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.

Margolis JO, McGrath BJ, Kussin PS, Schwinn DA. Do not resuscitate (DNR) orders during surgery: ethical foundations for institutional policies in the United States. *Anesthesia and Analgesia* 1995;80:806–9.

About 15% of patients with DNR orders undergo surgical procedures. Most of these surgeries, which are increasing as advance directives become more common, are palliative—for patient comfort or to simplify their care. Many clinicians continue to debate whether they should honor DNR orders in the perioperative period. In large part, this results from the unusual nature of anesthesia and surgery, which commonly involve suppressed breathing, endotracheal intubation, volume and drug loading, and iatrogenic physiological stressors. Many physicians claim that honoring preexisting DNR orders is neither practicable nor ethical. These authors review four alternative hospital policies: 1) automatic suspension of DNR orders in the perioperative period, 2) informed suspension of the DNR orders during the perioperative period, 3) continuing DNR orders except for airway intervention, or 4) continuing all DNR orders during the perioperative period. Consistent with recent guidelines of the American Society of Anesthesiologists and The American College of Surgeons, the authors recommend option 4, continuing all DNR orders after discussing this with the patient. They can implement any agreed-upon modifications, such as using intubation and artificial ventilation during surgery. They believe option 4 is the only one that honors both patient self-determination and professional integrity. They also wisely suggest that all hospitals quickly implement policies to address this issue.

Fitzgerald DJ, Milzman DP, Sulmasy DP. Creating a dignified option: ethical considerations in the formulation of prehospital DNR protocol. *American Journal of Emergency Medicine* 1995;13:223–8.

Cardiopulmonary resuscitation (CPR) has become a medical nightmare. CPR was originally designed to help those whose hearts stopped beating or who stopped breathing due to reversible causes. It now is the only medical procedure in US hospitals that must be performed unless there is an order not to do so. This concept has been taken to extremes in the prehospital arena where ambulance crews in many jurisdictions must perform CPR on patients who did not want it, if they are accidentally called. (Accidentally calling an ambulance for expected home or nursing home deaths is not unusual. The public is so accustomed to dialing 911 in emergencies, and they do so automatically—or because of their physician or home-health nurse's bad advice. Once 911 is called and told there has been a death, they will respond, even if you do not give an address, because they have it on their computer.) This system's problem has found both systems and legislative answers in prehospital DNR protocols and prehospital advance directives. These authors helped devise a DNR protocol for Washington, DC. DNR protocols require physicians to write an order instructing paramedics to withhold life-sustaining treatment. Patients wear the order in a specially sealed bracelet on the patient's wrist and the order is also entered into a central computer. The authors congratulate themselves on the ethical foresight they had in implementing this protocol. Unfortunately, they completely missed the "ethical boat," as an accompanying editorial points out (Iserson KV: If we don't learn from history . . .: ethical failings in a new prehospital directive. *American Journal of Emergency Medicine* 1995;13:2:241–2). Modern prehospital advance directive statutes allow patients to initiate their own directives to paramedics using a readily identifiable

Cambridge Quarterly of Healthcare Ethics (1996), 5, 178–180. Printed in the USA.

form. The new DC protocol, however, limits its use to those patients with a physician with whom they can and wish to discuss end-of-life decisions. The authors actually point this out with a section entitled, "How can the patient best participate in the process?" The best way is for them to initiate and guide the entire process. Ultimately, the best answer will be to publicize alternatives to calling for 911 emergency aid.

Wiesing U. Epistemology and medical ethics. *European Philosophy of Medicine and Health Care* 1995;3:5–20.

