PERSPECTIVES IN GENETIC COUNSELING

NATIONAL SOCIETY OF GENETIC COUNSELORS, INC.

Volume 6, Number 4, December 1984

GENETIC COUNSELORS ON INSTITUTIONAL ETHICS COMMITTEES AND INFANT CARE REVIEW COMMITTEES(1)

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The 1980s have been marked by a flurry of discussion about the expanding role of genetic counselors. One of the more exciting areas to be explored is the role of genetic counselors in moral decisions in medicine.

Genetic counselors are accustomed to dealing with a number of health care issues (particularly perinatal health care issues) that raise legal and ethical problems: abortion, artificial conception, prenatal diagnosis, patient autonomy and the right to privacy, the withholding of treatment and sustenance from defective newborns, and informed consent. Because of their experience and comfort in dealing with these issues, and their orientation as patient advocates, genetic counselors have a vital role to play in the burgeoning movement to form committees to address these issues. Such committees may take the form of institutional ethics committees (IECs) or infant care review committees (ICRCs). IECs establish policies and guidelines, provide consultations, and arrange educational activities within their hospitals, while ICRCs focus on a more narrowly defined range of problems regarding the care and treatment of developmentally impaired newborns.

Rapid technological advances in medical care have created new and difficult ethical and moral dilemmas. These, together with the impact of the Baby Doe regulations and their recent revisions, have given an increasing number of institutions the impetus to establish IECs and ICRCs as an internal means of dealing with this complex array of problems. The standardization of both IECs and ICRCs continues to receive much national and local attention. The committees generally include experts from a variety of disciplines, depending on the needs and the availability of experts at a given institution, and in some instances already include genetic counselors.

Institutional Ethics Committees

To appreciate fully the current momentum in the drive to establish IECs, one must understand something of their history. Although some committees did exist in the 1970s and earlier, more committees have come into existence since 1980 than in all the previous decades combined; this trend shows no sign of abating. Although many of the committees formed in the 1970s were established in response to the publicity surrounding the Karen Ann Quinlan case, a large part of the more recently escalated formation of IECs appears to be attributable to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavorial Research and its subsequent series of reports (2).

This rapid growth in the number of IECs has resulted in a fragmentation of efforts, less than optimal communication, and some confusion as to how such committees should function. The American Society of Law and Medicine, to which many genetic counselors belong, has provided leadership in the formation of IECs by means of its workshops and publications. In addition, the society has joined the Institute of Public Law at the University of New Mexico to establish the National Center for Institutional Ethics Committees. The center has four primary functions: 1) to engage in research on the activities and functions of IECs throughout the country, 2) to prepare and make available various educational resources and materials useful to IECs, 3) to publish the *Ethics Committee Newsletter,* and 4) to create a clearinghouse for consultants and speakers. The clearinghouse will maintain a registry of health care professionals who will serve as consultants in establishing IECs, assist in educating the committee or institutional staff, or advise on specific cases. The center intends to coordinate the process of connecting institutions with consultants, and will also work to provide specialized experts to established committees that need advice in particularly complex areas (3).

The early IECs of the 1970s were marked by an obvious dearth of genetic counselors and other non-physician health professionals. Although this is changing, genetic counselors are still underrepresented. The growing importance of clinical genetics makes this an appropriate time for genetic counselors to make their expertise available to IECs (4). Ideally, broad representation on IECs will increase the effectiveness with which local hospitals resolve ethical dilemmas and thereby lead to greater autonomy by eliminating the need for government intervention, perhaps even preventing future problems such as the Baby Doe case.

A Brief History of the Baby Doe Regulations

The medical and legal issues raised by withholding treatment from severely handicapped newborns were dramatically brought to light in the spring of 1982 in Bloomington, Indiana following the birth and subsequent death of an infant with Down syndrome and a tracheo-esophageal fistula. The infant died when available medical treatment was withheld and legal attempts to force treatment were unsuccessful. In response to this case, in April 1982, President Reagan issued a statement forbidding the withholding of any service to handicapped infants on the basis of that handicap.

Nearly a year later, in March 1983, the first set of Baby Doe regulations was announced. Known as Baby Doe I, the regulations were to enforce the Reagan dictum by posting in hospitals notices concerning a handicapped infant's right to treatment and by providing a telephone hotline to report infractions.

By April 1983 the Baby Doe I regulations had been rigorously challenged. In the summer of the same year, Baby Doe II was proposed. Again, there were many challenges and questions, to which the Department of Health and Human Services (DHHS) responded with Baby Doe III, which sought compromises on many of these differences. These last rulings appeared in January 1984 and again provoked lively debate.

