Abstracts of Note: The Bioethics Literature

This section is meant to be a mutual effort. If you find an article you think should be abstracted in this section, do not be bashful—submit it for consideration to feature editor Kenneth V. Iserson care of *CQ*. If you do not like the editorial comments, this will give you an opportunity to respond in the letters section. Your input is desired and anticipated.

Thornton JG, Lilford RJ: Clinical ethics committee. *British Medical Journal* 1995;311: 667–9.

Why haven't clinical ethics committees become established in the United Kingdom? This paper looks at the experience of one specialized pediatric committee in the north of England and speculates on why they saw no further cases in the following year.

Some clues to the answer to our question are given by the authors' views on the functions of a clinical ethics committee (CEC). They suggest that the committee is there 1) to give guidance when clinicians "may not know what to do [ethically]"; 2) to test public opinion on difficult decisions; and 3) to help teams come to a decision when views are not unanimous. There is little hint of the involvement of the patient in decision making, or any suggestion that increasing patient autonomy is desirable. Equally, when the problems of CECs are discussed, we hear of the patient who "risks being harmed by CECs," because a committee is likely to be used when "a doctor is uncertain whether a patient's request is permissible." In the two cases that the committee did discuss, one concerning the antenatal diagnosis of Huntington's chorea without one parent's knowledge and the other concerning a complex cardiac abnormality in a fetus leading to a request for late termination of pregnancy, the authors feel that the advice given might be perceived as having "serious net negative consequences." They also feel that "the committee interferes with the doctor-patient relationship" and "reduces clinical freedom."

In the light of this strong negative feeling toward CECs, it is not surprising the authors conclude that "perhaps doctors in Britain are not yet ready to surrender" their autonomy over "clinical moral dilemmas." If two clinicians who were sufficiently motivated to set up a CEC are left feeling like this, it will be a long time before ethics committees become widespread in the U.K.

[Ian Jones, Bolton, UK]

Iserson KV, Lindsey D: Research on critically ill and injured patients: rules, reality, and ethics. *Journal of Emergency Medicine* 1995;13:563–7.

Honest clinicians will usually admit that much of today's medical care relies on experience unsupported by investigation, and emergency medical care is no exception; research is necessary to improve this care. Critically ill and injured patients are the patients who will most benefit from improvements in emergency medical diagnostic and treatment methods. Yet the U.S. federal bureaucracy has effectively banned research on these patients, since they cannot generally give "informed consent." These authors argue that, with the proper safeguards, research on critically ill and injured patients should be performed in the emergency medicine and emergency medical systems (EMS) settings without informed consent. To require such consent when not obtainable compromises both the researchers who must get such consent and the patients who must continue to endure old, and often untested therapies.

Fetters MD: *Nemawashi* essential for conducting research in Japan. *Social Science and Medicine* 1995;41:375–81.

Westerners often believe that their ethical policies, protocols, and systems can and should be universal. Despite voiced protestations, those from the West assume that what has worked for them can easily be imported into other cultures unchanged. Such is the case in an American scholar's efforts to conduct social science research on end-

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of-life care in Japan. He found that their system for research approval not only had to conform to the unwritten rules of Japanese culture, but that he could not transgress a key cultural taboo—the subject of death by brain criteria.

With prestigious sponsors, adequate funding, and advance preparation, the author arrived in Japan for a 10-week research visit. During that time, he was to interview physicians about end-of-life decision making. He had ties to a Japanese medical college that he had previously visited, and where he had gotten informal approval for his project. Interested in solidifying the good relationships, he kept his Japanese collaborators current on the project's timeline and status before he returned to actually collect the data. When he returned to Japan, however, his cultural naiveté ran into *nemawashi*, the complex method through which Japanese groups make decisions. The author describes the process as "the art of contacting the *right* people in the *right* order and obtaining group consensus." Rather than simply going to an IRB as would happen in many Western countries, over a 3-week period his "personal advocate," a highly respected department chair (*the* professor) met successively with the director of foreign students, the ethics (research) committee, the hospital director, the department chairs at their meeting, the general faculty, and finally the person who had to make the decision, the dean. Each person or group reviewed the project and needed assurance that the subject of death by brain criteria would not be raised.