Does medicine have an internal morality? More importantly, can bioethics say anything more than "Be ethical!"? Those are the questions Professor Wiesing attempts to answer in this article. In trying to find an answer, he reviews the epistemological status of medicine, describing how, beginning in the mid-19th century, the profession wanted to shape itself into a natural science. The hope was that as a natural science, physicians' actions would become reliable, exact, and reproducible. He demonstrates that this goal, while still the current expectation of practitioners and the public, is impossible. His most convincing arguments revolve around the difference between knowledge and action. Knowledge must be verified, should not be regulated, is mostly statistical and can be supported to a certain probability, can be revised or clarified, and must be exact. Action, however, must be legitimized and regulated; may be either permitted, demanded, or forbidden; is irreversible (although the consequences can be reversible); and cannot be only partly completed. The practice of medicine has never taken on the characteristics of scientific knowledge, because reliable knowledge does not automatically mean reliable action. As he says, "practice has always been practical and it still remains this way today." He goes on to show that (Western) medical practice has always had a specific and essentially unchangeable structure. The structure and inexactness of medicine cannot be changed, so that physicians can only guarantee that they will conscientiously care for their patients. Medical ethics, if it attempts to regulate medical practice, therefore must identify the goals toward which physicians strive and regulate the moral environment under which they strive for these goals. Medical ethics can then more precisely identify and phrase moral demands on physicians, eliminating unrealistic expectations. Medical ethics derives strength from many of the physician virtues that have survived from antiquity. Medicine may not have an "intrinsic morality," but it certainly has a "culture" that can be a sound basis for medical ethics. This pragmatic basis for medical ethics does not answer whether its normative elements are right or wrong, but whether it does justice to our understanding of ourselves. As he says, "This basis of medical ethics is not absolutely founded, but it is well-founded. It is – to use an aesthetic term – good style."

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

Why do bioethics committees, physicians, and hospital staff members make the decisions they do about patients? This paper adds to the sparse work in that important area. It discusses why healthcare providers feel as they do about one of the most tragic human conditions, acute quadriplegia. When ventilator-dependent patients with this condition request termination of life support (because they cannot do it themselves), why do bioethics committees or primary physicians often request psychiatric consultations? Although the putative reason is to assess decision-making capacity, the question arises: why is this consultation still sought when the patient appears calm, is able to state the nature of his or her injury, and can clearly state that discontinuing life support will result in death? Using a case discussion, the authors point out that a bioethics committee's decision may be strongly influenced by the members' personal identification with the patient and family (countertransference). Their losses may terrify committee members, as well as the involved physicians, with the terror being greater the closer the similar characteristics. The authors suggest that their decisions might vary if the patient's age, socioeconomic status, or race differed from that of the committee members. The authors conclude that using a psychiatric expert is in everyone's best interest, and that the bioethics committee's group wisdom and judgment are excellent at working out such complex biopsychosocial-legal-ethical problems.

Rasell ME. Cost sharing in health insurance – a reexamination. *New England Journal of Medicine* 1995;332:1164–8.

Those interested in decreasing US healthcare expenditures often advocate making consumers more cost conscious through cost sharing — either through copayments and coinsurance or through increasing the costs for the more expansive insurance policies. Dr. Rasell argues that the negative aspects of these plans far outweigh any likely benefits and are, in any event, not necessary to contain costs. Cost-sharing advocates stress that direct patient charges will decrease the amount of medical care individuals use. She points out, however, that the United States already trails all other third world nations in the annual number of physician contacts (5.5 per person as compared with, for example, 6.9 in Canada and 12.9 in Japan). The annual number of acute inpatient days, 0.9 per person, is matched only in the United Kingdom and trails far behind Germany (2.3) or Canada and France (1.5). The problem that copayments could presumably solve — decreased utilization — is therefore not a major US concern. US citizens, however, pay the same amount of out-of-pocket expenses for healthcare as Canadians, and more than any other major industrialized country. Cost sharing does not preferentially reduce unnecessary as compared with necessary care. It does, however, reduce the use of many types of preventive services, such as Pap smears and mammography. Those in whom cost sharing leads to negative health outcomes are the less healthy and the poor. Children are uniquely affected. She dismisses one answer, income-related cost sharing, as substantially increasing the already overinflated administrative costs of health insurance. If cost sharing is already considerable and utilization rather low, why are costs so high? Dr. Rasell posits that much of the high costs result from high physician fees, high administrative costs, less efficient delivery of services due to excess capacity and underutilization, and high levels of procedures and other intensive care. She believes that cost sharing will minimally affect these nonmarket forces. Cost sharing might decrease utilization even further, with cost shifting driving prices up and with no decrease in overall costs. Cost-sharing proponents' second idea, that of increasing the costs of extensive insurance policies, is dismissed with the weak arguments that insurance companies' behavior is uncertain and they have limited abilities to alter costs based on risks. Overall, Dr. Rasell makes a convincing argument that cost sharing may not be the panacea needed to rescue the US healthcare system.