

This section is meant to be a mutual effort. If you find an article you think should be abstracted in this section, do not be bashful—submit it for consideration to feature editor Kenneth V. Iserson care of *CQ*. If you do not like the editorial comments, this will give you an opportunity to respond in the letters section. Your input is desired and anticipated.

Burger AM, Erlen JA, Tesone L. Factors influencing ethical decision making in the home setting. *Home Healthcare Nurse* 1992; 10:16–20.

The home healthcare setting differs markedly and uniquely from the medical institution within which scholars and clinicians have discussed bioethical issues and raised dilemmas for public debate. Yet the challenges to the home healthcare nurse (sometimes called a visiting nurse) may be greater than those in the grand institutions. These nurses who periodically visit a patient's home to assess their disease state, render care, and give medical advice may often be faced with knotty ethical dilemmas without a place to turn for help. To date, their plight and that of their patients has been only scantily addressed in the bioethics literature. As these authors point out, patients in the home healthcare setting are usually much more autonomous than institutionalized patients, giving the nurse and other caregivers much less latitude for paternalism. Yet, over time these caregivers may know their patients better than other healthcare providers and may run up against more financial and social barriers to care. These nurses have a great deal of independence in their care of patients but are not supported when they face not uncommon ethical dilemmas. This situation should be remedied through the institution of home healthcare ethics committees, having a consulting ethicist available to them and bioethics in-service training. A better suggestion might be for these agencies to link up with (dare I say, contract with?) existing bioethics committees or consultants who have the expertise and clinical case load to warrant their existence. The medical community should no longer bioethically isolate these important healthcare professionals.

Swenson MD, Miller RB. Ethics case review in health care institutions: committees, consultants, or teams? *Archives of Internal Medicine* 1992;152:694–7.

This is yet another article on the “proper” model for bioethics case consultation. Unlike most, however, these authors take a somewhat more balanced (some might say politically correct) view of the entire activity. They see committees, consultants, and small bioethics teams as each having their own advantages and disadvantages but sometimes able to work together in harmony in a single institution. The authors point to the consultant's advantage of personal contact with patients, their flexibility (only in terms of time) and efficiency, and the possibility that they may be preferred by clinicians over bioethics committees. They do point out that consultants have disadvantages but fail to point out that they often have ideological rigidity and a single value set and differ in knowledge and ability. They see bioethics committees as having diverse viewpoints and being more reflective than consultants, but with the problems of having adverse group dynamics, being too powerful within the institution, and being intimidating to patients, families, and clinicians because of their size. The authors' solution is to add a third layer—the small-group consulting team, which they admit is already common throughout the bioethical community. As many bioethics committees found through trial and error, these small consulting teams often function more effectively and efficiently than the entire committee, yet they always know Big Brother will provide quality assurance to their consultation by reviewing whatever they do. These authors suggest that bioethics committees with or without a consulting group can coexist with an independent bioethics consultant. In most institutions, however, this is politically and administratively untenable.

Abel F. Dynamics of the bioethics dialogue in a Spain in transition. *Bulletin of the Pan American Health Organization* 1990;24:521–9.

Bioethics began to develop in Spain after the downfall of the dictator Franco and the

reinstatement of the monarchy in 1975. However, two things are still lacking: public debate on fundamental bioethical issues before public policy is instituted and physician endorsement of patient autonomy. Spain has enacted several laws on bioethically related issues without adequate public input; they have all suffered the same fate. The 1979 law on organ donation used the concept of presumed consent, following the model European legislation. Because this concept was not well received by the populace, government administrators subsequently imposed draconian restraints on physicians before they could harvest an organ, essentially blocking this program. A law liberalizing artificial reproductive techniques and abortion suffered the same fate. Spain has a number of very active bioethics centers that reside primarily in private institutions, such as the Borja Institute on Bioethics. Notably lacking in their conferences on pertinent bioethical issues, however, have been health professionals. This is not an accident. Spain's official medical organizations have rarely participated in the nation's bioethics dialogue, and "benevolent paternalism, combined with occasional tyranny" is the rule in the Spanish physician-patient relationship. Spanish physicians consider themselves moral as well as medical agents. Yet, one bright spot shines in clinical bioethics. The hospital ethics committee at the San Juan de Dios Maternal and Infant Hospital of Barcelona was established in 1974 and has served as Spain's bioethics committee model, constantly adapting to new demands from its environment. Two stumbling blocks exist for those who are trying to promote bioethics within Spain's medical system. Many people still have reservations about the tie between bioethics and Catholic morality, a tie that is associated with Franco's fascist social and political system. The other is that Spanish physicians are increasingly worried about legal entanglements, seeing bioethical issues as simply a complicated legal problem best dealt with through their professional organizations. Spain's bioethics situation is apparently not that different from that of many other countries, including the United States.

Truog RD, Brett AS, Frader J. The problem with futility. *New England Journal of Medicine* 1992;326:1560-4.

