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.

Bebeau MJ, Davis EL. Survey of ethical issues in dental research. *Journal of Dental Research* 1996;75:2:845–55.

Ethics in dental research or even more general ethical issues in dentistry have not been a hot topic for those writing in the ethics literature. In an attempt to bring ethical issues in dental research to the forefront, the American Association for Dental Research (AADR) surveyed its leaders to determine the prevalence of problematic research practice.

They first attempted to determine what these leaders thought were the most problematic ethical areas in dental research. Overall, they felt the most serious ethical breaches were behaviors that undermined the trustworthiness of science, such as falsifying or fabricating research data, retaliation against whistle-blowers, failure to present negative results, plagiarism, unauthorized use of privileged information, publishing students' work without acknowledgment, or failure to disclose conflicts of interest. These practices, while more serious, were less common than breaches that disrespected others' works, such as gift authorship, citing sources without reading them, presenting results in conflict with their published abstract, or publishing single studies in multiple parts. All respondents had observed the less serious breaches at least once. Many had also observed the more serious breaches: plagiarism (55%), falsification of data (30%), and retaliation (10%).

In general, respondents believe that ethical behavior in dental research generally parallels the behavior in general science areas. This is not particularly a good sign, since they "occasionally" or "often" see fabrication and falsification of data (32%), deliberate misrepresentations (30%), or sloppy science (71%). The authors recommend that the AADR develop a more specific research ethical code, case materials to use when training researchers, an ethics committee or consultation service, and procedures for addressing allegations of scientific misconduct.

Covinsky KE, Landefeld CS, Teno J, Connors AF Jr., Dawson N, Youngner S, Desbiens N, Lynn J, Fulkerson W, Reding D, Oye R, Phillips RS, for the SUPPORT Investigators. Is economic hardship on the families of the seriously ill associated with patient and surrogate care preferences? *Archives of Internal Medicine* 1996;156:1737–41.

As part of the SUPPORT study, this paper analyzes whether economic hardship resulting from serious illnesses is associated with preferences to forgo life-prolonging care. This substantial question is frequently asked by clinical ethics consultants, clinicians caring for the terminally ill, and the families involved in these decisions.

These researchers found, as have other researchers, that surrogates' decisions often do not accurately reflect patient preferences. The question is whether these differences result from any financial gain derived from the surrogates' decisions. This study found that the decisions made by surrogates in families reporting financial hardship do not vary from patients' wishes any more than do those made by other surrogates. However, both surrogates and patients in families reporting financial hardship had a greater desire for comfort care than for life-extending measures (odds ratio 1:26) than did those from other families. This was true even when the patients' conditions were controlled for demographics, illness severity, functional dependency, depression, anxiety, and pain.

This reinforces the importance that families' economic well-being has on healthcare decisions. While this paper emphasizes decisions at the end of life, we must remember that many families must also decide

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between bread and their child's antibiotics. Bread often wins.

Halevy A, Brody BA, for the Houston City-Wide Task Force on Medical Futility. A multi-institution collaborative policy on medical futility. *JAMA* 1996;276:571–4.

Futility has, up until now, been a catchphrase for physician withdrawal from cases. Futility policies have had three common flaws: the futility definitions are inadequate, the processes of determining futility raises questions of openness and fairness, and no ethical framework grounds physician or institution opposition to requested interventions. These authors previously developed criteria to judge whether operational futility policies could be supported by particular definitions of futility. They reluctantly concluded that the clinical reality is that unique patients and diseases result in futility judgments that are not easily formulated into general substantive definitions. They also concluded that most futility policies reflect narrow spectra of opinions, and that the ethical frameworks presented in policies do not justify overruling patient autonomy.

To address these issues, a task force representing the major hospitals in the Houston, Texas, area developed a community-wide futility policy based on process, rather than on a definition of futility. The key elements of the process are that the patient or surrogate is involved from the outset, that the option to transfer the patient's care to other physicians or institutions is presented early in the process, that unilateral physician action is avoided, and that the patient or surrogate is assured that the clinicians will not abandon caring for the patient, even if a specific treatment is judged futile. The process, as published, has leeway for differences in institutional resolution, such as the option of replacing the phrase "inappropriate intervention *may* be terminated" with "inappropriate intervention *must* be terminated."

The mark of the policy's success is that of the three hospitals now using these nine-step guidelines, none have gone beyond step 3, involving chaplains, social service, or the bioethics committee in the mediation. This may prove to be a reasonable and rational way to tread the narrow path between surrogate hope (or guilt) and physicians' increasing distaste for the technological imperative to intervene, whether or not it benefits the patient.

Gruenberg PB. Nonsexual exploitation of patients—an ethical perspective. *Journal of the American Academy of Psychoanalysis* 1995;23:425–34.

