnosis. Yet ethics committees can provide a forum to discuss the relevant issues as committee members and medical staff alike strive to improve patient care and make decisions that are appropriate both medically and ethically.

On the basis of my experience at ethics committee meetings, I believe that a valuable educational opportunity is available not only for students in medical fields, but for students in areas such as law, philosophy, and theology as well. By attending ethics meetings, students from these and other related fields could gain a fuller appreciation for ethical issues associated with medicine and come to realize that improving patient care is an ongoing and complex process.

Prison Dilemmas: Corrections Committee Faces Tough Cases

(Continued from page 8)

- studies.** The Committee developed the policy for inclusion in investigational studies. This policy serves as the basis for all such studies throughout the department.
2. **Institutional Review Board.** The Committee made recommendations on the composition and function of the Department's IRB. Special consideration – any IRB dealing with prisoner subjects, must include a member who is a "prisoner or a prisoner advocate"
 3. **Executions.** There have been lively discussions about the ethics of participation of health care providers in the execution process. The Code of Ethics of the American Medical Association proscribes such participation, but state statutes in Florida and many other states require such

involvement.

4. **End of Life Care for Prisoners.** With longer sentences, and elimination of early release, the prison population is aging, and is sicker. More will be dying in prison. The committee made recommendations, and also conducted a panel presentation at a statewide workshop.
5. **Palliative Care for Prisoners.** Assure access for eligible prisoner patients. Monitor appropriateness and adequacy of program.

These are but a few of the issues addressed by the committee. The committee is active, with spirited discussions. It has been of substantial help to the department in resolving ethical concerns, and it is hoped that this unique body will continue to provide the correctional system with fresh perspectives, from both sides of the bars.

Balance in Pain Management is Hailed as Optimal Strategy

(Continued from page 1)

unintended, effect of also increasing diversion and abuse.

Similarly well-intentioned activities focusing on the deterrence of opioid diversion will usually create significant barriers to effective pain management.

The problems of policy and practice that can arise when activities geared toward increasing or decreasing access to opioids become unbalanced were addressed on January 14, 2002 at a meeting sponsored by the Florida Partnership for End-of-Life Care. Held at the Florida State University College of Law, the "Forum on Pain Policy: Balancing Patient Care and Drug Abuse Prevention" provided an opportunity for reflection on the past several decades of drug regulation in Florida, and a glance at the future of public policy that may, if not carefully crafted, unduly restrict the ability of health care providers to work with their patients and caregivers to relieve suffering.

Keynote speakers were David Joranson, M.S.W., Director of the Wisconsin Pain and Policy Studies Group, and Jennifer Strickland, Pharm.D., a member of the interdisciplinary pain team at Moffitt Cancer Center in Tampa and President of the Florida Cancer Pain Initiative. Joranson provided an overview of pain policies under federal law and under the laws of other states. Strickland described the many challenges clinicians face in their care of patients and their efforts to comply with regulatory requirements. Reactor panelists from the Office of the Attorney General, The Governor's Office of Drug Control, the Agency for Health Care Administration, and Florida State University College of Law faculty added perspective to these presentations.

There was general agreement with the principle of "balance," in pain management policy. Neither patient care nor abuse pre-



Florida's Partnership for End-of-Life Care co-sponsored the Tallahassee forum on pain management and drug abuse.

vention should be emphasized at the expense of the other. Public policy should seek to both enhance patient care and eliminate drug abuse. Clinical practice, on the other hand, presents difficult choices that may require emphasis on access to analgesia even though this approach may lead to some "leakage" from the closed medication use system.

The catalyst for this discussion, which began many years ago and will undoubtedly continue into the foreseeable future, is a bill introduced in the Florida Senate (SB 636, House companion HB 701). This bill would, if passed, establish a multiple hard copy and electronic monitoring system for most controlled substances.

