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Current Literature

Catholic Physicians' Guild

Chapter 36 is a splendid analysis and critique of contemporary [illegible]ological dissent.

While the book is somewhat intimidating by its sheer size, the autho[illegible]as used every editorial skill to make it easy to use. Each chapter is divided in[illegible]several "Questions." The briefest answer to the question is signified in the tex[illegible]y bold print. Numbered paragraphs, in larger print, provide answers to the qu[illegible]tions in sufficient detail for the ordinary student. More detailed analyses and ex[illegible]nations are given in finer print. The summaries at the end of each chapter are he[illegible]ul. The table of contents itself is sufficiently detailed to provide a preliminary [illegible]verview of the book, and the indices are well constructed.

This publication is one which no one seriously interested in cont[illegible]mporary moral questions can ignore.

— Ronald D. Lawler, O.[illegible] M. Cap.
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Current Literature

Material appearing below is thought to b[illegible] of par ticular interest to Linacre Quarterly *reader[illegible] because of its moral, religious, or philosophic con[illegible]nt. The medical literature constitutes the primary[illegible] but not the sole source of such material. In general,[illegible] bstracts are intended to reflect the substance of th[illegible] original article. Contributions and comments from[illegible] readers are invited. (E. G. Laforet, M.D., 2000 W[illegible]shington St., Newton Lower Falls, MA 02162)*

To have suggested, a decade ago, that fiscal matters had any major relevance to medical ethical dialogue would have been considered crass at best. Today, in the era of cost-containment and DRGs, the situation has changed dramatically. Witness the following trio of items.

Owen D: Medicine, morality and the market. *Lancet* **pp. 30-31 7 July 1984.**

Physicians have been major economic decision-makers in health-care systems. The emphasis, however, has been on treatment of sickness rather than on the maintenance of health. This has led to an enormous expenditure of capital without a proportionate yield. In the USA, for example, life-expectancy of adults has not increased between 1950, when the national medical care budget was $12 billion, and 1982, when it was $275 billion. Resources must be redistributed using, *inter alia*, self-help programs for different populations of patients. An aging population requires a reorientation of attitudes on the part of physicians. "The traditional, moral values of medicine should be a counterweight to the mechanistic, technological, cost-effectiveness of the market place."

Wall CA: Economics and ethics: issues of the eighties. *Am J Surg* **148:186-190 Aug 1984.**

Massively escalating health care costs resulted in deregulation of the industry. This has resulted in a smaller market place for surgeons; this can be increased only by expanding the indications for surgery. This economic issue obviously results in an ethical conflict for the surgeon. The new realities require a new marketing approach since the traditional major marketing tool, capability, is no longer sufficient. However, the surgeon still "perceives ethical issues in terms of patient welfare."

Johnson DE: Life, death, and the dollar sign: medical ethics and cost containment. *JAMA* **252:223-224 13 July 1984.**

With retrospective reimbursement there was generally no problem with erring on the side of active treatment even when extremely expensive and when the prognosis was very doubtful; third-party payers had no direct voice on how funds were expended. Prospective financing has changed the scenario dramatically, and the incentive to limit expenses raises distinct ethical problems for the physician, who is now subject to pressures for cost containment on the one hand and the fear of legal liability on the other. Some type of shared responsibility and patient advocacy, as by a disinterested committee, is needed to assist the physician to make these difficult decisions.

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Kass LR: The case for mortality. *Am Scholar* **52:173-191 Spring 1983.**

Much research aimed at the retardation of aging is now underway. Serious questions have been raised about the desirability of this effort. Were success to be achieved, there would be important sociologic and economic results. Apart from this, however, there are questions about whether or not an increase in longevity is desirable in itself. Boredom and tedium are possible prospects. Furthermore, the seriousness of life requires a terminus. ("Mortality makes life matter.") Man longs not for length of days, but for character, virtue, and moral excellence. "It is probably no accident that it is a generation whose intelligentsia proclaim the meaninglessness of life that embarks on its indefinite prolongation and that seeks to cure the emptiness of life by extending it."

Lasagna L: A duty to die? *The Sciences* **(NY Acad Sci) 24:7-8 1984.**

The increased life expectancy resulting from medical advances has produced the problem of large numbers of chronically ill elders who require an inordinate expenditure of medical resources. This is the case even though some have argued that sickness is not an inevitable concomitant of aging. The challenge of equitable distribution of health care resources in this situation is enormous. Governor Lamm of Colorado recently asserted that the old and sick have a duty to die and get out of the way. It is obvious that society "already prefers youth and vigor to age and wisdom. Will we move from social neglect of the elderly to age-adjusted genocide?"

Robertson GS: Ethical dilemmas of brain failure in the elderly. *Brit Med J* **287:1775-1777 10 Dec. 1983.**

Senile dementia and its resulting loss of dignity is greatly feared by the elderly. Ethical guidelines are needed so that management of such demented patients is sensible, ethical, and in conformance — as far as possible — with the earlier expressed wishes of the patient.

Drane JF: Competency to give an informed consent: a model for making clinical assessments. *JAMA* **252:925-927 17 Aug 1984.**

Assessment of competency to give informed consent is complex. There is obviously no standard which is universally applicable. A standard of competency based on a sliding scale of dangerousness (standards 1, 2, 3) provides some clarification of the issue.

(For reference): The American College of Physicians' Ad Hoc Committee on Medical Ethics: American College of Physicians Ethics Manual. Part I: History of Medical Ethics, the physician and the patient, the

physician's relationship to other physicians, the physician and society. *Ann Int Med* 101:129-137 July 1984; Part II: Research, other ethical issues. Recommended reading. *Ann Int Med* 101:263-274 Aug 1984.

Farfel MR, Holtzman NA: Education, consent, and counseling in sickle cell screening programs: report of a survey. *Am J Public Health* 74:373-375 April 1984.

Of approximately 52,000 persons screened for sickle cell tendencies, informed consent was not obtained in 13,000. Education and counseling were also deficient in many screening facilities.

Davidhizar R, Wehlage D: n the client with chronic schiz hrenia consent to nursing researc J Adv Nurs 9:381-390 1984.

Nursing research requires at the accepted standards of infor d consent be met where applica . This involves providing the sub t with adequate information and nsuring that the subject is competent under- stand it. The first is readily tained, but determining competenc may be difficult, particularly in th case of clients with schizophrenia. s group has been neglected in nursin esearch because of concerns about t compe- tency issue. Nevertheless, st dards of competency to give inform consent can be met with this group.