While on paper it seemed that he only needed the dean's approval for the research, the author explains that like the much-weaker concepts of consensus building, concurrence, or structuring, used to get agreement in Western groups, *nemawashi* is much more formalized, hierarchical, and inflexible. He stresses that for those wanting to do research in Japan, getting formal approval can be a very time consuming process, approval needs to be obtained through *nemawashi* and must go through a highly respected personal contact-advocate who can guide the individual through the process (and usually speak for him or her).

This paper highlights the major differences between some of the world's dominant cultures. It is not just language that is different. We must tread carefully when we would export our culture, mores, and philosophy.

American Academy of Pediatrics Committee on Fetus and Newborn and the American College of Obstetrics and Gynecologists Committee on Obstetric Practice: Perinatal care at the threshold of viability. *Pediatrics* 1995;96:974–6.

A cutting-edge issue in clinical perinatology and neonatology is the extremely-low-birthweight infant, now considered those born during or before their twenty-fifth week of gestation or who weigh less than 750 grams at birth. In this joint paper from both the pediatricians and the obstetricians, the current state of knowledge is reviewed, as well as the limitations on antenatal predictions and recent long-term survivor outcome, and the difficulties and process of counseling parents. The paper details the limitations on estimating gestational age, either through history or ultrasonography. It also speaks to the wide variations in outcomes, both survival in the neonatal period and the various serious health-related sequelae related to birth from 23 to 25 weeks gestation or with birth weights between 500 and 800 grams. The tables alone are worth reviewing, for bioethics committee use during consultations or when discussing situations with the perinatal/neonatal teams. Particularly useful are the statements clarifying that some "aggressive" obstetric care, such as cesarean sections to deliver these infants, have shown no benefit, and that "physicians should avoid characterizing managements of uncertain benefit as 'doing everything possible.'" The paper, in fact, outlines the significant risks for women with extremely-low-weight infants undergoing cesarean sections—especially the risks to a chance of future vaginal delivery. The paper also emphasizes discussing with parents that antenatal decisions may be altered once an infant is delivered and a more accurate evaluation can be made. They also briefly detail the caring and humane steps to take when a decision has been made to withhold or to discontinue life support in these infants. While large neonatal units probably already follow these procedures, smaller units unaccustomed to these situations may benefit from reviewing them. In sum, this is a key paper—brief, well-researched, and easily understood. It is essential reading for those who work in the realm of perinatal or neonatal bioethical dilemmas.

Committee on Ethics, American College of Obstetrics and Gynecology: End-of-life de-

cision making: understanding the goals of care. *International Journal of Gynecology and Obstetrics* 1995;50:208–14.

Amidst a typically predictable rehash of commonly voiced biomedical views on end-of-life issues in patient care, the ACOG Ethics Committee summarizes in its position statement what seems to me to be a terrible and potentially disastrous misunderstanding of the goals and functions of bioethics committees. The position statement goes through a discussion of the terrible dilemmas faced by women with terminal illnesses when they must decide between preserving or not harming the life of their unborn child and enhancing or possibly saving their own lives. The committee then discuss the importance of autonomy, emphasizing that physicians must deliver adequate information to their patients, and go on to discuss a physician's conscience clause wherein a practitioner may opt out of procedures or courses of treatment that he or she finds morally objectionable. This is all pretty much freshman-level bioethics. The disturbing note sounds at the end of the paper. After discussing conflicts between the patient and the physician, the committee goes on to say, "When, because of divergent beliefs on this matter, risks and benefits are valued differently by patient and physician, there is a potential for conflict. This potential highlights the importance of candid discussion of these matters in advance of a situation of conflict or crisis. *The proper course for resolving conflicts that do arise is discussion of the case with an ethics committee or consultant.*" [Italics are mine.] This statement, the paper's "bottom line," signals a complete misunderstanding of how clinicians should use bioethics committees. Ethics committees are not courts to hand down verdicts, nor are they there to convince patients to accept a physician's judgment (or visa versa). When patients with decisionmaking capacity, who have been given adequate information, weigh their options and make a decision, it is not the role of bioethics committees to intervene to change their minds or further empower the clinician. Rather, if the clinician, patient, or family need deliberation or advice on how to proceed from that point, they should access the committee. It is to be hoped that obstetricians and gynecologists who read and cite this position statement will have enough knowledge of bioethics committees to know, on their own, how to best use them. Unfortunately, experience has shown that they probably won't.

