The Linacre Quarterly

Volume 55 | Number 4 Article 17

11-1-1988

Current Literature

Catholic Physicians' Guild

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Material appearing below is thought to be of particular interest to Linacre Quarterly *readers because of its moral, religious, or philosophic content. The medical literature constitutes the primary, but not the sole source of such material. In general, abstracts are intended to reflect the substance of the original article. Contributions and comments from readers are invited. (E.G. Laforet, M.D., 170 Middlesex Rd. Chestnut Hill, MA 02167.)*

(Council Report): Ethical issues involved in the growing AIDS crisis. *JAMA* **259:1360-1361 4 March 1988**

The AIDS crisis has raised numerous ethical issues for physicians. For example, a physician may not refuse to treat a patient solely on the basis of seropositivity. Furthermore, while the right of an AIDS patient to confidentiality must be respected, a conflict may arise when there is infringement on the safety of another. In jurisdictions where there is no mandatory reporting of AIDS patients to public health authorities, the physician faces a dilemma. Specific statutes should be drafted to address this problem. In the case of a physician who is seropositive or has AIDS, no activity should be undertaken which carries risk of infecting the patient.

Rosner F: Withdrawing fluids and nutrition: an alternative view. *N Y State J Med* **87:591-593 Nov 1987**

In 1986, the Council on Ethical and Judicial Affairs of the American Medical Association stated that artificial feeding and hydration are forms of medical treatment and may therefore be ethically discontinued in the case of terminally ill or permanently comatose patients. This runs counter to medical tradition in which feeding and hydration have been considered supportive care and hence are always required. ". . . even if the courts legally sanction the withdrawal or withholding of fluids and nutrition in some instances, legal permissibility is not synonymous with moral license. . . . Caution is urged before the acceptance of fluid and nutrition as medical treatment rather than supportive care becomes uncontrollable. . . ."

Skrabanek P: The physician's responsibility to the patient. *Lancet* **pp. 1155-1156 21 May 1988**

The ideal doctor-patient relationship is being eroded by the intrusion of the state into many of its aspects. These include ruling some actions illegal (euthanasia, abortion, prescription of addictive substances), mandating violations of confidentiality (reporting drug addicts), and medicalizing health by propaganda and other means. The physician's responsibility to the patient is also threatened by cancer screening programs which are promoted without proof of effectiveness, without informed consent, and without concern for possible harm. "The ideology behind the current health promotion rhetoric is an unhealthy mix of utopian and totalitarian thinking."

Grimes DS: Should patients who smoke be referred for coronary artery bypass grafting? *Lancet* **p. 1157 21 May 1988**

The resources of the National Health Service are limited and "rationing" is held by some to be inevitable. Some argue that smokers with coronary artery disease are responsible for their own ill health and should not be referred for coronary artery surgery unless they are willing to discontinue smoking. On the other hand, some maintain that smokers are taxpayers and are equally deserving of treatment.

Historically, the National Health Service has maintained an authoritarian attitude in giving to the "more deserving" rather than to the most needy. ". . . issues such as the ineligibility of smokers for coronary artery surgery should be made not by the random opinion of individual doctors, but by a more formal policy statement. . . . These are issues which are not medical but are managerial, financial, or ethical . . . ."

Emanuel EJ: Do physicians have an obligation to treat patients with AIDs? *New Engl J Med* **318:1686-1690 23 June 1988**

The obligation of physicians to treat patients with AIDS derives from the fact that medicine is a profession and not a commercial enterprise. Personal risk must be accepted as part of this professional obligation. The obligation is not absolute, however, and may be limited by such factors as excessive risk, minimal (or questionable) benefits, and competing obligations to other patients, self and family.

Callahan S: Sanctity and quality of life deserve equal commitment. *Health Prog* **69:75-76 June 1988**

"Sanctity of life" and "quality of life" are often seen as opposing concepts in ethical debates. However, they are really complementary and, when used properly, may furnish helpful insights.

Schneiderman LJ, Spragg RG: Ethical decisions in discontinuing mechanical ventilation. *New Engl J Med* **318:984-988 14 April 1988**

The decision to terminate mechanical ventilation in a patient who depends upon it involves ethical considerations that include the patient's autonomy, his best interests, medical indications, and external factors.

Gillon R: Ethics of fetal brain cell transplants. (editorial) *Brit Med J* **296:1212-1213 30 April 1988**

The treatment of Parkinson's disease by the transplantation of fetal brain cells has raised ethical issues. In general, the recipients have occasioned no moral dilemmas in the areas of autonomy, beneficence, nonmaleficence, and justice. In the case of the women whose aborted fetuses were used, problems with autonomy and informed consent were possible, but not inevitable. As for the fetus, if the abortions are performed in accordance with the Abortion Act, they are lawful. Some object that the Act is morally unacceptable and hence use of fetal parts after abortion is also unacceptable. Others, however, hold that the matter of the morality of abortion is irrelevant to the use of fetal parts thus obtained. Finally, some consider that the interests of society might be threatened by this technic. An appropriately constituted national bioethics committee could address their concern.

(see also: Embryos and Parkinson's disease. *Lancet* p. 1087 14 May 1988; BMA guidelines on the use of fetal tissue *Lancet* p. 1119, 14 May 1988.)

