From the Executive Director

Literally central to this issue of the HCECG Bulletin is the Executive Summary of the End-of-Life Care Practices Report that many of you or your colleagues took the time to complete a year ago. The summary gives us a snapshot of end-of-life care practice at a number of organizational members of the Ethics Consortium. Some of the survey findings may affirm your experience or expectations. For example, respondents believe that keeping patients comfortable - particularly, free from or in control of their pain – is of key importance in providing high quality end-of-life care. The report also provides preliminary data that indicates the need for end-of-life care education and improved clarity about the honoring of advance directives and do not resuscitate orders. We hope that you will take the time to read the summary and to share a copy of the full report with health care professionals and administrators at your organization.

Perhaps most promising is that the information from this report has been utilized to create a second phase of research, in which more representative samples of physicians, nurses, social workers, and chaplains involved in end-of-life care in the state will be surveyed. We anticipate that those surveys, which will be sent out by early March, will provide a much more comprehensive snapshot of end-of-life care practice across the state. If you receive a survey, please take the 20 minutes we estimate it will take to complete it. These research efforts will help to identify opportunities for improvement in Georgia at the clinical, educational, and policy levels.

Also note that we are looking forward to our May 22,23 annual HCECG conference, Ethics in A House Divided: Connecting Decision Makers in Health Care Organizations. This event will bring a variety of health care professionals together to discuss how multiple resource divisions and individuals at our organizations do or could work together to resolve complex issues. Accommodation to patient demands (including cultural, religious and racial requirements); added pressures in a nursing shortage; admission

Continued on page 4
**What We Do**

The Health Care Ethics Consortium of Georgia (HCECG) was founded in January 1994 following a three-year planning period funded by Emory University and the Georgia Humanities Council. Clinicians and health administrators statewide participated in the formation of a network of health care organizations that shared a common interest in bringing ethics analysis to patient care and organizational issues. The current membership of the Consortium includes 65 health care organizations. The membership is comprised of hospitals and health systems, home health agencies, hospices, long term care facilities, managed care organizations and rehabilitation centers. The Emory University Center houses the staff of the Consortium.

The Consortium provides educational programs and consultative services for physicians, staff of member organizations, and the community. HCECG offers six regional meetings per year, two in each of three regions of the state: north Georgia, southeast Georgia, and southwest Georgia. An annual conference attracts participants from across the state. Educational programming addresses a wide variety of issues chosen from the interests of our member institutions.

Topics have included: improving care at the end of life, guidelines for case consultation, ethics and communication, organizational ethics and Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), and family involvement in decision making. Meetings are videotaped and the tapes are made available to members through our lending library.

Primary funding for the Consortium comes from membership dues. The Center for Ethics at Emory University provides support for the Consortium through staff time, office space, and numerous in-kind donations. Member institutions provide in-kind contributions by hosting regional meetings and supporting staff involvement on our advisory board and other committees. The remainder of funding comes through individual gifts and foundation support for specific research areas.

Other services to Consortium members include:

- CME and other CEU credits for health professionals
- Support for implementation of JCAHO standards regarding organizational ethics and patients rights
- Orientation for new ethics committee members
- Access to ethics resource people and materials; consultation service available
- Surveys regarding the status of ethics activity in the state
- Networking with other ethics consortiums nationally
- Membership directory
- Sharing of member policies and procedures related to ethics

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**From the Editor’s Desk**

As I sit here considering what to say, I am struck by the number of ethical issues that currently face professionals in the field of healthcare. In the last 2 days alone, I have found myself presented with enormous issues that will provide healthcare professionals ongoing opportunities for ethical analysis in the years and decades to come. Yesterday I watched a national television program on the human genome project. We have not even begun to scratch the service of the ethics that will evolve from what we have and will learn from this most valuable research. The Sunday newspaper headlined an article on the new patients’ privacy rule. The article presents fairly uniform agreement that patients have a right to privacy. It also presents some of the questions many have about how implementation to these rules as they appear to be written may impede the provision of timely and quality patient care raising questions of justice. On an on-line news site I read about a proposal being made in Japan to imbed microchips on patient’s fingernails. This microchip will contain vital information about the patient and is being developed in response to unacceptable numbers of healthcare errors. Medical errors and how best to address them is a concern not only for institutions but also for bedside practitioners.