Rogers C, Field HL, Kunkel EJ: Countertransference issues in termination of life support in acute quadriplegia. *Psychosomatics* 1995;36:305–9.

Christopher Reeve's experience with acute traumatic quadriplegia has brought the issue of decision making about continued treatments or withdrawal of these treatments to the public's attention. It has also made ethicists more aware that the dilemma of whether acutely depressed patients (and only a pathological few won't be experiencing situational depression because of their new condition), can have the decisionmaking capacity to withdraw or withhold treatment. These authors explore the issue of why medical personnel choose to involve bioethics consultation through a case example. Their case is that of a white, 44-year-old male attorney who suffered a c-4 fracture with ascending paralysis to c-2, quadriplegia, and ventilator dependence. The patient was married and had children. The attending neurosurgeon epitomized the staff's feelings when he said, "I don't blame the guy. If I were in his position, I would want to die too." The entire nursing staff, who expressed gratitude that psychiatry became involved with the case, expressed consternation with the patient's request to withdraw ventilator support, sympathy for the patient's wife, and concern about his children. The psychiatrist opined that the patient did have decisionmaking capacity, but suggested that the hospital's ethics committee also become involved. This committee felt that the patient's decision to withdraw his ventilator was appropriate. Their psychiatric consultant pointed out, however, that such decisions may be influenced by countertransference, i.e., committee members identifying with the patient.

Countertransference, as expressed by the neurosurgeon, is identifying how one believes one would feel if one were the patient. This attitude becomes most pronounced when the noninvolved person (physician or bioethics committee member) is close to the patient's demographics (age, race, gender, etc.). Many medical staff, especially those who work in surgical intensive care units, experience countertransference with spinal cord injured patients, since they are usually within a similar demographic group. This often brings out their anger, frustration, and fears—all leading to bioethics consultations. The authors conclude by recommending that this is one type of case in which the bioethics committee can usefully act as a sounding

board for the staff (an important, but often scoffed at, bioethics committee activity).

Kielstein R, Sass H-M: From wooden limbs to biomaterial organs: the ethics of organ replacement and artificial organs. *Artificial Organs* 1995;19:475–80.

As we proceed into the future world of organ and tissue replacement therapy, these authors ask us, very reasonably, to step back and at least look at some of the big ethical issues that confront us now and, most importantly, will confront us in the future. Rather than taking up a single issue related to organ and tissue transplantation, as most authors do, this paper makes a serious effort to briefly discuss all of the current and possible techniques to replace or enhance organs and tissues. These include research, allocation, organ donation, artificial organs, xenografts, biomaterials, and neuromaterials. They propose seven theses:

1) Organ replacement therapy is medically and morally beneficial and that all efforts should be undertaken to further research and application for the patient's good.
2) Moral and medical risk assessment must include awareness of cultural differences and should be shared with patients and research subjects.
3) Funding and design of organ replacement research should, in addition to biomedical principles of efficacy and utility, be governed by bioethical principles of humanitarianism and subsidiarity to promote social justice and the accessibility of medical services.
4) Given the rich diversities in public and individual values in the global village, the introduction and application of organ replacement therapy has to meet standards of value-compatibility as well as biocompatibility to provide for good clinical practice.
5) The development of biologic materials, xenografts, of transgenic cells, tissues, and organisms is not only ethically acceptable, but mandated by medical ethics and the ethics of care for the disadvantaged.
6) There are caveats when neuroprosthesis development and application violates personal identity and human dignity, when questionable "enhancement" programs and ideologies put machines in control of humans, and when medicine surpasses its primary role in caring for and supporting those who are sick, suffering, and disadvantaged.

The authors' last recommendation not only is their most important, but holds significance for all bioethical areas:

7) Individuals involved in the process of the ethical assessment of organ replacement and biomaterials should have available to them access to an as yet to be established interdisciplinary international ethics committee on organ replacement therapy.

Given the response to other such reasonable and necessary calls for proactive action in bioethics, this call too will be ignored.