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.

Brown J. The spectrum of informed consent in emergency psychiatric research. *Annals of Emergency Medicine* 2006;47(1):68–74.

Chemical restraint of combative and agitated patients, who are often under the influence of drugs or alcohol, is common in the emergency department setting. Various medications are used and multiple studies have been done to assess their efficacy. To do these studies in the United States, obtain IRB approval, and publish the results, consent in some form would be required.

To evaluate the variation in requirements for informed consent, this author conducted a computer-assisted literature search of the National Library of Medicine holdings and then used these articles' references to identify 144 studies evaluating the chemical tranquilization of agitated patients. He excluded studies performed outside the United States and those performed before the current U.S. Food and Drug Administration regulations came into effect. He included research not yet published but presented at national meetings, as well as one study currently under way but that otherwise met the inclusion criteria. He then reviewed the articles and contacted the authors when the entire articles were unavailable or needed further clarification.

Only 12 studies met inclusion criteria, and *the approach to informed consent varied widely*. The primary method of enrollment in seven studies was informed consent. Three studies used a waiver of informed consent, but in these cases the federal regulations underlying these waivers varied. One study implied that neither consent nor a waiver of consent was needed. In one case, the primary method for consent was not specified. The author concludes that there is poor agreement about the application of current informed consent regulations in emergency psychiatric research. Regulations are interpreted in a variety of ways, so that they become irrelevant. He believes that there needs to be much greater clarity about the use of informed consent waivers in emergency research in general and in emergency psychiatry research in particular.

Janvier A, Barrington KJ. The ethics of neonatal resuscitation at the margins of viability: Informed consent and outcomes. *Journal of Pediatrics* 2005;147(5):567–8

Aggressive interventions for extremely low birth weight babies have become common. These Montreal-based authors sought to determine the adequacy of records of parental counseling in mothers with threatened preterm delivery before 27 weeks gestation, whether interventions performed at birth were consistent with recorded antenatal decisions, and whether extent of resuscitation affected the occurrence of serious short-term morbidity. To do this, they analyzed the antenatal consultation and resuscitation records and the short-term outcomes of 65 mothers with threatened delivery at 21 weeks to 26 weeks 6 days gestation and of their 61 infants who were born before 27 weeks.

Although the adequacy of records varied among individuals, they found that discussions about survival rates and the frequency of disabilities resulting from prematurity were more likely to be recorded before 25-weeks gestation than after. A decision not to resuscitate was present in 6 of the 13 consultations performed before 23 weeks gestation, but in none of the 52 consultations at 23 weeks or later. A decision to resuscitate only if the infant's condition at birth was good was found in seven consultations, six of which were at less than 24 weeks gestation. All infants born at 23 weeks and above were resuscitated, including the infants with conditional resuscitation decisions. Three of the six infants receiving heart massage were discharged alive without major short-term morbidity

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(e.g., severe intracranial hemorrhage, periventricular leukomalacia, or threshold retinopathy). All eight infants of less than 25 weeks gestation that, 3 min postbirth, still had a heart rate less than 100 beats/min despite active resuscitation either died or had major short-term morbidity.

The authors concluded that *antenatal consultation records often lack important information that other clinicians may need to make instantaneous decisions*. Variations in physician documentation practices are substantial and affect the care offered to infants at the threshold of viability.

Lago PM, Piva J, Kipper D, Garcia PC, Pretto C, Giongo M, Branco R, Bueno F, Traiber C, Araujo T, Wortmann D, Librelato G, Soardi D. Limitação de suporte de vida em três unidades de terapia intensiva do sul do Brazil. [Life support limitation at three pediatric intensive care units in southern Brazil] (in Portuguese) *Journal of Pediatrics (Rio de Janiero)*. 2005;81(2):93–5.

These authors performed a retrospective chart review to describe the causes of death and factors involved in the decisionmaking process related to life support limitations at three university-affiliated pediatric intensive care units in Porto Alegre in southern Brazil. Three pediatric fellows at each of the hospitals reviewed the medical records of all patients who died during 2002 in their pediatric intensive care units.

They assessed the data based on the general case characteristics, the length of hospital stay, the end-of-life plans, and the participation of patients' families and the Ethics Committees. They also assessed whether the patient had undergone unsuccessful cardiopulmonary resuscitation, was declared dead by brain criteria, or had "life support limitations," that is, do-not-resuscitate orders, withholding or withdrawing life-sustaining treatment.

They found that more than 53% of these patients had received full cardiopulmonary resuscitation, whereas 35% did not because they had previously documented life support limitations at the time of death. Among the three hospitals, there was a statistically significant difference ($p = 0.014$) in the incidence of limitation of life support for their pediatric ICU patients (25% in one hospital vs. 54% and 45% in the other two). The most frequent form of life support limitation (70%) was a do-not-resuscitate order. Life support limitation was associated with the presence of chronic disease (odds ratio = 8.2; 95%CI 3.2–21.3) and length of stay in the pediatric intensive care unit (odds ratio = 4.4; 95%CI 1.6–11.8). The patient's family or Ethics Committee were involved in the decisionmaking process in less than 10% of the cases.

The authors conclude that *cardiopulmonary resuscitation is offered more frequently for pediatric ICU patients in parts of southern Brazil than is observed in northern countries*. This finding and the *low incidence of family and ethics committee participation in the decisionmaking process* reflect the difficulties to be overcome by those professionals who are responsible for handling critically ill children in southern Brazil.

Ganzini L, Volicer L, Nelson WA, Fox E, Derse AR. Ten myths about decisionmaking capacity. *Journal of the American Medical Directors Association*. 2005;6(3 Suppl.):S100–4.

One of the most difficult parts of teaching medical ethics is the idea of decisionmaking capacity. Based on their study of clinicians and ethics committee chairs and a subsequent report prepared by the National Ethics Committee (NEC) of the Veterans Health Administration (VHA), these authors offer 10 common myths about decisional capacity that provide a structure to teach this all-important clinical ethics topic.

As a matter of practical reality, the role patients will play in decisions about their healthcare is determined by whether their clinicians believe that they have decisionmaking capacity. Because so much rides on assessments of capacity, clinicians who work with patients have an ethical obligation to understand this concept.

The authors identified the following 10 common myths that clinicians hold about decisionmaking capacity: (1) decisionmaking capacity and competency (a legal term) are the same, (2) lack of decisionmaking capacity can be presumed when patients go against medical advice, (3) there is no need to assess decisionmaking capacity unless patients go against medical advice, (4) decisionmaking capacity is an "all or nothing" phenomenon, (5) cognitive impairment (such as in alcoholics or psychiatric patients) equals lack of decisionmaking capacity, (6) lack of decisionmaking capacity is a permanent condition, (7) patients who have not been given relevant and consistent information about

their treatment lack decisionmaking capacity, (8) all patients with certain psychiatric disorders lack decisionmaking capacity, (9) patients who are involuntarily committed lack decisionmaking capacity, and (10) only mental health experts can assess decisionmaking capacity.

By describing and debunking these common misconceptions and providing a model to teach this topic, this article attempts to prevent errors in the clinical assessment of decisionmaking capacity, thereby supporting patients' right to make choices about their own healthcare.