

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.

Weir RF. The morality of physician-assisted suicide. *Law, Medicine & Health Care* 1992; 20:116–26.

This author reluctantly develops an argument for physician-assisted suicide (PAS) in some instances, although he believes that it departs from medicine's traditions and should not be necessary in an optimal setting. He first describes five reasons to prohibit PAS: 1) the medical profession is committed to healing; 2) physicians should not cause death, and PAS differs little from active euthanasia; 3) patients should not request PAS because it compromises the physician; 4) PAS would lead to mistrust and abuses; and 5) PAS is unnecessary and usually due to inadequate treatment. Dr. Weir does not believe these arguments are compelling. He believes they are only partially true and leave out much of the reality about modern medical treatment/care. He advances five arguments for PAS: 1) to respond to current medical reality; 2) to alleviate patient suffering; 3) to optimize patient control; 4) to minimize harm to the patient and others; and 5) to act out of compassion. He qualifies his defense with several conditions for participating physicians that may not be wholly realistic: not participating if the patient has treatable depression, use only when there are no effective medical options that a patient will accept, and hold several conversations with the patient and include a close friend or relative in the discussion at least once. Specific recommendations include lifting restrictions on PAS only for physicians, limiting the circumstances where it is legal, and developing a uniform model law that states could adopt. Although Dr. Weir's ideas are neither new nor fully developed, this paper may act as a starting point for a rational discussion of the issue in the midst of hysteria.

Baskett PJF. Ethics in cardiopulmonary resuscitation. *Resuscitation* 1993;25:1–8.

This author proposes international guidelines to ethically restrict cardiopulmonary resuscitation (CPR) to those who could benefit from the procedure. CPR routinely follows an unexpected stoppage of the heart in patients without any known life-threatening condition. He proposes that with some pre-existing conditions or senility, questions about the appropriateness of CPR arise. A primary decision point should rest with the patient or attending physician. How the physician makes the decision is unclear, except that it should not be based on "doctor pride," where the physician refuses to acknowledge that the patient has end-stage disease. He rightly points out that a do-not-resuscitate (DNR) order never implies a decrease in the caring and the nursing care delivered to the patient. If CPR is attempted and the patient does not quickly respond, the author lists the medical criteria that may indicate success will not be forthcoming (e.g., long interval between basic and advanced life support). He lists age as one of the criteria, although his data are skimpy at best. He does, however, raise an important point for rescuers that is seldom mentioned – there is a small but reported incidence of infections passed from victim to resuscitator. Protection of the rescuer must be weighed against the probability of successful CPR. Overall, this paper offers some good guidelines for a DNR policy that all modern healthcare facilities must now develop because of the presumption that CPR will be given in all cases of cardiorespiratory arrest.

Brown KH. Descriptive and normative ethics: class, context and confidentiality for mothers with HIV. *Social Science and Medicine* 1993;36:195–202.

The ethical norms governing confidentiality, based on the principle of autonomy, may not hold with American mothers infected with HIV. This multisite study, involving physician, nurses, social workers, and others, found that institutional imperatives and professional assessments often override patient claims to confidentiality about their medical condition. Some of the difficulty lies with the mother-child relationship and the strong feeling that the child's protection takes precedence over certain interests of the mother. Workers seem willing to sacrifice the mother's confidentiality to assure that a child is tested for HIV, if not treated. The relative lack of authority patients have over information medical institutions and professionals transmit about their condition and the professional's class-based assumptions about the mother's need for confidentiality influence whether confidentiality is maintained. Mothers (and their children) often experience hardships from loss of insurance, jobs, or freedom once they are exposed as being HIV positive. The authors feel that at least in the case of HIV-infected mothers, they must have increased control over release of their medical information, and any release of information must be based on individual circumstances rather than social stereotypes.

Holley JL, Nespore S, Rault R. Chronic in-center hemodialysis patients' attitudes, knowledge, and behavior towards advance directives. *Journal of the American Society of Nephrology* 1993;3:1405-8.

Although patients on chronic hemodialysis must be aware that their existence is tenuous, just prior to implementation of the federal Patient Self-Determination Act (PSDA), these authors found that although 77% of the patients at their major medical center had discussed their wishes about life-sustaining care with someone close to them, only one third understood the role of a healthcare proxy (surrogate) and only 42% understood that they could complete a living will. Only one fifth of these very ill patients had completed an advance directive. The authors found that patients whose prior renal transplant had failed thought there was nothing more important than for the physician to discuss advance directives during a clinic visit. Patients with 12 or fewer years of formal schooling, however, were particularly concerned that after completing an advance directive a patient could change his mind and not have a chance to tell any-

one. This concern and the attitude of former transplant patients suggest important strategies for using advance directives in this patient population. It is hoped that advance directives are now being used in more than the 8% of hemodialysis units that had policies for obtaining advance directives before the PSDA went into effect.

