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Editor's Forum

Paul Byrne, MB, ChB, FRCPC
Interim Director and Clinical Professor, John Dossetor Health Ethics Centre, University of Alberta
Staff Neonatologist, Stollery Children's Hospital

Recent developments in cognitive psychology and neuroscience have provided insights into how people make decisions, both large and small. These developments have been studied with respect to the process of clinical judgment. Health care professionals recognize a "good clinician" across the entire spectrum of practice but identifying what the description means has been more elusive. A "good clinician" is expected to possess science based knowledge, an inquiring open mind, humanist qualities such as empathy and compassion, and a commitment to care for the sick. Clinical decision-making is taught as a linear process of investigation; evidence gathering, data analysis, further interpretation, diagnosis, treatment options, etc.

However, when physicians' actions are studied in real clinical situations surprising results are found. Expert clinicians do not use a conscious linear approach but seem to use multiple sensory inputs simultaneously to quickly get a "clinical impression" of what the problem is. Most of this occurs unconsciously and rapidly and is followed by a slower reflective evaluation of this first impression. Clinical expertise is associated with high accuracy (but not infallibility) using this heuristic approach based on unconscious cognitive biases. Unfortunately there is also considerable risk of error if the initial impressions are not kept open to reflection, revision, and admission of uncertainty. Croskerry (2002) describes a wide variety of cognitive biases that trap clinicians by limiting their ability to reexamine their clinical judgment.

Truscott's paper describes an elegantly simple process for dealing with complex ethical decisions which relates to some of the above research findings. His heuristic, *Listen, Think, Feel, Act* is not a linear process. It represents deep involvement with problems in clinical ethics. The process has relevance to healthcare encounters in general and highlights the essential ethical nature of all such encounters.

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By applying *Listen, Think, Feel, Act* (maybe as a mantra) caregivers will likely improve the quality of decision-making and care, and will become more reflective about their own clinical and ethical practice. The latter is a much neglected need in the context of health systems being scrutinized for efficiency above all else.

In keeping with the practice of clinician self reflection on decisions and actions Lützén asks us to consider our attitudes towards time in clinical practice. She describes how caregivers think of time exclusively as "countable time" by which she means trying to cram as much as possible into each day at work. Busy clinicians will recognize themselves in her description of being in an environment which pulls in many directions at the expense of time spent with any individual or family. While efficiency is important and desirable, she urges us to remember to spend "uncountable time" in clinical encounters. "Uncountable time" requires knowing what is needed and desired by the patient, knowing that good choices require time, and accepting that for ethical reflection to occur, time is essential. Lützén's examples illustrate how systems analysis such as that identifying inefficiency and waste, (but often ignoring peoples' time as they park the car, find the clinic, queue in triage, etc.) requires time perspectives from patients to have meaning in a context of ethical care. Considering time in terms of the others we serve, rather than according to our timetable, transforms countable time into ethical moments that she calls "moral time". I was reminded again that one rarely hears patients or families complaining that the doctor or nurse "spent too much time with us today".

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A Simple Heuristic for Complex Ethical Decisions

Derek Truscott, RPsych, PhD
Associate Professor, Department of Educational Psychology
Associate Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