What is futility and how can questions of futility be resolved? The concept of futility obscures many deep and unresolved aspects of modern medical treatment. Futility ob-

scures the values of patient, family, medical team, and society. If the concept of futility is to be used, the classic question first must be answered: "Futile in relation to what?" Although employing futility in a medical setting attempts to objectify withholding or withdrawing care, it is unclear whether such decisions are really value free. The closest thing to a value-free definition of futility is "physiologic futility," where medical intervention holds absolutely no chance of success. These authors, however, use a much narrower definition of physiologic futility than many others when, for example, they acknowledge cardiopulmonary resuscitation on a ruptured heart as futile but do not acknowledge other instances when CPR would be unsuccessful. They also point out that physicians using statistical probabilities are prone to severe and systematic errors in estimating a patient's prognosis. They did not, however, acknowledge APACHE II as a new and much more sophisticated prognostic tool for intensive care unit patients. Physicians often invoke futility when the patient or family and the medical team are in conflict over a further course of action. The authors believe, as has been shown in bioethics committees, that better communication may resolve many of these conflicts. Substantial and valid value conflicts, however, may still exist between those of patient and family self-interest and those of the medical team who wish to avoid cruel treatment and to see that their knowledge and skills are used wisely and effectively. In the end, the authors acknowledge that it may only be through societal consensus of some knotty issues that some of these conflicts get resolved on an individual level. They believe that the concept of futility is, in the main, an unacceptable shortcut to get to these answers but leave the clinician without any new options to use.

Schneiderman LJ, Jecker NS, Jonsen AR. Medical futility: its meaning and ethical implications. *Annals of Internal Medicine* 1990; 112:949-54.

These authors started the current battle over the concept of futility by publishing explicit quantitative criteria and less objective qualitative criteria they suggested could clarify the concept. In short, their definition of a futile intervention is when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of published empiric data) that in the last 100 cases a medical treatment has

been useless. What the authors are trying to define is an intervention where the "expectation of success . . . is either predictable or empirically so unlikely that its exact probability is often incalculable." In their minds, the concept of futility differs from merely rare, uncommon, or unusual occurrences. They also distinguish it from acts that are physically or physiologically impossible (contrast this with Truog *et al.*'s paper), from those interventions that are so bizarre that they must be considered implausible, and from miracles. To define the qualitative aspects of futility, they specify that for an intervention to be considered effective it also must be beneficial. A beneficial medical treatment does not merely "cause an effect on some portion of the patient's anatomy, physiology, or chemistry," but "appreciably improves the person as a whole." Specifically, they feel that the patient has no right and the physician no obligation to continue biologic life without conscious autonomy. They feel that physicians have no obligation to respect patient autonomy or family wishes to act (or not act) in the face of a futile situation. They ground this on physicians' historic moral obligation to work in the best interest of their patients.

Faber-Langendoen K, Bartels BM. Process of foregoing life-sustaining treatment in a university hospital: an empirical study. *Critical Care Medicine* 1992;20:570-7.

This study describes the method of withdrawing or withholding life-sustaining treatment in a major university hospital over a 2-month period. As most workers in the field are coming to realize, foregoing treatment is usually not a single, discrete decision, but rather a series of steps over a period of time. The authors found 70 deaths over their 2-month study period, 74% of which were preceded by foregoing some life-sustaining medical treatment. The others died despite full resuscitative measures. Comparing these two groups, the authors found a prevalence of malignancies and patients who could not participate in the decision-making

process among those who eschewed treatment and cardiovascular disease and participation in medical decisions among those who wanted all medical interventions. There was no difference between the two groups in method of payment for their care. When medical treatment was foregone, the decision not to resuscitate or intubate was most often the first decision (39/52 patients). Subsequent decisions to forego care were sequenced for the group. Treatments were withdrawn or withheld, on average, in the following order: dialysis, vasopressors, transfusions, monitoring, intravenous fluids, laboratory studies, total parenteral nutrition, other medications, antibiotics, and enteral feedings. When a ventilator was already in use, this was, on average, the last modality to be withdrawn. The authors found that 73% of the patients received medications for pain, dyspnea, or agitation during treatment withdrawal, and the balance did not require any additional medications. Those patients kept on mechanical ventilation during withdrawal of other modalities required no change in medication. They were, however, already heavily medicated. Those patients who underwent "terminal weaning" from ventilators did require additional medications. The authors rightly question why this "terminal weaning" occurred. Was it to benefit the patient or merely appease the conscience of the family and medical staff? If the latter, this common technique is probably unethical, not to mention inhumane. The authors also note that physicians frequently designated that patients were to receive "comfort care" during withdrawal of treatment, but the subsequent care for these patients varied substantially. It seems clear that there are few guidelines and almost no undergraduate or residency education directed toward foregoing medical treatment. Neither do we usually ask very ill patients to define what their goals of medical treatment are, either verbally or through their advance directives. As these authors point out, it is time for a change.