Abstracts of Note: The Bioethics Literature

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.

Zoloth-Dorfman L. Face to face, not eye to eye: further conversations on Jewish Medical Ethics. *Journal of Clinical Ethics* 1995;6: 223–31.

Several well-known texts and many articles describe "Jewish medical ethics." Most of these writings stem from a minority Orthodox perspective and do not illuminate majority thinking as much as they confuse and often alienate readers seeking the thinking, traditions, and views of Jewish patients. In this article, which itself is a response to another dogmatic piece in the same journal (Rosner F: Jewish medical ethics. *Journal of Clinical Ethics* 1995;6:202–17), the author clearly describes the method Jews have long used to develop basic ethical principles. As she discusses, method is key to understanding Jewish thought, because most of the concepts are undergoing a millennias-long debate, with current participants still arguing with past sages' commentaries in the Oral Law, The Talmud. In talmudic "time," rabbis reply to the commentaries of their dead predecessors as if they are talking face-to-face. The key is an open, vital, continuous discussion of important issues. Very little is immutable in Jewish thought, but rather is subject to changing conditions and new ideas. The author describes Judaism as a "modified casuistic deontology." The Torah's motivation, commandments, centrality, and binding nature makes Judaism deontological but casuistic because it is inductive and subject to case modification. In the discussions, consequences, once enacted, are reexamined and debated. As she says, the real world matters. Jewish ethics may not be as neat and tidy as some more organized ethical formulations, but as she says, it consists of "everyone quoting, gesturing, trying to hear the voice that comes from the history and context and moral authority of their text. The process of our speaking together as travelers holding the maps printed in our own languages is one of translation, which is to say, at its best it is idiomatic, neolexilogical, and evolutionary." In contrast to the oft-quoted narrower and more stifling perspective of Jewish medical ethics, this well-written piece on the traditional Jewish ethical method may shed light on what Jewish medical ethics really means.

Fletcher JC, Hoffmann DE. Ethics committees: time to experiment with standards. *Annals of Internal Medicine* 1994;120:335–8.

Most hospitals and some other healthcare institutions now have bioethics committees as at least a minor part of their administrative structures. Their presence has now been implicitly blessed by the Joint Commission on Accreditation of Healthcare Organizations and most have or are working toward a consistent set of activities. Committee quality seems to vary greatly; but even at their best, clinicians, patients, and surrogates do not use committees well. Standards to measure and control bioethics committees are inevitable given the committee's legal and quasilegal authority in various jurisdictions. This being the case, these authors suggest that the ethics community should begin to seriously study committee effectiveness and to experiment with different quality standards for committee membership and operations. The topics for investigation had much discussion: single consultants versus committees, role conflicts among committee members, efficacy and impact of ethics consultations, and the form of committee recommendations. Their recommendations for standard setting have likewise been widely discussed: committee access, member education and training, case consultation procedures, consult documentation, committee process review, and appeal. Their most in-

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triguing, and therefore their most contentious, suggestion is to have a "minimal" and an "exemplary" level of training for committee members. Minimal training (which most committee members not working in ethics would consider extraordinary) includes "a thorough orientation to the history and literature of ethics committees and to the specific mission and duties of their own committee . . . [and] a course of study of ethical concepts, types of ethical problems most frequently faced by clinicians and patients, and methods of ethical decision making . . .[and] . . . relevant health law and differences between legal and ethical considerations . . ." Those involved in case consultations would, in their scheme, have additional training. Standard setting is reasonable and inevitable, and efficacy studies are necessary if only to prove to ourselves that we do something worthwhile. We must balance all such proposals, however, with reasonable expectations and a practicable time line.

Ringheim K. Ethical issues in social science research with special reference to sexual behavior. *Social Science and Medicine* 1995;12: 1691–7.

