Dangerous Intersections: Law, Ethics, and HIV-Infected Health Care Workers

By Leonard M. Fleck, Ph.D.

Should hospitals screen all their health care workers for HIV infection on a routine basis? And should they then exclude from any patient care activities (or fire) any health care workers who turn up HIV-positive? Just one year ago these questions would have been viewed as being somewhat academic since there had been no documented case of transmission of HIV from a health care worker to a patient. That, of course, changed a little less than a year ago when it was revealed that a Florida dentist who was HIV+ had infected three of his patients. This was followed shortly thereafter by further revelations of dentists and surgeons who had recently died of AIDS whose patients were now being retrospectively contacted to see whether or not they might have been accidentally infected in the course of receiving medical or dental care. As if to add fuel to the fire, in late 1990 the Center for Disease Control released estimates that there were 360 HIV-infected surgeons in the United States and about 5,000 practicing physicians who were HIV-infected (out of 500,000). If we do a simple extrapolation from these figures to non-physician health care workers, then there are about 35,000 such individuals who are HIV+.

When we get to numbers this large, then it almost seems as if we have answered the question posed at the beginning of this essay. Yet, what I shall want to argue here is that that knee-jerk answer is the wrong answer, that neither the law nor ethics ought to support the idea of widespread, mandatory HIV-testing of health care workers. Further, there is neither adequate moral nor legal justification for having such testing as a condition of initial or continued employment with a health care institution.

There is no doubt in my mind that the vast majority of patients would prefer not to receive care of any kind from an HIV-positive physician. Several reliable opinion polls confirm this as well. But should any moral weight be attached to this preference? Or should laws be enacted that would allow the coercive powers of the state to be used to assure that this broad public preference is not ignored? Again, I would argue that what we are talking about are “perverse preferences” that have no claim to either moral or legal authority. During the decades of the ‘50s, ‘60s and beyond I strongly suspect that there were large numbers of whites who would have preferred not to receive care from black health care professionals. This was simply a product of discriminatory attitudes, exactly the kind of preference that should not be legitimated through law or morality, especially in a society committed to the ideal of equal respect for all.

The obvious response is that individuals who are HIV-infected are not being discriminated against; rather, it is the deadly disease they carry which might infect unsuspecting and vulnerable patients which is the real (and legitimate) object of discrimination. Further, the argument goes, patients have no effective way of finding out for themselves which health professionals might put them at risk. Consequently, hospitals, as a place where patients are put at heightened risk because of the invasiveness of procedures done there, ought to have special moral and legal responsibility for protecting patients who entrust themselves to these institutions. Someone might make the additional argument that

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insurance companies should require an HIV-test as a condition for obtaining malpractice insurance, thereby protecting both their own economic interests and the public interest in access to safe health care. Prima facie, this seems like a more plausible line of argument. However, there are countervailing moral considerations that need to be given their due.

We begin by noting that there are very high costs associated with any program of massive HIV-testing. There are about four million health professionals in the United States who might have to be tested twice each year. In economic terms alone those costs are massive. But one of the predictable consequences of any such massive testing program is that health professionals will demand that all patients submit to an HIV-test, the reasonable argument being that health professionals are ten times more likely to become infected as a result of patient contact than the other way around. That multiplies severalfold the number of HIV tests that would have to be done each year.

If the cost of all this testing were "merely economic," there might be some justification for it. But there are very high human and moral costs as well. Right now the two most reliable tests we have are the ELISA and Western Blot. But even if these tests were done exclusively at reference labs where you have the highest possible standards for processing and interpreting these tests (which is not a real world possibility when we are contemplating doing eight million tests a year), we would still end up with 100-150 false positive test results for each round of testing of health professionals, which would be after three tests had been done. For those individuals their lives would be devastated—wrongly! Still, if we were able to prevent a thousand vulnerable and unsuspecting patients each year from becoming HIV-infected through the health care system (and ultimately dying as a result), that might not be too high a price to pay. But is that the tradeoff we would be making?