Highlights of Baby Doe III include the provision of life-sustaining treatment to handicapped and seriously ill newborns unless medical procedures are "clearly futile and will only prolong the act of dying" (5). Patients requiring treatment under these rules would include certain cases of Down syndrome and

spina bifida. However, infants with anencephaly would still be allowed to die without interference. The Baby Doe III regulations also included the DHHS' encouragement for hospitals to establish infant care review committees (ICRCs).

Infant Care Review Committees

In response to perceived deficiencies in the Baby Doe II regulations, the American Academy of Pediatrics (AAP), with the support of the American Society of Law and Medicine, suggested that hospitals establish ICRCs. It was their belief that "hospital-based ICRCs, comprised of both physicians and nonphysicians, are in the best position to review treatment decisions involving infants under hospital care" (6). This recommendation, although slightly modified, was incorporated into Baby Doe III. The ICRCs proposed by Baby Doe III are strictly advisory and have no legal authority. However, the committees would work toward institutional autonomy in several ways. They would respond to hotline calls in instances where developmentally impaired newborns might not be receiving appropriate treatment, establish hospital policy for case types, give advice in certain situations, and conduct retrospective case reviews in non-treatment situations. The ICRC would be required to meet regularly, with additional meetings occasionally called for consideration of an individual case.

The ICRCs are to adhere to the "interpretive guidelines" of DHHS, the "Principles of Treatment of Disabled Infants," which were drafted in January 1984 by representatives of a number of disability organizations, and the recommendations delineated by the report of the President's Commission (3).

DHHS proposes that an ICRC include at least the following seven core members: a pediatrician or neonatologist, a nurse, two hospital administrators, an attorney, two representatives of a disability group or a disability expert, two members of the lay community, and a member of the institution's medical staff, who is to serve as a chairperson. It is interesting to note that the eighth member, an ethicist or member of the clergy, was eliminated from the committee proposed by AAP. More important, as DHHS saw the goals focusing on medical issues and not moral issues, they also modified the AAP's proposed title, Infant *Bioethical* Review Committee to better suit their needs.

It seems only natural for genetic counselors to lend expertise to the ICRCs being formed in their institutions. The movement is burgeoning, and Surgeon General C. Everett Koop's office will be distributing materials to assist in the establishment of ICRCs in the very near future. The time in the history of health care delivery in the United States for devoting energy and attention to formalized efforts to promote moral medical decision making is here to stay; genetic counselors must expand their roles accordingly.

Addendum

Where we are now: Since the publication of the third generation of Baby Doe regulations, and the subsequent ruling of the courts that Section 504 of the Rehabilitation Act does not apply to infants, there has been a rethinking on the part of DHHS regarding the foundation of these cases. During the summer of 1984, legislation was negotiated with various interested groups, and in October, President Reagan signed into law the Child Abuse Act of 1984. This represents a major shift of focus, from handicapped discrimination to child abuse.

The act says the provision of money to states for welfare services will be contingent on their compliance with this legislation, directing that treatment take place unless an infant is born dying or unless in the view of the physicians it would be futile to continue. By threatening to withhold funds from any state that is not in compliance, the act changes the policing function of these problems to child welfare agencies and makes each state's appropriate agency the responsible party for supervising what takes place with respect to children or infants in the area of hospitals. DHHS now has 60 days from the time the act was signed to issue regulations that will put into effect what the legislation directs. Still pending are the specific provisions, extending the ones already in place for child abuse and neglect, which will cover what takes place in neonatal units.

Vol. 6, No. 4, December 1984

Perspectives in Genetic Counseling is published quarterly by the National Society of Genetic Counselors, Inc. Editorial staff, 1984-1985; editor, Joseph D. McInerney; resources, Beth A. Fine; legislation and funding, Edward M. Kloza; book reviews, Joan Fitzgerald; counseling case reports, Carla B. Golden. Manuscripts, correspondence, address changes, and inquiries concerning subscriptions should be sent to *Perspectives*, BSCS, The Colorado College, Colorado Springs, CO 80903. See this issue for instructions for contributors.