Holm S: New Danish law: human life begins at conception. *J Med Ethics* **14:77-78 June 1988**

Responding to difficulties associated with the new reproductive technologies, the Danish Parliament in May 1987 passed a bill that establishes an ethical council. The bill contains the controversial statement that human life begins at conception. The ethical council is empowered to propose legislation and to enforce temporary bans in the area of new reproductive technology.

_____: It's over, Debbie. *JAMA* **259:272 8 Jan 1988**

A resident, called "in the middle of the night" to see a patient who had trouble getting rest, found a 20-year-old woman with terminal ovarian cancer. The intravenous administration of 20 mg morphine sulfate was followed by respiratory depression and death.

Gaylin W, Kass LR, Pellegrino ED, Siegler M: 'Doctors must not kill'. *JAMA* **259:2139-2140 8 April 1988**

The resident in the foregoing episode committed a felony (premeditated murder), behaved unprofessionally and unethically,

and violated a major canon of medicine, viz., doctors must not kill.

Vaux KL: Debbie's dying: mercy killing and the good death. *JAMA* **259:2140-2141 8 April 1988**

Although the action of the resident as described above was morally unacceptable, it raises a deeper question about humane care of the dying. Active and direct euthanasia, while proscribed in principle, may be morally acceptable in exceptional cases.

Lundberg GD: 'It's over, Debbie' and the euthanasia debate. (editorial) *JAMA* **259:2142-2143 8 April 1988**

The *JAMA* published "It's Over, Debbie" in order to provoke debate by the medical profession and by the public at large about euthanasia. Publication does not, however, constitute endorsement of the author's views by either the American Medical Association or the editor.

DeVries WC: The physician, the media, and the 'spectacular' case. *JAMA* **259:886-890 12 Feb 1988**

Media involvement in the 'spectacular' case (e.g., artificial heart implantation) is unavoidable and represents a necessary symbiosis with physicians. However, three principles are important: (1) concern for the patient and family is paramount, (2) accuracy is an absolute requirement, and (3) advance preparation is essential.

Thomas JA, Hamm TE Jr, Perkins PL, Raffin TA, & the Stanford University Medical Center Committee on Ethics: Animal research at Stanford University: principles, policies, and practices. *New Engl J Med* **318:1630-1632 16 June 1988**

Biomedical research requires the use of a variety of subjects, including animals. The decision to use an animal model involves scientific, legal, ethical, and economic considerations. Considerable debate has arisen regarding the moral status of animals, especially in the past 10-15 years. Some would attribute to animals rights similar to those of humans while others entirely reject the notion of animal rights. An intermediate commonsense view permits the use of animals in research but requires humane treatment, i.e., the prohibition of unnecessary pain and suffering. At Stanford, humane treatment of experimental animals is assured by several oversight organizations.

(see also: Smith SJ, Hendee WR: Animals in research. *JAMA* 259:2007-2008 1 April 1988).

Caspar R: Food and water: symbol and reality. *Health Prog* **69:54-58 May 1988**

The act of giving food and water to the needy is a reality that reflects the communitarian aspect of the human family and our commitment to nurture our more vulnerable members. The technology that delivers artificial nutrition and hydration to an irreversibly comatose patient is, some would say, a symbol of that reality. As a symbol, what does it communicate, to whom, and for whose benefit? The critical examination of the ethics surrounding this issue requires the careful navigation of one of the busiest intersections, where ethics, law, technology, medicine, and the Church enter, converge, and exist — each with its own preoccupation and destination. Symbols are a type of representation which point beyond themselves to something else. If the act of giving food and water is symbolic, to what reality does it point? Surely this reality is care. . . . But is this care realized when a patient who is dying is tethered to the technology of artificial nutrition and hydration against his or her will? The meaning communicated by this symbol in such a case is intended only for the care-givers and society. For patients who have lived in the spirit of Christian faith, the message may be a death-denying one, out of keeping with the hope of resurrection and eternal life. (Author's summary)

Lowance DC, Singer PA, Siegler M: Withdrawal from dialysis: an ethical perspective. *Kidney International* **34: 124-135 1988**

A patient with end-stage renal disease on long-term dialysis decided to dis-

continue his therapy. This raised numerous ethical issues such as patient autonomy and abandonment by the physician. "In instances of intractable disagreement or 'ethical impasse,' they should encourage, but never coerce, their patients to accept treatment."

Modell EM: Telling patients the truth: a matter of respect. *Pharos of Alpha Omega Alpha* **51:13-16 Spring 1988**

". . . lying, because it fails to show respect for persons, is *prima facie* wrong; . . . physicians have an obligation to disclose the truth."

Botkin JR: The legal concept of wrongful life. *JAMA* **259:1541-1545 11 March 1988**

The legal concept of wrongful life, although fairly new, promises to be extended as prenatal diagnostic capabilities increase and improve. While judicial rejection of wrongful life action does not relieve the physician of the responsibility to provide competent prenatal counseling, it reaffirms the traditional respect of the courts for the intrinsic value of life. "Children with disabilities will not be better served by the further development of the concept of life without value."