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.

Lizza JP. Persons and death: what's metaphysically wrong with our current statutory definition of death? *Journal of Medical Philosophy* 1993;18:4:351–74.

Physicians who believe in the concept of brain death (not all do!) use "whole-brain" criteria in the United States to pronounce people dead. The President's Commission recommended this standard in 1981, although some members and others argued that a "personhood" standard was more appropriate. The Commission rejected this argument, in part, because they felt that philosophers did not have a consensus about this. Lizza again argues for the personhood standard, saying that all major philosophers actually agree (and he says, they have always agreed) that personhood requires some potential for cognitive function. When this is absent, such as with anencephaly and the persistent vegetative state, the individual should be declared dead by brain criteria. The "whole-brain" definition for brain death remains the norm, however. Those who argue in favor of the whole-brain definition of death fear that deviating from this standard represents a threat to the senile and severely mentally challenged, places an unfair burden on medical techniques generally inadequate to determine when higher brain functions have ceased, and a challenge to the lack of a societal consensus. Lizza rejects all three arguments. He argues that the *dementia* of the senile and mentally challenged differs markedly from the *amentia* of PVS patients and anencephalics. He admits, however, that medicine lacks adequate tools to accurately diagnose the absence of higher brain function in many settings. (PET scans and similar modalities are, of course, available in some places, very expensive, and not thoroughly tested for diagnosing cerebrocortical death.) Despite this lack of technology, he would willingly accept diagnostic errors "in some rare cases," although how rare it would be remains uncertain. Of note, we now know that even our clinical diagnosis of whole-brain death, usually a much easier clinical syndrome to diagnose than cerebrocortical death, is often in error—although not to an extent that anyone will alter their behavior. Finally, Lizza's attempt to demonstrate a societal consensus fails miserably. He actually shows that no consensus exists, either among healthcare professionals or the public, but says that this is simply evidence of gross misunderstanding of what death really entails. He suggests that future bodies similar to the President's Commission should not be hampered by this confusion, but should advocate for a higher brain criteria for brain death.

Virmani J, Schneiderman LJ, Kaplan RM. Relationship of advance directives to physician-patient communication. *Archives of Internal Medicine* 1994;154:909–13.

Do advance directives enhance physician-patient communications about end-of-life decisions? Advance directives, including living wills and healthcare powers of attorney, were supposed to promote and enhance discussions between physicians and their patients. These authors found that in their study of oncologists and their terminal cancer patients, 56% of the patients had completed an advanced directive, although in more than three-fourths of the cases, their physicians believed they had not. Similarly, the authors found significant disparity between the number of physicians who believed they had discussed the patient's future health plans and patients who believed that this discussion had never taken place. Most commonly, both physicians and patients believed that this discussion failed to occur because "the subject never came up." This actually represents the major weakness of the study—they used oncologists who probably reject

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the idea of their patients dying longer than any specialty other than neurosurgery. One wonders whether the study may have had different results using another physician population. Also unanswered is whether advance directives promote discussions within families about healthcare choices. This, in the end, might represent a greater achievement than discussions with physicians.

Fleetwood J, Unger SS. Institutional ethics committees and the shield of immunity. *Annals of Internal Medicine* 1994;120:320–5.

Do ethics committees already have liability protection or should this type of protection be specifically legislated? Should clinicians following an ethics committee's advice have liability protection? Legal immunity is a legal bar to a claim that might otherwise be brought against a person. Specific laws define this immunity that is intended to promote a recognized societal interest over otherwise protected interests of persons. These authors review the history and current legislative situation of ethics committee immunity and of clinician immunity for following committee advice and they decide that clinicians should not have this protection. Although the President's Commission endorsed immunity for all parties involved in ethics committee activities, including the clinician, Maryland and New Jersey failed to include protection for clinicians when they mandated ethics committees. Hawaii and New York's proposed legislation, however, included liability protection for both committees and clinicians. Yet different state courts have varied widely in how they viewed ethics committees and their decisions, ranging from imposing liability protection for those who followed the advice (NJ), ignoring ethics committees (GA), using their determination as evidence (MN), and disdaining the entire ethics committee process (MA). These authors argue that not only is the "expertise" on ethics committees questionable, but that both society and the courts expect physicians to take responsibility for the care of their patients, despite outside pressures or advice. They also note, correctly, that while ethics consultations are now optional, granting clinicians immunity if they follow committee determinations may make physicians feel compelled to take this advice—and prompt hospitals to mandate committee consultations in many instances.

