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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., 170 Middlesex Rd. Chestnut Hill, MA 02167.

Peterson LM: Refusing medical treatment. *Perspect Biol & Med* 31:454-460 Spring 1988

If life-saving or life prolonging treatment is refused by a patient who is competent, this decision is usually accepted by the physician out of deference to the patient's autonomy. Such a response, however, is not necessarily appropriate. Issues that impinge on the validity of a competent patient's decision to forego therapy in these circumstances include the urgency of the decision, the effect of illness, certainty of the consequences, conflicts between desires, and the opportunity for deliberation. "Rather than regarding the choice of all rational persons as valid, it seems preferable to examine the reasons and circumstances of each choice in light of what we know about human behavior in illness situations."

Callahan S: Conflict over moral status of embryos continues. *Health Prog* 69:26-28 April 1988

Advances in reproductive technology have intensified the debate about the moral status of the embryo. Three different views on this issue have emerged. The first ("a permissive prochoice position") holds that the moral value of the fertilized ovum and of the fetus depends upon the decision of the pregnant woman to invest or humanize it, or not to do so. A second approach equates the moral value of the embryo with its developmental status, and fixes some definite point (12 weeks, or viability, or the time of brain development, e.g.) beyond which the moral status of the embryo is established. The third view (as

in the Vatican statement) asserts that the fertilized ovum marks the beginning of a new life and as such has immediate moral status. "Obviously, our ethical, theological, and commonsense thinking depend on prior conceptions of the world and its origin, destiny, nature, and creator. . . . We stand at the threshold of developing paradigms in science and theology."

Gillon R: Refusal to treat AIDS and HIV positive patients. *Brit Med J* 294:1332-1333 23 May 1987

Whether or not there is significant risk of contracting disease in the course of treating AIDS or HIV positive patients, doctors have a moral obligation not to refuse such treatment. While such an obligation is not absolute, it is an important component of the professional commitment. Furthermore, it is not altered by disapproval by the physician of patient-behavior that may have been responsible for the disease.

(See also: Smith T: AIDS: a doctor's duty. *Brit Med J* 294:6 3 Jan 1987)

Nelson LJ, Milliken N: Compelled medical treatment of pregnant women: life, liberty, and law in conflict. *JAMA* 259:1060-1066 19 Feb 1988

Although some have advocated legal implementation of a public policy that would force pregnant women to alter their behavior or to undergo treatment for the sake of the fetus, this would be an unwise step. A pregnant woman who does not intend to have an abortion is ethically obligated to accept ordinary medical treatment and to avoid harmful behavior in the interest of her fetus, but this should not be enforced legally.

Nevins MA: New Jersey's right-to-die cases: round three. *Ann Int Med* 107: 927-929 Dec 1987

Starting in 1976 with the Quinlan case, the New Jersey Supreme Court has made several landmark rulings in right-to-die cases. While its more recent pronouncements have tended to return such decision-making to the bedside, the court nevertheless expects physicians to eschew authoritarianism and to collaborate with the patient.

Hamel RP: Advance directives compatible with Catholic moral principles. *Health Prog* 69:36-40, 88 April 1988

Decisions regarding life-sustaining treatment for incompetent patients are typically difficult and stressful for surrogate or proxy decision makers. . . . Advance directives allow currently competent persons to express their wishes about medical treatment before a possible incapacitating situation. Such directives seek to realize basic values of human dignity, respect for self-determination and human life, and communication and discussion with the person concerning treatment. Three types of directives are the living will or instruction directive, proxy directive or durable power of attorney, and a combination of the two . . . (Author's summary)

Lesse S: Ethics in the postindustrial era - quo vadis? *Am J Psychotherap* 41:333-335 July 1987

Since medicine has moved from being an individualistic profession to the status of an institutional business, a code of ethics based on a one-to-one relationship between patient and physician is anachronistic. As a first step in the progress from an individualistic professional ethics of medicine to an institutional one, prospective medical students should be evaluated in terms of their ethical and humanistic qualities.

Grondelski JM: A dilemma for institutions with consciences. *America* 158:213-215 27 Feb 1988

Institutions have traditionally been recognized as having a right to assert or implement their moral visions. Recent court decisions have tended to erode this right. In the Jobs case, for example, the New Jersey Supreme Court ruled that a feeding tube should be removed even though it was contrary to the policy of the nursing home. Nor would transfer to another institution for such a purpose be permitted, since there had been no prior disclosure by the first nursing home of its policy. Such legal decisions pose significant moral dilemmas, since the way is paved for governmental ethics to supersede those of other institutions.

Berkowitz RL, Lynch L, Chitkara U, Wilkins IA, Mehalek KE, Alvarez E: Selective reduction of multifetal pregnancies in the first trimester. *New Engl J Med* 318:1043-1047 21 April 1988

Advances in reproductive technology have resulted in an increased incidence of multiple gestation. Serious medical and social problems are associated with pregnancies involving three or more fetuses. Therefore the procedure of selective reduction of such pregnancies was developed, whereby the number of fetuses *in utero* can be reduced using either transvaginal suction or transabdominal injection of KCl.

(See also related editorial: Hobbins JC: Selective reduction - a perinatal necessity? *New Engl J Med* 318:1062-1063 21 April 1988)

Higgs R: Living wills and treatment refusal. *Brit Med J* 295:1221-1222 14 Nov 1987

When a patient becomes mentally incompetent, his ability to consent to therapy — or to refuse it — is *de facto* voided. In this circumstance the antecedent preparation of directions while the individual is still competent ("advanced directives", "living wills") may provide some guidance. While "natural death

acts" have been passed in the majority of U.S. states, they have no legal status in Britain, where there seems to be a more trusting relationship between patients and doctors. Nevertheless, despite certain objections, living wills might have a useful role, especially if seen as advisory devices rather than as legal weapons.

Plum KC: Moving forward with de-institutionalization: lessons of an ethical policy analysis. *Am J Orthopsychiat* 57:508-514 Oct 1987

The policy of deinstitutionalization of the mentally ill was formulated and implemented without formal ethical analysis, and the cost-benefit ratio of this change is still not known. Regardless of the latter, however, such policy making should have involved some consideration of moral principles, particularly those of distributive justice and of respect for individuals.

Lantos JD, Miles SH, Silverstein MD, Stocking CB: Survival after cardiopulmonary resuscitation in babies of very low birthweight. Is CPR futile

therapy? *New Engl J Med* 318:91-95 14 Jan 1988

Since survival rates in infants of very low birth weight who undergo cardiopulmonary resuscitation are so poor, CPR in these circumstances should be considered experimental rather than validated therapy and should be instituted as such with the informed consent of the parents.

Hillman AL: Financial incentives for physicians in HMOs. Is there a conflict of interest? *New Engl J Med* 317:1743-1748 31 Dec 1987

Since HMOs are largely concerned with cost-control, physicians in such organizations may be exposed to a conflict of interest in which this institutional aim may be allowed to supersede the interest of the individual patient. This does not necessarily follow, since HMOs use a variety of contractual obligations to encourage cost-control on the part of physicians. However, financial incentives should be carefully structured in order to avoid a conflict of interest.