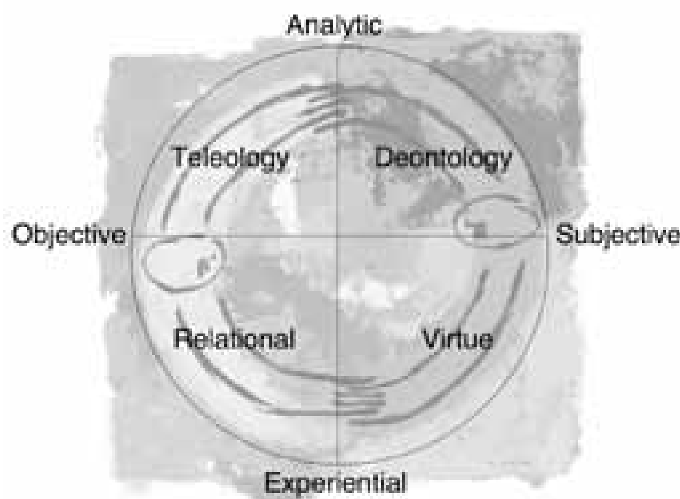
Even sincere and earnest health care professionals fairly often find themselves in situations that are challenging to resolve in an ethically acceptable manner. Much of the time in our busy work days we are actually making decisions of an ethical nature without even being conscious of doing so. We take rapid stock of the information we have at hand and use what we believe about the nature of the world to construct a meaningful understanding of what is going on, what is likely to happen, and what we should do. For the majority of situations that we encounter, this process works remarkably well (Kahneman, 2011). Indeed, we would face what athletes call "paralysis by analysis" if we stopped to methodically consider every decision we had to make. Such experiential ethical reasoning tends to be automatic, holistic and emotional with little, if any, awareness of even having made a decision (Haidt, 2001). It is based upon our appraisal of the situation which is then filtered through our emotional reaction to that understanding (Vergés, 2010). When we encounter novel or ambiguous situations, however, experiential reasoning can lead us astray (Kahneman, 2011).

In addition to this intuitive, emotionally inflected, and rapid "system for jumping to conclusions" is a second system that checks the responses made by the first (Kahneman, 2011). It is a more deliberate, slower and rational system that thinks about the world more rigorously. This second system is not only slow but inefficient, taking more time and requiring a lot of energy compared to the first. If we are strongly motivated toward a particular course of action, or are tired or distracted, we are prone to *rationalize* our behaviour after the fact rather than *reason* our way to an ethical course of action (Bandura, 2002). We need only think of the captain who ran the Costa Concordia cruise liner aground off the Italian coast claiming that "I tripped and I ended up in one of the lifeboats" and then remained there for an hour waiting to be lowered into the water.

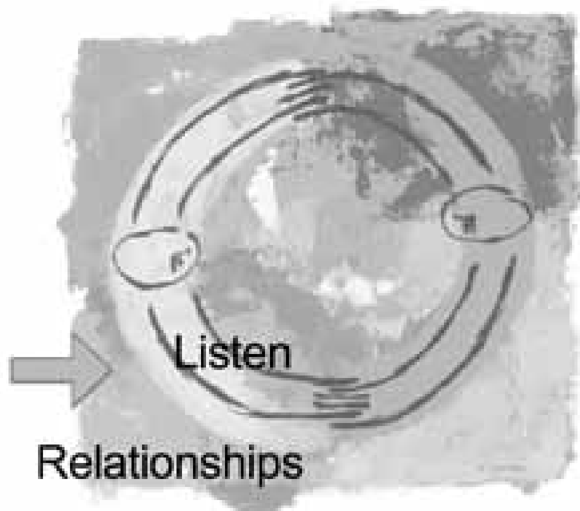
Analytic ethical reasoning using this second system involves a deliberate, logical, critical process of problem solving (Reynolds, 2006) based on professional ethical duties, standards and expectations. Professionals are expected to be able to justify our ethical decisions according to such critical-evaluative reasoning (Kitchener, 1984). Indeed, existing models of ethical decision making are predominantly analytical and actually discourage intuitive reasoning or advise us to "set your biases aside" (Cottone & Claus, 2000). Given that reasoning takes place on both experiential *and* analytic levels of processing, making good ethical decisions isn't a matter of deciding which system is the right one, it's a matter of incorporating both (Craigie, 2011).

If we combine an *objective-subjective* dimension to reflect the kind of information we attend to (Strack & Deutsch, 2004) with the *experiential-analytic* dimension to reflect the systems that we use to process this information, we can map an integrated model of the four dominant systems of Western ethical thought, as diagrammed in the accompanying figure. Teleological ethics is an analytic and objective approach to ethics operating from the premise that right actions are those that produce desired outcomes. Teleology is therefore concerned with the *consequences* of our actions. Deontological ethics is an analytic and subjective approach that calls upon us to act as if the rationale that underlies our action were to become a universal duty. It is therefore often referred to as *duty* ethics. Virtue ethics is an experiential and subjective approach that encourages us to ask, "How will my actions embody the type of person I want to be?" It is concerned with our *motivation*. Relational ethics is an objective and experiential approach that asks us to act out of concern for and consideration of others (Austin, Bergum, & Dossetor, 2003). It is concerned with the fact that ethical actions always take place in *relationships*.

