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 editors Kenneth V. Iserson and Barry Morenz at bmorenz@email.arizona.edu.

Gaudine A, Thorne L, LeFort SM, Lamb M. Evolution of hospital clinical ethics committees in Canada. *Journal of Medical Ethics* 2010;36(3):132–7.

In the 1980s, a trend to develop clinical ethics committees (CECs) began in hospitals in Canada. National surveys of Canadian CECs were conducted in 1984 and 1989, but little subsequent research related to CECs has been done. The purpose of this study was to investigate the current status of hospital CECs in Canada and how Canadian CECs have evolved over the past 20 years. A survey similar to that used in the 1984 and 1989 studies was sent to the chief executive officers (CEOs) of all Canadian hospitals with at least 100 beds. Two hundred and sixty-five surveys were mailed, and 126 completed surveys were included in the final sample, a response rate of 51%. Approximately 85% of responding hospitals reported having a functioning CEC or a CEC in development, compared to 58% in the 1989 study and 18% in the 1984 study. More than half of these CECs had been formed in the past 10 years, with the earliest CEC established in 1966. As was seen in the two earlier studies, the size and composition of CECs varied markedly. The total number of committee members ranged from 5 to 26, and committees typically consisted of some mix of physicians, nurses, clergy, administrators, bioethicists, social workers, community/lay representatives, board members, lawyers, psychologists, and therapists. Most CECs obtained new members through volunteers (24.5%), appointments (22.6%), or a combination of the two (1.9%). This represents a change from the 1980s, when most CEC members were direct appointments. Though 72.6% of respondents perceived a need for ''special training'' in order to serve on a CEC, only 43.8% indicated that their CEC members received such training. Compared to CECs surveyed in the 1980s, CECs in the study appeared more regular and formalized, with over half meeting at least 10 times per year and almost all recording meeting minutes. Similar to previous Canadian surveys, the majority of CECs (88%) reported that their primary role was advisory. Common CEC functions included planning ethics education for CEC members and healthcare professionals, providing support for healthcare providers, and counseling patients and families. Compared to the prior studies, there was more emphasis on education, counseling, and support and less focus on advising about policies and procedures. Respondents perceived the CEC to be most effective in areas of education, counseling, and support and providing advice on policies and procedures. Many of the CECs (35–43%) were not involved in evaluating the effectiveness of the committee or in monitoring the quality of ethics consultation services. Respondents viewed the overall impact of the CEC in their organization as beneficial and indicated that the greatest benefit came from providing a forum for answering ''tough'' ethical questions. CECs were perceived as having the least impact on providing a form of legal protection for hospital and medical staff. Areas commonly recognized as appropriate for CEC involvement included reviewing clinical policies related to ethical issues and providing staff with ethics-related information. *More clearly defined roles of CECs and actual outcome measures of ethics consultations would inform hospitals in Canada and elsewhere about how to best utilize CECs to meet the needs of patients, families, health professionals, and organizations.*

De Vries R, Stanczyk A, Wall IF, Uhlmann R, Damschroder LJ, Kim SY. Assessing the quality of democratic deliberation: A case study of public deliberation on the ethics of surrogate consent for research. *Social Science & Medicine* 2010;70(12):1896–903.

Deliberative democracy (DD) is a relatively new and increasingly popular method for incorporating public opinion into public, including healthcare, policies. Deliberative

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democracy's goal is to inform, and perhaps transform, the opinions of citizens by a fair, respectful, and transparent interchange of viewpoints and then to use these informed views as the basis for democratic policymaking. Many of the healthcare issues for which DD is used fall under the auspices of biomedical ethics. Seen as an alternative to policymaking as usual, the top-down process heavily influenced by expert and interest group testimony, DD regards citizens' views as an important and necessary source of public policy.

There are a number of ways of organizing DD sessions, but they generally involve gathering a group of citizens, supplying them with information relevant to the policy in question, giving them time to interact with each other and with experts in the policy area, and then collecting their informed and considered opinions. Although all agree that "good" input—that is, input that is the product of careful and thorough reflection—is an essential aspect of useful and effective deliberation, questions have arisen about the quality of these deliberative sessions.

These authors developed and tested measures of "quality of deliberation" as part of a DD project to help guide policies surrounding surrogate permission to enroll persons with dementia in medical research. They found that participation in the DD sessions had a prolonged influence on their attitudes toward surrogate consent for research on adults with dementia and examined the process by which this change occurred.

They used both quantitative and qualitative data from their DD sessions to examine four aspects of the deliberation: (1) equal participation by all members of the session, (2) respect for the opinions of others, (3) a willingness to adopt a societal perspective on the issue in question (rather than a focus on what is best for participants as individuals), and (4) reasoned justification of one's positions. *They demonstrated that DD can be reliably used to elicit public opinion and showed how analysis of the quality of deliberations can offer insight into the ways opinions about ethical dilemmas are formed and changed.*

Davidson LA, Pettis CT, Joiner AJ, Cook DM, Klugman CM. Religion and conscientious objection: A survey of pharmacists' willingness to dispense medications. *Social Science and Medicine* 2010;71:161–5.