Social science reasserts that funders still receive proposals saying, "there are no ethical considerations for this project." This paper, originally used by the World Health Organization (WHO) to develop its policies, describes the ethical dilemmas that arise in social science research, and some of the WHO consensus conference's findings on how to deal with them. The author uses sexual and reproductive research as the paradigm for the discussion. She first notes that most social science professional ethical codes are insufficient to guide researchers' behavior in the unusual circumstances that often pertain, especially in non-Western countries. She then describes a consensus conference by the WHO's Council on International Organizations of Medical Sciences (CIOMS) that tried to deal with some research ethics issues in social science. The answers to the knottiest dilemmas, however, remain unclear. While CIOMS, for example, requires that research subjects must also be among the study's beneficiaries, the author acknowledges that in research such as that involving HIV-positive individuals, they get no benefit from the study (although their uninfected countrymen and -women may benefit). While consensus exists that subjects' autonomy should be respected, questions arise about how valid a subject's participation decision is if the community leader or elder has already given "permission." Likewise, how coercive are monetary and other incentives, especially for poor subjects? Not only does this raise ethical issues, but it may confound study results. Finally, questions of confidentiality must be addressed for issues that may compromise individuals' well-being in their communities. Spouses, elders, teachers, and government agencies should not have access to individual's answers, particularly about sensitive, sexually related material. This may flaunt local convention, but it is ethically imperative, despite cultural norms. These ethical issues are not unique to the social sciences, because they also arise in biomedical research, and have also been poorly addressed.

Graber MA, Gjerde C, Bergus G, Ely J. The use of unofficial "problem patient" files and interinstitutional information transfer in emergency medicine in Iowa. *American Journal of Emergency Medicine* 1995;13:509–11.

Confidentiality remains an important bulwark of the physician–patient relationship. Two common practices among US emergency departments violate confidentiality, yet this paper appears to be the first that describes its frequency. Emergency department (ED) personnel often keep a book with the names of suspected drug abusers, "frequent flyers," and other ED "abusers." They also call other EDs in their area to notify them of such patients when they appear in an ED. These authors found that this practice is common, even in relatively rural Iowa, where 58% of the hospital EDs keep such logs and nearly all make and receive calls about "problem" patients. That these practices exist stems, in part, from ED personnel's conflicting loyalties and responsibilities. They must, when possible, preserve patient confidentiality; but at least in the case of potential drug abusers, state laws and medical board regulations often require them to do everything possible to avoid giving drugs to those who will misuse them. This dilemma has led to the current situation. As it stands, not only may these entries be incorrect and based on limited or skewed information, but they do not even have the same access controls as medical records. These practices raise important issues for those concerned about patient confidentiality and physicians' responsibilities.

Esserman L, Belkora J, Lenert L. Potentially ineffective care: a new outcome to assess the

limits of critical care. *Journal of the American Medical Association* 1995;274:1544–51.

Intensive care units now consume about 1% of the US gross national product, or about $62 billion in 1992. Higher cost technologies will only increase costs for individual patients. Therefore, the only way to decrease costs will be to decrease the number of patient-days in these units. As repeatedly predicted, predictive scales have now been used to discriminate reasonably well between intensive care unit (ICU) patients for whom care is "effective" and those for whom it is not. Prior attempts, especially those using either age or a specific diagnosis, have been unable to predict long-term survival. Using the APACHE III multivariate model, the authors used the product of the day 1 and day 5 predicted mortality to determine which patients would receive "potentially ineffective care" (PIC). They defined PIC as "care given to patients who, despite prolonged intensive support, die either in the hospital or shortly after hospital discharge." (The word "potential" seems to be merely a bone thrown to the ethics community.) After deriving their model from 402 sequential ICU admissions, they validated it on an additional set of patients. The importance of this model is that while they could only predict 37% of the patients who fell into the PIC category, 98% of the predicted patients died during or soon after hospital discharge. The relevance to those in biomedical ethics is that this study, and similar studies that will inevitably follow, will allow third-party payers to determine which patient's ICU care "is worth" paying for. While debates over "futility" continue, the cost savings estimated at between $1.8 million and $5 million per year for the authors' hospital alone will enormously sway public policy. Third-party payers and policymakers can easily calculate national cost savings. In this time of budgetary alarm, social needs and financial imperatives will affect ICU usage before society reaches consensus about what we mean by and how we want to deal with ineffective or futile treatment. This paper signals that new direction.