Right now there is no evidence at all to suggest that there are large numbers of patients who have become HIV-infected through the health care system. The Center for Disease Control in February of 1991 issued a report in which they offered a statistical projection of the number of Americans who might have been infected as a result of receiving care from an HIV+ health professional during the past decade. At the low end that figure is 13 individuals and at the high end it is 128 individuals. What that low end figure means is that slightly more than one person per year in the United States would become infected through clinical contact. That such things might happen is regrettable, but it is not obvious that that is sufficient to morally justify the harm that would be inflicted each year on 200-300 health professionals who would be falsely labelled HIV+.

The figure at the high end might tempt us to make a different moral judgment. However, there are other costs that are morally relevant that ought to dissuade us from making such a judgment. For example, I would argue that health professionals do have a serious moral responsibility to care for HIV-infected patients, and this is a responsibility that falls upon each health professional. Moreover, I recognize that there are risks to which health professionals are exposing themselves in providing such care, but the risks are not excessive. However, the risk equation does change in ways that have moral consequences if health professionals have to worry about losing their jobs, health insurance, and so on as a result of becoming HIV-infected. This still might not provide sufficient moral justification for their refusing to care for HIV-infected patients, but it would add moral weight to that side of the argument and provide a psychological incentive for refusing to care for such patients. And if this became a general attitude in the profession, then HIV-infected patients are the ones who would suffer.

There is another moral cost associated with mandatory HIV-testing that needs to be noted, and that is the violation of the privacy rights of health professionals. These are serious rights whose violation can only be justified if we can show that there is a compelling public interest we are protecting that cannot be protected in any other way other than through this overriding of individual rights.

Preventing the infection (and presumed death from AIDS) of some number of patients seems to be such a compelling public interest. However, we need to remind ourselves at this point that what we are really talking about is risk reduction. If we have only a limited budget for reducing the risks of a fatal unfortunate outcome for patients, then we ought to spend that money in a way that will maximize the number of lives or life-years that
are saved. From this perspective it would seem that the likelihood of a patient becoming HIV-infected from clinical contact is a very, very low probability event. Much more likely is the probability that a patient will die as a result of a nosocomial infection or as a result of poor medical care from a drug or alcohol impaired health care professional. Again, patients are as vulnerable and ignorant in these regards as they are of the HIV-status of health care workers who care for them. That is, patients generally have no idea at all of the fatal risks to which they are exposed in connection with the nosocomial infection rate of their community hospital, nor do they know which health professionals represent a risk to them because of a drug or alcohol problem. If this is true, then it would seem that both economic and moral rationality would require that these greater and more prevalent risks to the public welfare be addressed before draconian measures are employed to exclude HIV-infected health care workers from clinical contact with patients. Certainly, hospital administrators would not be acting in the collective best interests of their future patients if they were to squander limited resources for risk reduction on eliminating the extremely remote risks associated with HIV before they eliminated the equally serious but more proximate and prevalent risks noted above.

Even though I have suggested that there are more proximate risks that require the attention of professional leaders and hospital administrators, what I have not suggested is that even these risks would necessarily warrant the violation of individual rights to privacy through, for example, random testing for drug or alcohol abuse. And the fact is that hospitals have been wary of instituting any such programs, probably because they would not survive legal challenge. The same should be true of any program of mandatory HIV-testing. Again, the relevant moral consideration is whether there are alternative approaches to achieving a legitimate public health objective that would not require this violation of rights. What Keith Apeigren, M.D. (Dept. of Surgery, MSU) and I have argued in a recent paper (soon to be published somewhere) is that health professionals who are in high-risk categories for HIV-Infection because of behavioral choices have a moral obligation to know their HIV-status so that they do not expose others (patients or partners) to unnecessary risks. Such testing would be done voluntarily and at a testing site where they were more confident that their rights to privacy would be respected absolutely. We also recommend that their personal physician know their HIV-status so that their overall health can be monitored, and so that if there is deterioration in their clinical skills in the later stages of the disease (such as HIV dementia) they can be advised to withdraw from practice. This sort of voluntary approach protects the moral rights of individuals (both patients and health professionals) while at the same time protecting reasonably well, but not perfectly well, legitimate public health interests.

