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.

Vevaina JR, Nora LM, Bone RC. Issues in biomedical ethics. *Disease-a-Month* 1993;34: 871–925.

This small text (or very long article) covers six ethical issues of practical interest to clinicians: informed consent, organ transplantation, genetic interventions, do-not-resuscitate orders, withholding and withdrawal of life-sustaining treatment, and HIV–AIDS-related issues. Rather than breaking new ground, this paper can serve as an introduction or survey for individuals interested in clinical ethics. Bioethics educators will therefore want to look at this article to see if it will be useful in their teaching programs. For this purpose, its greatest advantages stem from the obvious interest generated by the topics, its clinical orientation, and its brevity. Typical of medical and legal writing, however (one author is both a physician and lawyer), the article's writing style is terse, turgid, and technical. If the audience cannot handle this, they may want to use one of the more user-friendly texts in bioethics. Yet, if the audience consists mainly of clinically oriented physicians, they may not be put off by the style as much as they appreciate the clinical applicability and brevity. As for the subject matter, the authors have broken most main topics into appropriate and descriptive subtopics. They begin with an overview of the area and then discuss particular knotty questions. In the do-not-resuscitate (DNR) section, for example, they separately discuss when a DNR order is ethically appropriate, who should be involved in the decision-making process, and what occurs when there is conflict about the order. Brevity, however, leaves the reader with questions, which may prove useful in teaching. The importance of "medical futility," for example, is mentioned in several places but barely discussed. This allows the instructors to use this article to initiate meaty dialogue and thought. Definitely worth a look.

Guttmann A, Guttmann RD. Attitudes of healthcare professionals and the public towards the sale of kidneys for transplantation. *Journal of Medical Ethics* 1993;19:148–53.

Should transplantable organs from living donors be for sale? The western transplant community generally says no, responding with laws in all western countries banning the sale of organ and tissues. In most countries with transplant programs, living donors must be related, either genetically or emotionally, to the recipient (except for blood and bone marrow donation). Yet organ transplant programs in several developing countries, such as Brazil, Egypt, and India, have no guidelines governing the prevalent use of paid donors, and widespread poverty assures a constant supply of willing subjects, especially for kidneys. The situation in these countries is further complicated by the lack of a dialysis program large enough to serve most of the population in need. The option for those not getting dialysis is, of course, death. These authors tried to determine how acceptable the practice of paid kidney donation was to Canadians, both in a Canadian and an Indian scenario. The Canadian scenario posited an individual on dialysis who was having progressive dialysis-related symptoms. The Indian scenario described an individual whose only hope for survival was a transplant, for which he would need a paid donor. Half of the respondents were given each scenario. The authors surveyed the public, first-year medical students, and medical personnel both involved and not involved in transplantation. Although the number of respondents was relatively small, they found the public and first-year medical students (presumably not yet acculturated into the society of medicine) more willing to allow the practice of paid donation than were either group of medical professionals. Factors all groups considered important in allowing the sale was the severity of the dis-

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ease, the uncertainty of receiving a cadaver kidney, the donor's health, and the donor's medical risk (in the best circumstances, about one death per 1,600 nephrectomies). Price determination for the kidney also concerned the respondents. Most wanted neither the transplant physicians nor the hospital determining the price, preferring the government to be involved in this decision. The climate surrounding organ donation and transplantation is changing. Those involved in the debate need to understand that because of different financial and medical circumstances around the world, different responses to organ sales have emerged. The public may now be more willing to accept this than are medical professionals. The debate, then, must be oriented differently to the two disparate audiences.

Moss AH, Stocking CB, Sachs GA, Siegler M. Variation in the attitudes of dialysis unit medical directors toward decisions to withhold and withdraw dialysis. *Journal of the American Society of Nephrology* 1993;4:229–34.

