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O’Keeffe ST. Development and implementation of resuscitation guidelines: a personal experience. *Age & Ageing* 2001;30(1):19–25.

This author attempted to involve elderly, ill patients in their own healthcare decisions about cardiopulmonary resuscitation. Using accurate information about the likelihood of success, he found, as many of us have, that the task is difficult, if not nearly impossible. O’Keeffe used a group of patients who were at least 65 years old and who had been admitted to a community acute care hospital in Galway County, Ireland. After reviewing the literature, he classified the patients, based on their condition, according to their estimated likelihood of survival to discharge after resuscitation: <1%, group A; 1–10%, group B; and >10%, group C. He then tried to inform patients who retained decisional capacity in group A that cardiopulmonary resuscitation would be inappropriate. He also gave the information to competent patients in group B and asked for their preferences as well. Of the 147 patients in the study, 39 were in group A, 26 in group B, and 82 in group C. Of the 36 patients in groups A and B (55%) who retained decisional capacity, O’Keeffe discussed cardiopulmonary-resuscitation decisions with only 17 (26% of total group and 47% of those with decisional capacity). He felt that acute distress or anxiety in the other patients precluded effective communication. Of the 23 patients or family members from whom cardiopulmonary-resuscitation preferences were sought, four opted for full cardiopulmonary resuscitation despite the likelihood of a poor result and six for limited cardiopulmonary resuscitation (usually witnessed-arrest only and no ventilation). The author concluded that, although limiting the use of cardiopulmonary resuscitation is a useful option for

patients, relatives, and the medical staff, it is difficult to involve acutely ill elderly patients in such decisionmaking.

Baldwin-Ragaven L, London L, De Gruchy J. Learning from our apartheid past: human rights challenges for health professionals in contemporary South Africa. *Ethnicity & Health* 2000;5(3–4):227–41.

Physicians, as those in the profession are generally loath to admit, have repeatedly grossly and systematically violated ethical norms. The most well known of these have been those complicit in pseudo-scientific tortures associated with authoritarian governments. The authors, from the University of Cape Town, South Africa, examine common participation of their country’s health professionals and their organizations in human rights abuses under apartheid. Much of the authors’ information came from testimony to the South African Truth and Reconciliation Commission, especially the TRC Health Sector Hearings by the Health and Human Rights Project in 1997. This was a systemic and case-based analysis of the health sector’s role in human rights abuses under apartheid. The airing of ethical failings by medical professionals has challenged the nation’s health sector to find ways to remain committed to human rights in the future. These authors argue that the health sector can effectively move forward only after a process of self-reflection, both personal and institutional, which would facilitate a thorough and accurate analysis of why things went so wrong. They recognize, however, that changing national and global circumstances—including the seemingly insuperable resource constraints, inimical economic policies, and the demobilization of civil society—have made human rights issues

less morally absolute as they may previously have been. They also suggest that, within South Africa, the politics of transformation has generated expediencies that threaten to rewrite history in ways that fundamentally cheapen human rights. To address this, the authors propose a set of objectives that places accountability of health professionals in a human rights framework. They developed a matrix linking these objectives to key role players in the health sector and identifying activities specific to each role player. They suggest that the lessons learned by South African healthcare providers may help others in the international community further their understandings of the complex relationship between health and human rights and of how best to implement strategies for the attainment of human rights in health.

Sing A, Salzman J, Sing D. Problems and risks of unsolicited e-mails in patient-physician encounters in travel medicine settings. *Journal of Travel Medicine* 2001; 8(3):109–12.

E-mail and other public web sources of medical information are a part of the new era of information technology and a part of modern life; how health professionals deal with those resources should be a matter of great interest, although so far it has engendered relatively little debate—especially among bioethicists. In this study, the German authors assessed the ability to obtain and the accuracy of information that so-called international travel experts provided to unknown patients about pretravel and posttravel malaria prevention. The study compared the behavior of travel clinic and tropical medicine physicians and other providers of travel-related medical information services toward unsolicited e-mails from fictitious patients in pretravel and posttravel scenarios. They also tested the quality of any preventive medicine (teleprevention) advice given. The authors sent two different e-mails to 171 physicians members of travel health or tropical medicine societies, as well as to services offering advice on travel health issues identified by an AltaVista search. These e-mails, from two different fictitious travelers, asked for advice regarding malaria prophylaxis in a pretravel scenario and described symptoms suggesting acute malaria. Of the addressees contacted, 43.3% and 49.7% respectively, replied to the pre- and posttravel e-mails. Of those suggesting antimalarial chemo-

prophylaxis in the pretravel scenario, 13.2% proposed inadequate regimens, and at least 3.5% of the posttravel replies were inappropriate. As has been noted elsewhere, both patients and physicians must be aware of the limitations of e-mail communication. The authors suggest that we need guidelines to protect physicians against the legal and ethical consequences of this new communication technology. Their study suggests that patients also need more than the advice *caveat emptor*.

Maixner AH, Morin K, for The Council on Ethical and Judicial Affairs, American Medical Association, Ethics Standards Group. Confidentiality of health information postmortem. *Archives of Pathology & Laboratory Medicine* 2001;125(9):1189–92.

Questions have arisen during the past century about postmortem disclosure of information about powerful and famous (but not so much about infamous) people. Progressively stringent laws governing the release of patient information and the increasing public interest in postmortem findings due to advances in genetic technologies led the AMA's Council on Ethical and Judicial Affairs to address the issue of the control of private health information after a patient's death. The Council developed this report to guide physicians in the management of patients' health information postmortem. MEDLINE and BIOETHICS-LINE database literature searches using the search terms "postmortem" and "health information," qualified with "confidentiality" or "privacy," yielded a combined total of 129 references. The authors culled additional references from the policies of various healthcare organizations and used these to help develop a consensus report with input from the federation of state medical and specialty societies. The College of American Pathologists also reviewed the report. The report emphasizes the importance of maintaining confidentiality for information held within a deceased patient's medical record. However, these protections are subject to certain exceptions. By removing individual identifiers, confidentiality can be upheld when such information is used for educational or research purposes. For disclosures in which the identity of the deceased patient is known, a number of considerations are provided to assess when disclosure would be ethically permissible. This report has been adopted by the AMA's House of Delegates.

Serour GI, Dickens BM. Assisted reproduction developments in the Islamic world. *International Journal of Gynaecology & Obstetrics* 2001;74(2):187-93.

A significant portion of the world's population is Muslim, and Muslims have specific ethical concerns about a number of bioethical issues, one of which is assisted reproduction technologies (ART). These authors from the Al-Azhar University, Cairo, describe the outcome of a workshop to consider use of ART in the Islamic world that the International Islamic Center for Population Studies and Research, at their institution, organized in November 2000. The workshop reinforced a 1997 recommendation that a Standing Committee for Shari'a Medical Ethics be constituted to monitor and assess developments in ART

practice. The workshop addressed, among other issues, equitable access to services for infertile couples of modest means and equipment and personnel standards that ART centers should satisfy before offering such services. Participants also proposed acceptable uses of preimplantation genetic diagnosis. They encouraged the use of follicular maturation research in animals, leading to human applications, including in vitro maturation and in vitro growth of oocytes. They also addressed embryo implantation following a husband's death, induced postmenopausal pregnancy, uterine transplantation, and gene therapy. Although the group condemned human reproductive cloning, they found acceptable the cloning of human embryos for stem cell research.