Mori T. National regulation of and achievements in assisted reproduction in Japan. *Journal of Assisted Reproduction and Genetics* 1992;9:293-8.

The first ethical reviews and ethics committees in Japan centered on issues of assisted reproduction. The Japan Society of Obstetrics and Gynecology initiated an ethics committee, eventually becoming the Ethics Committee on Practice and Research, in 1982. They eventually came out with five statements governing assisted reproduction involving in vitro fertilization-embryo transfer (IVF-ET) with fresh embryos, research using human gametes or preembryos, pre-conceptual sex selection, cryopreservation, and microinsemination. These policy statements resulted in practices that differ from those of other countries. Being listed with the Japanese Registry of Reproductive Medicine, for example, is mandatory and is de facto licensing. In addition, only married couples may undergo IVF-ET procedures or cryopreservation of ova and embryos. Surrogate mothers are completely prohibited. The use of donor sperm in IVF-ET is also prohibited (although donor sperm can be used for other procedures). Finally, pre-conceptual sexing by separation of sperm cells may only be done to avoid sex-linked recessive genetic disorders and not to obtain the desired sex of a child for other reasons. Anticipating ethical questions about the efficacy of assisted reproduction, they cite 1990 rates of 13.5% live births for IVF and 20.8% live births for gamete intrafallopian transfer. The resulting children, if over 1,000 g at birth, seem to develop normally.

Youngner SJ, Arnold RM, and the Working Group on Ethical, Psychosocial, and Public Policy Implications of Procuring Organs From Non-Heart-Beating Cadaver Donors. Ethical, psychosocial, and public policy implications of procuring organs from non-heart-beating cadaver donors. *Journal of the American Medical Association* 1993;269:2769-74.

Is it ethical to take transplantable organs from patients (with their or a surrogate's consent) who are taken to the operating room,

withdrawn from life support, and two minutes after their heart ceases to function (ventricular fibrillation, electrical asystole, or electromechanical dissociation) operated on to remove organs? That procedure constitutes the "Pittsburgh Protocol" these authors defend. They believe that if organ procurement organizations use this protocol, a substantial increase in transplantable organs will result. The danger, as the authors point out, is that this protocol raises questions about the nature and scope of two fundamental moral requirements that have governed organ procurement: the dead-donor rule, which says that vital organs should only be procured from dead patients, and the rule that the care of living must never be compromised in favor of potential organ recipients. The authors raise several straw men to knock down while defending the protocol but fail to answer some basic questions. First, in an attempt to be sure they do not hasten a patient's death, physicians under this protocol forgo the standard sedation used to avoid suffering in aware patients being terminally withdrawn from ventilators. As the authors note, this "may interfere with optimal patient care." Second, the authors lightly skip over both the use of this protocol in nonterminal patients who are ventilator dependent, potential advances in the use of acutely dead patients arriving in the emergency department as donors, and how close this protocol comes to the next step of simply anesthetizing these patients, harvesting their organs, and then shutting off the machines. Whether one agrees or disagrees with their protocol, the authors note that ethicists on both sides of this debate have cautioned "that practices that increase organ procurement in the short run at the expense

of public trust might, in the long run, decrease Americans' willingness to donate organs." That result would be tragic.

Freedman B. Offering truth: one ethical approach to the uninformed cancer patient. *Archives of Internal Medicine* 1993;153:572-6.

How do healthcare workers balance the need to tell a patient the truth about a serious medical condition with a family's wish, sometimes culturally based, to spare the person from dealing with the awful details? Many providers have independently come to the conclusion that offering information to an alert patient in a sensitive manner is the best option. This article delivers one of the best descriptions of the technique. The key, as Dr. Freedman says, is "offering truth—rather than inflicting it—to allow the patient to choose his or her own path." Offering truth "represents a brief dance between patient and health-care provider," where the provider provides an opportunity for the patient to learn the truth at whatever level of detail desired, but no more than that. The patient, as Dr. Freedman describes, "has a right to know, she does not have a duty to know. We would not force this information on her—indeed, we cannot." As this article points out, a side benefit to this approach results when families, attempting to maintain their own cultural mores, are comforted by a clinician's approach to truth telling that does not conflict with their traditions. Because the family frequently acts as the patient's decision maker, it becomes important to defuse tension between the clinicians and family. As happened in one case he describes, "People were able to look each other in the eye again."