References and Notes

1. This paper is an expansion of a panel discussion held at the NSGC Education Conference, Denver, Colorado, 14, 15 June 1984. A summary of that discussion, titled "Genetic Counselors and Ethical Decision Making in Perinatal Health Care," will appear in the conference proceedings, to be published by the March of Dimes Birth Defects Foundation.
2. Kushner T and Gibson J: Institutional ethics committees speak for themselves. In *Institutional Ethics Committees and Healthcare Decisionmaking,* Doudera AE and Cranford RE, eds., American Society of Law & Medicine, 1984.
3. Kushner T and Gibson J: National Center for Institutional Ethics Committees established. In *Ethics Committee Newsletter* 1(3):1, 1984.
4. The National Center for Institutional Ethics Committees has established a clearinghouse for consultants and speakers. Those interested in registering with the clearinghouse or in obtaining a qualified consultant should contact: National Center for Institutional Ethics Committees, University of Miami School of Medicine, Miami, FL 33101.
5. Principles of treatment of disabled infants. In *Ethics Committee Newsletter* 1(3):3, 1984.
6. Wehrle P: Statement of the American Academy of Pediatrics. In *Ethics Committee Newsletter* 1(3):4, 1984.
7. Murray T: At last, final rules on Baby Doe. *Hastings Center Report* 14(1):17, 1984.

Suggested Reading

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment.* Washington, DC, 1983.

Doudera R and Cranford R, eds.: *Institutional Ethics Committees and Healthcare Decisionmaking.* Boston, American Society of Law and Medicine, 1984.

Harron F, Burnside J, and Beauchamp T: *Health and Human Values - A Guide to Making Your Own Decisions.* New Haven, Yale University Press, 1983.

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CASE REPORTS IN GENETIC COUNSELING

Case #3

The consultand is a 38-year-old woman who came for counseling during her second pregnancy. Her first pregnancy resulted in a male who, according to the consultand, died shortly after birth due to a "missing back of the brain." We have been unable to obtain medical records; the condition was most likely anencephaly.

At the time of the counseling session, the consultand was approximately 18.5 weeks pregnant. The father of the baby was "one of two possible men," and different from the father of the first pregnancy. There was no significant family history of birth defects or hereditary disorders.

The patient was counseled that anencephaly was the most likely diagnosis of the first child, and that this factor, along with age, made the patient a candidate for amniocentesis. We discussed the risks and benefits of amniocentesis, as well as MSAFP analysis and ultrasound. The patient elected to have an amniocentesis. The amniocentesis was performed successfully, and results revealed a normal AFP level and a 47,XXX karyotype.

We met again with the consultand and her very supportive friend to discuss the implications of 47,XXX. The consultand is a rather tall woman who, although she clearly understood the information discusssed, is of dull intellect. I mention height and apparent intelligence to suggest that one could not rule out the possibility that she herself has 47,XXX (1,2).

During the second counseling session, the consultand was undecided about continuing the pregnancy. A dilemma arose at this point. I felt that the decision to continue or terminate the pregnancy was the consultand's. I believed that it would be an educated decision, because she seemed to understand the implications and expectations associated with 47,XXX. My concern was that if the consultand is 47,XXX and she chose to abort the pregnancy, would she then, in a sense, be "aborting a fetus just like herself?"

I saw two possible alternatives:

1. let the consultand decide to abort or not based on the implications of 47,XXX without mentioning or testing her chromosomes, or
2. offer to test the consultand's chromosomes (there was enough time) so that she could make her decision based on those results.

There were pros and cons for each alternative. What if we tested the consultand's chromosomes and found her to be 47,XXX? Would we tell her? How would she feel about herself? Would she feel more guilty about the 47,XXX fetus? Would testing her bias her decision? Should her decision be based on the full spectrum of possible outcomes of 47,XXX, rather than how she "turned out?"

At the time, I was concerned that failure to offer chromosome testint might constitute withholding of important information. Are we potentially missing the cause of the 47,XXX fetus? What if she finds out years later that she is 47,XXX? What if she "aborts a fetus just like herself?" If she did, would she ever find out?

I attempted, hesitantly, the second option. Basically, we told the consultand the following: "We feel that there is some chance, a small chance, that you are carrying a chromosomal rearrangement that might explain why the baby got the extra chromosome. It's not likely, but if you want to find out, we can test your chromosomes." The consultand's reply was, "No, I don't want that. Besides, I'm not going to have any more babies anyway. I'm getting my tubes tied after this and that's it." Admittedly, this was a weak attempt on my part, but her assertion that she would not be having more children at least solved one potential problem.

Due to this exchange, we did not test the consultand's chromosomes. She left the counseling session undecided about how to proceed. She spoke with other friends and called a week later having decided to terminate the pregnancy; the abortion was performed.

