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.

Bushy A, Raub JR. Implementing an ethics committee in rural institutions. *Journal of Nursing Administration* 1991;21:18–25.

The bioethics committee movement is up and running, but our rural brethren have been largely ignored (or have ignored us). This unique article attempts to redress that by detailing some of the problems encountered and potential solutions when organizing a rural bioethics committee. The authors note that although rural regions have distinct social, economic, geographic, and demographic characteristics that differ from those of the urban/suburban locale of most ethics committees, they have similar bioethical dilemmas, albeit less publicized and with some unique twists. One important aspect governing the structure of rural bioethics committees, perhaps the most important, is geography. Assuming sufficient interest among the key players, a committee set up to serve a local area may still suffer from a lack of expertise, overcommitment of a small physician staff, and inadequate financial resources for education or logistic support. Residents of rural communities also know each other much better than those in an urban environment, potentially leading to catastrophic problems of confidentiality that would seldom be encountered by an urban ethics committee. Yet if the committee is set up to serve large healthcare systems or wide geographic areas, they face difficulties of accessibility because of distance, weather, and poor transportation facilities. The authors describe one system with a bioethics committee potentially traversing five states and 1,500 miles. These committees also face a dilemma of providing varied representation while not enlarging the committee beyond a functional size. Of most interest, the authors discuss a step-wise method of developing an ethics committee in a rural area and describe why a traditional membership may not be appropriate. They emphasize the need for participation by the rural healthcare facility administrator and hospital trustee and make an interesting case for including the local funeral director. The authors also describe how to locate a social worker in the rural environment and suggest reasons for rotating clergy membership on the committee. They also describe potentially less onerous methods of ethics self-education for the rural physician and nurse and methods to consider in financing a rural ethics committee effort.

American College of Obstetrics and Gynecology Committee on Ethics. Deception. *International Journal of Gynecology and Obstetrics* 1992;27:63–4.

This ACOG committee addresses unjustifiable deceptive physician behavior, in a declaratory opinion. Speaking to their membership of obstetricians/gynecologists, who have a long-standing tradition as the most paternalistic specialty, they describe deception as the deliberate misrepresentation of facts through words or actions to make a person believe that which is not true. They describe three types of deception: deception as explicit lying, deception by implication, and deception by omission of key information. So far so good, but they then go on to say that "deception, even when it is intended to benefit the patient, always requires justification" and they relegate these "rare cases" to the topic of informed consent. The ACOG ethics committee then describes deception in what is probably the rarer situation, that which solely serves the physician's interest. Rightly, the committee recognizes that self-serving deception is a "means of abusing power in a professional relationship," and roundly condemns its use. A tautology, however, is not difficult to produce; physicians who lie solely for personal gain do not constitute an ethical quandary, they transgress all fiduciary re-

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sponsibilities of the profession. The ACOG committee's statement by omission, therefore, merely reaffirms the paternalistic nature of their specialty. They missed the big picture.

Engel CC. Psychiatrists and the general hospital ethics committee. *General Hospital Psychiatry* 1992;14:29–35.

This prize-winning paper makes a case for hospital psychiatrists having an important role to play on ethics committees. Their skills in group process assessment, mental status examination, and character assessment have diverse applications within an ethics committee's functions. Psychiatrists can facilitate communication, both on the committee and as committee-based ethics consultants. Engel discusses the relationship between human emotions and ethical decision making in terms of two key questions that arise for a psychiatrist: to what degree are emotional factors relevant to moral decision making, and do emotions ever impair our ability to appropriately make decisions? As the author notes, some psychiatric consultations mask ethical dilemmas, and a psychiatrist may help committees clarify often heated emotional issues. They can also act as committee leaders and effective members because, as a group, they are perceived as reflective, tolerant of ambiguity, slow to act, humanizing and approachable about moral aspects of healthcare, and practiced in the art of facilitating communication. The author cautions, however, not to equate a psychiatrist with an ethicist or to think of psychiatry as "the ethics specialty," although these disciplines possess similar styles and patterns of thinking. Traditional psychiatric training fails to provide formal preparation for resolving ethical dilemmas, and the average psychiatrist has only a dim experiential awareness of the many ethical problems faced daily in general medical practice.