Perhaps you may be thinking, “These are not my issues.” And that may be true – today. But these issues will become everyone’s issues in the days yet to come. So what can you do? First and foremost, stay informed. Take the opportunities that are presented to you to learn about these issues. Talk with colleagues about the ethical implications of these findings and studies. Consider how they affect your work and what they will mean to the quality of care of your patients. Ethics does not exist within each of us alone, but rather within the communities in which we live and work. And it is within these communities that we will discover what is right and what is wrong with respect to these issues.

—— Karen Trotochaud, MN
Action Ideas

The Community Education and Health Services Division (Educare) of Houston Healthcare Complex coordinated a 4-hour countywide Health Fair held on October 28, 2000 at the Houston Mall in Warner Robins. Participation was open to health related organizations in the middle Georgia area.

In September, the Houston Medical Center's Biomedical Ethics Committee, of which the Perry Hospital's Biomedical Ethics chairman, is a member, decided to participate in the Health Fair. The information to present to the public would include both hospitals of the Complex: Perry and HMC. A board was created displaying the purpose of the committee, members names, the policy, advance directives, patient's rights, information explaining possible reasons for consults, and the Complex's membership in the HCECG.

682 people from the community attended the Health Fair where they were handed a Durable Power of Attorney, a Living Will and Patient Rights at the Biomedical Ethics booth. Also distributed was the brochure entitled “Communicating your Health Care Choices”. We found that this method of informing the public about the Biomedical Ethics committee was very favorable. It certainly created a lot of dialogue.

Paired committee members manned the booth for 1-hour periods.

We feel it was very successful and plan to become a part of the fair every year.

——— Jane Kirkland
Director of Education
Houston Healthcare Complex

Are You an Aspiring Author?

Do you wish or need to be published to advance or maintain career goals? Do you have a burning issue that you would like to bring to the Consortium for discussion? Are you an avid reader who would like to share a recently read book? Do you have a particularly interesting clinical case that you feel others could benefit from reviewing and discussing? Then the HCECG Bulletin is looking for you. We are in need of submissions of all sorts for upcoming issues of this newsletter. You do not need previous experience – just put your pencil to paper and we will edit as necessary. If you have questions or would like to submit an item, please contact newsletter editor Karen Trotochaud at (404) 727-2796 or ktrotoc@emory.edu.

HBO Presentation of Wit

HBO will air a special movie presentation of the Pulitzer Prize-winning play Wit on Saturday, March 24, 2001 at 9 p.m. Wit is a compelling drama about end-of-life issues. In the movie, Vivian Bearing, played by Emma Thompson, is a renowned professor of literature who is diagnosed with advanced ovarian cancer. With elegant phrasing and emotional power, Wit compels us to reassess our own lives, just as Vivian Bearing must do.
From the Executive Director

Continued from Page 1

decisions in nursing homes, and response to medical error will be some of the topics considered. I am pleased that Carol Taylor, Director of the Center for Clinical Ethics at Georgetown, and Larry Minnix, President of the American Association of Homes and Services for the Aging, will join us for opening and closing talks on the day. We hope that you will make plans to join us and will tell your colleagues.

