

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.

Byk C. The European Convention on bioethics. *Journal of Medical Ethics* 1993;19: 13–6.

The Council of Europe recently embarked on the ambitious task of preparing a Convention on Bioethics, essentially a treaty for all member nations. The Council, in existence since the end of World War II, represents 27 democratic European countries. Since 1983, it has developed a series of bioethics recommendations through a standing committee of multidisciplinary experts, the Comité Ad-Hoc de Bioéthique, since 1992 called the Comité Directeur de Bioéthique. The Committee's function was to fill the political and legal gaps resulting from the rapid development of biomedical sciences. They developed papers outlining bioethics issues, which member nations used as the basis of constructive dialogue on sensitive bioethical issues. Their reports and recommendations covered such areas as organ and tissue donation and transplantation, genetic testing and engineering, the use of human embryos and fetuses, protection of the mentally ill, and DNA "fingerprinting." Since September 1991, the Committee has worked on a document (convention) providing more specific guidelines on organ transplantation and the use of human substances. The convention, now in draft form, will reemphasize general bioethics principles, including a respect for human dignity, the protection of individual integrity, assertion of public responsibility regarding the application of biomedical sciences, prohibition of all commercial agreements concerning the human body and its organs, and a ban on all forms of discrimination. More importantly, the convention will encourage the establishment of national bioethics committees and set down guidelines for the use of genetic information. The Committee and the European Council anticipate that the protocols will stimulate needed discussion within and

among member nations and will eventually find their way into domestic legislation in these countries. It will be interesting to see if they achieve any parts of these ambitious goals.

Truog RD, Fackler JC. Rethinking brain death. *Critical Care Medicine* 1993;20:1705–13.

When is a person dead? When a physician says they are dead. There are no criteria to declare death except where the decedent may become an organ donor, and then the rules about brain death are not laws but simply administrative policy. Pliny the Elder said, "So uncertain is men's judgment that they cannot determine even death itself." The authors suggest that the clinical criteria we now use for "brain death," whole-brain inactivity, do not work and are not valid. Physiological parameters (such as intact hypothalamic-endocrine function and some cerebral electrical activity) demonstrate this. This gap between our definition and reality leads the authors to suggest that it would be preferable to use a "higher brain" (neocortical) definition of death rather than relying on the loss of vegetative brain function as we now do. They argue that "brain death" should be based on "irreversible loss of the capacity for consciousness." They do note, however, that the current procedures for pronouncing a person dead by brain criteria are simply a subset of their suggested definition and so should be continued until there is a societal consensus on a new, more rational definition.

Jecker NS, Schneiderman LJ. An ethical analysis of the use of "futility" in the 1992 American Heart Association *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care*. *Archives of Internal Medicine* 1993;153:2195–8.

The arbiters of cardiac resuscitation in the United States have taken up the futility

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argument, and its most vocal proponents are not pleased with the results. Jecker and Schneiderman take the American Heart Association (AHA) to task for their "so-called strict rendering of medical futility." They object to the AHA instructing healthcare providers to eschew cardiopulmonary resuscitation (CPR) only where 1) basic and advanced life support have already been attempted without restoration of circulation and breathing, 2) no physiological benefit can be anticipated because vital functions are deteriorating despite maximum therapy, and 3) no survivors after CPR have been reported under the given circumstances in well-designed studies. The authors are particularly incensed over the two examples the AHA cites as not being futile. The first is attempting to resuscitate a person in a persistent vegetative state and the second is any case where although the prognosis for a successful resuscitation is known to be dismal there is some small chance for survival. The AHA fears that physician bias and value judgments may prevent some providers from providing CPR when it is indicated. The authors contend that these are just the cases when CPR may not be indicated. They suggest that a "patient-centered" rather than "organ-centered" approach to futility be used and that a reasonable interpretation of statistical futility (the frequency with which a procedure fails) is the only practical method of analyzing CPR outcome data. Although I sympathize with the author's position, the *Guidelines* were compiled by AHA committees that tried to accommodate all positions without fully satisfying almost anyone. Clearly, they achieved that end in their discussions of futility.