An Integrated Model of Ethical Systems

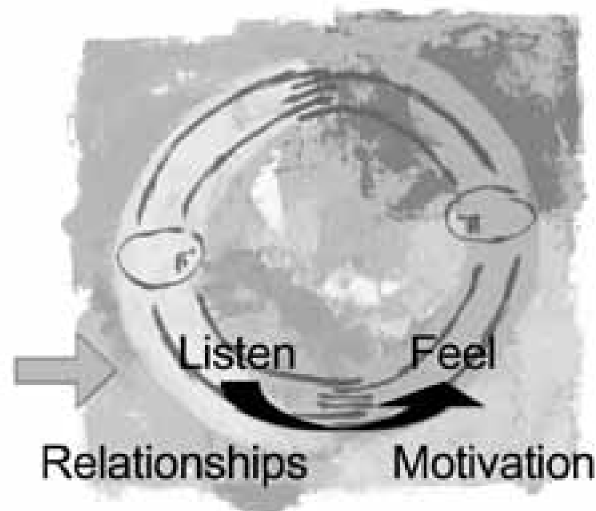


It should be fairly obvious that each of these approaches has something important to say about being ethical. Given the role that the analytic and experiential systems play in our ethical reasoning, we are therefore more likely to arrive at an ethically sound decision if we incorporate all of them into our deliberations. A simple heuristic that I have developed from an idea of my colleague Dr. Jim Evans, who unfortunately passed away before we could fully articulate it together, is *Listen, Feel, Think, Act.*



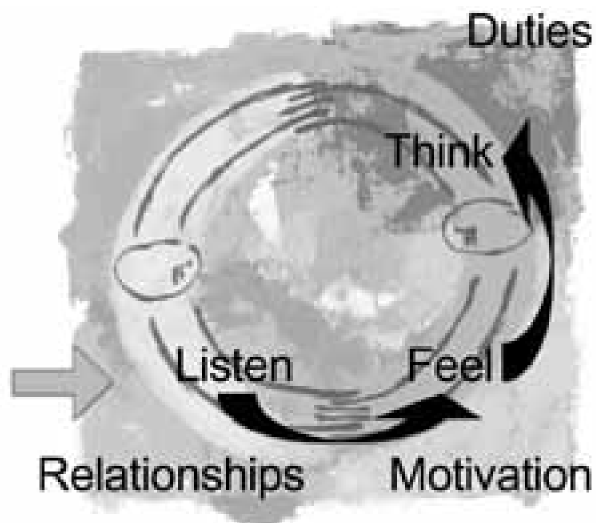
LISTEN. When faced with an ethically challenging situation, relational ethics directs us to listen to and understand the values, needs and perspectives of others. This means taking as much time as is necessary to understand the social circumstance of our decisions and actions. How often have we rushed to a decision based on limited information, only to later find out that the situation was more—or less—complicated than we first thought? By stopping to listen to others with compassion we can better appreciate the social context of the problem we are faced with. A guiding question that I often find useful is, "Why now? Why has this problem manifested today and not before or next week?"

FEEL. Having careful listened to others in order to understand the interpersonal circumstance, virtue ethics has us consider how we feel about it. That is,



