Abstracts of Note

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.

Brody H. Noel MB. Dietitians' role in decisions to withhold nutrition and hydration. *Journal of the American Dietetic Association* 1991; 91:580–5.

Decisions to limit nutrition and hydration in irreversibly or terminally ill patients have become more frequent, and clear-cut principles or rules are not always possible. The authors discuss basic moral rules and principles that an institutional ethics committee (IEC) could use to aid clinicians in making decisions concerning withholding/withdrawal of nutrition and hydration. They briefly discuss six considerations when an IEC deliberates on this type of case: alternatives to artificial nutrition, patient prognosis for recovery of function, total management plans and goals of therapy, wishes of patient or surrogate, the ability of a patient to make a choice, and the benefits/burdens of artificial treatment. Five misleading or distracting distinctions that may overlay such deliberations are discussed: stopping versus not starting treatment, ordinary versus extraordinary care, food as basic life support versus food as medical treatment, terminal versus nonterminally ill patients, and patient age. Legal considerations in such recommendations are also discussed. The authors say that although dietitians are not commonly included on IECs, their involvement may provide valuable clinical insights in this area.

Wall MG, Wellman NS, Curry KR, Johnson PM. Feeding the terminally ill: dietitians' attitudes and beliefs. *Journal of American Dietetic Association* 1991;91:549–52.

If dietitians are to play a more active role in institutional ethics committee deliberations about whether to advise clinicians or the ethical appropriateness of instituting or continuing artificial nutrition or hydration, the prevailing position among this group should be known. A survey sent to 590 registered dietitians involved in nutritional support resulted in a 42% ($n = 250$) response rate. In general, dietitians were more willing to discontinue total parenteral nutrition than to discontinue enteral, noninvasive enteral, or oral feedings. They thought that feeding could be discontinued if it causes pain or worsens the condition, if death is imminent, or if the patient has requested that feeding be stopped.

Annas GJ. Ethics committees: from ethical comfort to ethical cover. *The Hastings Center Report* 1991;21:18–21.

Professor Annas takes bioethics committees to task for making patient care decisions for which no one individual is responsible and for which only the New Jersey Supreme Court (*Quinlan*) has delegated immunity-granting authority. They have no standard mission, operate under no governing regulations, and are impossible to evaluate. He feels that ethics committees are unsuited to case consultation and that individual consultants do much better in this role. He is particularly disturbed by the heavy intrusion of the law (and lawyers) into institutional ethics committee deliberations, "encouraging lay people to attempt to practice law," but without the legal protections of due process. He even suggests that since the primary function of IECs (and IRBs) is to protect their institution, their name might be reasonably changed to "risk management" or "liability control" committees. In a closing comment he suggests that IECs "do ethics," which does not include legal considerations, but should "begin where the law ends."

Feutz-Harter SA. Ethics committees: a resource for patient care decision-making. *Journal of Nursing Administration* 1991;21:11–2, 44.

Taking the opposite view from Professor Annas, Ms. Feutz-Harter, a nurse and prac-

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ticing healthcare lawyer, feels that institutional ethics committees (IECs) are necessary to respond to public concerns in a more timely manner than can the judicial system, to preserve the integrity of the traditional decision-making team, and to provide a more systematic approach to decision making. She feels that IECs have a broad base of support among the legal, medical, and ethics communities. However, to be "an attractive alternative to the judicial process," IECs have to carefully consider two organizational issues: patient confidentiality and safeguards for due process, including notification of parties, allowing them to be present and to offer evidence, and ensuring representation for the patient. She feels that if IECs act "conscientiously and sensitively, there is little likelihood of liability" when acting in an advisory capacity. She strongly advocates for IECs in all healthcare settings.

Singer PA, Pellegrino ED, Siegler M. Ethics committees and consultants. *Journal of Clinical Ethics* 1991;1:263–7.

The authors provide their views of the benefits and dangers inherent in case consultations by bioethics committees and bioethics consultants. They believe that the central goal of ethics consultations is to assist the primary physician, the patient, and the family to reach a right and good clinical decision. They then describe dangers common to both processes: assumption of actual decision making, abrogation of moral decision making and responsibility by the healthcare team or family, and skewed decisions resulting from group dynamics or the imposed values of the consultant. The outcomes of bioethical case consultations have been rarely measured, perhaps because even the desired outcomes are unclear. Nevertheless, the authors feel that the consultation function will become more important as advances in technology, moral pluralism, and legal interventions further complicate clinical ethical decision making. Although it would be optimal for institutional ethics committees and consultants to educate clinicians to make better ethical decisions, thus eliminating their own roles, the authors are not optimistic that this will occur.

Benjamin M. Philosophical integrity and policy development in bioethics. *Journal of Medicine and Philosophy* 1991;17 Jun.:375–89.

Because critical reflection and a willingness to challenge basic assumptions is basic to philosophy, the author questions whether philosophers (or by implication, anyone with deeply felt convictions) can sit on policy-making bodies, particularly those involved with biomedical ethics, and not compromise their principles. Policy-making bodies must produce practical, politically acceptable, and timely recommendations, often requiring compromise away from a strongly held moral position. For a philosopher to endorse a committee's compromise position and simultaneously hold a personally more polar position depends upon the nature of the compromise, the circumstances of the compromise, and the relationship between compromise and integrity. The author concludes that compromise may be integrity preserving if the individual pursues the course of action that seems to follow from the most highly cherished and rationally defensible values and principles. Secondarily, the philosopher always has a role as teacher on such bodies, enabling committee members to become more fluent in disciplined ethical discourse—employing the vocabulary of ethics and making, recognizing, and analyzing ethical arguments and distinctions.