In this busy year at the Consortium, I want to particularly acknowledge some of the individuals who have continued to provide leadership for our efforts. Over the last 6 months the Advisory Board has been through a self-assessment process to identify opportunities for development. The decision was made to retain a small core (6) of current members in order to invite new Board members who can help us in the next phase of development of the Consortium. We appreciate the continued service of the board members listed on the front of the newsletter. A number of the board members who are rotating off are individuals who were present in the formative months of the Ethics Consortium and have provided countless hours in counsel to and hands-on involvement in, the Consortium’s many activities. HCECG is indebted to these individuals: John Anderson, Memorial Medical Center; Barbara Hanevold, Emory Center for Rehabilitation Medicine; Martha Harrell, Georgia Hospital Association; Cindy Leipold, Northside Hospital; Eve Levine, William Breman Jewish Home; Kevin Murrell, Medical College of Georgia; Pat Szucs, Visiting Nurse Health System; and Gail Ulmer, John D. Archbold Memorial Hospital. We thank them for their passionate support of our efforts and look forward to their continued involvement in other dimensions of the Consortium.

—— Kathy Kinlaw, M.Div.

GEORGIA Collaborative to Improve End-of-Life Care

Opens Call for Presentations

On June 8, 2001 the GEORGIA Collaborative to Improve End-of-Life Care will host its third annual conference. The Best Practices Conference to be held at the Loudermilk Center in Atlanta will provide the opportunity to learn from presenters about their best practices on end-of-life care in acute care settings, nursing homes, hospices, and within the community. Project descriptions for oral and poster presentations are currently being accepted. Oral presentations will consist of 20-minute presentations, followed by questions and answers. Poster presentations will be displayed on table presentation boards for review during breaks and the lunch session. The deadline for submission of a presentation description is Monday, March 26, 2001. For additional information or questions, please contact Glenn Landers at 404-463-9562 or go to the GEORGIA Collaborative website, www.gaeolcare.org.

HCECG WEBSITE

www.hcecg.org

In 2000, the HCECG proudly entered the world of internet technology, by launching our very first website. We encourage all members are to visit our website for up-to-the-minute information regarding the HCECG. Some of the information offered on the website are:

- Membership registration information and forms
- Registration forms for Regional Meetings
- Information about the upcoming Annual Meeting
- Links to other websites we feel will be of interest to our members
- Listing of our videos and forms to borrow them
- Posting of our Newsletter
- 1997 HCECG Futility Report
- Faculty and staff bios

The website is updated frequently and we are always open to suggestions from you. If you have any suggestions for us, please contact Kim Gardner, webmaster, at kagardn@emory.edu.
End-of-life Care Practices
A Survey of Organizational Members of the
Health Care Ethics Consortium of Georgia
Prepared by Emory University Center for Ethics
January 2001

Executive Summary
(condensed)

Care of the dying is a multi-layered issue. The causes, places and timing of death, and ways in which death occurs provide a challenge both in understanding how we die, and, for health care professionals and family care givers, in providing high quality end-of-life care.

Despite a rich and growing literature on death and dying, there has been limited research on current end-of-life care practices. The Institute of Medicine’s 1997 report, “Approaching Death: Improving Care at the End-of-life,” notes that the evidence base for what constitutes effective end-of-life care is weak (IOM, 150) and that “methods of quality measurement and improvement … for care at the end-of-life … are at a fairly early stage of development.” (IOM, 152) The report calls for further research strategies that:

• “allow clinicians and others directly responsible for end-of-life care to evaluate and improve what they are doing on a continuing basis” and
• “help policy makers, patients, families, and the public to hold organizations and individuals accountable for how reliably and effectively they care for dying patients.”(IOM, 123)

The Current Survey

In fall 1999, representatives of member institutions of the Health Care Ethics Consortium of Georgia were asked to complete a comprehensive survey describing current end-of-life care practices at their institutions. The Consortium is a network of organizations that provide direct patient care in a variety of health care settings (acute care, long term care, hospice, rehabilitation, home health). One hundred and one (101) individual respondents, primarily from acute care settings (63.3% from hospitals and medical centers; another 7.1% from health systems), provided pilot data on or about the following aspects of end-of-life care:

- Advance Directives
- Pain Assessment and Management
- Palliative Care
- Family Support
- Do Not Resuscitate Decisions
- Hospice and Continuity of Care
- Hastened Death