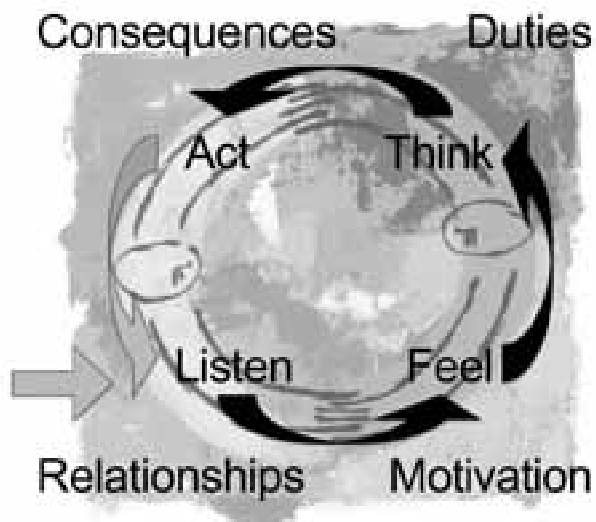
we go inward to honestly plumb our motivations. It is rare that we don't have strong feelings about an ethical dilemma. Rather than ignoring them or trying to hold them in abeyance, we treat feelings as guides to our true motives. From this raw material our virtues are formed—by bringing our emotions into our ethical considerations we harness their power to motivate us toward right action. After all, doing the right thing is often arduous and just because others want us to or we know it's the right thing to do, doesn't mean that we will be able to see it through to its resolution.

THINK. After taking into account the interpersonal circumstance and our personal motives, deontological ethics directs us to ask, "Does a relevant professional ethical duty, standard of conduct, or guideline exist?" This question obligates a review of relevant professional documents, starting with professional practice standards, codes of ethics, professional guidelines, and perhaps even the scholarly ethics literature. Next, we can compare and contrast our experiential preference with our duties as professionals. If there is incongruence, we are expected to think long and hard before acting, and to be prepared to justify our decision if we chose to act in a manner inconsistent with our ethical duties. Often, we will consider our motivation in a new light and perhaps even experience a shift in our personal morality such that we feel differently about what we



prefer to do. In situations when no ethical standard outweighs the others, a number of actions may be ethically appropriate. If we have diligently listened to others, examined our feelings, and considered our professional duties, the number of acceptable courses of action will typically have been reduced considerably. In fact, it is not uncommon that there is only one truly acceptable course of action.

ACT. If there are more than one possible courses of action that are congruent with the social, motivational, and professional duties of a given ethical dilemma, teleological ethics directs us to take stock of the likely short-term, ongoing, and long-term consequences of each alternative. All other things being equal, we are expected to choose the alternative that is likely to cause the least amount of harm and the most benefit (in that order). Finally, we must carry-out the decision that resulted from this process. Often, our actions bring to light additional dimensions of the situation which may lead to a redefinition of the problem, or change the circumstances in significant ways, necessitating consideration of further alternatives which have impactful consequences, and so on. This is why the model is presented in a circular, iterative form.



When confronted with ethical dilemmas that are new or particularly challenging, we should pause and proceed through a deliberate decision making process so that we might *discover* what course of action is best, rather than *justify* what we want to do. As we encounter more and more new situations and this reflective process is repeated, our implicit moral values become more congruent with the explicit ethical expectations of our profession through greater awareness of ethical circumstances, enhanced ability to incorporate our personal motives into our ethical reasoning, repeated exposure to our professional ethical duties, and experience with the consequences of our actions (Rest & Narváez, 1994). In this manner we can develop a more “informed intuition” and ethical decisions that are congruent with professional ethical values become more reflexive. It also helps us to become more internally motivated, resulting in higher engagement in ethical tasks, better decision making, more persistence, and assumption of greater responsibility for the outcomes of our actions (Ryan & Deci, 2000).

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Lack of Moral Time – A Health Care Nemesis

Kim Lützén, RN, RNT, PhD
Professor, Karolinska Institute, Stockholm, Sweden
Assistant Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

My aim in this paper is to discuss the concept of "moral time" and suggest that it has a natural place in health care ethics. The dimension of time in relational ethics is portrayed as "ethical moments that make a difference" (Bergum & Dossetor, 2005, p. 2). An *ethical moment* is brief, yet fits into a time-frame consisting of sequences of events in the past and the anticipated future. Viewed from a relational ethics perspective, time is situated in terms of the "other" (Levinas, 1987). This means respect for a patient's experience of time is essential in order to create an *ethical moment*. Moreover, reflecting on how time permeates our everyday life can be transposed to the ethical moment in the health care setting. Thus, I begin by sharing some personal reflections on time.