How do dialysis physicians decide to initiate or withdraw dialysis from their patients? These authors suggest that the decisions are often based more on the physician than they are on the patient. Ethical guidelines are lacking, resulting in a capricious use of the (government-paid) dialysis system. The authors surveyed 524 physicians directing dialysis units (61% response). They found that 92% would usually honor a competent patient's request to stop dialysis. They would, however, 98% of the time, consult with the patient's family first. Yet 17% would initiate dialysis in a patient known to be permanently unconscious. (For those concerned with rising healthcare costs, perhaps this group should be quickly targeted. Why hasn't the profession already done so?) More problematic is the group who said they would determine whether to continue or start dialysis (68%) or withhold or withdraw dialysis (32%) in a severely demented patient. Virtually all would consult with families of newly demented patients about withdrawing dialysis, with the implication that many might not withdraw treatment if the family resisted. Although many of these decisions may be ethically controversial, only 39% said they definitely would consult with a network ethics committee, if one were available, in difficult cases. Another 41% said they might consult with such a committee, and nearly 20% said they would not (although a few of these would be willing to talk with their own hospital's committee). Although the authors suggest that practice guidelines might assist nephrologists in making decisions about appropriately withholding and withdrawing dialysis, they fail to explicitly suggest that financial disincentives for inappropriate use might work wonders. Dialysis in the United States is a financial windfall for the providers. This study might suggest that in some circumstances, the situation has become absurd.

Edwards BS. When the physician won't give up. *American Journal of Nursing* 1993;93(9): 34–7.

Intensive care unit nurses frequently complain that some physicians insist on aggressive treatment far beyond the point when the patient can hope to benefit. Many ethics committee's cases result from such conflicts. This author suggests that opening lines of communication may improve the understanding between both sets of caregivers. She suggests that physicians respond to facts, so the nursing staff does well to make the case for a change in intervention by reviewing the patient's chart. She also suggests that nurses may be the local information source about bioethics. This expertise can be bolstered, especially early on or with new physicians, by showing them journal articles or books that reflect this same ethical thinking. She also reiterates the importance of using the patient-care conference, emphasizing that the nurses must be prepared to discuss the case, in detail, and have set goals for the meeting. Realistically, she offers the bioethics committee consult as a last resort "when all else has failed." Indeed, this is the position in which bioethics committees frequently find themselves. Perhaps she could have suggested some ongoing education, so the initial communication problem could have been averted, or at least lessened at its outset.

Siegler M, Amiel S, Lantos J. Scientific and ethical consequences of disease prediction. *Diabetologia* 1992;35(Suppl. 2):S60–8.

Rapid advances in immunologic and genetic tests have given clinicians the opportunity to predict, with variable accuracy, whether individuals will get particular diseases. These authors discuss the very real dangers, and occasional benefits, of these programs, concentrating on the specifics of predicting Type I (insulin-dependent) diabetes mellitus. Similar presymptomatic testing programs exist to screen newborns for

metabolic diseases and cystic fibrosis and to screen adults for sickle cell and Huntington's disease. Like Type I diabetes, these diseases are chronic and incurable and cannot now be prevented. As these other screening programs have demonstrated, both benefits and difficulties develop with these testing programs. An ethical problem encountered with all testing programs comes from the chance that people without a predilection for the disease may test positive. As clinicians well know, this event (a false-positive result) is intrinsic to all laboratory tests. When applied to most diseases, the inaccurate results are much fewer in an at-risk population (such as first-degree relatives of those with the disease) than in the general population. Yet, with diabetes 90% of new cases occur in the general population, so testing this population remains tempting. Social and ethical problems that develop with these screening programs include discrimination in employment and obtaining insurance (those with sickle-cell trait), substantial costs of screening and devastating effects on individuals and families after a false-positive diagnosis (Huntington's disease), or an inability to show any medical benefits of screening (cystic fibrosis). The authors suggest that predictive screening programs should 1) clearly define their goals in advance, 2) demonstrate that they can achieve these goals in pilot studies, 3) demonstrate the efficacy of the testing process, 4) test only after informed consent or, in minors, if there is a reasonable expectation that a positive test will result in benefit to the child, 5) offer posttest counseling, 6) maintain good quality control of the tests, 7) assure the confidentiality of test results, and 8) have a reasonable cost:benefit ratio. As more predictive tests rapidly become available, it will be the bioethics community rather than the health providers, insurance industry, or government that will need to take the lead so we do not get enmeshed in a web of bad information, ruined lives, and wealthy laboratories.