Participants in the Forum were generally supportive of law enforcement activities intended to reduce substance abuse, but they expressed concern that there may not be persuasive evidence that this high level of surveillance will produce benefits without adversely affecting the quality of patient care in Florida.

Schiavo Family Mediation Fails; Right-to-Die Case Heads to Trial

DAVID SOMMER
The Tampa Tribune

CLEARWATER – Family members battling over Terri Schiavo's life will face each other once again in a trial, a judge has ruled.

Michael Schiavo and his in-laws, Bob and Mary Schindler, called a truce last fall in their dispute over Terri Schiavo's right to die. Rather than follow an appeals court order to choose a total of five doctors to examine Terri Schiavo and give opinions on her chances of improvement, the family decided to try to resolve its dispute through mediation, with a retired judge acting as referee.

But the talks broke down, and neither side feels there is much hope of an out-of-court settlement, lawyers in the case told Pasco-Pinellas Circuit Judge George Greer. Greer told both sides to resume following the appeals court's directions on selecting doctors. The judge also scheduled a trial to begin Oct. 14; it will be the second in a decade long family feud.

Terri Schiavo, now 38, suffered a heart attack in 1990 that cut off oxygen to her brain and left her in what her husband's doctors describe as a comalike, persistent vegetative state. Michael Schiavo says his wife has no hope of improvement and would not want to be kept alive with the help of a feeding tube implanted in her stomach.

The Schindlers say their daughter reacts to them with laughter, tears and moans during bedside visits and could improve if given aggressive therapy.

In February 2000, after a trial, Greer ruled that Terri

Schiavo made statements prior to her illness indicating she would not want to be kept alive with no hope of recovery.

Since then, the two sides have fought a legal battle that went as high as the U.S. Supreme Court, while a series of deadlines for disconnecting Terri Schiavo's feeding tube came and went. At one point last year, the tube was disconnected for several days on one judge's order, only to be reconnected on another judge's order.

About half of a \$700,000 medical malpractice award intended for Terri Schiavo's perpetual care has been spent on care, and on Michael Schiavo's legal bills. Her parents have accused their son-in-law of seeking to inherit the money upon his wife's death.

Michael Schiavo has accused his in-laws of wanting him out of the picture so they could inherit the money.

In October, the 2nd District Court of Appeal ruled that Terri Schiavo should be kept alive only if the Schindlers can prove that medical advances could help their daughter.

The appeals court said each side should pick two doctors, with Greer choosing a fifth, to examine Terri Schiavo and offer their opinions. Greer said that process will culminate in the October trial. In order to prevail, the Schindlers must prove that new treatments can improve their daughter's quality of life to the point that she would want to undergo them if she were able to make the decision, the judge said.

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Perry Como's End-of-Life Care Caused Rift in Family

KATHRYN QUIGLEY
The Palm Beach Post

WEST PALM BEACH — Crooner Perry Como was very ill at the end of his life, and his medical condition so concerned his children it created a rift between two of them, according to court records.

His daughter, Therese Thibadeau of Jupiter, battled with her older brother, Ronald Como of Indiana, over their father's medical care while he was alive and questioned her brother's ability to be the personal representative of the estate after their father died last May.

Como was almost 89 when he died in his Jupiter Inlet Colony home. He had Alzheimer's disease.

Perry Como signed a living will in 1999, saying that, if there were "no reasonable expectation of my recovery from extreme physical and mental disability," he should be allowed to die.

Last year, Thibadeau began to voice concerns about Perry Como's care. She wanted to bring in hospice workers to make her father feel more comfortable.

According to court documents, she claimed that Ronald Como refused to allow hospice workers to attend to her father. She also stated that her brother wanted to place their father on a respirator and have a feeding tube inserted, against the wishes in his living will.

Her brother denied that. "I will abide by my father's wishes and allow him to die and not be kept alive by medications (or) artificial means," he wrote in a court document. However, Ronald Como said he did not give permission for hospice workers to care for their father because he didn't believe Perry Como wanted that.

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