After reviewing psychoanalysists' and most psychotherapists' traditional barriers between themselves and their patients, the author describes ways therapists can exploit their patients. He concentrates on the nonsexual exploitation of patients, which has gotten relatively little attention, distinguishing moral barriers for psychotherapists that other clinicians see as normal behavior. He sees that, however, as a deficit in others rather than too much stringency among psychotherapists. He notes that "our ethical principles were molded by our understanding of the unconscious, of transference, and [of] other displacements."

As he notes, one of the deterrents to talking sensibly about exploiting patients is that harm to patients is not a necessary component. In many cases, patients are grateful to be "exploited," although the clinician-patient relationship may suffer. His definition of "exploitation" is anything that benefits the therapist but does not move the patient's treatment forward.

Gruenberg divides nonsexual exploitation into five categories: financial, personal, fame and notoriety, power, and theory and philosophy. Financial exploitation may include using patient-generated stock tips or providing information about a patient's wealth to nonprofit fund-raisers. Personal exploitation may mean having a patient help obtain a position for a relative. Fame and notoriety may involve letting others know about famous patients or accepting invitations from these patients to socialize with other famous people. Power has included therapists influencing others to their political persuasion. Theory and philosophy touch most directly on general experience. This includes therapists whose interests include such areas as abuse, cults, or violence. They may guide patients to "remember" nontruths to further their own ideologies.

While many of these areas of exploitation reside in an ethical gray zone, that is where the hardest questions lie. Gruenberg poses these questions to psychotherapists. They might as easily be addressed to the entire clinician community.

Mullan K, Allen WL, Brushwood DB. Conscientious objection to assisted death:

can pharmacy address this in asystematic fashion? *Annals of Pharmacotherapy* 1996; 30:1185–91.

Many voices have weighed in on debates about physician-assisted suicide (PAS). This article finally speaks for those who ultimately dispense the medications—the pharmacists. As these authors point out, what is generally regarded as PAS is "pharmaceutically assisted death." This means that pharmacists will usually fill physicians' prescriptions for the lethal doses.

While physicians can usually make their own value-based decisions about whether to participate in PAS, pharmacists may be caught in a conflict between their values and those of their employers. This cuts two ways, depending upon a pharmacist's personal convictions. Either they can object to the practice that their employer has authorized, or they can approve of the procedure when their employer does not. Now that PAS is common practice in the Netherlands, legal in parts of Australia, and may become legal elsewhere, this ethical dilemma has become a practical, rather than a theoretical, problem. What should pharmacists do?

These authors propose that pharmacy associations adopt formal positions to allow employee pharmacists not to participate in filling prescriptions that "conflict with [their] personal views of morality or religious beliefs," but with the provision that pharmacists must notify their employers of such objections. What the proposed resolutions do not include, however, is what to do when pharmacists do believe filling such prescriptions is appropriate while their employers do not.

Every medical system, however, has ways around using pharmacists to (knowingly) dispense drugs for PAS if for any reason pharmacists won't participate in the process.

Jones JS, White LJ, Pool LC, Dougherty JM. Structure and practice of institutional review boards in the United States. *Academic Emergency Medicine* 1996;3:804–9.

Who are the U.S. institutional review boards (IRB)? Meeting behind closed doors at medical institutions across the country, mandated by federal guidelines to evaluate "research involving human subjects," we have little clue as to who they are or how they function. This survey addresses that question.

The authors sent questionnaires to the IRB chairs at all 907 U.S. hospitals with at least 400 beds. While they had only a 54% return rate (and 41 of those denied having an IRB), this information remains a valuable snapshot of these bodies. The average IRB has 14 members (range 3 to 55), with 27 medical specialties or departments represented. Internal medicine most commonly has representation (76% of IRBs responding), followed by nursing services (74%), pharmacy (73%), and general surgery (50%). The least common representatives are from ophthalmology (15%), emergency medicine (12%), and orthopaedic surgery (10%). The average number of lay representatives on IRBs is 3 (range 0 to 24).

Most (59%) IRBs meet at least monthly, reviewing an average of 7 research proposals per meeting (range 1 to 90). The typical review process is that an IRB member critiques a research proposal. Some (35%) then have a subcommittee review the proposal. Two-thirds then ask the investigator to present at their meeting. Nearly all then vote on the proposal and give written notification of their final decisions or requests for revising the proposals.

The responding IRBs commonly reject research proposals for improperly designed consent forms (54%), unacceptable risks to subjects (34%), ethical or legal reasons (24%), lack of institutional resources (12%), poorly written proposals (12%), funding problems (7%), and less common reasons, including conflicts of interest (3%).

This survey sheds a little light on the mysterious world of IRBs. It is somewhat surprising, given their power, that the federal agencies under whose auspices they work haven't done more to assess not only their process, but also their efficacy.