These categories of care reflect most of the “quality domains” identified by the American Geriatrics Society (AGS) as areas where improvement and assessment of end-of-life care are needed. (AGS, 1997)
A. Major Findings

- The lack of a common language in end-of-life care continues to be a challenge in describing current practice.
  - There was no common definition of “end-of-life.” Thirty-three percent (33%) of respondents thought of end-of-life as beginning at the diagnosis of a terminal illness. Nineteen percent (19%) considered end-of-life as the final hours (or days) prior to death. Eleven percent (11%) defined end-of-life as the period beginning when a prognosis of 6 months or less to live is given.
  - Respondents considered a number of documents to be “advance directives” in Georgia. In addition to the 2 legally identified advance directives, the living will and the durable power of attorney for health care, 74% of respondents considered Do Not Resuscitate orders to be advance directives, and 38% identified organ donor cards as advance directives.

- Keeping patients comfortable, especially helping them maintain control of their pain, is one of the most important components of high quality end-of-life care. A pain management policy was reported by 56% of respondents. Fifty-five percent (55%) agreed that their institution’s pain assessment practice was effective; utilization of a pain assessment tool was reported by 58%. Forty-eight percent (48%) of respondents agreed that pain management practice at their facility was effective.

- Fifty-nine percent (59%) of respondents rated their facility as effective or highly effective in providing high quality end-of-life care.

- Only 10% of respondents were familiar with the Georgia Medical Board guidelines for the treatment of pain. Only 36% of respondents reported being offered courses in pain assessment or management during their professional education.

- The degree to which patients’ wishes, as expressed in advance directives, are honored is not clear. Ninety-three percent (93%) of respondents agreed that it is easier to plan for and provide care if an Advance Directive exists. However, when asked about the degree of difficulty in carrying out a patient’s advance directive instructions, 27% of respondents agreed that health care teams often find it difficult to implement advance directives.

- Sixty-four percent (64%) indicated that Do Not Resuscitate (DNR) orders are written late. Respondents were divided about whether patients with DNR orders are resuscitated in the face of family dissent.

- Ninety-one percent (91.5%) of respondents reported that patients/residents are aware of home hospice care. Yet an average of 42% of terminally ill patients are actually referred to hospice care, with a wide range in the actual percentages being referred.

- Seventy-seven percent (77%) of survey participants agreed that it is permissible to utilize legal treatment methods to decrease patient pain and suffering, even if death is hastened as side effect. Seventy-two percent (72%) of respondents also agreed that hastened death as a side effect of liberal opioid use does not equate with physician assisted death.

- Sixty-five percent (65%) of respondents believed that terminally ill patients should not be allowed to request and receive lethal medication doses, even under strict regulations. Sixty-two percent (62%) believed that physicians should not be allowed to assist patients in dying.

- Ninety-eight (98%) of respondent believed there can be a “good death”.

B. Methodology

The End-of-life Care Practices Survey used a 130-item questionnaire developed by the Health Care Ethics Consortium of Georgia at the Emory University Center for Ethics based on a review of the literature, and reviewed by lead organizations in the Georgia Collaborative to Improve End-of-life Care.

The questionnaire was tested with health care professional members of the advisory board for the HCECG. The Emory University Human Investigations Committee approved the survey. The questionnaire included Likert scale (1-5) items, yes/no, limited response, and open-ended questions. The majority of questions (57) were Likert items on a 1 to 5 scale where 1 indicated “strongly disagree” and 5 was “strongly agree.” In this report, results are often reported as the percentage of respondents who answered “disagreed,” meaning they answered 1 or 2 (strongly disagree and disagree) or “agreed,” meaning they answered 4 or 5 (agree and strongly agree).

