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.

Elo G, Dioszeghy C, Dobos M, Andorka M. Ethical considerations behind the limitation of cardiopulmonary resuscitation in Hungary—The role of education and training. *Resuscitation* 2005;64(1):71–7.

Although the long-term overall success of cardiopulmonary resuscitation (CPR) is still less than hoped for, its value cannot be questioned when carried out appropriately in selected cases. Resuscitation frequently brings only short-term success and many patients suffer severe consequences, resulting in an economic, medical, and ethical burden to society. These authors investigated the ethical factors limiting resuscitation, including Do Not Attempt Resuscitation and the termination of resuscitation, in Hungary, as has previously been done in other European countries. During 2003, the authors personally contacted 72 doctors who were working in intensive care units and asked them to answer an anonymous, structured questionnaire, including five-point visual analog scales assessing the role of different ethical issues in initiating and ceasing resuscitation efforts in conjunction with medical experience, sex, ideology, and education. They categorized responses into the categories of autonomy, futility, obtainable quality of life, resource utilization, and "other." They found that *the decision not to attempt resuscitation was mostly dictated by the opinions of the department head and the patient's attend ing physician* (3.53 ± 1.30). Other significant factors in the decision were the presumed obtainable quality of life (3.13 ± 1.40), objective futility (3.11 ± 0.94), and patient autonomy (2.02 ± 1.63). Decisions to terminate resuscitation efforts were primarily dictated by the objective futility criteria (3.39 ± 0.88), obtainable quality of life (3.31 ± 1.50), and subjective futility (3.19 ± 1.47); autonomy played a small role (1.57 ± 1.67). Physicians who had taken an internationally accredited Advanced Life Support training course (ERC/RC(UK)/AHA) or who had more recently completed their medical training had a greater tendency to use patient autonomy as a decisionmaking factor.

Tuech JJ, Pessaux P, Moutel G, Thoma V, Schraub S, Herve C. Methodological quality and reporting of ethical requirements in phase III cancer trials. *Journal of Medical Ethics* 2005;31(5):251–5.

The approval of a research ethics committee (REC) and obtaining informed consent from patients (ICP) could be considered the main issues in the ethics of human subject research. These authors assessed the research methodological quality and the ethical quality in numerous published randomized phase III cancer trials and the relationship between research quality and ethics. Using all randomized controlled trials for phase III cancer published in 10 international journals between 1999 and 2001 ($n = 231$), they assessed methodological quality using Jadad scores and ethical quality using the Berdeu scores. They found that the studies' mean Jadad score was 9.86 ± 1.117. The methodological quality was poor in 75 RCTs (Jadad score <9). The mean Berdeu score for ethical quality was 0.42 ± 0.133. The mean ethical quality score for studies with poor methodological quality ($n = 75$) was 0.39 ± 0.133; it was 0.43 ± 0.133 for those with good ($n = 156$) methodological quality ($p = 0.07$). The ethical quality of trials has improved over time, with more recent studies having better ethical scores ($p < 0.001$). There was, however, no correlation between methodological

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quality and the number of participating patients ($R^2 = 0.003$, $p = 0.78$), between ethical quality and the number of participating patients ($R^2 = 0.003$, $p = 0.76$), or between ethical quality and methodological quality ($R^2 = 0.012$, $p = 0.1$). ICP and REC approval were not obtained for 21 and 77 trials, respectively. The authors conclude that *the association between methodological quality and the reporting of ethical requirements probably reflects the respect shown for patients during the whole research process*. These results suggest that closer attention to the conduct of clinical research, as well as the reporting of its ethical aspects, is needed.

Ashcroft RE. Access to essential medicines: a Hobbesian social contract approach. *Developing World Bioethics* 2005; 5(2):121–41.

