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## Current Literature

Catholic Physicians' Guild

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## Current Literature

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., 2000 Washington St., Newton Lower Falls, MA 02162)

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**Gellhorn A:** Violations of human rights: torture and the medical profession. *N Engl J Med* 1978; 299: 358-359.

The incidence of torture as an instrument of repression has been increasing world-wide, and medical studies have now documented not only the physical but also the psychological effects. The medical profession has been involved in the treatment of torture victims to a great extent. Unfortunately, there is also evidence of complicity by some physicians in the application of torture.

**Holmes C:** Bioethical decision making: an approach to improve the process. *Med Care* 1979; 17:1131-1138.

There are deficiencies in the current system of making bioethical decisions, including limited input by the general public. The process might be improved by a two-step approach involving (1) the use of branching logic "to separate the bioethical dilemmas into a series of independent, sequential decision points along a decision-making tree" and (2) the use of explicit criteria "to decide whether each individual component is ethical or technical in nature."

**Langham P:** Parental consent: its justification and limitations. *Clin Research* 1979; 27:349-358.

Parents have generally been invested with a *right* to determine treatment of their children. The special parent-child relationship from which this is thought to derive, however, is due to confusion between ownership and par-

enthood. Under ordinary conditions parents satisfy the conditions of proximity and expertise needed to care for their child. In illness, however, it is the physician who most satisfies these conditions and it is he who should have the major role in medical decision-making for the child. "Any restrictions on the physician's control will come not from an overriding *right* of the parents, but either from the fact that nonmedical considerations are involved or from a desire for checks and balances."

**Lo B, Jonsen AR:** Ethical decisions in the care of a patient terminally ill with metastatic cancer. *Ann Int Med* 1980; 92:107-111.

Refusal of treatment, euthanasia, and therapeutic side-effects posed difficult ethical problems in the management of a patient with metastatic cancer. Appropriate decision-making requires a thorough appreciation of the medical aspects, a consideration of treatment alternatives, and a consideration of the ethical dimension of each therapeutic option. This process may be complicated by psychological factors such as stress, misunderstanding, and premature termination of the deliberative mechanism.

**Curran WJ, Casscells W:** The ethics of medical participation in capital punishment by intravenous drug injection. *N Engl J Med* 1980; 302:226-230.

Death by injection of a lethal drug has been adopted by four states as a new means of capital punishment. This

raises serious ethical questions about the participation by physicians in such judicial executions. Throughout history, however, explicit and traditional codes of medical ethics have opposed such a perversion of the healer's role. The proposed new method of capital punishment "presents the most serious and intimate challenge in modern American history to active medical participation in state-ordered killing of human beings" and should be formally condemned by the medical profession in the United States.

Byrne PA, O'Reilly S, Quay PM: Brain death — an opposing viewpoint. *JAMA* 1979; 242:1985-1990.

Legislation defining death on the basis of brain-related criteria equates the irreversible cessation of total brain function with the death of the human person. This is due in part to the ambivalences of "death." Irreversible or not, cessation of total brain function is not synonymous with total destruction of the brain or with the death of the individual. It is therefore morally unacceptable to most Orthodox Jews and Christians to harvest vital organs or otherwise treat patients as though they were already dead on the basis of these criteria. (For an editorial response see Veatch RM: Defining death: the role of brain function. *JAMA* 1979; 242:2001-2002.)

Relman AS: Michigan's sensible "living will." *N Engl J Med* 1979; 300:1270-1271.

Therapeutic decisions in hopeless cases have been traditionally difficult, and the intrusion of conflicting legal opinions has produced massive confusion. A bill filed in the Michigan legislature would obviate many of the problems by deferring to the decision of a proxy nominated in advance by the patient.

Holden C: Ethics in social science research. *Science* 1979; 206:537-540.

Social science researchers are beginning to chafe under the regulations

concerning privacy, consent, deception, and harm that have long been applied to biomedical investigators. There are two schools of thought concerning ethical aspects of social science as well as of biomedical research. Consequentialism (or utilitarianism) maintains that the ethical propriety of an act can be judged by its consequences; the nonconsequentialist (or deontological) position, on the other hand, insists on absolute moral values. Deception has traditionally played an important role in social science research and the deontological approach would question its morality.

Silber TJ: Placebo therapy: the ethical dimension. *JAMA* 1979; 242: 245-246.

Since placebo therapy involves deception, its morality may be viewed from two traditional aspects. The consequentialistic approach would permit it if the results were acceptable; the deontologic approach would condemn it since it involves the immoral act of deception. A decision regarding the ethics of placebo therapy may also be reached by "building down" or by "building up." The former involves the general condemnation of placebo therapy on deontological grounds and then proceeds to define strict limitations in situations where there is no alternative. The latter begins by acknowledging that the use of placebos is a deception, but builds up from that by indicating that there is a fine line between deceit and deception and that, in a given situation, effectiveness may provide justification. The matter, however, remains controversial. "When placebo therapy is given, it needs to be part of a careful clinical plan moving actively in the direction of health. Thus, placebo therapy is accepted as moral when it enhances physician-patient communication, and is accompanied by active efforts to achieve health. Conversely, placebo therapy is viewed as immoral if it diminishes or replaces patient-physician communication and there is no genuine pursuit of health."