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**Weed DL.** Science, ethics guidelines, and advocacy in epidemiology. *Annals of Epidemiology* 1994;4:166–71.

Should epidemiologists, those who study the patterns of diseases in populations, also advocate for specific interventions that may prevent these diseases? This article examines the question by examining three of the profession's ethical codes, questioning the specialty's underlying ethical principles, and reviewing two current epidemiological issues in women's health: alcohol use and breast cancer. Although epidemiologists' findings play a vital role in developing health policy, their role as advocates of a specific policy is controversial. Some within the profession feel that advocacy is not compatible with their role as scientists and that any advocacy should be done as a private citizen, not in their role as epidemiologist. Two of the three ethical codes within epidemiology suggest that these professionals do have an advocacy role, although it must be scientifically based and distinguished from the role of scientist. Arguments against an advocacy role for epidemiologists include their distortion of facts, destruction of scholarship, lack of impartiality, and sloppy research. Considering breast cancer and alcohol use in women, questions also arise as to how one can honestly advocate specific health policy in the face of scientific uncertainty. One suggestion is that the "thoughtful advocate" will always acknowledge these uncertainties and be willing to change his mind when new data appears. Weed finally suggests that there exists both a historical and an ethical basis for advocacy. Ethically, he feels that public health advocacy on the part of epidemiologists is based on beneficence that is explicitly stated in the profession's ethical codes. He suggests, however, that the explicit obligations of epidemiologists be expanded to include a commitment to disease prevention.

**Martin DK, Meslin E.** The give and take of organ procurement. *Journal of Medical Philosophy* 1994;19:61–78.

Perpetuating myths is not one of the roles of bioethics articles, but some unfortunately have that impact. This article purports to demonstrate how the gifting of organs and tissues in the North American model of organ donation is less useful than the taking of organs that is done elsewhere. Although the basic concept has merit, these authors use common myth, rather than facts, to justify their position. For example, they claim that healthcare professionals approach families to request donations because the deceased usually has not indicated his preference to donate. Not true! The protocol of asking families for their consent is followed in all cases—and they can overrule the deceased's written wishes. They further attempt to skew the term organ donation to mean giving to an institution. In fact, studies have shown that families donating their loved one's organs and tissues benefit from knowing that individuals, not institutions, benefit from these gifts. In many cases, they later learn who received one or more of the organs, and this knowledge helps them to overcome their grief. The authors then suggest that organ transplants do not help the recipients. Have they ever met anyone who has been on hemodialysis and then received a kidney transplant? These people are ecstatic that they are once again leading normal lives. Even in a philosophical paper, a little reality testing is in order. Finally, when suggesting the alternative of "taking" organs unless there is a specific objection, the authors greatly overstate what has happened in Europe. Although the European Community has passed presumed consent legislation for organ donation, and many individual national legislatures subsequently passed their own enabling legislation, this has led to an increase in organ donation in only a few

countries. In the balance, bureaucrats opposing this practice have found easy ways to block it. Simultaneously, and not mentioned in this article, one organ procurement region in Britain increased their procurement rate above any in Europe by increasing their public and physician educational program about the usefulness of these final gifts. Although we do need to improve the methods we use to obtain organs and tissues for transplantation, perpetuating myths and half-truths about the process helps neither public policy nor professional awareness of the real problems.

**Oddi LE, Cassidy VR.** The JAND as a measure of nurses' perception of moral behavior. *International Journal of Nursing Studies* 1994;1:37-47.

How do we measure the quality of ethical decision making? Nursing studies have used two measures, the Defining Issues Test (DIT) and the less well-known Judgment About Nurses' Decisions (JAND). This paper discusses JAND's usefulness from a conceptual, developmental, and statistical viewpoint. The JAND is a series of stories with ethical dilemmas. The "correct" nursing action in each case was derived from the 1976 American Nurses' Association's Code for Nurses. The author notes that the Code contains conflicting messages and ambiguous statements, and is vague in many areas. This may result in many different interpretations. Further, while the Code has been revised since 1976, the JAND has not. This makes the response options in the JAND invalid in comparison to the existing Code. The author further discusses problems with the JAND in terms of its scoring, statistical reliability, and validity. The author, therefore, concludes that any studies using the JAND should be viewed warily until the test can be further refined.

**Zink MR, Titus L.** Nursing ethics committees – where are they? *Nursing Management* 1994;25:70-6.

Why have nursing ethics committees (NECs) and who has them? These authors describe what they see as the reasons to have separate nursing ethics committees, and the functions of such committees, and those committees existing in Connecticut in 1991. They feel that NECs provide a forum where nurses can discuss ethical issues surrounding increasing high technology, decreasing resources, and changing delivery systems. These are topics the authors feel are neither

appropriate nor of interest to institutional ethics committees, although they seem to be what our ethics committee addresses regularly. They also say that NECs educate nurses in ethical concepts, decision making, and legal standards, and "provide a forum for the nurse to act as a patient advocate." They then identify eight specific goals of NECs: 1) identify, explore, and resolve ethical issues in nursing practice; 2) educate nurses in bioethics and nursing ethics; 3) prepare nurses for interdisciplinary decision making regarding ethical issues; 4) serve as a resource group for "informal consults"; 5) review nursing ethics materials; 6) review departmental policies related to ethics; 7) encourage nursing ethics research; 8) prepare nurses to serve on institutional ethics committees. Their survey found that two-thirds of the respondents had institutional ethics committees and all of these had nursing representation. They found six institutions reporting the presence of NECs, and nine more who were interested in starting an NEC. One NEC had been operating for 10 years, but how active the other committees are is unclear. The authors suggest that there is interest in NECs, although they do not seem to make a convincing case that the NEC serves a beneficial purpose.

**Muller MT, Van der Wal G, van Eijk JThM, Ribbe MW.** Voluntary active euthanasia and physician-assisted suicide in Dutch nursing homes: are the requirements for prudent practice properly met? *Journal of the American Geriatric Society* 1994;42:624-9.

As Americans and Canadians debate euthanasia and physician-assisted suicide (EAS), it is instructive to see what is happening in The Netherlands. The Dutch set out specific legal requirements for "prudent" practitioners to follow for both interventions. Their State Commission on Euthanasia also delineated these requirements in their *Vision on Euthanasia*. The standards say that the patient must experience his or her suffering as unbearable and hopeless; the wish to die must be well-considered and persistent; the request must be voluntary; the physician must consult at least one other physician; the physician is not allowed to issue a certificate testifying to natural death and must keep records of all of these patients. This paper examines whether nursing home physicians have diligently followed these standards. In their study of 69 nursing home physicians who said they had administered EAS at least once, they met all of the require-

ments only 42% of the time. The most common deviation (38% of the time) was to sign a death certificate saying that the patient had died a natural death. This lapse and the failure to keep records in some cases markedly altered results. Most of the other requirements were followed in the vast majority of cases. Although the requirements specified and nearly all patients stated that they had unbearable and hopeless suffering, the main reasons they wanted EAS were fear or avoid-

ance of a deteriorating condition (25%) and fear of suffocation (15%). Unbearable suffering (14%) was named as the third most common main reason for their request. Despite the 42% compliance rate with all of the requirements (a number that will be widely quoted, I suspect), the physicians in this study followed the patient-protective requirements consistently. Perhaps the Dutch model is not so bad after all.