The public may well expect perfect protection. But the argument of this essay has been that such an expectation is neither reasonable nor morally or legally justified. There is a large task for public education here, and it will not be an easy task. But it is a task that health care leaders are morally obligated to undertake long before they would consider any mandatory policies for HIV-testing of health care professionals. Since most of my readers are here in Michigan, it is worth mentioning that I serve on a task force for the Michigan Department of Public Health that is exploring an appropriate policy response to the issue of HIV-infected health professionals. One of the analysts in that department took the CDC figures for the likely number of patients who will become HIV-infected through clinical contact during the next ten years and applied those projections to Michigan. On the low side the estimate is that .4 patients will be infected in Michigan between now and the year 2000. On the high side the estimate is that four patients would be infected. Numbers like that would hardly warrant a radical policy response aimed at preventing a public health disaster.

Finally, a comment is in order regarding hospital liability. That fear can drive administrative decisionmaking just as readily as it drives public demands for HIV-testing of health care professionals. But such fears have neither a rational nor a moral warrant. Speaking as a philosopher (not an attorney), I do not believe that hospitals ought to be held liable if one of their physicians accidentally infects a patient with HIV, say, by their being nicked in surgery and bleeding into a patient. That is not a risk which that hospital could have avoided except by violating basic legal rights to privacy of their staff. (By way of contrast, if that surgeon's clinical skills had noticeably deteriorated, and if that deterioration had simply been ignored by clinical colleagues, then it would be legitimate to hold the hospital liable.) Still, I am enough of a realist to know that hospitals will likely be held liable and be faced with million-dollar lawsuits under these circumstances. My response is that this is a risk which the institution must simply accept, but which can be spread out as a social cost, in much the same way that all of us as future patients in Michigan must accept the risk that we might be one of those four patients who is accidently infected with HIV. Outcomes like that are tragic, but the alternative is the deliberate and unwarranted violation of basic moral and legal rights. That would not be tragic. That would be wicked.
Do the Right Thing

By Marc Dedenbach, J.D.

"The Laboratory of the State". What an interesting concept. Justice Sandra Day O'Connor acknowledged the difficulty we have in making ethical decisions for the terminally ill patient, and indicated that clarity in the arena will only be achieved by those of us who work hard in the "Laboratory of the State".

I had the pleasure of being a panelist with some ethicists and lawyers whose expertise were founded in medical ethics and health law. Our audience was young doctors in training. Nothing appeared more clear than the anguish which these young physicians experienced in having to wade through the difficult medical, legal, ethical and moral decisions attendant to treating the terminally ill patient. So often their focus was on the fear of being sued by making the wrong choice. Quite often their expressed concerns focused on whether they were making the right choice for the patient. At one point, I indicated to these young physicians that, in my experience, I found the work of health care providers to me more often right than wrong. I attempted to encourage them by recognizing their incredible ability to be able to find appropriate answers to very sophisticated and confusing problems. I told them that, quite often, their decisions regarding treatment options for terminally ill patients were more often right than wrong.

I also informed them that, from a legal perspective, they are dealing in a confusing and sophisticated arena. One need not be a lawyer to make the right decision nor an ethicist to understand the nuances of morality. My message to the young doctors was that sometimes they have to reach inside and respond from their gut to determine what is appropriate under the circumstances.

With the passage of the Medical Durable Power of Attorney Act and the recent pronouncement from the United States Supreme Court in Cruzan vs. The Director of the Missouri Department of Health, a common misperception exists which suggest that there is vivid clarity in the law as to what is appropriate under any given set of facts and circumstances. The truth of the matter is that these cases are not always clear and that, with great regularity, treatment decisions involving the terminally ill patient are irremediably morally ambiguous. Since the facts and circumstances of each and every case are different, formulas that we develop as guides to decision making are not universally applicable. With this heightened state of litigiousness, many health care givers are overly concerned about being on the receiving end of a summons and complaint. Societal demands for precision and "good outcomes" have created in some of us a belief that unless we are absolutely right, we are absolutely wrong. The truth of the matter is these decisions are not always clear but that they are, in my decade of experience as a health lawyer, usually appropriate.

It is quite likely that it will be years before there is clarity in the law which would provide appropriate guide posts for our decision making. It is even more likely that, from a legal perspective, these decisions will never be guided by pristine legal principles. Equally true is the fact that ethical principles, societal demands, social policy, and our own individual sense of right and wrong will rarely come together in such a fashion as to render these decisions morally unambiguous.