Scott E, Mitchell JM. Ownership of clinical laboratories by referring physicians: effects on utilization, charges, and profitability. *Medical Care* 1994;32:2:164–74.

Does physician referral of their patients to healthcare businesses that they partially own contribute to higher healthcare costs? Many lawmakers consider this practice to be a "legalized kickback" to the referring physician, skimming off insured patients and inhibiting nonjoint venture operations from succeeding. Proponents of this practice disagree, saying that this has often been the only way to raise capital and provide services to medically underserved populations. Empirical data to support either side of the argument has been lacking, although these joint ventures have been used to fund clinical laboratories, ambulatory surgical centers, home health agencies, diagnostic imaging and radiation therapy centers, psychiatric hospitals, and rehabilitation/physical therapy centers. This study of general clinical laboratories is part of a larger Florida study of health providers. It demonstrated that for average-sized general clinical laboratories who got most of their business from referrals rather than through contracts, the per-patient gross revenue was 30% higher and the net revenue was 26% higher in joint venture than in nonjoint venture labs. This resulted, in part, from about a 40% markup on tests in joint venture labs as compared with a 17% markup in nonjoint venture labs. The average patient had 3.2 laboratory procedures at the joint venture labs compared with only 2.1 at the nonjoint venture labs. This study supports the contention of critics that physician joint ventures result in increased utilization of services and higher charges to consumers.

Lantos J. Ethical issues: how can we distinguish clinical research from innovative therapy? *American Journal of Pediatric Hematology/Oncology* 1994;16:1:72–5.

With rapid progress in some areas of medicine, how can we distinguish between innovative therapies and clinical research? With the accelerated pace with which new therapies are now being introduced in hematology/oncology (and AIDS), the old rubric of measuring risks and benefits against "standard therapy" no longer applies. Because of the potentially significant differences in mortality and morbidity offered by new therapies, both the old and the new must sometimes be considered "nonvalidated" forms of treatment. The author points out that the real difference to the patient in some cases will be the loyalty of their phy-

sician, which may be compromised by the obligations of a clinical research protocol. As he says, the goal of creating generalizable knowledge (research) does not, by itself, necessarily create greater hazards for patients than they face from the loyalty of a compassionate but uncurious clinician. When patients wish to participate in clinical research, they need to balance the risks of the research with their hopes for personal benefit. This is especially true in settings, such as with bone marrow transplants for sickle cell disease, where entire communities have a stake in and have politicized medical practice.

Pritchard IA. Integrity versus misconduct: learning the difference between right and wrong. *Academic Medicine* 1993;68:9:S67–S71.

Ethics policies to guide scientists now seem to fall into one of two categories: promoting scientific integrity or condemning scientific misconduct. This author attempts to explain why promoting integrity will be more successful than identifying prohibited behavior. The primary problem with misconduct policies is that they are problem-based, listing what is wrong, but failing to give scientists a "right" course to follow. As the author says, "there are innumerable other ways and incentives to be bad." Also, an idea of what constitutes *good* scientific conduct (a virtue ethic) must logically precede any discussion of *mis*conduct. Although academics invoke academic freedom to protect themselves from outside meddling, the ambiguity of this negative right will do little to stave off outside interference. That this author can only say that educating future scientists will be difficult suggests that more groups will feel the need to oversee scientific research. The author promotes a virtue ethic in the laboratory as well as the classroom. As he notes, however, "cultivating personal scientific integrity is a truly formidable educational task because inculcating and refining the virtues that scientists should have means changing behavior, attitude, reasoning, and knowledge."