

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.

**Bai K.** Characteristics of ethics committees of Japanese medical schools. *Medicine and Law* 1992;11:337–43.

The term “ethics committee” does not mean the same thing everywhere in the world. Japanese ethics committees, for example, mainly focus on large health policy issues on which there is, as yet, no national consensus. The issue that they deal with most often is that of cadaver organ transplantation and death by brain criteria. The 80 medical school-based ethics committees were voluntarily started to evaluate human-subject research, and that is their official mandate. These committees, virtually all male and heavily dominated by senior faculty physicians, have actually done little to evaluate research proposals and risks; evaluation of new drug studies are now done by other committees. They also have not bothered with bioethical issues related to clinical care or individual cases, although most are closed to public scrutiny on the basis of patient confidentiality. Few have been involved with bioethical education. What they concentrate on is the cutting edge issue in Japanese medicine (if not a major societal issue) – can a person be declared dead by brain criteria alone? This issue is very divisive in Japan, where religious sentiment and authorities oppose the concept. Nevertheless, because of the pressing need for heart, heart–lung, and liver organ donations from “living cadavers,” a number of Japanese ethics committees have given their own approval of “brain death” criteria and approved these donations and transplants. However, none have yet been done. The author speculates that the reasons given, such as “poor condition of the donor’s organ,” simply were indications that the hospital would not do a transplant until there was a national consensus. An official consensus

is expected within a short time from the government’s Provisional Commission for the Study on Brain Death and Organ Transplantation. What then will be the role for Japan’s ethics committees?

**Rodwin MA.** The organized American medical profession’s response to financial conflicts of interest: 1890–1992. *The Milbank Quarterly* 1992;70:703–41.

Are conflicts of interest a new issue within the medical profession in the United States? Not at all. Organized medicine has addressed the issue since the first American Medical Association (AMA) Code of Ethics was adopted in 1846/47, which said physicians should act in the interest of their patients, not own patents on surgical instruments or medicine, and shun unnecessary visits to patients. The legal definition of a conflict of interest has two parts: an individual with an obligation, fiduciary or otherwise, and the presence of conflicting interests that may undermine fulfillment of the obligation. For most of the past century, fee splitting has been the conflict-of-interest issue with which physicians have been most involved. The author traces the efforts with respect to conflicts of interest by two organizations, the AMA and the American College of Surgeons (ACS). Fee splitting began in the United States in the 1890s, when apothecaries and medical supply firms began paying physicians for using their services. By 1900, the practice was prevalent among general practitioners and surgeons. These “kickbacks” were repeatedly denounced by the press and individuals within the profession (many of whom were disciplined for speaking out). Commonly, surgeons paid general practitioners for referrals, and the surgeons were in turn paid by undertakers. One physician

wrote in 1899, " 'Tis but a step to the undertaker's — a short step indeed from some commission men's operating tables — so let us arrange for a fixed standard of percentages all around." By the early twentieth century, the ACS was campaigning against fee splitting (perhaps because they commonly had to be the ones to pay?). Only later did the AMA jump on the bandwagon. Eventually, the AMA wrote a very strict Code of Ethics; it was to be enforced by state organizations and licensing boards — it wasn't. Yet over the years, blatant fee splitting has gone the way of the horse and buggy. More sophisticated arrangements, most commonly self-referral (including medical school "practice plans"), have appeared. Although the ACS has opposed most of these business arrangements, the AMA has gradually weakened its position so that it now mainly prohibits those actions that are illegal rather than unethical. The author believes that in coming years, more legislation such as the 1989 OBRA, that banned some self-referrals of Medicare patients, will appear to help control costs. Legislation will probably be necessary because, as one writer said about the AMA, the supposed watchdog of the physician's ethical stance, "A voluntary Association cannot afford to contribute too lavishly to its own dismemberment."

**McDonnell M.** The inside story: a simulation game on ethical, legal, and political decision making in health policy for nurse practitioners. *Journal of the American Academy of Nurse Practitioners* 1992;4:82-4.

Simulations were the rage in the late 1960s. Although they may not be making a comeback everywhere, the author has successfully adapted the technique to give students a taste of the political strife and compromise that comes with trying to implement public policy in the face of ethical dilemmas. Her scenario revolves around HIV and the interaction of four groups with a Board of Health. The groups are the people involved with 1) a young HIV-positive mother, her 18-month-old daughter, and a private day care center that refused to accept her daughter; 2) a physician with an HIV-positive patient and the patient's partner; 3) an attorney for a local hospital and Family Planning Clinic personnel questioning what consent adolescents can and should give for HIV testing; and 4) a college dean, an HIV-positive fraternity man, and a local prostitute. The game, played in three

parts, begins with individual assignments and discussion within each small group, including a "Board of Health" group. They then all meet together at a meeting and pepper the Board members with questions, receiving the Board members' interpretation of how they should act. From the author's description, the interpretations are not always well received. Finally, there is a debriefing out of the assigned role to discuss steps in the health policy-making process: problem identification, policy formulation, policy adoption, and policy implementation. The game can be played by 15-50 people, with an optimum size of 4-6 participants in each group and the Board.

**McCrary BF.** Ethical concerns in the practice of military aviation medicine. *Aviation, Space, and Environmental Medicine* 1992;63:1109-11.