When given these competing and often times conflicting societal pushes and pulls, most care givers must acknowledge that their capabilities are truly limited. Not only may they not cure everyone who is mastered by their disease-so too they may not always orchestrate a smooth blending of competing and conflicting societal pressures. As Justice Sandra Day O'Connor has said, the challenging task of protecting a patient's liberty interest is entrusted to the Laboratory of the States. And although there are many of us in the Laboratory who are working diligently to develop formulas of sufficient clarity that health care givers and receivers will know what is appropriate under the circumstances, the truth of the matter is (should those formulas ever be completed) there is a far better chance that a moral ambiguity will always be present than be eliminated. Until then, we will have to forge the awesome power of medical technology with the delicate sensitivities of human compassion. That is the only way that we will be able to do the right thing.

MHR Interview with Center Associate Daniel Bronstein

MHR: Let's begin for a moment by discussing your recent book, Demystifying The Law: An Introduction For Professionals. You very effectively present a basic breakdown of the mechanics of the American legal system in a way which should be helpful to a broad spectrum of professionals, from scientists to accountants to doctors. It is somewhat depressing to realize how extensive one's ignorance is of even the most rudimentary aspects of the law. For instance, the distinction between the various levels of the courts and their respective duties and responsibilities.

Bronstein: Well, as I say in the book, you should have learned that in ninth grade civics. You're right though as to what the intent of the book was. Originally, the publisher approached me to do a book on environmental/public health law, and I said that you can't write such a book since it will become outdated every year as the statutes are amended and so on, unless you intend to
issue supplements every year, which I don't intend to write. But I have a series of standard lectures which I give to various audiences that I'd be willing to write up as a book. It is meant, as I said, primarily for professionals of one type or another, but that does not necessarily mean people with advanced degrees. I've attempted to write in a very informal conversational style so that anyone can understand it, although when you get into the more detailed stuff, obviously, a college degree helps.

MHR: Is there anything specific that you find when you give these series of lectures to physicians that they inevitably say, "That's something I always wanted to know." or "That's something I was unaware of."

Bronstein: Well, obviously, the thing that physicians or medical students are most interested in is discussion of torts and especially malpractice. I always find it much easier, as I do in the book, to discuss tort law in general and give them that whole background and then get into the difference that it makes if you call it a malpractice suit. Which, of course, is basically the kind of duty that has to be breached. But otherwise there is no difference between malpractice and any other sort of tort or personal injury suit. By the way, one of the groups I've found who buy the book is lawyers who give it to their clients who are involved in a major malpractice suit and are wondering why it's taking so long, what's going on here. They give them that and say, "Read this and get off my back."

MHR: As long as we've raised the issue I'd like to talk a little bit more about malpractice. Marc Dedenbach has outlined a position in his article for this issue of the Medical Humanities Report which basically advises doctors to "do the right thing" and that the law will in most cases protect them. What is your response?

Bronstein: My position has always been a little more cynical. My point has always been that people who are unhappy with an outcome are going to sue. The odds are very good. There's no way you can prevent yourself from being sued if you're a doctor. You can take care that they don't win the suit, but there's no way to stop them from suing. For years at the case conferences what I would always say was,"Somebody's going to be unhappy so you're going to get sued. You're going to get sued whichever decision you make, so you might as well do what you think is right. But it will not avoid legal problems." And to some extent Marc is saying the same thing,"Do what's right, and if you're sued, you'll probably win."

MHR: There's been a great deal of talk about the increase in tension and hostility between the legal and the medical professions. A general impression is that lawyers have been "going after" the doctors. Could you comment on what you perceive to be the facts vs. what is only perception.

Bronstein: I think that the reality is that it's not true. I think that the perception is there. There are so many more malpractice suits because there are so many more patients. There are so many more doctors. I suspect that the claims-per-treatment-instance is probably unchanged. I did this type of law for five years when I got out of law school back in 1966. I worked both sides, both plaintiff and defendant. There were fewer doctors and there were fewer lawyers. The population in general has grown.

MHR: The perception does remain that lawyers are instigating lots of nuisance suits and that lots of good doctors are being driven from the field because of this activity.