During a phone conversation about one month later, I told the consultand that should she consider another pregnancy, she should come back for counseling, preferably prior to conception. (Will we test her chromosomes? What if we discover 47,XXX?) The conversation ended with her saying she has changed her mind and is not ruling out future pregnancies.

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References

1. Robinson A, Lubs HA, Bergsma, D; eds; *Sex Chromosome Aneuploidy.* Birth Defects Original Article Series XV(1), 1979.
2. Stewart D, ed: *Children with Sex Chromosome Aneuploidy.* Birth Defects Original Article Series XVIII(4), 1982.

Response to Case #1 (Vol. 6, No. 2, June 1984)

I read with interest the case report concerning the abortion of a fetus of the "unwanted" sex following genetic amniocentesis. I have been involved with similar cases and certainly felt many of the mixed emotions that were described in the initial report by Dr. Toriello and Ms. Martin and in the response by Ms. O'Connor. I would like to offer more specifics about the cases seen here as a response to Ms. O'Connor's statement that there were no data to support the assumption that if one pregnancy was terminated on the basis of fetal sex, other pregnancies will be also.

The first encounter with this issue arose only on follow-up. A couple, both physicians of Far Eastern ancestry, came for an amniocentesis for reasons of "anxiety" (the woman was 32 years old). They had one daughter. The amniotic fluid analysis indicated a chromosomally normal female. When we contacted the obstetrician to obtain information about the pregnancy outcome, we were told that the pregnancy had been terminated because the fetus was another female. After this experience, the woman went through a period of severe depression. She did want more children, but she felt that she could not go through the amniocentesis-abortion experience again. She became pregnant twice after this. Neither pregnancy was monitored by amniocentesis; each resulted in a normal male.

The second encounter with this issue was more difficult, partly because the couple's intention to terminate the "unwanted" sex was stated from the beginning, partly because decisions were based on inaccurate information, and partly because the couple came back for testing of a subsequent pregnancy. This second couple, both well educated and of European ancestry, came for an amniocentesis because of a maternal age of 39 years. The woman's pregnancy history consisted of three healthy sons and two early elective abortions. Her husband had a son by a previous union; that child lived with the couple. The couple made it clear that they intended to terminate the pregnancy if the fetus were male. Although the laboratory staff did not feel comfortable with this situation, we decided we could not refuse to perform the analysis, because the woman was over 35 years of age. Also, we could not perform the analysis but refuse to reveal the sex of the fetus because of the state regulations that prohibit withholding such information. The couple demanded that amniocentesis be performed at 13 weeks (rather than the usual 16-18 weeks) so that, if a male or abnormal fetus were detected, a simpler termination procedure could be used. Without informing our laboratory, the obstetrician withdrew some extra amniotic fluid and sent it to an inexperienced endocrine laboratory to have the testosterone level assayed. When we phoned the obstetrician with the results of a chromosomally normal female, we were informed that the patient had terminated the pregnancy two weeks earlier on the basis of the endocrine tests indicating a male fetus.

Exactly one year later, the same couple presented for another amniocentesis. At that time the obstetrician informed us that he had never told the couple that they had aborted a normal female fetus. Also, he told us that the woman had been on multiple courses of clomid to conceive this pregnancy. The laboratory staff expressed the same ambivalent feelings as before, but did agree to analyze the case with the restriction that no intervention be performed until the chromosome results were called out. As before, the couple demanded that the amniocentesis be performed at 13 weeks. Genetic counseling for this amniocentesis was very brief, partly because the couple had been counseled previously and partly because I had so many negative feelings about what this couple had done that I wanted to minimize my contact time out of fear of expressing some of my feelings to them. The results of the amniotic fluid chromosome analysis indicated that the fetus was a chromosomally normal male. The pregnancy was terminated the next day. When we called the obstetrician with the results, we requested that any further amniotic fluid samples from this couple not be sent to this laboratory. Admittedly, this was simply shifting the dilemma from our laboratory to another. However, the entire staff felt that they could not handle another sample from this couple.

The couple did, indeed, become pregnant again and an amniocentesis was scheduled to be analyzed by another laboratory in town. The pregnancy miscarried before the amniocentesis. After that, the couple decided not to attempt any more pregnancies.

I find the contrast between these two couples and how they dealt with the amniocentesis-abortion experience to be quite interesting. Obviously, the numbers are so few that no generalizations can be made. In all honesty, the laboratory's policy toward cases like these is made one step (or is it stumble?) at a time. We do try to "allow a couple to choose a course of action that seems appropriate to them," in the words of Ms. O'Connor. However, one must take into consideration the strain that these cases put on the rest of the staff on the case.

