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**Zuloaga RL.** Bioethics in Peru. *Bulletin of PAHO* 1990;24:545–9.

According to this author, the application of bioethics in Peru has, to date, been at best rudimentary. The discipline has not yet acquired a distinct identity; only a few committees review ethical problems that arise in the course of medical practice, and bioethics is still taught mainly at schools of philosophy and theology. At the same time, health professionals have raised bioethical questions and identified situations where bioethical approaches might be effectively applied, including research on human subjects, interventions relating to human reproduction, treatment of AIDS patients, treatment of dying patients, organ transplants, and management of handicapped children. This article reviews developments in each of these areas as seen from a Peruvian perspective.

**van der Wal G, van Eijk JThM, Spreeuwenberg C.** Euthanasia and assisted suicide. II. Do Dutch family doctors act prudently? *Family Practice* 1992;9:135–40.

These authors studied a random sample of Dutch family physicians to determine whether they observed the procedural requirements for performing active euthanasia and the reasons why they and their patients participated in this activity. Of their respondents, 83% said that in their last case of active euthanasia or assisted suicide (they mixed the two) the first discussion about it was at the patient's suggestion, 10% at the physician's initiative, and 6% at the family's suggestion. Only one-third of the patients put their request in writing. Only one in seven family members put their request in writing. In three quarters of the cases, the time between the initial request and implementation was less than 1 month and in at least one third, less than 1 week. Only 3% were within 24 hours of the initial request.

"Pointless suffering" was the most common reason given by patients for explicitly requesting euthanasia or assisted suicide (56%). At the time of the last request for this help, the physicians felt that no additional treatment was available in 90% of the cases. Patients felt their situation was "to a very large extent" intolerable 85% of the time, whereas only 60% of their physicians believed it was this bad. A total of 12% of the physicians neither had the required formal discussion with another independent physician nor with any other health professional before assisting their patient. The authors conclude that some Dutch family physicians do not observe the procedural requirements, although the majority practice prudently.

**Kuhse H, Singer P.** Euthanasia: a survey of nurses' attitudes and practices. *The Australian Nurses Journal* 1992;21(8):21–2.

This 1991 survey of nurses in Victoria, Australia, showed that of the respondents (49% response rate), 85% had participated in active euthanasia at the request of a physician, and 80% of these had done it more than once. In contrast, although nearly two-thirds had been asked by patients to help end their lives, both passively and actively, only 10% had complied with a request for passive euthanasia and 5% with active euthanasia. Moral objections were the reason given by only 16% of those who declined to perform active euthanasia. The respondent nurses are heavily in favor of introducing a Netherlands-type euthanasia system to Australia. About 75% of the nurses approved its introduction, in contrast to approximately 60% of physicians (the authors' 1987 study). The results, however, suggest that Australia may begin to see the same legislative activity towards clinician-assisted suicide that is now occurring in the western United States.

**Rocha J, Boseley S, Gracie C, Tomforde A, Bose A, Brew J, Stephen C, Jones M, Geveisser M, Rugman J.** A world of conflict over abortion. *World Press Review* 1992;39:22-4.

The authors present an up-to-date review of the attitude towards and availability of abortion in some of the world's major countries. They found that in Brazil, although abortion is a criminal offense, it is so widely practiced that one-fourth of the state's obstetric-gynecology budget each year goes for treating the complications of botched abortions. In Britain, abortions can legally be performed now to the 24th week. In China, family-size restrictions propel parents into aborting female fetuses; this also occurs in India. Germany is divided along East-West lines, with the old East Germany having liberal laws, the West restrictive. Japan has a liberal abortion law complicated by a lobby of physicians who profit from the procedure; Turkey may have a similar problem. Although Romania and Russia use abortion as birth control, South Africa's laws are very restrictive, seeing abortion as "a rejection of motherhood."

**Barnett AH, Blair RD, Kaserman DL.** Improving organ donation: compensation versus markets. *Inquiry* 1992;29:372-8.

These authors argue that a market-based system of organ procurement (from cadavers) is superior to both the current altruism-based system and a system based only on compensation. They suggest initiating a market-based system, in which cadaveric organs are purchased by profit-seeking firms that specialize in organ acquisition. This would, in their opinion, solve both the problem of potential donor families refusing to donate and the problem of them never being asked. They dismiss as naive the current system of altruism, where individuals make arrangements and families agree to donate organs and tissues solely based on their willingness to help others. In their view, it provides little incentive for donation because organ procurers must appeal exclusively to a sense of community and benevolence on the part of the deceased's family. It also provides no incentive for physicians to ask for a donation, which is admittedly an unpleasant task. The authors feel that a market-based system is ethically justified by the desire to save potential recipients' lives outweighing any public policy that imposes a single moral position on others. (Some may, of course, question whether altruism must be pervasive in our society for it to survive.) The authors attempt, unsuccessfully, to ar-

gue that the four major ethical arguments against a transplant organ market system are bogus. They say that 1) the poor will not be coerced into donating because it is not the system's fault they are poor; 2) the poor will not be priced out of receiving transplants any more than they are now with the high costs of the procedure (and follow-up); 3) potential organ donors will not have care terminated too early for a profit motive because they will die anyway and the parties will still profit; 4) organ quality will not be diminished because donor families will not be financially induced to lie about the prior condition of their donor-relative. These arguments are rather naive, superficial, and neglect the realities of medical practice. (None of the authors are clinicians.) Nevertheless, arguments for a market-based system are certain to emerge; some might even prove ethically acceptable to our society. This article, however, only outlines some of the issues.