Spital A. Consent for organ donation: time for a change. *Clinical Transplantation* 1993; 7:525-8.

People still donate their organs and tissues after death at a dismally low rate. Some have proposed mandated choice as a way to get those who wish to be donors to make that evident to others. Such a system would require all competent adults to signify on their driver's licenses whether they want to be donors, and if so, what they want to donate. Although advocates usually emphasize this part of the system, the more important element of mandated choice requires surgeons to harvest the usable organs and tissues without asking for survivors' consent. Rather than being presumed consent, mandated choice would require organ/tissue

harvesters and survivors to respect people's wishes after they died. Is the American public ready for this system? (Many European countries already have passed beyond this stage and use presumed consent, presumably on a utilitarian basis.) Spital has previously surveyed college students about mandated choice, finding that 90% or respondents favored this system. This paper reports on a Gallup poll he commissioned to evaluate the attitudes of the general public. Although only 25% of respondents said that they had signed an organ/tissue donor card, 65% would support a mandated choice system. He found the greatest support again among younger people, with 80% of those under 30 years of age favoring mandated choice. Only 20% of all respondents said that families should be able to override the deceased person's wishes concerning organ or tissue donation. As evidenced by the recent support given the system by the American Medical Association's Council on Ethical and Judicial Affairs, it is clear that mandated choice is a system whose time has come.

Iserson KV. A simplified prehospital advance directive law: Arizona's approach. *Annals of Emergency Medicine* 1993;22:1703-10.

Many of the approximately 400,000 deaths that occur outside hospitals or chronic care facilities each year in the United States are not only expected but also welcomed as relief from terminal disease. However, patients who lack decision-making capacity cannot communicate to emergency medical services system and emergency department personnel their wish not to be the recipient of advanced life support procedures. Prehospital advance directives (PHAD) offer that opportunity. This paper describes Arizona's ground-breaking, simplified PHAD statute and the method used to quickly develop a consensus among its bar association, hospital association, and medical association so it could be enacted into law. Arizona's law addresses several controversial areas yet to be worked out by other states, such as the absence of "terminal illness" as a prerequisite to its use, needing only a "good-faith" effort at patient identification rather than identification bracelets, expanding who can pronounce death to basic ambulance personnel, using the form for children, and extending its use into the emergency department. The author indicates that placing the PHAD in statute ensures that a statewide attempt will be made to comply with its provisions, and as a law it should be more permanent

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than advance directive protocols based on administrative fiat. Other locals wanting to follow Arizona's lead must not seek a perfect statute. Rather, Arizona's experience suggests that legislators will need to strike a balance between the needs of the citizens and the fears of lawyers wary of any potential liability for the state or the emergency medical services system.

Caralis PV, Davis B, Wright K, Marcial E. The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatments, and euthanasia. *Journal of Clinical Ethics* 1993;4:155-65.

How do the attitudes of different cultures affect their discussions of end-of-life issues, including medical care, with their families and physicians? This relatively small study, performed at the University of Miami, demonstrated that the attitudes of American blacks, Hispanics, and non-Hispanic whites differed significantly from each other in important areas effecting bioethical policy and decision making. For example, all groups would usually want their families to make their healthcare decisions if they were unable to communicate, but 21% of non-Hispanic

whites would want their physician to make the decisions, based on prior discussions. Hispanics and blacks were only one third as likely as whites to trust these decisions to their physicians. This finding suggests that no group is ready to accept physician-initiated healthcare decisions based on a medical determination of futility. All three groups, however, had similar feelings when asked to execute advance directives. About half of all patients felt that it gave them comfort to be asked, but the response of one fourth was sadness or anger. Importantly, 5% felt that being asked meant that they were about to die. As to physician-assisted dying, 61% of non-Hispanic whites and 53% of Hispanics believed physicians should assist patients to die, but only 36% of blacks feel that way. Half of non-Hispanic whites and Hispanics would want this help for themselves, but only 20% of blacks would desire this help. Perhaps of greatest import, this study found that cultural attitudes toward medical care crossed socioeconomic boundaries. This study's confirmation of American society's distinct cultural separateness is perhaps the most important lesson for bioethics consultants.