Ethics and Critical Care Medicine. EDITED BY JOHN C. MOSKOP AND LORETTA KOPELMAN. Boston, Kluwer Publishers, 1985. $34.50.

CHANGES in health care technology, organization, and reimbursement are also changing critical care ethics. To address this evolving field, East Carolina University School of Medicine sponsored a symposium in which some of America's most distinguished medical ethicists participated. This book contains eighteen essays presented at the March 1983 symposium, entitled "Moral Choice and Medical Crisis."

Two speakers examine critical care ethics in the context of contemporary American society. Veatch attributes the unusual predominance of critical care issues in American medical ethics to four factors: commitment of considerable resources to critical care, ambivalence about medical technology, staunch individualism among patients, and a tradition of paternalism among physicians. Reich warns that, as corporations acquire increasing control over American health care (including critical care), medicine must reassert its traditional values of professional integrity, patient autonomy, and balanced consideration of costs and equity.

Although they can recommend no solutions, several speakers address the problem of scarce critical care resources. Perrin, for example, considers all of the methods currently used to limit expenditures from a state crippled children's fund to be ethically unacceptable. Arguments favoring either preventive care or critical care impress Moskop as equally refutable. Englehardt challenges society to recognize the limits of critical care resources and to make entitlement decisions accordingly; Margolis, however, contends such decisions cannot be morally justified.

A few authors consider issues regarding the care of individual patients. Kopelman argues that Hippocratic beneficence — the physician's pledge to benefit the sick — promotes compassion for the critically ill patient. Honoring patients' choices is the supreme value in therapy, according to Pellegrino and Katz. Katz, however, imposes on patients the duty to reflect about their choices, and on physicians the duty to communicate with patients about those choices. Reiser suggests that our acknowledging Nature's power to heal and man's relative powerlessness should lead to proper restraint in critical care.

What, then, does this book teach about critical care ethics? Future resources will almost certainly be limited. We Americans should no longer deceive ourselves that medical resources are limitless, and that everyone who needs critical care will get it; we must assess our resources realistically. In addition, the ethical principles already articulated for critical care are extremely broad at best. Clinical application of the principles of beneficence, respect for patients' autonomy, and proper restraint in choosing therapy require considerably more definition than the speakers give. What does beneficence require the physician to do for chronically vegetative, ventilator-dependent patients? What justification should the physician require from the acute myocardial infarction patient to accede to the patient's wishes for premature discharge? What is proper therapeutic restraint for cancer patients who want cardiopulmonary resuscitation? More use of cases to illustrate the application of these principles in actual patient care would help in approaching these and similar questions.

This book lays the conceptual groundwork for posing important questions in critical care ethics: How should limited resources be used? and What *specifically* does ethics require in treating critically ill patients? Medicine and ethics must address these questions openly and propose answers. Unfortunately *any* answers will probably entail some tragic consequences. Yet we must make the best choices possible and accept responsibility for them. "Tragedy is a part of human life," one ethicist says in the book, "and morality goes hand in hand with tragedy." — *Henry S. Perkins, MD, University of Texas, San Antonio, TX*

ERRATUM

An error appeared in the article, The Functional Status Questionnaire: Reliability and Validity When Used in Primary Care (J GEN INTERN MED 1986;1:143-149). The formula for calculation of FSQ scale scores, on page 145, should read:

$$SS = \frac{\left(\sum_{i=1}^{n} yi\right) - n}{n} \cdot \frac{100}{k}$$

where

SS = transformed FSQ scale score
yi = individual questionnaire response score
n = number of questions in the scale for which valid information is available
k = maximum minus minimum valid response score