**Fletcher JC.** Fetal therapy, ethics and public policies. *Fetal Diagnostic Therapy* 1992;7: 158-68.

In his review of prenatal fetal diagnosis and therapy (as contrasted with fetal tissue therapy, although he also speaks about the U.S. government's position on this), Dr. Fletcher addresses the major ethical problems and the most common approaches to them. The ethical problems he addresses are the risk/benefit assessment in research or innovative treatment, the selection of cases for treatment, how to obtain optimal informed consent, treatment of twin pregnancies, and refusal of a fetal therapy proven successful. He considers the selection of cases to be the most frequent and difficult ethical dilemma. Because there is little evidence from controlled trials, it is often unclear in clinical practice which patients will benefit from new fetal interventions and which will merely gain survival but with a "half-corrected" problem. Another problem stems from a mother's "kin altruism"—how to obtain adequate informed consent. The author suggests using an impartial physician to "speak for" the fetus, integrating the mother's own physician and rest of the family into the process, and requesting an ethics or psychiatric consultation. Interestingly, he gives only passing mention to a topic of major ethical debate, gene therapy. What this article makes clear is that we are now only on the forefront of a new age of major ethical dilemmas as perinatal medicine widens its scope and abilities to intervene in the fetus.

**Tong R.** The epistemology and ethics of consensus: uses and misuses of "ethical" expertise. *Journal of Medicine and Philosophy* 1991; 16:409–26.

This paper examines the epistemology and ethics of consensus, focusing on the ways in which decision makers use and misuse ethical expertise. The major questions raised and tentative answers given are the following: 1) Are the "experts" really experts? The author tentatively believes that ethicists are bona fide experts who often represent specific interest groups. 2) Is the experts' authority merely epistemological or is it also ethical? The author believes that the experts' authority consists not only of their command over specific matters of fact or value but also of their ability to achieve "consensus" about what is "true" or "false," "right" or "wrong." 3) Should the authority of expertise be limited? The author feels that it should not only be limited in the area of facts but also in the area of values. Persons who are ethics "experts" must be particularly careful to practice an ethics of persuasion rather than an ethics of compulsion. Their role is not to force a group consensus upon decision makers' individual moral perceptions and deliberations; rather it is to help decision makers come to their own conclusions about what they ought to do.

**Spital A.** Mandated choice. *Archives of Internal Medicine* 1992;152:2421–4.

This study examines whether young, healthy, well-educated college students would accept mandated choice or presumed consent for organ donation. Mandated choice, as this author describes it, would be a legal requirement for all competent adults to decide whether they wished to donate their organs or tissues after death. Presumably (and unlike the present system in the USA), their wishes would be followed by physicians, despite a family's objections. The organ or tissue harvesters could use the law's requirements as a shield from survivor hostility as they now do with required medical examiner autopsies. Unlike mandated choice, presumed consent gives physicians (and others) the legal right to harvest a person's organs and tissues if the deceased did not leave a written objection or the family does not object. The author notes that 13 European countries now use presumed consent for organ donation, and some have successfully used these laws to markedly increase donations. What he does not say, however, is that 14 U.S. states already

have a presumed consent law for eye donation. He also omits a discussion of two factors currently limiting organ and tissue donation in the USA: 1) protocols requiring organ and tissue harvesters to obtain family permission despite clear directions from the deceased and 2) medical examiners refusing to release the body for donation. These are important factors in the current shortage of organs for transplant. Nevertheless, the author did find that in his college-student sample, 90% would approve a mandated choice law and 62% would approve a presumed consent law. Only 13% believed that families should be able to override a decedent's decision based on either of these two laws.

**Iserson KV.** The limits of health care resources. *American Journal of Emergency Medicine* 1992;10:588–92.

This article reviews four ways the USA could restructure its healthcare system to more effectively utilize and more equitably distribute its limited healthcare resources. The author first suggests improving political decision makers' understanding of the healthcare budget and making them more accountable for their decisions. He advocates a federal budget process that would allow lawmakers to actually prioritize resource allocations. A second suggestion is to institute some radical changes in the healthcare system itself, including reducing the total number of specialist physicians and making primary care, especially in underserved areas, more attractive. Additionally, he suggests instituting technology assessment to evaluate medical devices, reducing administrative overhead, and limiting physician conflict of interest, antitrust actions against providers, and malpractice litigation. His method for limiting malpractice litigation would be through statutes mandating liability protection for the documented use of accepted practice parameters. This, however, introduces the ethically and politically dangerous idea of a societally approved "acceptable risk" for those patients who are harmed when clinicians follow practice parameters and do not perform potentially beneficial diagnostic or therapeutic interventions. In any restructuring, the author feels that physicians should be involved in decisions affecting the entire system and patients in decisions affecting themselves. Lastly, he suggests that the nation must use a standard planning tool, the setting of desirable, achievable, and measurable goals, if the healthcare system is to actually be improved.