I became interested in the meaning and experience of time some years ago when I happened to be sitting beside a patient with progressive AIDS. We were both waiting our turn for a doctor's appointment, which gave us time to talk, mainly to complain about how doctors in general do not keep their appointed time. He said, "You see, every *minute* for me is valuable. Sitting here and *waiting* reduces the quality of my *life* that remains – I feel that waiting steals the little time that is left of my life". I thought about all the persons that I had kept waiting as well as my own experience of waiting. What this person said made much sense.

A more recent example of how time can personally be experienced, took place in a hospital foyer where many people sit and wait for booked taxis. I overheard an elderly woman complain that it "took too long" for the taxi to come and she became increasingly worried that she had been forgotten. An elderly gentleman sitting beside her asked quite calmly why she was in a hurry to which she replied that she just "wanted to get home". The gentleman thought about this a few seconds and then asked "what are you going to do there? Sit and look out the window waiting for something to happen?" In both of these events, time was important yet experienced in different ways relative to *others* who had some control of their time.

A patient who suffers a severe illness and has a feeling of not having enough time may experience being neglected or forgotten. For example, a dying

person who thinks *and* feels that, "it is taking too long for the nurse to come and help me" experiences that time is gliding away. A nurse who responds to the patient suffering with pain by saying, "I'll be back in a minute with some pain-relief" and then returns ten minutes later is not genuinely conscious of the patient's personal experience of time as well as her promise to the patient. Awareness of an inevitable death means that every minute of waiting is important and becomes a debit in the remaining days or hours. In many cases, the question "how long do I have left to live?" provokes an existential anxiety.

Why is time important? When we almost compulsively look at our watches or smart-phones; we want to know whether we will be late for a meeting or have time to complete an assignment. We synchronize our watches and adjust them when travelling to a new time zone. The clock exists everywhere in many industrial societies and to live without knowing the clock time interferes with our social existence. We, who are health care professionals, take this with us in our practice. The defensive expression, "I don't have time" is so commonly heard that it is almost too trivial to write about. Yet, the expenditure of time, for example the time it takes for the ambulance to transport a person suffering a coronary infarct to emergency care, is often crucial for his or her survival.

Philosophical Views on Time

According to the traditional philosophical interpretation, time is *linear* composed of three dimensions, past, present and future. In Wikipedia, two distinct views on the conception of time are presented. One view is that time represents a "fundamental structure of the universe", a dimension in which events are sequential and can be measured or be *countable*; in other words, within the linear concept of time that most cultures recognize. *Countable time* can be measured (e.g., pulse is counted in 60 seconds). Since time is linear it lacks a specific direction and has neither a beginning nor an end. Linear time is taken for granted. It is continuous, infinite and irreversible.

A contrasting view of time is described as *uncountable time* or how persons construct, interpret or relate to time. Although *uncountable time* is perceived in different ways most persons have the capacity to be aware of the flow or passing of time. A minute can be experienced as an hour or that "time stands still" if a person is apprehensive of an upcoming event that either will be enjoyed or will diminish anxiety or worry. Yet, days can also be experienced as minutes flying by if a person anticipates a coming event as unpleasant. Kant (2007) refers to time as the "mental measuring system". For example, the first thing most of us are likely do when we wake up from a long sleep is look at the clock. Even if the alarm is set, we check out that it is correct. Clock-time re-orientates us to reality of the day ahead. We may perceive that we have little time between certain events, which means that conflicts between these arise.

Donald Black (2011) in studying why conflicts occur on another level than the personal, particularly related to crimes and deviant behavior, claims that the main cause of conflicts is the advance of social time; the greater the distance and the faster the changes, the more severe the conflicts are. In brief, social time includes relational time that is the degree of intimacy between people; vertical time changes in equality; and cultural time reflects diversity between people. Although Black's theory of moral time is intended to explain "global" conflicts, his description of relational time situates time in terms of ethics of the "other", notably Levinas (1987). Some of his explanations regarding social time can certainly be relevant in health care practice.

