

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.

**ten Have HAMJ, Welie JVM.** Euthanasia: normal medical practice? *Hastings Center Report* 1992;22:34–8.

Reporting on and reinterpreting the data from two Dutch studies on euthanasia, these authors argue that rather than being much less common than thought, physician-controlled killing in The Netherlands is pervasive. Part of the problem, of course, is the inadequacy of language. “Euthanasia” does not serve to distinguish the nuances these authors present. Nevertheless, they point not only to the 400 cases of assisted suicide each year but also to 2,300 additional cases where “any action that intentionally ends the life of someone else, on the request of that person” is practiced. This number, however, represents only about one-fourth of those patients, usually “suffering severely from cancer but virtually all mentally competent” who request this help. Although the authors play with other figures in the reports, the most disturbing is that physicians caused or hastened the death of about 1,000 incompetent patients without any request at all because the physicians believed them to be suffering severely. This seems to be acceptable by the Dutch judiciary and much of the medical community. The authors claim that the debate over euthanasia in The Netherlands has shifted from medical-ethical arguments justifying or opposing it to sociopolitical discussions about whether and how to regulate or legalize the practice. They fear that the “euthanasia movement” that began in the 1970s as a method to regain control from medicine of the individual’s dying process has resulted “in physicians acquiring even more power over the life and death of patients . . . in most cases of ending human life, it is the physician who decides that it is appropriate to hasten death.”

**Pounder DJ, Prokopec M, Pretty GI.** A probable case of euthanasia amongst prehistoric

aborigines at Roonka, South Australia. *Forensic Science International* 1983;23:99–108.

Is euthanasia a modern or at least historic concept? These forensic pathologists and anthropologists do not believe so. They report on the remains of an Australian aboriginal woman about 30 years of age and of “delicate body build” who appears to have been mercifully killed about 2 millennia ago. The woman’s skeleton was unearthed, along with about 200 others, by a research team from the South Australian Museum at a site that was used as a campsite and burial site from about 16,000 B.C. until European settlers arrived in the early 1800s. The woman’s remains contained a full-term fetal skeleton whose position, combined with abnormalities of the sacrum, indicates that the woman died following a failure to complete delivery. The woman’s skull was deformed by a “fracture à la signature,” that is, the classic indication of a skull injury from a blunt object; they believe the lethal weapon might have been a wooden war club similar to that still used in the area in which the remains were found in the 1840s. The authors postulate that because serious complications such as a failed labor would have resulted in a painful and inevitable death in Aboriginal Australia, this woman was euthanized, perhaps with her acquiescence. They relate similar incidents that took place in Greece during the early part of the 20th century. While the debate rages over euthanasia for patients dying despite modern medical practice, it is well to note that the ancients used euthanasia from the desperation and despair of not being able to offer alternative comfort to their comrades.

**LaPuma J, Stocking CB, Darling CM, Siegler M.** Community hospital ethics consultation: evaluation and comparison with a university hospital service. *American Journal of Medicine* 1992;92:346–51.

The authors performed a concurrent study to evaluate the activities and success of a full-time physician-based bioethics consultation service during its first 2 years in a large community teaching hospital. These results are compared with their prior study of ethics consultations in a university hospital. They performed 104 consultations in the community hospital, but these consults were requested by fewer than 10% of the hospital's medical staff. The most common reasons for consulting the ethics group (most requests were for several reasons) were to assist in decisions to forego life-sustaining treatment (74%), resolve disagreements (46%), and assess patient decision-making capacity (30%). Requesting physicians seemed to want the consultant to define the problem, explain the issues, help resolve the problem, and teach them this process. More than one-fifth of the community hospital physicians changed their perception of which ethical issues were most important in the case after the consultation. Nearly all (97%) of the physicians thought that they would request another bioethics consultation in the future. The university and community hospital ethics consultations were surprisingly similar, from the independent perspectives of the requesting and the consulting physicians. Sixty percent of the patients about whom they consulted in the community hospital lived to leave the hospital.

**Dautzenberg PL, Bezemer PD.** Quantitative and qualitative aspects of cardiopulmonary resuscitation in aged in-patients. *Netherlands Journal of Medicine* 1991;39(5-6):366-72.

