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.

Milliken AD. The need for research and ethical safeguards in special populations. *Canadian Journal of Psychiatry* 1993;38:681–5. (pages 686–90 repeat the article in French.)

Agencies of the U.S. government recently moved to obstruct vital research in emergency and critical care areas under the impracticable premise that all patients must give informed consent before they become research participants. Writing for the Canadian Psychiatric Association, Milliken proposes much more realistic standards to protect at-risk populations while promoting societal good and advancing medical science. This official position paper makes seven recommendations:

1) Continue research in problems affecting special populations, because they may suffer unnecessarily if this research is abandoned.
2) Distinguish research from quality assurance record reviews.
3) Review research protocols through an independent body with a wide spectrum of backgrounds.
4) The review should determine the study's scientific merit and the degree of risk to the patients.
5) True informed consent (with voluntary agreement) should be assured in patients with decision-making capacity. For those without such capacity, a substitute method of inclusion into such studies must be found. Not to do so discriminates against this already vulnerable group.
6) Three special vulnerable groups (children, the mentally infirm of any age, and prisoners) have been abused in the past. Safeguards must be in place to particularly protect these groups.
7) A system of compensation should be established for any who suffer ill effects from their research participation.

Similar suggestions have been made in the United States and elsewhere, but have so far been generally ignored. It is to be hoped that in the future more rational minds will guide the direction of research ethics and include both protections and the ability to find ways to better help suffering, yet vulnerable, patients.

Kjellin L, Nilstrun T. Medical and social paternalism: regulation of and attitudes towards compulsory psychiatric care. *Acta Psychiatry Scandinavia* 1993;88:415–9.

Over the past decades, many countries have made physician-directed involuntary psychiatric commitment more difficult. Based on the desire to secure legal safeguards and reduce the infringement on patient rights, many areas of the United States and Canada, and many countries in Europe revised their laws to reduce the number of involuntary psychiatric hospital admissions. Both the Council of Europe and the United Nations have recommended this step. It seems, however, that no one asked the patients—until now. Kjellin and Nilstrun attempted to determine how not only physicians, hospital staff, and relatives felt about the need for involuntary psychiatric commitment, but also the patients themselves. To do this, they interviewed a consecutive sample of involuntary and voluntary adult patients admitted to psychiatric hospitals in Sweden. They excluded patients over 70-years-old, alcohol abusers, and drug addicts. They conducted the interviews at discharge or, if not discharged at that time, 3 weeks into the hospital stay. They also did follow-up interviews 4–8 months later. Most patients believed that there is a need for compulsory psychiatric treatment, with 81% of the committed and 87% of the voluntary admissions feeling this way. When they asked about specific indications for commitment, however, there was less agreement. Half of the voluntarily ad-

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mitted patients believed commitment was justified when the patient did not realize his or her need for treatment; nearly 40% of the committed patients agreed with this. Yet only 24% of voluntarily admitted and 29% of committed patients believed that commitment should be based on the patient posing a danger to him- or herself. The authors also interviewed psychiatrists, general practitioners, social workers, relatives or the patients, and a random sample of the general population. Eighty-five percent of the public and more than this in all other groups believed that involuntary commitment was necessary if a patient posed a danger to him- or herself. Nearly all psychiatric staff (97%) and general practitioners (95%) agreed with this statement. When asked whether not realizing that they needed treatment was a cause for commitment, all groups agreed, but to a slightly lesser extent. When asked whether being a danger to relatives or society warranted involuntary commitment, the public sample markedly diverged from everyone else. Most of the public (91%) believed that this danger warranted commitment, while only 67% of psychiatric staff, about 60% of patients' relatives, and only 36% of social workers felt this way. A relatively high percentage of patients themselves (about 40%), however, agreed that involuntary commitment was justified if they posed a danger to others. All groups except social workers believed that physicians were the ones they most wanted to make decisions about commitment. Having legal authorities make the decision ran a very distant second place. Interestingly, in 1992, Sweden revised its laws making it much more difficult to involuntarily commit a psychiatric patient. The authors' work suggests that no one will be pleased with the result.

Lee DKP, Swinburne AJ, Fedullo AJ, Wahl GW. Withdrawing care: experience in a medical intensive care unit. *Journal of the American Medical Association* 1994;271:1358–61.

Bioethics, although it involves many aspects of biomedicine, often arrives at patient bedsides with difficult decisions about withdrawing or withholding medical treatment. Little work has been done so far to describe or analyze what these decisions involve and how medical personnel, families, and patients arrive at their decisions. This paper represents a good beginning to a small body of literature that will inevitably increase. The authors retrospectively reviewed the status and decision-making process in 28 consecutive patients in an adult medical intensive care unit in whom mechanical ventilation, dialysis, or vasopressors were withdrawn. They attempted to distinguish between physiological, neurological, and quality-of-life rationales for withdrawal. Noting that regional differences in attitudes and standards of medical treatment occur (a fact often omitted from such discussions), they found that, in general, a do-not-resuscitate order preceded the withdrawal of other intensive treatment by 48 hours or more, while this did not occur in other series. In their review, however, the withdrawal of artificial ventilation often occurred simultaneously with the withdrawal of other life-supporting measures. The authors stressed that they have had a protocol for withdrawal of intensive care measures for many years. They strive to reach a "physician–patient accommodation" about the desired goals of further treatment. This shared decision making often incorporated quality-of-life discussions, albeit with limited information available to the participants, because they believe that little of this information has been published. Therapeutic, time-limited trials of certain interventions were tried in 75% of the patients. Of interest to those who anticipate that computerized prognostic systems will make ICU triage easier, they found that their system (APACHE II) failed to identify even patients who eventually fell into the "physiologically futile" category until significant time had elapsed. To emphasize the need for humility in ICU and bioethical practice, nearly 15% of their patients whose treatment was withdrawn with the anticipation of death survived to discharge.