Time Becomes *Moral Time*

Reduction of work time in the name of efficiency is *the* primary instrument in *strategies* that will make health care delivery more economically

effective. Often time studies adopt industrial models, such as "lean thinking" that focus on production, which means that the quantity produced and the time it takes for production is objectively measured economically. In health care practice, the main element of this model is applied in health care management, which means that exact time is allocated for all routine activities - for all patients. Winch and Henderson (2009) point out that the "uncritical adoption of production-line manufacturing" in hospitals creates tension between production and care. While the term "production" may be suitable in manufacturing it is not ethically appropriate for attending to the patient as a human being with complex health care problems. Reflecting on a patient's individual need of talking about his or her worries often competes with other obligations.

Efficiency, a normative value, interpreted as "more work in less time" can also be a research on "quality improvement". For example, Monforto, *et al.* (2012) report on the outcomes of a project aimed at studying if time changes for scheduled nursing assessments, impacted on clinical decisions and patient discharge. The interesting aspect of this study was that the authors concluded that by changing time for some basic nursing activities, improved work flow could be observed. There was no mention of whether the patients' perspective or the moral obligations of nursing care were taken into account in evaluating the outcomes of this project.

Scully, *et al.* (2007) argue that time is essential in moral decision-making for patients as well as health care professionals; "Choices need time, the fullness of time, time being the horizontal axis of morality – you make a decision and then you wait and see" (p. 210). Their focus on using time to "preserve moral space" is described in their study of patients' experience of time in the process of pre-natal genetic testing. Eight persons who faced a personal decision whether to have amniocentesis, a chorionic villus biopsy or DNA test to confirm a possible abnormality were interviewed as to their decision-making process. Time was an essential element and was experienced by the participants as an ethical dilemma. First, they needed to make a decision whether to go through prenatal genetic testing or not; and following the consequences of either choice, making a decision that they could live with. "Taking the patient's perspective", the authors conclude, implies that a focus on the ethical issues close to the clinical encounter will not take into account that the final decision happens outside the time-frame of the "clinical story".

Concluding Reflections

Waiting for results of a biopsy, undergoing dialysis, waiting for the physician, waiting for pain relief, waiting to die are only a few examples of situations conveying a moral plea that unfortunately are not always attended to. The relationship between time and ethics in health care practice can be seen from two perspectives; from the perspective of ethical reflection on the meaning of time in the one-to-one encounter here and now or from the perspective of reflection on the consequences that moral actions may have in the future, in "another time" or in a "new era". Are moral actions "right" today also justified tomorrow? Patients as well as health care professionals, face moral decisions that require time for reflection and dialogue.

Making time for ethics, reflection and dialogue, is often replaced by *countable* time, "we don't *have* time for ethics." Not having time implies that time is filled with other concrete activities leaving little space for reflection on ethical issues. Unfortunately, we neither hear the confession, "we do not *take* time for ethics" nor the moral awareness "we do make space for ethics." Lack of moral time is indeed a health care nemesis.

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Dr. John Dossetor honoured with the Canadian Bioethics Society's 2012 Lifetime Achievement Award

Dr. Dossetor has a highly respected national and international profile in medicine and health care ethics. He has made many significant contributions as a pioneer in Nephrology and his involvement in early kidney transplantation. Early in his medical career Dr. Dossetor recognized the central role of health ethics in clinical practice and the need for education of physicians in ethics.

In 1985, Dr. Dossetor, then Director of the Divison of Nephrology and Clinical Immunology at the University of Alberta Hospital and Professor of Nephrology at the University of Alberta, took a sabbatical to study medical ethics.

