

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.

**Deber RB, Kraetschmer N, Irvine J.** What role do patients wish to play in treatment decision making? *Archives of Internal Medicine* 1996;156:1414–20.

Patient autonomy has become such a stock phrase in medical ethics that we often stop thinking about what it means at the bedside. When should and do patients really make autonomous decisions? Do they even want to make such decisions? Physicians, ethicists, and patients' rights advocates continually disagree over such issues. This paper puts some clarity into the discussion by describing that the hypothesized distinction does exist between two components of healthcare decisionmaking: problem solving and decisionmaking.

The authors surveyed patients scheduled for coronary angiography using several methods, including vignettes. In each case they looked at whether patients were more likely to want to make their own decision or to let the physician make the decision. Their findings seem to confirm the hypothesis that there are two components to medical decisionmaking we need to consider. Patients generally wanted physicians to do the problem solving tasks. This takes professional expertise, such as making the diagnosis. Decisionmaking, however, involves patient values, such as how much pain they are willing to endure, how much risk they are willing to take, and what a "bad" outcome means. For these decisions, patients want to either make or share the decision in noncritical situations, especially when the potential outcomes may involve their quality of life. When life and death decisions are involved, they more often prefer that physicians make the decisions.

As the authors point out, while the distinction between problem solving and decisionmaking may clarify both discussions about patient involvement in decisionmaking and how the thoughtful physician inter-

acts with patients when making these decisions, the distinction between the two may fuzzily overlap during the complex process of diagnosis and treatments. Making a diagnosis, for example, is problem solving, but undergoing the tests or wanting the information produced is decisionmaking. Once a diagnosis is made, the treatment options are determined by problem solving, while which ones a patient is willing to undergo is decisionmaking. Not discussed is the complex information needed to make these decisions—information that patients rarely receive in the required detail. In some instances, however, such as with cancer treatments, enough time and clear alternatives are often available to allow patients to get this information and make the decisions. Cancer treatment is probably the best example of this problem-solving/decisionmaking model in operation. It can and should be extended to our discussions and practice in other medical areas.

**Alexandrov AV, Pullicino PM, Meslin EM, Norris JW, for the members of the Canadian and Western New York Stroke Consortium.** Agreement on disease-specific criteria for do-not-resuscitate orders in acute stroke. *Stroke* 1996;27(2):232–7.

Acute, severe strokes often occur suddenly and without warning. Every year 550,000 people in the United States have a stroke and 150,000 of them die. Cardiopulmonary resuscitation does not improve this outcome. Mortality during the first week after a stroke is mainly due to swelling compressing vital brain centers. Even experienced practitioners may have difficulty making accurate prognoses in the first few days after a stroke. However, it is important to give the patient or family the best possible information to guide their decisions about therapeutic intervention, including do-not-resuscitate (DNR) decisions.

To help provide this information, a group of 26 experienced academic neurologists and neurosurgeons from the United States and Canada used a modified Delphi technique (repeated and refined questionnaires) to develop a consensus on clinical criteria for instituting DNR orders for patients who had suffered a stroke. They suggest that these criteria be used in conjunction with an institution's current DNR policy, giving the patient or surrogate additional information on which to base their decisions.

The clinical criteria this consensus group developed were that "a DNR order may be written" at any time that two of the following three criteria are met:

- 1) Severe Stroke. A stroke lasting more than 24 hours with persisting and sometimes deteriorating neurological deficit, hemiparesis or severe hemiplegia, and either impaired consciousness, global aphasia, or a lack of cognition.
- 2) Life-Threatening Brain Damage. Brainstem compression caused by a large intracerebral hemorrhage, a large hemispheric infarction with a midline shift, infratentorial strokes at multiple levels, or cerebellar lesions.
- 3) Significant Comorbidities. Pneumonia, pulmonary embolism, sepsis, recent myocardial infarction, cardiomyopathy, and life-threatening arrhythmias.

Although they practice in somewhat different healthcare systems, Canadian and U.S. physicians demonstrated no difference in their responses to the questionnaires.