Medicines that are vital for the saving and preserving of life in conditions of public health emergency or endemic serious disease are known as essential medicines. In many developing world settings, such medicines may be unavailable or unaffordable for the majority of those who need them. Furthermore, for many serious diseases such as HIV/AIDS and tuberculosis, the medications' patent holders can monopolize their manufacture and supply and price them well above marginal cost. Recent international legal doctrine has placed great stress on the need to globalize intellectual property rights protections and on the rights of intellectual property rights holders to have their property rights enforced. Although international intellectual property rights law does permit compulsory licensing of protected inventions in the interests of public health, the use of this right by sovereign states has proved highly controversial. In this paper *the author argues in support of states' sovereign right to expropriate private intellectual property in conditions of public health emergency*. This argument turns on a social contract argument for the legitimacy of states. The argument shows, further, that under some circumstances, states are not merely permitted to license inventions, but are actually obliged to do so, on pain of failure of their legitimacy as sovereign states. The argument draws freely on a loose interpretation of Thomas Hobbes' arguments in his *Leviathan* and on an analogy between his state of war and the situation of public health disasters.

Verhagen AA, Sol JJ, Brouwer OF, Sauer PJ. Deliberate termination of life in newborns in The Netherlands; review of all 22 reported cases between 1997 and 2004. [Dutch] *Nederlands Tijdschrift voor Geneeskunde* 2005;149(4):183–8.

On average, three cases of deliberate termination of life in newborns are reported in The Netherlands annually. The public prosecutor uses fixed criteria to assess the cases. To gain insight into the reporting and assessment of active termination of life in newborns in The Netherlands, the authors retrospectively collected and compared the data on all cases of deliberate termination of life in newborns up to the age of six months that were reported to the public prosecutor from January 1997 to June 2004. Physicians reported 22 such cases, all of which involved newborns with spina bifida and hydrocephalus. *Deliberate termination of life was acceptable to the physicians because of the presence of hopeless suffering, with no means of alleviating the suffering*. In all cases, at least two doctors were consulted outside the medical team. In 17 of 22 cases, a multidisciplinary spina bifida team was consulted. All parents consented to the termination of life; in four cases they explicitly requested it. To perform the termination, physicians used a combination of analgesics, sedatives, and paralyzing drugs in 14 cases and only analgesics and sedatives in 8 cases. For the public prosecutor the termination of life was acceptable if four requirements were properly fulfilled: the presence of hopeless and unbearable suffering, parental consent to terminate life, appropriate consultation with outside physicians, and appropriate techniques for the termination. The mean time between reporting of the cases and the decision concerning prosecution was 5.3 months. Because all reported cases of active termination of newborn life were found to be in accordance with good practice, none of the cases were prosecuted.

Hurst SA, Hull SC, DuVal G, Danis M. How physicians face ethical difficulties: A qualitative analysis. *Journal of Medical Ethics* 2005;31(1):7–14.

Physicians face ethical difficulties daily, yet they seek ethics consultation infrequently. The authors believe that our understanding of ethical decisionmaking in day-to-day medical practice is poor due to the lack of systematic data on the strat-

egies that clinicians use to resolve such difficulties without ethics consultations. To remedy that situation, they performed a national survey of internists, oncologists, and intensive care specialists using computer-assisted telephone interviews (n = 344, response rate = 64%). They asked participants to relate a recent ethical dilemma they had encountered in their medical practice. Using the grounded theory approach, they coded and analyzed elements of 310 ethically difficult situations the physicians encountered in their practice and described in their open-ended responses. They found that when facing such situations, the physicians sought to avoid conflict, obtain assistance, and protect the integrity of their conscience and reputation, as well as the integrity of the group of people who participated in the decisions. These efforts sometimes reinforced ethical goals, such as following patients' wishes or their best interests, but they sometimes competed with them. The goals of avoiding conflict, obtaining assistance, and protecting the respondent's integrity and that of the group of decisionmakers could also compete with each other. The authors believe that *in resolving ethical difficulties in medical practice, internists entertain competing goals that they do not always achieve*. Additionally, the means that they employ are not always the most likely to achieve those aims. Understanding these aspects of ethical decisionmaking in medical practice helps physicians struggle with ethical difficulties and ethics consultants who wish to help them in this process.