The Linacre Quarterly

Volume 54 | Number 2 Article 19

5-1-1987

Current Literature

Catholic Physicians' Guild

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.*

Johnson DG: Aeronautics Act and the doctor-patient relationship. *Canad Med Assoc J* **135:1254-1256 1 Dec 1986**

In 1985 Bill C-36, an overhaul of the Aeronautics Act, became law in Canada. Certain of its provisions dramatically alter the relationship between physicians and pilots. For example, in order to maintain their license, pilots must inform their physician of their occupation and must give consent for the physician to convey to appropriate authority any information relating to a medical condition that may make flying hazardous. Pilots have complained that this destroys the trust and confidentiality that have traditionally characterized the doctor-patient relationship. Some physicians concur. Although the objectives of the Act are praiseworthy, the manner of its implementation requires revision in order to preserve the confidential relationship between physician and pilot-patient. (See also Dixon B: The cost of confidentiality. *The Sciences* - NYAcadSci - 24:11-12 July-Aug 1984.)

Till JE: Quality-of-life assessment. *Humane Med* **2:100-104 Nov 1986**

Quality-of-life studies are aimed at improving health care but may raise problems of an ethical nature. For example, it has been shown that quality-of-life factors may influence the therapy offered to patients; vulnerable patients may be "selectively offered more risky radical treatments" than the less vulnerable.

Theis EC: Ethical issues: a nursing perspective. *New Eng J Med* **315:1222-1224 6 Nov 1986**

In the hospital situation, nurses are accountable not only to physicians and employers but also to the patient. The nursing ethos of unquestioning obedience to the physician has been superseded by that of patient advocacy. Situations involving ethical issues may arise which set the nurse at odds with the physician. This may sometimes be avoided by appropriate communication and consultation.

On 13 April 1985 the *British Medical Journal* instituted a series of articles on philosophic medical ethics under the editorship of Dr. Raanan Gillon, Editor of *Journal of Medical Ethics*. The topics through the 27 July 1985 issue of *BMJ* were listed in a previous "Current Literature" section of *Linacre Quarterly* (53: 93 Feb 1986). The concluding series is as follows:

Telling the truth and medical ethics. 291:1556-1557 30 Nov 1985

Confidentiality. 291:1634-1636 7 Dec 1985

Consent. 291:1700-1701 14 Dec 1985

Where respect for autonomy is not the answer. 292:48-49 4 Jan 1986

Acts and ommissions, killing and letting die. 292:126-127 11 Jan 1986

The principle of double effect and medical ethics. 292:193-194 18 Jan 1986

Ordinary and extraordinary means. 292: 259-261 25 Jan 1986

On sickness and on health. 292:318-320 1 Feb 1986

"The patient's interests always come first"? Doctors and society. 292:398-400 8 Feb 1986

Doctors and patients. 292:466-469 15 Feb 1986

Conclusion: the Arthur case revisited. 292:543-545 22 Feb 1986

Siegel K: Psychosocial aspects of rational suicide. *Am J Psychotherapy* **40:405-418 July 1986**

Western society has developed a more tolerant attitude towards suicide, particularly in the case of "rational suicide". The essential characteristics of "rational suicide" include a realistic assessment of his situation by the individual, unimpaired mental processes, and a motive that would seem understandable to the majority of disinterested observers. True examples of "rational suicide", however, are quite rare. Many of those who insist on a right to suicide "are in a number of ways psychodynamically quite similar to the vast majority of suicides whose acts are clearly desperate and tragic". For these and other reasons it does not seem appropriate to establish the right to rational suicide in law. "As the societal norms concerning suicide are rendered increasingly ambiguous, an important countervailing force to the suicidal tendencies of large numbers of people is weakened . . . Society must seize every opportunity to unequivocally affirm the value of each human life, even those that may be compromised by illness, disability or in some other way."

Dawson J: Easeful death. *Brit Med J* **293:1187-1188 8 Nov 1986**

Although active euthanasia at the request of the patient seems common in the Netherlands, there is little likelihood that the legal proscriptions against it will be relaxed before the next general election. In the United Kingdom, on the other hand, the prevailing ethos is that euthanasia destroys good medicine and that "compassion and the patient's consent are not sufficient to justify professionally assisted suicide." However, the British Medical Association has been urged by its 1986 annual representative meeting to reconsider its proscription of euthanasia.

Couzinet B, Le Strat N, Ulmann A, Baulieu EE, Schaison G: Termination of early pregnancy by the progesterone antagonist RU 486 (Mifepristone). *New Eng J Med* **315:1565-1570 18 Dec 1986**

In 85 of 100 women with early pregnancy (within 10 days of an expected but missed menstrual period) applying for legal abortion, the use of the progesterone antagonist RU 486 resulted in complete abortion. This drug therefore seems to be a safe and effective agent for the termination of early pregnancy.