In June 1986, the Joint-Faculties Bioethics Project at the University of Alberta and the University of Alberta Hospitals was launched. Dr. Dossetor, as first Professor of Bioethics at the University of Alberta, and his colleagues undertook responsibility for bioethics teaching in the medical curriculum and prepared a bioethics manual *(A Handbook of Health Ethics*, used until recently) as a teaching resource. In addition, the *Bioethics Bulletin* (a bioethics newsletter, subsequently renamed *Health Ethics Today*) was launched to increase interest and awareness of bioethics issues. Joint-Clinical Ethics seminars (currently Health Ethics Seminars) were developed, plus a graduate course (presently INT D 570, Healthcare Ethics) in healthcare ethics was introduced. The Bioethics Project evolved in 1990 into the Division of Biomedical Ethics, Faculty of Medicine, University of Alberta, and in 1993 into the Bioethics Centre, in association with the University of Alberta Hospitals and Faculty of Nursing.
Dr. Dossetor served as Director of the Division of Bioethics and Bioethics Centre from 1990 - 1996.
In January 1998, the Bioethics Centre was renamed

the John Dossetor Health Ethics Centre in honour of Dr. Dossetor's outstanding contributions to health ethics at the University of Alberta and across Canada.

Dr. Dossetor has 295 medical /scientific publications and has authored and co-authored 10 books. His latest book, *Beyond the Hippocratic Oath*, published in 2005, is a memoir of the evolution of modern medicine and bioethics which is reflected through his own experiences.

In 1992 Dr. Dossetor was awarded the 125th Canadian Confederation commemorative medal for work with the Kidney Foundation of Canada. In 1995 he was named an Officer of the Order of Canada for his achievements in the fields of medicine and bioethics; and was further awarded the Queen's Jubilee Gold Medal in 2003. In 2007 Dr. Dossetor was the first recipient of the Canadian Medical Association's Dr. William Marsden Award in Medical Ethics.

The Lifetime Achievement Award presentation took place on Thursday, May 31, 2012 at the Canadian Bioethics Society's Annual Conference in Montreal.

UPCOMING EVENTS

Dossetor Centre Health Ethics Seminars:

21 September 2012

What should I do when I don't know what I should do? Stories from the archives of a would-be ethicist

Derek Sellman, RN, PhD

Associate Professor and Director of the unit for Philosophical Nursing Research, Faculty of Nursing, and Associate Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

19 October 2012

Some thoughts on the integration of ethical systems

Derek Truscott, RPsych, PhD

Associate Professor, Counselling Psychology, Department of Educational Psychology and Associate Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

23 November 2012

Resuscitation: why do we bother?

Peter Brindley, MD, FRCPC, FRCP

Intensivist, General Systems Intensive Care Unit and Neuro Sciences Intensive Care Unit, University of Alberta Hospital
Associate Professor, Division of Critical Care Medicine and Associate Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

14 December 2012

Toward the goals of harm avoidance and waste reduction

Dawn Davies, MD, FRCPC, MA

Medical Director, Pediatric Palliative Care Program, Stollery Children's Hospital
Associate Professor, Department of Pediatrics and Associate Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

All seminars take place in Classroom F (2J4.02), Walter Mackenzie Health Sciences Centre, University of Alberta, 12:00 – 1:00 pm. Seminars available via Alberta Health Services' Telehealth Videoconference.

To subscribe to the seminar mailing list, please e-mail: dossetor.centre@ualberta.ca

Please check the John Dossetor Health Ethics Centre website at www.bioethics.ualberta.ca/ for complete details.

CANADIAN BIOETHICS SOCIETY ANNUAL CONFERENCE

New Heights and Broader Plains: Expanding Vistas for Bioethics

May 29 – June 1, 2013
Banff, Alberta

The upcoming Canadian Bioethics Society Annual Conference will be held May 29 - June 1, 2013, at the Rimrock Resort Hotel in Banff, Alberta. Please refer to www.bioethics.ca/2013 for updated information.

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University of Alberta
John Dossetor Health Ethics Centre
5-16 University Terrace
EDMONTON, AB T6G 2T4
Email: dossetor.centre@ualberta.ca

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John Dossetor Health Ethics Centre
University of Alberta
5-16 University Terrace
Edmonton, Alberta, Canada T6G 2T4
Telephone: (780) 492-6676 • Fax: (780) 492-0673
Website: www.bioethics.ualberta.ca/
Email: dossetor.centre@ualberta.ca

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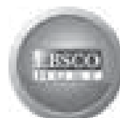

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