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Current Literature

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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.)*

Krais WA: The incompetent developmentally disabled person's right to self-determination: right-to-die, sterilization and institutionalization. *Am J Law & Med* **15:333-361 1989**

The rights of the mentally incompetent person include the right to die, the right not to be sterilized, and the right not to be institutionalized involuntarily. Exercise of these rights, however, proves difficult in practice. Autonomy in these cases is best preserved by the best interest test rather than by the substituted judgment standard.

Luce JM: Ethical principles in critical care. *JAMA* **263:696-700 2 Feb 1990**

The special nature of the intensive care unit may heighten ethical conflicts associated with the accepted principles of beneficence, nonmaleficence, autonomy, disclosure, and social justice. In fact, these concepts may themselves clash. However, "many of the most ethically difficult ICU situations could be avoided if patient interests and wishes were defined before admission by the patients, their surrogates, and their primary physicians."

Schade SG, Muslin H: Do not resuscitate decisions: discussions with patients. *J Medical Ethics* **15:186-190 Dec 1989**

Because of the psychological pain that it may entail, it is not desirable that all patients be informed of their DNR status. Furthermore, this information should be imparted in an incremental fashion. This problem may be perceived as yet another manifestation of the paternalism vs. autonomy debate, and yet the duty of the physician is "first to ascertain whether the patient wishes to enter into such a discussion".

Gindes D: Judicial postponement of death recognition: the tragic case of Mary O'Connor. *Am J Law & Med* **15:301-331 1989**

In a recent decision the New York Court of Appeals rejected termination of life-sustaining treatment in an incompetent patient. In so doing it was in error. If there is no clear instruction from the patient, such decisions are best left to family members.

Warwick SJ: A vote of no confidence. *J Medical Ethics* **15:183-185 Dec 1989**

The generally accepted notion of patient confidentiality may pose an insoluble dilemma. On the one hand, some would consider confidentiality to be an ethical imperative admitting of no exceptions. On the other hand, some would permit a breach of confidentiality if an innocent third party would otherwise be injured. This quandary can be avoided by accepting that medical confidences are unnecessary.

Hyman DA: Aesthetics and surgery: the implications of cosmetic surgery. *Perspect Biol & Med* **33:190-202 Winter 1990**

Surgery which is strictly cosmetic and has no health implications debases medicine "as it becomes the handmaiden of vanity and self-indulgence"

Gula RM: The virtuous response to euthanasia. *Health Prog* **70:2427 Dec 1989**

To show what makes euthanasia an affront to Catholics' most basic convictions, Catholics must be a virtuous community of interdependence, care, and hospitality. The Catholic community's challenge in opposing euthanasia is to help convert society from an aggregate of individuals pursuing their self-interests to an interdependent covenantal community. The Catholic healthcare community may contribute to the bonding which can make living interdependently liberating and life-giving by being a catalyst for collaboration between the subcommunities within the Church — hospitals, schools, parishes, and religious organizations. To oppose euthanasia, caring must become the alternative to curing. Caring accepts decline and death as part of being human. . . . In a community of hospitality the dying should be able to live as free from pain and as much in control as possible. Everyone who has contact with the sick, the elderly, and the dying has the moral responsibility to communicate that they are worthy of respect and are not being isolated or abandoned. Hospitality must also be directed to care givers. The lack of support for those who spend endless hours caring for the terminally ill has been a crucial factor in cases of euthanasia.

—Author's Summary

Linenthal AJ: Past and present: Can fee splitting continue to be an "evil"? *Pharos of Alpha Omega Alpha* **52:42 Spring 1989**

The medical profession has long considered the practice of fee-splitting to be unethical. However, present-day economic and legal realities suggest that the condemnation of this practice should be reconsidered.

McCarthy G: Obstacles to the treatment of detainees in South Africa. *Lancet* **pp. 1066-1068 13 May 1989**

Physicians who attempt to care for detainees in South Africa confront many problems in medical ethics. Because of the necessity of working with prison personnel, it is difficult to report ill-treatment of detainees. Furthermore, the enormous caseload of patients makes it impossible to render acceptable medical care. And when a detainee is removed to a general hospital for medical reasons the physician has no guarantee of clinical independence. "Detention without trial is a root cause of ill-health" and the South African medical profession must call for its end.

Kass LR: Neither for love nor money: why doctors must not kill. *The Public Interest* **No. 94, pp. 25-46 Winter 1989 (reprinted in** *Human Life Rev* **15:93-115 Fall 1989)**

Since medicine has become increasingly technological, it is expected to provide a technological solution to all problems including those associated with incurable or terminal illness. Euthanasia has therefore been urged as a legitimate medical activity. But because medicine is na intrinsically ethical undertaking, physicians must refuse to kill patients.

Turnock BJ, Kelly CJ: Mandatory premarital testing for human immunodeficiency virus: The Illinois experience. *JAMA* **261:3415-3418 16 June 1989**

A study of the first six months of a mandatory premarital testing program for HIV in Illinois demonstrated it not to be a cost-effective means of controlling this infection.

Duggan JM: Resource allocation and bioethics. *Lancet* **pp. 772-773 8 April 1989**

Sound ethical principles rather than economic and political factors should dictate the utilization and allocation of medical resources. This is a responsibility of those involved in the practice and administration of medicine and not solely that of the political establishment.

de Wachter MAM: Active euthanasia in the Netherlands. ***JAMA*** **262:3316-3319 15 Dec 1989**

Although active euthanasia remains a criminal offense in the Netherlands, it is practiced with legal complicity in some instances. Legislative proposals have been undertaken to legalize active euthanasia, but the issue has yet to be decided. "A certain public and professional tolerance" has been reached concerning active euthanasia. (see also: Borst-Eilers E: Euthanasia in the Netherlands. corresp. *Brit Med J* 295:1563-1564 12 Dec 1987; Harper T: Where euthanasia is a way of death. *Med Econ for Surgeons* 7:121-124 Jan 1988)