The questionnaire was sent to 120 health care organizations that were current or previous member institutions of the Health Care Ethics Consortium of Georgia. Each organization was asked to identify and forward the survey to 4 institutional representatives who were aware of end-of-life care practices at the institutions. Of the potential 480 respondents, 101 (21%) surveys were completed. There were no follow-up calls or additional mailings of the survey. Completed surveys were returned in November and December 1999. Responses were coded and entered into the SPSS Version 9.0.

Respondents were asked for their opinion. There were a high number of non-respondents on some questions. Frequencies of responses and means for all items can be found in the full report.

C. Profile of Survey Respondents:

Of 101 responses, respondents’ affiliations were as follows:

- 63.3% Hospitals or Medical Centers
- 11.2% Nursing Homes
- 9.2% Hospices
- 7.1% Health Systems
- 6.1% Home Health and Rehabilitation
- 3.1% Other (includes mental health facility, geriatric center and HMO)

Professional disciplines represented among respondents were as follows:

- 53.5% nurses
- 15.8% social workers
- 13.9% chaplains
- 11.9% physicians
- 5.0% administrators

Respondents reported a wide range in percentage of time spent caring for patients at the end-of-life or on issues concerning those individuals:

- 52% reported spending 10% or less time
- 24% reported spending between 11 and 49%
- 23% reported spending 50% or greater time

Respondents indicated that they had formal end-of-life care training:

- 55% had courses during their professional training
- 78% had continuing education
- 64% had training at the facility in which they worked
- 25% indicated “other” types of end-of-life care education
D. Study Limitations

The results of this survey should be treated as pilot data due to limitations in several areas:

(1) The small sample size (# = 101) of a potential 480 respondents from 120 organizations (21%) means that percentages and means should be viewed as rough estimates, and results which are not statistically significant should not be eliminated from further study.

(2) The initial survey was not intended to be representative of all institutions or health care professionals working in end-of-life care in Georgia. Questionnaires were sent to member organizations of the Health Care Ethics Consortium of Georgia, a network which may be more aware of end-of-life practices and decisions due to their interest in ethics. Institutional representatives were asked to distribute surveys to individuals who were informed about end-of-life care practices at their institution and who represented a variety of professional disciplines, but there is no way to know whether that diversity was represented in those who actually completed the survey. Respondents were willing to take the time to complete a lengthy survey and were willing to attempt to answer a wide range of questions about institutional and professional practice, in some of which they might have had little direct involvement.

One must bear in mind that 52% of respondents reported that they spent less than 10% of their time attending to individuals at the end-of-life or on the issues concerning their end-of-life care. This may not be unusual in most non-hospice settings where end-of-life care is only one of many types of care provided. However, these limitations should be noted and the results should not be generalized to other groups.

(3) In reviewing questions from the institutional perspective, the reader should recall that the influence of personal opinion may be especially strong. In reviewing questions from the end of the instrument, the reader should be aware that respondents may have been tired and less attentive than they were to earlier questions.

In spite of these limitations, these data are extremely valuable as pilot data in several ways. They suggest a starting point from which one can begin to estimate the prevalence of knowledge, attitudes and beliefs about end-of-life care practices. They also suggest directions for future hypotheses about the links between professional disciplines and personal attitudes towards end-of-life care, as well as between personal attitudes and institutional characteristics or practice standards.

E. Acknowledgements

This report was made possible through a Whitehead Foundation grant to the Health Care Ethics Consortium of Georgia (HCECG) at the Emory University Center for Ethics and the Georgia Collaborative to Improve End-of-life Care. Coordination of research was provided by Kathy Kinlaw, MDiv, Associate Director of the Emory University Center for Ethics and Executive Director of HCECG; and Aubre Jordan Wells, researcher for the Center for Ethics.

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Case Study

[This is a fictitious case but it does present issues that some of our member organizations have recently faced.]

