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Current Literature

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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.*

Fletcher J: Humanism and theism in biomedical ethics. *Perspect Biol & Med* **31:106-116 Autumn 1987**

Ethics in general, and biomedical ethics in particular, should be rooted in human experience rather than in theistic imperatives. A "marriage of pragmatism and humanism" represents the distinctive American contribution to the ethical dialogue.

Loewy EH: Treatment decisions in the mentally impaired: limiting but not abandoning treatment. *New Engl J Med* **317:1465-1469 3 Dec 1987**

Therapeutic decisions in patients who are mentally impaired are often perceived as all-or-none. However, there is a middle ground in which treatment options are kept flexible. "Rather than mandate all possible treatment until it is decided to discontinue all treatment, we must accept our inescapable obligation to make the hard and agonizing choice that tailors treatment to individual cases. To deny this is to deny the ambiguity of such cases and decisions and to disavow moral agency."

Zipp TM: Anchors of ethical decision making. *Health Progress* **68:16,22 (No. 9) Nov 1987**

Lacking an appropriate anchor for decisions, some people fall back on legal guidelines. Yet one cannot legislate good judgment or a sound physician-patient relationship. For that, one needs to use the humane qualities of grace, integrity, and reflective thinking. (Author's abstract)

Rosenstock L, Hagopian A: Ethical dilemmas in providing health care to workers. *Ann Int Med* **107:575-580 Oct 1987**

The physician practicing in the area of occupational medicine may face ethical dilemmas that arise from issues of loyalty, confidentiality, reporting of occupational hazards, and the maintenance of professional knowledge about occupational health factors. Except for the pre-employment examination, the primary loyalty of the physician is to his patient.

Rothman DJ: Ethics and human experimentation: Henry Beecher revisited. *New Engl J Med* **317:1195-1199 5 Nov 1987**

In 1966 the landmark article of Beecher on ethical abuses in human experimentation detailed several instances of unethical research in the American medical community. This had developed, in part, because of the utilitarian ethic that had held sway during the years of World War II. Calls for formal review procedures resulted in federal regulations that mandated, *inter alia*, informed consent and an acceptable risk: benefit ratio. It is likely that such overview of research involving human subjects will continue.

Doherty DJ: Ethically permissible. *Arch Int Med* **147:1381-1384 Aug 1987**

Decision-making in the area of biomedical ethics is based on experience. This may be interpreted differently, however, and thus there may be more than

one "correct" solution to a given ethical dilemma. "Ethically permissible", therefore, represents a carefully considered judgment for which only relative and not absolute certainty may be claimed.

Freedman B: Equipoise and the ethics of clinical research. *New Engl J Med* **317:141-145 16 July 1987**

Among the accepted ethical norms to which the clinical investigator is expected to subscribe is one which stipulates genuine uncertainty on his part about the merits of the treatment(s) being evaluated. Should he develop a treatment preference in the course of the study, his continued participation would be considered unethical by some. This has resulted in the premature discontinuation of some investigations. It is therefore suggested that the consensus of "genuine uncertainty within the expert medical community" ethically override the views of an individual investigator in such a case.

Zuger A, Miles SH: Physicians, AIDS, and occupational risk: Historic traditions and ethical obligations. *JAMA* **258:1924-1928 9 Oct 1987**

Historic analysis of the behavior of physicians in various pandemics yields no consistent pattern of behavior or of ethical obligation. The current AIDS epidemic has been marked by the reluctance of some physicians to care for patients with this disease. Neither the rights model nor the contract model provides adequate basis to mandate the care of AIDS patients by physicians. Such a basis is best grounded in virtue as derived from the fact that medicine is inherently a moral enterprise.

See also editorial comment on the above:
Pellegrino ED: Altruism, self-interest, and medical ethics. *JAMA* **258:1939-1940 9 Oct 1987**

Dan BB: Patients without physicians: The new risk of AIDS. *JAMA* **258:1940 9 Oct 1987**

Blackhall LJ: Must we always use CPR? *New Engl J Med* **317:1281-1285 12 Nov 1987**

Cardiopulmonary resuscitation (CPR) is usually undertaken as a matter of course unless the patient (or proxy) formally rejects it in advance. However, the dismal results of this procedure in certain types of cases suggest that it is not always medically appropriate. Therefore it should not be offered as an option when medical judgment indicates that it would not be useful. This approach would preserve the patient's autonomy since he would not be forced to choose between CPR or no CPR.

Beresford HR: The Brophy case: Whose life is it? *Neurol* **37:1357-1358 Aug 1987**

A patient in a chronic vegetative state had, prior to his disease, indicated that he would not want his life sustained if he were to become permanently unconscious. A Massachusetts court authorized withdrawal of nutrition, and he later died. Opponents of this decision expressed concern that it might furnish a "slippery slope" and lead to similar decisions in less defensible cases. However, our legal and social systems provide strong deterrents to this.

Jay A: The judge ordered me to kill my patient. *Med Econ (Surg)* **6:60-67 Sep 1987**

A court order directed the attending physician to remove a nasogastric feeding tube from his comatose patient. The physician refused and a second court hearing was held at which the original order was amended so that the physician was not compelled to remove the feeding tube. The patient was then transferred to another institution under the care of another physician.