While these criteria should aid those treating acute stroke patients to help families with prognostic information, and although this article repeatedly emphasizes that it is the patient or surrogate's decision to decide whether the physician should write a DNR order, one basic assumption raises a red flag. If these clinicians really believed in patient autonomy, as they claim to, then they would preface this piece with the statement that a patient's physician "may write a DNR order at any time their patient or surrogate requests it." That is not what it says. Maybe this is just another example showing that we still have a long way to go to achieve anything close to real patient autonomy.

**Crisp R, Hope T, Ebbs D.** The Asbury draft policy on ethical use of resources. *British Medical Journal* 1996;312(7045):1528-33.

General practitioners in England's National Health Service (NHS) often find themselves torn between two contradictory principles: to serve the best interests of each individual patient and to husband a health-care budget that is insufficient to provide the best care for each patient. One group of general practice partners met with ethicists to develop a draft policy on how to ethically use these resources. Their express purpose was to offer it as an initial model for the NHS.

In the authors' views, the policy provides a principled basis for distributing financial and medical resources within their practice. They assumed that they would operate within the NHS budgetary constraints and so would have to make decisions in cases where disagreements about resource distribution occurred.

In developing this statement, the authors considered three bases for rationing: Quality-adjusted life-years (QALYs), which they reject, in part because of its disregard for the chronically ill and those at the end of life; patient equity; and random selection (lottery). They also recognize the importance of patient autonomy and the presence of differing values when making resource allocation decisions.

They propose that the group develop resource allocation (rationing) policies and publish them annually. They would make policy decisions as required in specific patient cases that come to their attention. Their description of how these policies should be derived seems analogous to the policymaking function of U.S. bioethics committees, although NHS physicians' rationing policies involve fungible healthcare assets—if they are not used in one way, they can be used elsewhere. They eventually envision such groups being comprised of a variety of professionals, rather than just the physicians.

The factors they believe are relevant, in at least some circumstances, when rationing scarce medical resources are age, whether the patient has close relatives as dependents, and the patient's responsibility for causing his or her condition. Those factors they believe are not relevant include the patient's value to society, how highly the patient values his or her own life, race, sex, and whether other than close relatives are dependent on the patient.

The journal's editors thought this article important enough to have three individuals comment. They split over the document's effectiveness in dealing with the important issues. Most telling was a comment by Pe-

ter Dormer, who said, "If they had to choose between a saint and a rotter, each of equal age and each without dependents, then how would they solve the crisis?" They don't say. As they all agreed, this paper is a good and public start to what undoubtedly will be a long, long-needed, and often acrimonious debate.

**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(9):509-11.

Patient confidentiality has long been a fundamental part of the medical ethos. In some cases, though, it has been routinely breached to serve other 'higher' interests. For decades, one of these other interests has been to identify 'problem' patients, including drug abusers, 'frequent flyers,' and other emergency department 'abusers.' Emergency departments routinely kept logs of these patients. This study surveyed one state's emergency departments to identify how often emergency departments kept and used such logs and what policies, if any, governed a patient's entry into the log or department personnel's access to the information.

Ninety percent of the state's 42 full-time-staffed emergency departments responded. Of those that did, 58% kept such files, 14% controlled entry into the file, and 5% con-

trolled access to the file. On average, emergency department staff referred to the logs more than twice a week. In addition, nearly all of the departments (97%) contacted other departments to warn them of patients they perceived as drug seekers. On average, the departments made 23 of these calls per year.

The authors recognize that a conflict exists between protecting patients' confidentiality and other duties. In some cases, although not mentioned, state medical boards specifically task physicians with doing everything necessary to avoid dispensing controlled substances (e.g., addictive drugs) to potential abusers. This sets up a dilemma between the ethical and legal requirements. In addition, and perhaps the primary reason these logs exist, is that emergency department personnel hate, perhaps more than nearly anything else in their jobs, being played as 'patsies' by drug abusers. They use these logs as their defense against such abuse.

The main thrust of the article is that few protections exist on when this sensitive information is entered, who has access to it, and how it is used. This is the primary ethical dilemma that emergency medicine professionals can and should address. As of now, however, these black books rest unattended in emergency departments across the nation. Hopefully, your name has not been mistakenly entered on their pages.