Bronstein: I think it's nonsense. There are ambulance chasers among lawyers. There always have been and there always will be. But those types of people don't go in that much for malpractice cases. Malpractice cases require a lot of preparation and a lot of work. Ambulance chasers work on volume, on turnover. They'd much rather have somebody who's sitting at the stoplight and his car is rear-ended by somebody else. The potential award in the malpractice case is much greater, but the time it takes to do the case, do all the depositions, find your own experts...

MHR: Even knowing if you have a case.

Bronstein: That's right. All this is so much effort that it's very rare that ambulance chasers get into malpractice cases. They'd much rather have a simple automobile accident case which they know how to deal with, one they can handle in twenty minutes. The problems with the perceptions are several. First of all, verdicts have grown. But I don't think they are growing any faster than the rate of inflation, according to the General Accounting Office, they aren't.

MHR: Of course, that is the other common complaint. The juries are handing out outlandish settlements.

Bronstein: The General Accounting Office has done several studies recently and they've indicated that the awards are following the rate of inflation for the past thirty years. The problem is that people don't realize what the rate of inflation has been. When I started practicing law in '66, right out of law school I was making the munificent salary of $6500 a year and that was more than enough to live on. Nowadays, someone starting out could count on making $32,000, that's 500 percent. So a big malpractice case in my day might have been $300,000 and today it's going to be a million and a half. And as I always tell the doctors, if they think they have it bad, they should talk to their accountants. The accountant's malpractice insurance is absolutely astronomical. Talk about practicing defensive medicine, you should see the way these guys practice defensive accounting.

MHR: To follow up that last point. Several people have

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(Bronstein continued from page five)

claimed that, be it a false perception or reality, the belief that astronomical nuisance suits are always just around the corner has caused doctors to practice defensive medicine which is causing a large number of economic problems for the health care system.

Bronstein: I think that the perceptions and the reality are correct in that virtually everybody assumes that their patients are covered with unlimited health insurance. I think that if you had the current legal environment with the health insurance situation of twenty years ago you would not find people ordering those tests simply because they would be more sensitive to what their patients can and cannot afford. And then it would not become an issue in the malpractice cases because the standard practice would not be to order all those tests. Because what you're talking about is deviating from the standard practice. I speak as the son of an internist, who was a professor at Bellevue at NYU and generally considered the finest diagnostician in New York city. He died in 1970 when most of the tests didn't even exist. They were just in their infancy. If you asked him, "How'd you make that diagnosis?" he couldn't tell you, it just felt right. Now, as medicine has become more instrumentalized, we've gotten away from the feel of the clinician for what's wrong with the patient and we're overrelying on the lab reports and the various imaging specialties, etc., etc. Although, that's probably less true at MSU given the way we educate our physicians than at most medical schools.

MHR: There does seem to be a snowball effect. At one time most physicians diagnosed the way your father did, and this then was the established standard of care. However, as the physicians, rightly or wrongly as the case may be, perceive a legal threat they begin moving away from the clinician's feel, and order tests to safeguard themselves, which then alters the standard of care and so other doctors begin ordering the tests, and so on and so forth.

Bronstein: It's more than that. It's not just on the doctor's side. It's on the patient side as well. The patient expects 95 tests and in fact, is disappointed if the doctor doesn't run them. This comes back to the thing that everybody at medical humanities talks about all the time, the doctor as body mechanic. That's very much the public perception. Therefore, you have a very different attitude from the patient's perspective than you used to. When you take your car into the mechanic, by God, he's going to fix it. When you go into the doctor, by God, he's going to cure me. We don't accept excuses from our auto mechanics. They've got all this equipment in front of them and if they don't get it fixed, they must be screwing up. And that is moving towards public perception of physicians. It's an overselling of medical knowledge. As you can tell from my comments about my father, I hold very much to the Lewis Thomas picture of medicine. Much of medical practice is not technical, it's an art. It's not a science. But medicine has been overselling itself as a science and therefore the public is perceiving it as the body mechanic and expects comparable results.

MHR: In conclusion, do you have any suggestions for bringing down the tension levels between doctors and lawyers?