Johnny, a high school junior, was on the transplant list for severe cardiomyopathy following acute myocarditis. After an extended stay in the hospital he was able to go home. With a great deal of support from the staff, Johnny understood that he could die. The plan while he was waiting for a transplant was to continue to go to school for as long as possible, but if no heart became available, he would move to hospice care rather than go back into the hospital. His mother, on the other hand, never accepted the fact that he might die. Her current husband, Johnny’s stepfather, supported her view that a miracle would save Johnny’s life. Unfortunately, Johnny’s condition worsened and he was confined to home where he was cared for by his mother and followed by hospice.

Late one evening after having a bad day he suddenly suffered a cardiac arrest. His mother called 911. The hospital he was taken to was not the same as the one where he had been originally diagnosed and treated for the past several months. Without knowing his history, Johnny was resuscitated, intubated and placed in the Intensive Care Unit. The medical team found that he had suffered a stroke following the arrest. The medical team moved quickly to a diagnosis of brain death based on his presenting signs and symptoms and definitive tests.

When Johnny’s mother and stepfather were told that he was brain dead, initially they seemed to accept this. They asked to spend some time alone. When the nurse returned to the room, she found the door blocked. From inside the room, the stepfather shouted that no one was going to “Kill my son.” Johnny’s mother stated she just wanted to take him home and care for him herself. If any of the staff attempted to do anything against the family’s wishes, the mother and stepfather made threats of violence against them. These threats were considered to be serious including doctors, nurses, social workers and chaplains, the family continued to refuse to let anyone do anything to Johnny without their permission. Most of the time everyone was banned from the room. This was late Saturday evening. The healthcare team continued with this stand off until Monday morning. By this time the ICU had become quite tense. The parents were very intimidating to those staff that were allowed to care for Johnny, threatening to sue them if Johnny died or to call the local news station. At this point it was suggested that the Ethics Committee be called.

As a member of the Ethics Committee, how would you proceed with this situation? Several alternatives could be suggested. Since Johnny had met brain death criteria, he could be pronounced dead and removed from the ventilator by force against the wishes of his family. He could be kept on the ventilator in the ICU until the family agreed to withdrawal. Arrangements could have been made to send him home on the ventilator as the family was requesting. What would be the pros and cons to each of these options? Are their any other options you can think of? What options would be in the best interest of the patient? Of the family? Of the ICU and its staff? Of the hospital? If these are in conflict, how do you decide which one has priority?

——— Karen Trotochaud
Plan Now to Attend the Consortium's Annual Conference

In today's complicated health care organizations, difficult problems with ethical dimensions often land on the desks of administrators, physicians, risk managers, attorneys, chaplains, case managers, and other professionals, who often feel ill-qualified to address all the different facets of the dilemma. Yet they too often attempt to "muddle through" because they aren't sure what other organizational resources are available to help them frame the issue and seek an ethically appropriate resolution.

In our 2001 Annual Conference, scheduled for May 22 - 23 at Simpsonwood Conference Center, we will offer a framework for bringing disciplines together and tapping their synergy in resolving difficult problems. The conference title is "Ethics in a House Divided: Connecting Decision Makers in Health Care Organizations," and our purpose will be to utilize cases to learn how different disciplines approach problems and modeling behaviors intended to demonstrate how they might best work together. Framing the issue and challenging participants to examine how problems may be addressed in their home organizations will be the goal of our keynote speaker, Sr. Carol Taylor, CSFN, RN, PhD, an ethicist and professor at the Kennedy Center for Ethics at Georgetown University. The theme for her address is "Ethics, Integrity, and Everyday Decision-making." Following her presentation, professor Taylor will lead attendees in a group exercise, followed by in-depth discussions in small group breakout sessions.

As in the past, the second day of the conference will be the popular ethics committee workshop hosted by consortium executive director, Kathy Kinlaw. Organizational ethics teams are encouraged to stay and participate in this valuable conversation and networking opportunity.