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RESOURCES

Parent to Parent: About MPS and ML Disorders.
March of Dimes Metropolitan Chicago Chapter, 1983.

A very thoughtful mother of one of our patients has written a booklet about mucopolysaccharidoses and mucolipidoses.

According to the author, Pat Downey, her goals in the 16-page booklet are to:

1. alleviate partially the "serious lack of accessible information about these disorder,"
2. "assist parents in their search for help," and
3. urge participation in the March of Dimes National MPS and ML Registry.

Ms. Downey has met these goals successfully. The booklet opens with a section titled "What are MPS and ML Disorders," complete with a helpful chart listing all such disorders and their major clinical features. "Genetics - Why Me?" follows with a short, crash course on genetics. The remaining sections are titled "Exceptional Parenting" (well thought out and written as only a parent of such a child could write, for example, Ms. Downey discusses the daily-living aspects of caring for such a child); "Infant Stimulation"; "Our Children's Potentials" (an optimistic and healthy answer to a difficult question); "Medical Care"; "What about Research?"; "Where to Find Help" (in part accomplishing goal #2, above, including a listing of financial and medical services, and written material); and "References" (a surprisingly substantial listing). The booklet closes with a statement about the National MPS and ML Registry, complete with an enrollment application.

This booklet is thorough, full of information and insight, and is a great asset for parents of children with such conditions. I recommend that you keep a few copies in your drawer. Mrs. Downey is an optimist, but she does not fall into the common trap of unrealism. Her push for the National Registry is honorable and wise. *Parent to Parent* is available from the March of Dimes Metropolitan Chicago Chapter, 53 W. Jackson Blvd., Chicago, IL 60604, phone: (312) 341-1370. There is no charge for three copies or fewer. More than three copies cost 50¢ each. Discounts are available for parents' conferences.

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NSGC NEWS

Call for Abstracts

Paper presentations by the NSGC membership will comprise a significant portion of the fifth national education meeting "Strategies in Genetic Counseling: Religious, Cultural, and Ethnic Influences on the Genetic Counseling Process." The meeting will be held 7, 8 October 1985, at the Hotel Utah in Salt Lake City, preceding the American Society of Human Genetics meeting, to be held 9-12 October. Abstracts will be accepted from NSGC members, including student members, as well as from nonmembers with member sponsors. The deadline for abstracts is 1 May 1985. Papers or data presented may have been previously presented or published elsewhere. Contributors will be asked to choose whether they would like their abstract to be reviewed as a paper, poster session, or both. All abstracts will be reviewed, and contributors will be contacted by 1 June. The theme of the meeting will be considered in reviewing the abstracts, although any subject matter pertaining to genetic counseling is welcome. Please contact your colleagues for ideas and support in preparing a presentation. For additional information, contact: LuAnn Weik, Abstract Review Coordinator, Birth Defects Center, Milwaukee Children's Hospital, 1700 W. Wisconsin, Milwaukee, WI 53233. Abstract forms will be sent to the entire NSGC membership. All completed forms should be sent to LuAnn Weik at the above address.

Call for Nominations

Enclosed in this issue of *Perspectives* is a form for submitting nominations for the NSGC offices of president-elect, treasurer, and representatives of Regions I, III, and V. States and Canadian provinces comprising these regions are (I) CN, MA, ME, NH, RI, VT, NFLD, NB, NS, PEI; (III) AL, FL, GA, KY, MS, NC, SC, TN; (V) AR, CO, LA, MT, ND, OK, SD, TX, UT, WY, ALTA, MAN, SASK. All members of the society are encouraged to submit names of potential candidates. Your participation in choosing the leaders of your organization is essential to the nomination process.

The members of the 1984-85 nominating committee are Rosalie Goldberg (Region II), Elizabeth Gettig (Region III), Elizabeth Rehling (Region IV), Joan Westphal Fitzgerald (Region V), and Ann P. Walker (Region VI). The deadline for receipt of nominations is 15 February 1985; forms are addressed on the back and should be returned to Elizabeth Gettig.

ANNOUNCEMENTS

Additional copies of *Trisomy 18: A Book for Families* are now available for $2.00/copy. Please send all requests to Clinical Genetics Center, Children's Memorial Hospital, 8301 Dodge Street, Omaha, NE 68114. Make checks payable to: "Trisomy 18 Book."