The authors reviewed 18 studies of inpatient cardiopulmonary resuscitation (CPR) to identify the reasons for withholding this treatment from the elderly. They found, as have other investigators, that age as an independent factor is not a predictor of the success of CPR or the ability of a patient to eventually be discharged from the hospital. The authors discuss the assessment of medical futility leading to a "do not resuscitate" (DNR) decision in two ways. The studies they reviewed assessed "quantitative" factors, e.g., effectiveness of CPR in an age group, and "qualitative" factors, e.g., the patient's premorbid condition. They feel that the qualitative factors are important in making a DNR decision, but they are uncomfortable saying exactly how this should be addressed. Another complicating factor is what role the physician should have in this

decision and what role the patient or surrogate should have.

**Iserson KV, Mahowald MB.** Acute care research: is it ethical? *Critical Care Medicine* 1992;20:1032-7.

Research in "acute care" is a troubling area for Institutional Review Board approval and informed consent. Confusion about ethical and legal requirements has hampered acute care research efforts and stalled subsequent patient benefits. Acute care patients are the relatively few critical care patients who have suffered unexpected events that carry a high probability of mortality or severe morbidity unless immediate medical intervention is provided. The authors argue that acute care research is justified if the usual ethical requirements for research are modified to reflect the uniqueness of the situation. Their recommendations are to 1) use an explicit definition of acute care as distinct from other modes of critical care; 2) eliminate the requirement for informed consent (as usually understood); and 3) require stringent Institutional Review Board oversight regarding the unique ethical problems raised by this research. They further suggest that Institutional Review Board oversight include review of the protocol by a panel of individuals who represent possible enrollees in the proposed study.

**Surman OS, Purtillo R.** Reevaluation of organ transplantation criteria—allocation of scarce resources to borderline candidates. *Psychosomatics* 1992;33(2):202-12.

Selection of patients for organ transplants began with the "lifeboat" ethic where "God squads" endeavored to select organ recipients on a utilitarian, social-worth basis. Current national criteria for cadaver organ recipients is medical urgency and waiting time on the list. Who gets on the list, however, is still a matter of debate among physicians and ethicists. The generally accepted notion is that being listed as a candidate generally depends upon patient-centered medical need. The authors review the cases of six patients from a Boston liver-kidney transplant group to see why these marginal candidates received organs. Their patients had the common relative or absolute indications of age, being HIV positive, psychosocial difficulties, metastatic carcinoma, depression, drug dependency, and moderate mental retardation. They found that transplant team-centered circumstances, such as prior

Abstracts of Note

investment in the patient's care, prior success with similar patients, or a motivation to do a new procedure, outweighed the usual contraindications to transplant. As general policy, however, four lines of reasoning might apply to decisions about which patients get transplanted – each with different answers to the questions of including patients with marginal or unlikely benefit from the procedure.

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Line of reasoning	Benefit certain	Marginal likelihood of benefit	Benefit unlikely
1. Physicians duty	include	include as exception only	exclude
2. Patient's preference	include	include	include
3. Cost effectiveness	include	exclude	exclude
4. Scientific progress	include	include	include

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Regardless of what reasons or combination of reasons are used for accepting recipients,

the authors argue that there should be flexibility to allow for changes in donor organ availability and transplantation biology.

**Healy B.** Hearing on the possible uses and misuses of genetic information. *Human Gene Therapy* 1992;3(1):51-6.

In this transcript of the National Institutes of Health (NIH) director's comments about the potential of genetic therapy, she makes five points. First, she emphasizes that although our new genetic knowledge can markedly improve the human condition, it must be guided by the healing professions' traditional ideals. Second, genetic information may be misused, although she stresses that NIH will assist the scientific community in guarding against this. Third, she emphasizes that individuals have a right to voluntarily accept or reject genetic information pertinent to them and that utilitarian considerations should not change this. Fourth, she specifically advocates civil rights protecting from discrimination for those accessing their own genetic information. Finally, NIH's new center for social policy studies will investigate the ethical, legal, and social issues that attend genetic and other biomedical advances.