Tealdi JC, Minetti JA. Hospital ethics committees. *Bulletin of the Pan American Health Organization* 1990;24:410–8.

This article describes the development of bioethics committees in Argentina and compares them to U.S. standards for and development of ethics committees. Although Latin America generally has shown little development of bioethics committees, Argentina has seen the development of several committees, not necessarily tracking on the same path. As the authors say, "a good share of our ideas for stimulating bioethics in our countries may come to crystallize around HECs, despite the fact that it is not easy to guide their organization." Argentinean ethics committees began in the mid- to late 1980s in Buenos Aires, Tucumán, Mendoza, Lagomayor, Sauce, Mar del Plata, and Gonnet, the authors' committee. These committees were charged with a combination of overseeing research, dealing with malpractice concerns and family complaints, providing ethics education, setting policies, and doing consultations. Some succeeded, some failed and disbanded, and some are still in the formative stage. The authors describe their committee as a model, being composed of 6–12 professionals from a variety of disciplines and having tasks parallel to those in the United States: education, policy development, and nonbinding consultation. However, achieving group integration while carrying out these tasks has proved to be a formidable achievement—I guess we should have warned them.

Society of Critical Care Medicine Ethics Committee. Attitudes of critical care medicine professionals concerning forgoing life-sustaining treatments. *Critical Care Medicine* 1992;20:320–6.

This study of registrants at the Society of Critical Care Medicine's annual meeting evaluated the attitudes of these professionals about forgoing life-sustaining treatments in the critically ill patient. Despite problems with the sampling method and low response rate (52%), several interesting points come out. Of the physician intensivists, 5% claimed never to have withheld life-prolonging treatments and 8% never to have withdrawn life-prolonging treatments. Twenty-two percent of respondents said they would feel comfortable using vasopressors in a patient in a persistent vegetative state. Although 46% of all respondents equated withholding and withdrawing treatment, only 6% felt that withdrawing care was more acceptable than withholding. When faced with an irreversibly terminal patient, 10% were disturbed by either withdrawing or withholding care, and an additional 26% were more disturbed by withdrawing than withholding care. What is striking is to see the percentage of respondents who considered the following factors more than of "little or no importance" in making a decision to withhold or withdraw life support: social worth (12%), patient's previous mental/psychiatric history (24%), financial cost-benefit

analysis (39%), and nursing morale (50%). Correctly, the authors point out that these data must be viewed with care, because they represent what critical care practitioners think they do, rather than a measure of their actions. Nevertheless, this study seems to indicate a need for some intensive bioethics education in the intensive care units.

Blake DC. The hospital ethics committee—health care's moral conscience or white elephant? *Hastings Center Report* 1992;22:6–11.

Why has the consultation function of ethics committees not lived up to original expectations? Can ethics committees who feel unable to do consultations function well doing only education and policy development? This author argues that three elements of institutional medical politics have discouraged ethics committees from performing consultations: the power of physicians, the psychological tension attendant to sitting in judgment on morally problematic situations, and the intellectual bankruptcy inherent in a Western and American culture that cannot agree on what it means to live an ethical life. The author suggests that perhaps the only American societal consensus about an ethical life is that it concerns one's private affairs, and this increases suspicion about a bioethics committee that will dictate rules on these private matters. These obstacles may be much greater than the original proponents of ethics committees believed. The author goes on to propose that ethics committees devoid of consultation are incompetent to either provide ethics education (even the simply informative type) or develop policies. He suggests that committees can only work within a framework of casuistic case analysis, where paradigms and subsequent maxims are used to resolve knotty issues. These paradigms and the practical experiences from which they derive must be the touchstone for not only case consultation, but for education and policy development, rather than using lofty and often inaccessible ethical theory and principles. After describing the application of casuistry to bioethics committees, the author does have one nagging question: does the contemporary hospital or medical center constitute a moral community within which a casuistic bioethics committee can operate? Or has it simply become "a place of business, where some have a job (not a calling) and others find services (not a community of caring)"?