The Central Jersey Chapter of the March of Dimes, UMDNJ-Rutgers Medical School, and Rutgers University are sponsoring a conference titled "Chemicals and Our Environment: the Mother, the Fetus, and the Child–Implications for the Health Care Worker," to be held in New Brunswick, New Jersey on 1 March 1985. For further information, contact: Maria Licciardello at the March of Dimes: (201) 842-6326 or (609) 655-5742.

The American Porphyria Foundation has produced educational materials for public education about porphyria. Persons interested in obtaining the materials should contact: Desiree H. Dodson, Executive Director, American Porphyria Foundation. P.O. Box 11163, Montgomery, AL 36111.

Reviewers for *Perspectives*

The editorial staff of *Perspectives* is soliciting reviewers for manuscripts, books, and resource materials. Interested individuals will be asked to complete a short questionnaire about training, expertise, and areas of interest. Contact J.D. McInerney, *Perspectives,* BSCS, The Colorado College, Colorado Springs, CO 80903.

Grant From The National Foundation For Jewish Genetic Diseases

Once again, NSGC indebted to the National Foundation for Jewish Genetic Diseases (NFJGD) for its grant to defray expenses associated with the NSGC Board of Directors meeting. The nine-hour meeting was held following the close of the ASHG meeting on 3 November; support from NFJGD made it possible for board members to remain overnight to attend. Issues addressed include financial planning for the society, the 1985 national education meeting, the future of *Perspectives,* and various projects of the standing committees. The board thanks NFJGD for its continued support.

POSITIONS AVAILABLE

Genetic Counselors (2): The state of Delaware has two positions available for board certified or eligible genetic counselors. The first position will involve counseling for prenatal diagnosis clients and working with newborns at the Medical Center of Delaware, a newly-opened facility that handles 6,000 deliveries a year. Contact: Digamber S. Borgaonkar, PhD, The Medical Center of Delaware, P.O. Box 2850, Wilmington, DE 19805, phone: (302) 428-4875. The second position will involve setting up two satellite clinics in the southern portion of the state. Contact: Charles I. Scott, Jr., MD, A.I. Dupont Institute, P.O. Box 269, Wilmington, DE 19899, phone: (302) 651-5916. Both positions start in early 1985. Salaries based on experience.

Genetic Associate/Counselor: An exciting, rapidly-growing medical services company based in San Diego, California has an opening for a genetic associate/counselor. The individual selected will be expected to "wear several hats." This is definitely not a routine position. Ideal professional working conditions in one of the premiere biomedical areas in the United States. Premium compensation and participation. Send resume to: James D. Eisen, PhD, Karyon Scientific, Inc., 11199 Sorrento Valley Road, Suite A, San Diego, CA 92121. Karyon Scientific, Inc. is an Equal Opportunity Employer.

JOBS HOT-LINE NUMBER
Linda Nicholson: (302) 651-4234

INSTRUCTIONS FOR CONTRIBUTORS

Types of Manuscripts Accepted

Authors may submit articles dealing with the varies professional roles of the genetic counselor, counseling case reports, original research reports, articles addressing topics relevant to the profession of genetic counseling, or letters to the editor that deal with professional issues of the society.

Instructions

All manuscripts must be typed and *double-spaced.* Please submit three copies of each manuscript. The author's name, preferred title, address, and business telephone number must accompany all submissions.

Send all manuscripts, except case reports, to:
Joseph D. McInerney
Perspectives in Genetic Counseling
BSCS
The Colorado College
Colorado Springs, CO 80903

Send all case reports to:
Carla B. Golden
The Permanente Medical Group, Inc.
281 West MacArthur Blvd.
Oakland, CA 94611

Deadline for 1985 Issues

March Issue:	1 January 1985
June Issue:	1 April 1985
September Issue:	1 July 1985
December Issue:	1 October 1985

1985 RATES FOR
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Specific Instructions for Counseling Case Reports

The purpose of counseling case reports is to present organized discussions of the counseling and case management problems confronted in the clinical genetics setting. The format for counseling case reports is as follows:

1. Present a brief statement of the diagnostic information and the reasons for seeking genetic services.
2. Describe the counseling problems or case management difficulties encountered.
3. Discuss how the problems were addressed, including the rationale for your course of action.
4. Present a broader discussion outlining other methods one might use to deal with similar problems.

Sections (3) and (4) should include citations of the counseling or genetics literature to substantiate your discussion and methods.

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FIRST CLASS

[redacted]