Bronstein: I think that the whole thing is grossly exaggerated. Let's be realistic. What we are talking about is tension between the organized medical profession and the organized legal profession. We are not seeing tensions between doctors and lawyers. They are the same social group in any community you go to. They belong to the same clubs, they eat at the same restaurants, they go to the same concerts, etc., etc. So it is not a case of individual lawyers and individual doctors becoming antagonistic to each other. They will be friends with each other categorically.

Literature in Review


There is a widespread perception that the United States, already considered a highly litigious nation, has become even more so in recent years. This perception has generally been accompanied by a feeling of frustration on the part of non-lawyers due, in large part, to an unfamiliarity with even the most simple components of the legal system. Although there are a number of legal dictionaries available, there are comparatively few introductory texts which provide an overall view simple enough to be accessible to the layperson. Demystifying The Law is an excellent attempt to remedy this situation.

As the subtitle suggests, the book is designed to aid professionals in understanding those areas of the law which are most likely to affect them. The first part reviews the basics of the U.S. legal system, e.g., the structure of the court system and how it functions, the nature of precedents, etc. The second part discusses material that is key to comprehending some of the general issues that professionals get involved with. It is a bit more detailed than the other two sections and has a very clear explanation of the general principles of such items as the Administrative Procedures Act, the Federal Register, and the Code of Federal Regulations. The third part outlines other legal concepts which can arise in

This excellent and challenging book discusses virtually the whole range of ethical questions regarding circumstances where medical decisions must be made by someone other than the patient. Starting with an account of the concept of competence and its proper evaluation in the first half of the book, Buchanan and Brock go on to discuss the ethical framework for making proxy decisions (arguing for less moral authority for substituted judgment than it is usually given); problems raised by philosophical questions of personal identity for the authority of advance directives; and the limits of advance directives imposed by considerations of justice.

In the second half of the book, they go on to apply the principles and distinctions developed earlier to the special circumstances arising in the care of the elderly, of children, and of the mentally ill. These chapters are uniformly excellent. Their discussion of the competence and decision-making authority of minors is especially good; I've already found it extremely useful in a current project on the rights of informed consent for children regarding treatment by bone marrow transplantation.

Space doesn't permit adequate exploration of all of the arguments and positions taken up in the book, and so for the remainder of this review, I will focus on what I regard as a key organizing element: the concept of competence.

The concept of competence advanced by Buchanan and Brock shares much with the view dominant since the President's Commission reports, which as staff members they helped to write. The capacities necessary for making a competent decision start with the capacity for understanding the pertinent facts surrounding the decision at hand, including not only an intellectual grasp of the facts, but the capacity to imaginatively understand what it would "feel like" to experience the outcomes of the various alternative choices. The capacity for communication is also required, both as a means for others to evaluate understanding, and for the person to communicate the preferred choice. Competence also requires capacities for reasoning and deliberation, again not in the abstract, but as necessary for the person to draw implications from the fact situation to conclusions about how the various choices will affect the values and goals of the individual. Thus, the last capacity important for competence is the possession of a set of values that is "consistent, stable, and affirmed" by the person as her own.

Although all of these capacities are matters of degree, competence itself is not a matter of degree, but a "threshold concept". One is either competent to make a given decision at a given time, or not. The problem, then, is where to set the threshold.

Buchanan and Brock argue that the threshold is set by balancing the two values which are served by the informed consent process: the patient's well-being, and the patient's self-determination. The setting of a threshold level of competence requires a balancing of these two values because any such level steers between two dangers. A threshold that is set too high will result in false negatives, taking decision-making authority away from patients who were competent to exercise it, and thus compromising the value of self-determination. A threshold set too low will produce false positives, permitting incompetent patients to choose unwisely, compromising the value of protecting patient well-being.

Buchanan and Brock argue against a different view advanced by Charles Culver and Bernard Gert. For Culver and Gert, competence is the capacity of the patient to understand and appreciate the facts pertaining to a specific kind of decision, a capacity which exists and can be evaluated prior to and independently of the decision finally made, and which is the same for treatment refusal as it is for treatment acceptance. Culver and Gert agree with Buchanan and Brock that the decision whether the patient's choice will be respected requires consideration of the patient's well-being, but that is done by assessing the rationality of the decision, rather than the competence of the decision-maker.