Please look for forthcoming information with details about the conference and make plans to attend with a team of health professionals and ethics committee members from your organization. For the latest information about the conference, visit the consortium's website at www.hcecg.org

——— Ren Davis,
Conference Planning Committee Chair.
On September 13, 2000 the Medical College of Georgia hosted the Southeast Georgia Regional meeting. The program, From Theory to Organizational Practice and Policy: Developing an End of Life Model of Care, provided the attendees with information on the End of Life Care Pathway currently being piloted at Emory University Hospital and at Crawford Long Hospital. Ren Davis, Chair of the Crawford Long Ethics Committee, started off the meeting by correlating the work in the area of end of life care to principles of biomedical ethics. Jennie Perryman, RN, PhD, Primary Investigator, and Donna Arena, RN, PhD, Director, for the Renaissance Research Project, discussed how the Project got started. They briefly presented components of the End of Life Care Pathway including standardized adult comfort care orders, Do Not Resuscitate/Do Not Intubate orders, and a Treatment Options Decision Tree for End of Life Care. Their advise to others interested in developing end of life care protocols included recruit a multi-disciplinary team who are interested in end of life issues, consider formal and informal influences, meet regularly, assign sub groups to work on identified tasks, and be patient.

The Southwest Georgia Regional meeting was held at John D. Archbold Memorial Hospital in Thomasville on November 2, 2000. The title of this meeting was From Theory to Outcomes: Evaluating the Ethics Consultation Process and its Consequences. Kathy Kinlaw, Executive Director of HCECG, presented a national perspective on the state of ethics consultation evaluation. Ethics consultation evaluation is not well understood and is infrequently implemented. To help attendees begin to address this process, Nancy Thompson, PhD, provided information on how to conduct outcomes research. She presented specific examples of types of outcomes research as well as examples of how these can be implemented in the process of evaluating ethics consultation. The group was also able to see two examples of outcomes evaluations. Ren Davis, Chair of the Crawford Long Ethics committee, distributed and discussed Crawford Long’s Ethics Committee Self Assessment Questionnaire and Staff Assessment Survey. Marc Weinstein, MD, presented the Community Evaluation Survey conducted by the Midwest Bioethics Center. Participants were able to see how outcomes research theory could be implement to evaluate the work of ethics committees.

Kaiser Permanente in Atlanta hosted the North Georgia Regional meeting on Corporate Compliance and Organizational Ethics on February 22, 2001. Over 50 participants attended this educational session. Catherine Futch, Regional Compliance Officer for Kaiser Permanente, started the program with a description of corporate compliance, its history and its evolution. Woven into her presentation were the elements of the Kaiser program. Following this presentation compliance programs within differing healthcare settings were described. Marilyn Head, Director of Compliance, Risk Management and Safety at Piedmont Hospital, explained how compliance is implemented within a community hospital setting. Due to differing regulatory agencies, compliance within the home care environment presents a new set of challenges. Carol Williams, Director of Financial Administration and Corporate Compliance Officer, described the program within the Visiting Nurse Association. Anne Adams, Chief Compliance Officer for Emory Healthcare, Inc., presented the components of compliance within an academic institution. All speakers discussed their relationship with their institutions’ Ethics Committee and how compliance and ethics intersect with each other. The attendees were repeatedly informed of the critical importance of orientation and education with respect to compliance. The afternoon session allowed the participants to integrated the concepts about compliance with the those of ethics through small group discussion of selected case studies.

—— Karen Trotochaud
Upcoming Events

March 24, 2001  HBO will air a special movie presentation of the Pulitzer Prize-winning play *Wit.*

May 22-23, 2001  *Ethics in a House Divided: Connecting Decision Makers in Health Care Organizations*, HCECG Annual Conference and Ethics Committee Workshop, Simpsonwood Retreat and Conference Center, Norcross, Georgia.

June 8, 2001  *Third Annual Georgia Collaborative to Improve End-of-Life Care Conference, Best Practices Conference* Loudermilk Center, Atlanta, Georgia

The *HCECG Bulletin* would be pleased to post upcoming educational activities or events. For information about future postings, contact HCECG at hcecg@emory.edu or fax to  (404) 727-7399.