This brief article lays out the ethical dilemmas faced by all physicians in Occupational Medicine, but especially those working as flight surgeons within the military. Often overlooked, it is possibly one of the most ethically hazardous of all the medical specialties. The discussion revolves around three areas: loyalty, confidentiality, and reporting. To whom should the flight surgeon be loyal? Clearly, most flight crews mistrust the flight surgeon, believing that the physician's loyalty is to the commanders rather than the patient. This is especially important when the flight surgeon's medical findings can end a patient's career in aviation. It does not lead to a trusting physician-patient relationship. Superiors can also put pressure on flight surgeons, against their best judgment, not to ground a valuable flier. This potentially puts other crewmembers and the public at risk. The author's answer is that the physician must retain a loyalty to the patient if it does not compromise the military's mission. Confidentiality is another ethical conundrum. Medical documents are often copied for central commands, seriously compromising any degree of confidentiality. The author suggests limiting access to those with a "need to know." Again, the military mission prevails. It seems as if the flight crews are right. Finally comes the question of reporting. Flight surgeons, as do other physicians in Occupational Medicine, come in contact with people who appear to have had harmful health effects from workplace exposures. This situation is less ambiguous. The author contends that the

patient should always be informed and investigating authorities notified. At least in this area, the flight crews have a champion.

**Smith RG.** The development of ethical guidelines for medical practitioners by the General Medical Council. *Medical History* 1993;37:56-67.

In contrast to the development of formal physician codes of ethics in the United States, Britain has relied since 1858 on the findings of their General Medical Council (GMC) to elaborate standards of professional behavior and to discipline those who transgress their sometimes hazy rules. Legislatively established, the GMC has the dual roles of licensing physicians and removing licenses, similar to the state medical boards in the United States. Since the turn of the century, they have also published, bound, and distributed "Warning Notices," a compilation of brief advice on questions they had ruled upon in their judicial capacity. Early on, they dealt with practitioners who had not only been convicted of theft, fraud, forgery, perjury, abortion, indecent assault, attempted sodomy, and arson, but also those guilty of "infamous professional conduct," such as using unqualified assistants, committing adultery with patients, publishing indecent works, and improperly disclosing confidential patient information. In some instances, the time between their hearing the first case on a subject and the "Warning" advice was a bit excessive. The GMC first barred a physician from practice for financial offenses in 1861, yet the advice was not published for 97 years (1958). Similarly, they first "erased" a physician from the register for breaches of confidence in 1869, yet did not publish advice on this issue for 101 years (1970). In a single contrasting instance, the GMC published advice on drug offenses 6 months before they heard a case. Clearly there is a problem, in most cases, with the timeliness of the advice. There are also problems with reporting of the GMC's activities, an absence of an explanation of the reasoning behind their decisions, and a disregard for the precedence of prior cases. Even with the much broader power than their U.S. colleagues (AMA and ACS), the GMC has not done much better in elucidating its ethical positions.

**Ashwal S, Bale JF, Coulter DL, et al.** Persistent vegetative state in children: report of the Child Neurology Society ethics committee. *Annals of Neurology* 1992;32:570-6.

This paper presents data from a preliminary survey of child neurologists to see whether there was enough of a consensus to develop a position paper about the persistent vegetative state (PVS) in children. The results are from a 26% response rate from questionnaires sent to members of the Child Neurology Society. The authors found that 93% of respondents believe that a diagnosis of PVS can be made in children, but only 16% believe that this applies to infants younger than 2 months and 70% believe that this applies to children 2 months to 2 years old. The consensus was that at least 3-6 months of observation is needed before a diagnosis of PVS can be made; the length of observation is age dependent. Seventy-eight percent believed that a diagnosis of PVS can be made even in the presence of congenital brain malformations. The respondents believe that the average life expectancy (in years) following a diagnosis of PVS varies with age: newborn to 2 months, 4.1 years; 2 months to 2 years, 5.5 years; 2-7 years, 7.3 years; older than 7 years, 7.4 years. Surprisingly, 20% believe that infants and children in PVS experience pain and suffering. Indeed, 75% of respondents never withhold artificial nutrition or hydration from a child in PVS and 28% always give medication for pain and suffering. Further, 75% recommend neurodiagnostic testing, even though no test has been proven to be a predictor of PVS outcome in either adults or children. What this study seems to show is that attitudes other than scientific evidence are guiding a large portion of our child neurologists.

Report of the FIGO Committee for the Study of Ethical Aspects of Human Reproduction, Cairo meeting, December 13th-14th, 1991. *International Journal of Gynecology and Obstetrics* 1992;39:63-4.

FIGO's Committee for the Study of Ethical Aspects of Human Reproduction presented their findings on the ethical issues surrounding termination of pregnancy following prenatal diagnosis. This issue is of particular concern in developing nations where modern technology is being used to reinforce prejudices, especially against female infants. They found that women consenting to prenatal diagnostic procedures should state in advance what information they want withheld from them during their pregnancy, including the infant's gender. Parents should not be pressured into accepting a particular option following prenatal di-

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agnosis, but they should be discouraged from terminating a pregnancy based on minor or treatable problems. Factors to consider before terminating a pregnancy include the child's quality and longevity of life, the effect of the birth on the woman and family, the resources to support the child's care, and medical advances that may allow treat-

ment of a medical condition appearing only in adulthood. The Committee goes on to describe care, including the need for bonding, human milk, treatment, and occasionally in cases of severe malformation, injury, or extreme prematurity, the right to die without inappropriate or futile intervention.