Over the past few years pharmacists in some states have been legislatively granted the right to refuse to dispense certain types of medications to their clients if the pharmacist has "moral objections" to the use of the specific drug. Medications potentially grouped in the category of those some pharmacists have objected to include emergency contraception, erectile dysfunction agents, oral contraceptives, infertility drugs, and "medical abortifacients." However, little has been studied regarding the demographics (i.e., age, religion, and gender) of the pharmacists in question. This study attempts to highlight what, if any, demographic factors predict pharmacists' willingness to distribute the above named medications or refer patients to other pharmacists willing to do so.

Using age, religion, and gender, 668 pharmacists in Nevada were surveyed regarding their willingness to provide the medications listed above or to transfer or refer clients to another pharmacy known to provide these medications. Though over 90% of pharmacies in Nevada are located in Nevada's two metropolitan counties, the state's Board of Pharmacy database was used to mail survey's to all the state's 1,975 practicing pharmacists. Thirty-four percent responded (668), and males comprised 54% of the respondents. The four responses to each of the questions outlined in the four-page questionnaire included: "Dispense without moral objection," "Dispense but morally object," "Refuse to dispense on moral grounds but transfer to another pharmacist," and "Refuse to dispense on moral grounds and refuse to transfer." *Though no other demographics were noted to be statistically significant predictors of willingness to dispense the listed medications, religious affiliation was significantly associated with a pharmacist's willingness to dispense emergency contraception and medical abortifacients (i.e., those pharmacists indicating religious affiliations with Evangelical Protestant, Catholic, and "Other" religious groups were much more likely to refuse to distribute these medications compared to those indicating a "nonreligious" affiliation), whereas age was significantly associated with willingness to dispense infertility medications (i.e., pharmacists identifying themselves in the age group 71+ were much more likely to refuse to distribute these medications than their younger peers).*

Although there are numerous limitations to this type of study, it is interesting in its approach to an issue that has received little

relative discussion, namely, the role individual religious or moral beliefs play in the care patients receive not only from physicians but from other healthcare professionals as well. Perhaps more expansive studies conducted to determine the effects these decisions will have on patients in the future will lead to the implementation of additional guidelines addressing the potential need for full disclosure of a professional's beliefs and practices, especially if these beliefs and practices have the potential to adversely affect the outcome of healthcare decisions for patients or their families.

Rady MY, Veratijde JL, Mcgregor JL. Scientific, legal, and ethical challenges of end-of-life organ procurement in emergency medicine. *Resuscitation* 2010;81(9):1069–78.

Policies and procedures for organ donation and declaration of death have evolved since the first organ transplantations in 1967 and the President's Commission published its report on defining death in the Uniform Determination of Death Act (UDDA), enacted in 1981. In this article, the authors review the current neurologic and circulatory standards for determining death in heart-beating and non-heart-beating donors, respectively. They cite clinical and pathological observations that are inconsistent with current neurologic standards for determining death. For instance, they note that in organ donors 60% have shown minimal or no brain stem ischemia at autopsy. The authors also cite considerable variability in hospitals complying with brain death criteria guidelines. The Pittsburgh non-heart-beating donor protocol for circulatory death requires the loss of arterial pulse and circulatory arrest for 2 minutes, yet the authors cite a study documenting human brain capability of retaining integrated neurologic function even after 15 minutes of circulatory collapse in some circumstances associated with hypothermia and drug overdose. Extracorporeal membrane oxygenation (ECMO) has been effective in eliciting a return of full neurologic functioning after circulatory arrest, which can make current neurological and circulatory death protocols difficult, if not impossible, to interpret.

The U.S. Department of Health and Human Services initiated the Organ Donation Breakthrough Collaborative (ODBC) to promote best donation practices in hospitals. Fifty-eight organ procurement organizations (OPOs), which practice as private organizations independent of hospitals, have been designated by the ODBC. The OPOs work to develop "organ donation best practices" in hospitals and have stated goals of a 75% donor rate of consent for organ donation and an average of 3.75 organs recovered per donor. Procurement coordinators from OPOs work with medical teams and potential donors from the time patients come to an emergency room, and this collaboration continues until the patient dies and organs are procured. A set of measures entitled the RAPiD Program is being implemented at U.S. hospitals partly to identify and overcome barriers to organ donation from patients. As the authors note, "To create greater compatibility with national strategies that maximize organ procurement, RAPiD realigns the psychosocial characteristics of the hospital staff's knowledge of and adherence to policies about donation, patient advocacy, and the hospital–OPO relationship." These developments have the potential for creating ambiguities in clinicians' actions pitting the patient's best interests against the donor recipient's best interests. Procurement coordinators from OPOs have access to patients and their families during hospitalizations in the hospital without their roles being clearly defined. The authors argue the current practice of organ procurement with heart-beating donors or non-heart-beating donors is not compliant with the UDDA and recommend greater public discussion about defining death and legislative revisions amending or changing the UDDA. *The authors further argue that the "medical community should take the responsibility of scrutinizing legal, ethical, and cultural ramifications of current procurement practices to preserve societal trust and the integrity of the medical profession."*

These Abstracts of Note were written by Aimee Kaempf, Ken Iserson, Steven T. Herron, and Barry Morenz.