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.

Kenter MJ, Visser HK. Tijd voor professionalisering van het systeem van medisch-ethische toetsing in Nederland. [Time for professionalizing the system of medical ethics review in the Netherlands]. [Dutch] *Nederlands Tijdschrift voor Geneeskunde* 2003;147(35):1672–5.

Recent papers suggest radically altering medical ethics review committee (IRB) reviews in the Netherlands. If Dutch IRBs adopt review systems similar to those currently used in Great Britain and Australia, as has been suggested, these authors say that the committees, as currently constituted, could not fulfill the extended roles and responsibilities. At present, the Netherlands has a decentralized system of medical ethics review, which is based on peer review. The proposal is that professional medical ethics committees be established with full-time members who would receive an appropriate honorarium. Yet these authors claim that a radical change of the current human-subject research system is not warranted. They do agree, however, that there is a need for further improvements to the current peer-review system, especially providing honoraria for committee members, a budget for training, and adequate scientific and administrative support of the committee by a secretariat. They suggest that the fees levied for reviewing protocols could, in part, finance the committee and its secretariat. The centers involved in medical research would need to support any additional costs. The authors assert that providing such support will be in their best interest because it will demonstrate their wish to protect those persons consenting to participate as research subjects, which will in turn help maintain the confidence of both the public and future participants in clinical trials. It may also contribute to a positive image of the center as an attractive environment for medical professionals.

Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DO, Blustein J, Cranford R, Briggs KB, Komatsu GI, Goodman-Crews P, Cohn F, Young EW. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. *JAMA* 2003;290(9):1166–72.

Although ethics consultations are being increasingly used to resolve conflicts about life-sustaining interventions, few studies have reported their outcomes. These authors investigated whether ethics consultations in the intensive care setting reduced the use of life-sustaining treatments delivered to patients who ultimately did not survive to hospital discharge, as well as physician, nurse, and patient/surrogate reactions to these consultations. Between November 2000 and December 2002, the authors identified 551 adult intensive care unit (ICU) patients at seven U.S. hospitals in whom value-related treatment conflicts arose during the course of treatment. These patients were randomly assigned either to an intervention (ethics consultation offered) (n = 278) or to usual care (n = 273). They compared the number of ICU days and the use of life-sustaining treatments in those patients who did and did not survive to hospital discharge. They also compared the overall mortality rates of the intervention and usual-care groups. As part of the study, the authors interviewed physicians, nurses, and patients/surrogates about their views of the ethics consultation. They found that the intervention and usual-care groups showed no difference in mortality. However, ethics consultations were associated with reductions in hospital (–2.95 days, p = .01) and ICU (–1.44 days, p = .03) days and life-sustaining treatments (–1.7 days with ventilation, p = .03) in those patients who ultimately did not survive to discharge. The majority (87%) of physicians, nurses, and patients/surrogates agreed that ethics consultations in the ICU were help-

Cambridge Quarterly of Healthcare Ethics (2004), **13**, 310–311. Printed in the USA.
Copyright © 2004 Cambridge University Press 0963-1801/04 $16.00

https://doi.org/10.1017/S0963180104133197 Published online by Cambridge University Press

ful in addressing treatment conflicts. The authors conclude that ethics consultations are useful in resolving conflicts that may have inappropriately prolonged nonbeneficial or unwanted ICU treatment.

Campbell EG, Weissman JS, Clarridge B, Yucel R, Causino N, Blumenthal D. Characteristics of medical school faculty members serving on institutional review boards: results of a national survey. *Academic Medicine* 2003;78(8):831–6.

Who are the medical school faculty that serve on institutional review boards (IRBs) at U.S. academic health centers? To find out, these authors mailed questionnaires to a stratified random sample of 4,694 faculty members, drawn from the Association of American Medical College's 1999 faculty roster database, at 121 four-year medical schools in the United States (excluding Puerto Rico) between October 2001 and March 2002. Their goal was to profile those who served on IRBs and compare them with those who had not. Of the 2,989 faculty members responding (66.5%), 11% reported they had served on an IRB in the three years before the study. Of these, 73% were male and 81% were white (non-Hispanic), although underrepresented minority faculty members were 3.2 times more likely than white faculty members to serve on the IRB. Virtually all faculty IRB members (94%) conducted some research in the prior three years, with 71% having conducted clinical research and 47% serving as industry consultants. Clinical researchers were 1.64 times more likely to be on an IRB than were faculty members who conducted nonclinical research. No significant difference was found in the average number of articles published in the three years before the study comparing IRB faculty to non-IRB faculty. The authors conclude that faculty members who serve on IRBs tend to have research experience and knowledge that may be used to inform their IRB-related activities. However, they note that potential conflicts of interest may arise with almost half of all faculty IRB members serving as industry consultants. Other conflicts may arise, of course, due to the "old boys' club" of clinical researchers who know that approving some studies may later benefit them.

Mueller PS, Hook CC, Hayes DL. Ethical analysis of withdrawal of pacemaker or implantable cardioverter-defibrillator support at the end of life. *Mayo Clinic Proceedings* 2003;78(8):959–63.

Surprisingly, the question of how to treat patients or surrogates who wish to have implanted life-sustaining devices withdrawn occurs rather frequently. These authors describe a series of terminally ill patients who requested (or whose surrogates requested) that clinicians withdraw a pacemaker or an implantable cardioverter-defibrillator (ICD) and then discuss the pertinent ethical issues. Retrospectively reviewing the medical records of patients seen at the Mayo Clinic in Rochester, Minnesota, between January 1996 and June 2002, they identified only six terminally ill patients who requested (or whose family members requested) withdrawal of pacemaker or ICD support. The patients (three men, three women) had a mean age of 76 years, with five having pacemakers and one an ICD. Although five of the patients had advance directives indicating that they desired to withdraw medical interventions if death was inevitable, and two patients were in a condition to make their own requests, they still had ethics consultations. One patient died without withdrawal of support despite an ethics consultation that endorsed its permissibility. Another died while an ethics consultation was in progress. The request to withdraw support was granted in four patients, all of whom died within five days of withdrawing the device. The authors correctly conclude that granting terminally ill patients' (or their surrogates') requests to withdraw unwanted medical support is legal and ethical, noting that death after withdrawal of a medical intervention, whether external or internal, is attributable to the patient's underlying pathology; it is not the same as physician-assisted suicide or active euthanasia. They suggest that clinician familiarity with these concepts may lead to more expeditious withdrawal of unwanted medical support from terminally ill patients. Now the question is, what about nonterminal patients? Also, have ethics consultations replaced CPR as the final medical ceremony for the dying?

https://doi.org/10.1017/S0963180104133197 Published online by Cambridge University Press