However the philosophical or the practical problems of determining competence eventually get sorted out, Buchanan and Brock's invigorating treatment will remain a key point of departure for anyone who wants to better understand the ethics of treatment refusal.—Tom Tomlinson, Ph.D.

(Note: The above is excerpted from a longer review to appear in Medical Humanities Review)
Intensive Summer Ethics Institute

Due to the enthusiastic response of the participants in last August's intensive summer ethics institute, the Center for Ethics and Humanities in the Life Sciences will be offering a similar program this coming summer, August 10 through the 16. The institute will be staffed by nationally known faculty including Professor James Childress, Ph.D., of the University of Virginia, Haavi Moreim, Ph.D. of the University of Tennessee-Memphis, James Nelson, Ph.D., of the Hastings Center, David Doukas, M.D., of the University of Michigan, Leonard Weber, Ph.D. of Mercy College, as well as the staff of the Center: Howard Brody, Ph.D., M.D., Tom Tomlinson, Ph.D., and Leonard Fleck, Ph.D. The Institute is designed to meet the educational needs of members of institutional ethics committees, faculty in colleges of medicine and nursing, and hospital administrators. Topics will include informed consent, treatment refusal, withdrawing life-sustaining treatment, confidentiality, ethical issues in neonatal care, reproductive rights issues, AIDS-related issues, "gatekeeper" issues and health policy. But the primary emphasis of this Institute will be skill-building, especially skills needed to engage in productive moral conversation. Hence a substantial amount of time will be spent in small groups.

Because of a desire to improve accessibility to the Institute by out of state residents the location will be moved from Shanty Creek Resort to the Kellogg Center in East Lansing. For further information, call 517-355-7550 or write to the Center, C-208 East Fee Hall, Michigan State University, East Lansing, MI 48824-1316.
Update on Recent Activities at the Center

MYRON MAGEN RETIRES AS COM DEAN

An era is ending with the first change of Deans in the history of MSU’s College of Osteopathic Medicine. The Center for Ethics and Humanities in the Life Sciences wishes to salute departing Dean Myron S. Magen. He has always been a strong supporter of the inclusion of ethics and humanities in the curriculum of his College. He contributed a good deal of personal leadership in the formative years of the Medical Humanities Program and during its transition to its present Center status.

The Center also wishes to congratulate Douglas Wood, D.O. on assuming the leadership of the College. As Associate Dean, Dr. Wood has also been very supportive of our activities; and we look forward to many years of collaboration under his direction.

UPCOMING PRESENTATIONS AND PUBLICATIONS BY CENTER MEMBERS

Leonard Fleck has been appointed to the Michigan Department of Public Health AIDS Task Force which will be making policy recommendations regarding HIV-infected health care professionals. The committee met for the first time in May and will meet again July 2 at the Michigan State Medical Society building from nine to twelve noon.

The Just Caring Project is continuing to move forward and both Andy Hogan and Professor Fleck will be heading up a major statewide conference of health and business leaders which will be taking place in Lansing in October.

In November Professor Fleck will be speaking at the “Justice and the Human Genome” conference to be held at the University of Illinois in Chicago. His paper is entitled, “A Just Genetics: A Problem Agenda”. He will also be giving a talk on the ethics of marketing on August 16 to the Michigan Chapter of the American College of Cardiologists.

Tom Tomlinson will be in charge of the annual five week London Medical Ethics and History of Health Care program. Twenty-six students will be traveling this year to St. Bartholomew’s Hospital to study the nature of contemporary British decision making about who should receive, deliver and pay for health care.

Professor Tomlinson will be delivering a paper on September 14 to the conference on Humane Care and the Use of Laboratory Animals at the University of Washington in Seattle. His talk is entitled, “Ethical Issues Seminar: Use of Untested Controls”. On September 24 he will be reading his paper, “Compensation, Inducement, and Other Forms of Incentives for Donation” in Dearborn Michigan at the Transplant and Health Policy Center’s conference on organ procurement.

A forthcoming issue of The Gerontologist, will be publishing, “Ethical Issues of Intergenerational Reciprocity: Implications for Practice,” co-written by Professor Tomlinson, Suzanne Selig and Tom Hickey.