

## Abstracts of Note

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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.

**Solomon MZ, Jennings B, Guilfooy V, Jackson R, O'Donnell L, Wolf SM, Nolan K, Koch-Weser D, Donnelley S.** Toward an expanded vision of clinical ethics education: from the individual to the institution. *Kennedy Institute of Ethics Journal* 1991;1:225-45.

This paper describes a new educational program, *Decisions Near the End of Life*, developed by an interdisciplinary team at the Hastings Center to enable hospitals and nursing home staffs to better perform bioethics self-education. Centering on end-of-life uses of life-sustaining technologies, the process begins with an institutional self-assessment, followed by an action plan for improvement. Theory is eschewed in favor of the clinical paradigm. Institutional team members who will later act as instructors within their institution undergo a 3-day orientation program. Appropriate institution staff complete a survey of knowledge, attitudes, and self-reported practices about the use of life-sustaining treatments. The information from this survey is fed back to the institutional team, who then conducts two structured grand rounds and four seminars and then convenes committees to address identified problems. The *Decisions* package includes audiovisual and written material for the grand rounds and seminars. The focus of the program is claimed not to be the training of clinical ethicists, although the group's experience is that this program facilitates use of bioethics consultants, committees, centers, and courses. This program, still in its infancy, suffers from being time intensive, most conducive to larger institutions, and somewhat insensitive to external forces on clinical practice and institutional policies. It also costs \$4,000 per institution. Most institutions "buying into" the *Decisions* program will probably be those that currently lack an active bioethics program of their own.

**Elliott C.** Competence as accountability. *The Journal of Clinical Ethics* 1991;2:167-71.

This well-written article is a brief overview of determining clinical decision-making capacity, with its inherent problems, multiple definitions, and resistance to easy solutions. The basic problem, as the author points out, is that patient decisions may simply be very bad or irrational, whether encountered in the clinical arena, during experimentation, or surrounding "rational suicide." How to decide whether a patient has decision-making capacity is the first problem. He argues that the President's Commission Report's model of 1) possession of a set of values and goals, 2) the ability to communicate and understand information, and 3) the ability to reason and deliberate about one's choices is inadequate to performing this task. Likewise, he decries the sliding-scale model that relates decision-making capacity to the risk involved. This more commonly used model fails because it entangles the questions of decision-making ability and respecting patient decisions. Because patient autonomy is a paramount bioethical principle, at least in the United States, the only way not to follow a patient's wish is to declare him incompetent. Yet, as Dr. Elliott rightly points out, decision making relates more to a procedure's complexity than to any risk involved; to say otherwise may be mere sophistry. How then can decision-making capacity be assessed? The author's answer is less clear than the problems he expresses with others' answers. He begins by arguing that decision-making capacity is "the ability to make decisions about one's medical care for which one can be legitimately considered accountable." This does not mean that the decisions need be good, rational, or in his best interest—merely that the decision truly belongs to the patient. Although Elliott lists a num-

ber of adjectives to denote the presence or absence of decision-making capacity, his take-away message is that "the determination of competence should thus be guided by the question of whether a person can later be judged accountable for her decision. . . . Clinicians should ask themselves whether the mental life of the person is what we usually expect of a normal adult, and if the patient's mental life is deficient in some way, whether the deficiency is relevant to the decision at hand." Although this is certainly not the final answer, it constitutes a good new beginning.

**Enderlin A, Wilhite MJ.** Establishing incidence and administrative protocols for do not resuscitate orders. *Journal of Gerontological Nursing* 1991;17:3:12-16.

This study investigated the incidence and process of do-not-resuscitate (DNR) protocols in skilled or intermediate long-term care facilities in Illinois. DNR orders were accepted at 80% of responding long-term facilities, although it is unclear how the 19% without CPR-trained staff on all shifts intended to attempt resuscitation if it was needed and desired. Only 20% of respondents had written DNR policies, but most of these failed to meet most basic policy elements. Even for patients with decision-making capacity, only 13% said that the patient could make the sole decision not to be resuscitated, and 9% completely excluded the patient from this decision. Two limitations hamper interpretation of these results: the survey was performed in the period just prior to JCAHO's requirement that long-term care facilities adopt standards for withholding treatment, and the authors received only a 32% response to their survey. However, so little is known about this area that the results may be a significant guide to future studies.

**Moreno JD.** Consensus, contracts, and committees. *The Journal of Medicine and Philosophy* 1991;16:393-408.

Can social contract theory legitimize bioethics committees? Does "presumed prior consent," used frequently in medical practice, apply to bioethics committee consultations? The author explores these issues by analyzing the intuitive link between consensus as a form of committee decision making and social contract theory. He first points out that "consensus" signifies a continuum from explicit agreement, such as a vote (rarely taken by bioethics committees), to the silence of acquiescence in the face of an apparently emerging majority. Even with consensus, however, Western philosophy questions the meaning of social agreement about moral questions. Are we to take the skeptical posture of the epistemologist, the belief in the collective reasoned moral judgment of the cognitivist, or simply rely on the institutionally legitimated conclusions of the sociologist? The author looks to a modified Rawlsian approach to seek legitimacy, finally turning to the concept of "overlapping consensus," which, "like the platform of a political party, manage to find a way to include everyone without encompassing the totality of their points of view." This too fails, simply because of the pluralistic nature of our society. He concludes, however, that although social contract theory may authorize an activist bioethics committee only with patient or surrogate consent, the problem lies more with the inadequacy of theory to describe reality than with bioethics committee functions. Rightly, he concludes with the justifiable suggestion that "the legitimation of ethics committee decision making lies in improving our understanding of their procedures."