Crowley WF Jr: Progesterone antagonism: science and society. (Editorial comment on preceding article.) *New Eng J Med* **315:1607-1608 18 Dec 1986**

The use of the progesterone antagonist RU 486 to effect abortion in a reliable and safe fashion has several advantages. For one, it may obviate the need for surgical procedures by offering the possibility of "medical" abortion. Furthermore, it may permit the abortion to be accomplished in the private arena involving only the patient and physician. The societal implications are profound, however, since "medical science can only attempt to provide safe and effective alternatives: society must make the final choices".

Baughan ASJ: Confidentiality: the slackness of doctors. *Lancet* **p. 1150 15 Nov 1986**

The issue of the contract of confidentiality between patient and physician was raised at a recent (23 Oct) Royal College of Physicians conference on medical ethics. The consensus was that doctors were effective in protecting patients' privacy but that government agencies and paramedical people posed a threat to the maintenance of confidentiality. However, the author believes that physicians have become extremely slack in protecting the confidentiality of their patients, and cites numerous examples in support.

Habgood J: Searching for our moral roots. *Brit Med J* **293:1600-1601 20-27 Dec 1986**

Ethical decision-making has been increasingly thrust upon the medical profession as a consequence of the rapid advance of biomedical technology and of the moral confusion inherent in modern society. For those in the biblical tradition, answers to ethical dilemmas may seem easy at first but there are inevitable difficulties in trying to apply this tradition to modern day problems. And for others the uncertainties may be even more severe. Nevertheless, there are two basic values that provide moral roots—respect for persons and respect for human interrelatedness. And these may be augmented by the attitudes of wonder and of the readiness to admit ignorance. (Sermon preached at the 1986 ecumenical church service, held prior to the BMA's annual representative meeting, by the Lord Archbishop of York.)

Edwards WD, Gabel WJ, Hosmer, FE: On the physical death of Jesus Christ. *JAMA* **255:1455-1563 21 March 1986**

On the basis of the New Testament gospels, other contemporary literature, and the Shroud of Turin, details of the physical death of Jesus Christ may be determined. The available evidence indicates that death was the result of hypovolemic shock and exhaustion asphyxia. (This article elicited a remarkable epistolary response, predominantly objecting to the presentation of such material in a scientific medical journal, totaling 9 printed pages in the *JAMA* issue of 23/30 May 1986.)

Berseth CL: Ethical dilemmas in the neonatal intensive care unit. *Mayo Clin Proc* **62:67-72 Jan 1987**

Ethical dilemmas encountered in the neonatal intensive care unit were given a high profile by the Baby Doe regulations of 1984 and their later modification by the Supreme Court decision of 9 June 1986. Decision-making in this context frequently involves the interaction of ethical and of medical factors. These include: 1. the dependency of the patient; 2. the uncertainty of the outcome; 3. the possibility of inflicting undue trauma in the course of administering intensive care; 4. the hardship on the family if long-term support is needed; 5. the absence of established guidelines; 6. increasing costs, and 7. the pressure generated by the implementation of the diagnosis-related groups (DRGs) concept. A frequently neglected aspect of such decision-making relates to the emotional issues it generates. Increased emphasis on professional education, policy formulation, and case review is needed.

Donnelly WJ: DNR: The case for early retirement. *Arch Int Med* **147:37-38 Jan 1987**

While the order "DNR" ("do not resuscitate") is meant to convey only that emergency cardiopulmonary resuscitation (CPR) is not to be performed, in practice it is usually taken to mean that *any* vigorous treatment is to be avoided. This hidden but well-recognized message is by now inextricably associated with "DNR". Consequently it should be replaced by the more precise order "no emergency CPR".

Rostain A: Deciding to forego life-sustaining treatment in the intensive care nursery: a sociologic account. *Perspect Biol & Med* **30:117-134 Autumn 1986**

Technologic advances have permitted the survival of neonates who otherwise would almost certainly die because of prematurity, congenital defects, or serious illness. Because of the economic, social, and emotional factors involved, the appropriateness of such intervention is often questioned in specific instances, e.g., when there is severe mental retardation. The decision to forego life-sustaining treatment in the intensive care nursery is the result of a complex process. When there has been a failure of the group decision-making process to reach an acceptable solution, discussion about *basic* ethical issues may then begin. The methodology of sociology can contribute significantly to an understanding of the dynamic involved in making these decisions.