Snyder JW, Swartz MS. Deciding to terminate treatment: a practical guide for physicians. *Journal of Critical Care* 1993;8:177–85.

With the realization that most physicians and many bioethics consultants or committees haphazardly approach decisions to withdraw or withhold treatment, these authors developed a law-based, but ethically sound set of procedural guidelines. They developed a series of questions falling into one of three categories: medical (diagnostic) factors, patient (decision-making) factors, and contextual factors. (This construct sounds very similar to the Jonson, Siegler, Winslade scheme in their well-known *Clinical Ethics*, although it is not referenced.) In each category, questions stimulate the clinician/ethicist to seek enough information to make a reasoned decision. For example, under the

medical (diagnostic) factors, the reader is asked: "Is the patient brain dead?" "Are criteria from brain death policy met?" and "Is neurologic consultation needed?" It goes on to ask "If 'brain death' criteria are not met, what are the nature, extent and cause of injury or impairment?" It then questions the reversibility of the condition, prognosis (including the possibility of physiologically or statistically futile interventions), additional tests needed to validate the prognosis, and what exactly is to be withdrawn or withheld. Similar questions guide the reader through the other two categories. In addition, the authors provide a table showing the relative legal risk of withholding or withdrawing treatment under the three categories. Their table suggests that clinicians have the most legal support, for example, when withholding antibiotics, and the least support when withdrawing artificial nutrition and hydration. Although this table is certain to change over time, their basic strategy will remain sound. In part, it follows the thought processes that the careful, experienced intensivist or bioethics consultant now follows. The only improvement on their model will be to put it into the ever-present flow chart that clinicians so love. They have already put these questions onto a laminated pocket card. Distributing such a card among intensivists and house officers might make end-of-life decisions more uniform and greatly advance bioethics education and awareness.

Parker LS. Bioethics for human geneticists: models for reasoning and methods for teaching. *American Journal of Human Genetics* 1994; 54:137–47.

This paper promotes "preventive ethics" in both the teaching and clinical practice of bioethics. Seen from the perspective of the clinical genetics counselor, the author sees ethics as most useful if it looks ahead and tries to solve problems in advance, recognizing their social context. She suggests that we must move away from the "first generation" of bioethics modeled on acute care medicine where individual problem solution was the key, to a stance where we look at the entire sociopolitical scope of an actual or potential problem, seeking or developing a solution. One very pertinent example is the individual case of discrimination by life insurance companies because of abnormalities in a required genetic test. She justifiably feels that we must look to ethics to suggest broad societal solutions, rather than deal only with the one individual. (She does not mention, however, similar discrimination in education, employment, government assistance programs, military service, or even procreation that may loom on the horizon.) In the last section of this paper, the author suggests a scheme to use when teaching bioethics using "preventive ethics." Here she offers nothing new, but simply suggests minor modifications in existing case-based teaching strategies. Her message, however, remains important. Bioethics is appropriately evolving to where it reaches beyond the individual bedside or individual healthcare institution. This evolution indicates maturity.

La Puma J. Current models for clinical ethics consultation reimbursement. *Archives of Family Medicine* 1993;2:1276–80.

Clinical bioethics consultants seem to be appearing at most major medical centers. Yet no billing code exists for a bioethics consultation and individual clinicians or families have yet to pay for such a service. How do these clinical ethicists get paid? La Puma partially answers this question by saying that most (88%) of those he surveyed "donated" their time. This, however, is not the real answer. He really demonstrated that bioethics consultants who are not explicitly paid for their service receive compensation through another salary arrangement wherein they primarily received compensation for clinical or teaching services. Their consultation usually was seen as simply another part of their employment, often within the scope of a teaching facility or large private hospital. This type of reimbursement might be thought of as cost shifting, although many ethics consultants might shrink in horror at using this terminology. Those relatively few ethics consultants who receive explicit reimbursement for their activities work under a fixed contract or bill on an hourly or per-case basis. Most bioethics consultations in the United States, however, still seem to emerge from bioethics committees. The reason for this may be less the benefits of a committee than the often voluntary nature of its members. As long as healthcare institutions see themselves receiving bioethics consultations *gratis*, bioethics committees will exist. If bioethics consultations are to emerge from the dark corners of medical care, an explicit reimbursement system will need to exist. The danger, of course, is that as with everything else in modern medical systems, entrepreneurship follows dollars—and that may not be the best outcome for either the system or the patients.