"ETHICAL DILEMMAS IN THE PRACTICE OF MEDICINE"

1978-79 Noontime

Seminar Series

CA Francis
5/3/79.

Committee on Medical Ethics and Human Values

SYLLABUS FOR 1978-1979 NOONTIME SEMINAR SERIES

PREPARED BY

RICHARD T. HULL, PH.D.

UNDER THE DIRECTION OF THE

COMMITTEE FOR HUMAN VALUES AND MEDICAL ETHICS

SUNY AT BUFFALO SCHOOL OF MEDICINE

ROBERT DICKMAN, M.D. AND NORMAN SOLKOFF, PH.D., CHAIRMEN

NOONTIME SEMINAR SERIES
Sponsored by The
Human Values and Medical Ethics Education Committee,
SUNY at Buffalo
School of Medicine

The 1978-1979 Noontime Seminar Series will be organized as follows. In the fall term there will be five seminars organized about the general theme of utilitarian versus deontological ethics in medicine. In the Spring term there will be five seminars devoted to the general theme of Hippocratic ethics versus social responsibility. Each seminar will be advertised with a case study and associated readings provided in advance. The seminars will be conducted by 3-4 panelists and a moderator, will run 1 1/2 hours in length, and will allow for a 10 minute presentation by each panelist, a 15 minute intra-panel discussion, and a 40 minute period for audience questions and participation followed by a brief distribution and completion of questionnaires. The moderator will begin each session with a brief introductory statement, relating the specific seminar topic and case to the theme of the series and identifying some of the chief issues to be discussed.

The panelists are to be selected and instructed to enhance the bi-polar character of each seminar topic; they will be provided the reading materials well in advance, and a preliminary meeting of the panelists with the moderator to plan their remarks will be held three weeks in advance of the seminar.

1978-1979 Noontime Seminar Series
Sponsored by
Committee on Human Values and Medical Ethics
School of Medicine
State University of New York at Buffalo

All seminars will be held at 144 Farber Hall, Main Street Campus from 12:45 - 2:15 p.m.

Fall Theme: Utilitarian and deontological patterns of decision-making in medicine

1. Informed Consent and the Right to Withdraw Consent to Treatment
   Monday, September 11, 1978
2. The Right to Psychiatric Treatment
   Monday, October 9, 1978
3. Involuntary Sterilization of the Retarded
   Monday, October 30, 1978
4. Euthanasia and the Dying Patient
   Monday, November 13, 1978
5. Issues in Abortion
   Monday, December 4, 1978

Spring Theme: Conflicts between the Hippocratic/free enterprise and the civil service views of the profession

1. Justice and Health Care Delivery
   Monday, January 15, 1979
2. Allocation of Scarce Medical Resources
   Monday, February 5, 1979
3. Confidentiality of Psychiatric Information
   Monday, March 12, 1979
4. Incompetent Practice
   Monday, April 2, 1979
5. Nontherapeutic Medical Experimentation
   Monday, April 23, 1979

FALL SERIES:

Utilitarian and Deontological Reasoning in Medical Ethics

One who listens to a typical dispute over some ethical issue - some question of what ought to be done in a particular situation - is sometimes struck by the occurrence of two patterns in the arguments. One pattern points to the probable consequences for human happiness of this or that alternative, and ends up by recommending that alternative that seems to have the best prospects for making the most people involved happier, or the least prospects for an increase in unhappiness for those involved. The other pattern tends not to focus on consequences but rather on the actions involved. Some actions will seem to be obligatory and others to be prohibited, no matter what the results. Let us call these patterns of reasoning and argument, respectively, utilitarian and deontological.

It is not surprising that these same patterns may be observed in the contexts of arguments and reasoning over ethical issues in medicine. Indeed, these patterns often underlie positions that receive names of their own: in the contexts of both abortion and euthanasia, the quality-of-lifers square off against the sanctity-of-life proponents, and many (although not all) of the arguments the former carry the utilitarian pattern, with the latter being decidedly deontological in character.

With the increase in the public character of decision-making in medicine and the lack of a central, unitary religion and ethic in our rather pluralistic society, has come an increased need for health-care professionals to understand better their own ethical commitments as well as those of their patient-clients. This series seeks to illustrate these historically and contemporarily important patterns of thought as they arise and occur in decision making in the context of six important issues in biomedicine.

INFORMED CONSENT AND THE RIGHT TO WITHDRAW CONSENT TO TREATMENT

Should the physician be compelled to adhere to the requirements of informed consent in providing therapy to the patient, and to withhold or withdraw treatment that the patient refuses, even if to do so is not, in the physician's judgement, in the patient's best interests?

DATE, TIME, AND PLACE: Sept. 11, 1978, 12:45-2:15 p.m., 144 Farber Hall

Case Study: THE SIGNED FORM VERSUS THE PATIENT'S WISHES
(adapted from Howard Brody, *Ethical Decisions in Medicine*, No. 14, p. 59 (Boston, Little, Brown and Company, 1976)).

Suppose that a 35 year old, attractive, popular, married woman is referred to your surgical practice with a lump in her right breast which, under both her physician's manual examination and yours, strongly suggests malignancy. You explain to her that an accurate diagnosis will require doing a surgical biopsy, and that if examination of the tissue is positive for a malignancy, your opinion is that only a complete removal of the breast and associated lymph nodes and muscle tissue will offer hope of a cure. The woman tells you that she will authorize the biopsy, but that she will consent only to having the lump, not the entire breast, removed. She strikes you as "another of those women who are so emotionally messed up about their breasts that they would die of cancer rather than lose one", and you privately decide to give the appearance of going along with her whims for the present while reserving the option to remove the entire breast in her long term interests once she is under anesthesia.

As you are reviewing the records on the day of surgery, you note that they contain a consent form, signed by the patient, for "the operation of mastectomy". As you see her just before she is taken up, she reiterates her desire that you remove only the lump,but somewhat less forcefully (you suspect she may be weakening in her resolve). Her husband, who is present now but was not at the first consultation, appears distressed but says nothing. Do you have consent to perform right mastectomy when the biopsy comes back confirming the diagnosis of malignancy? At that point, should you seek consent to the radical procedure from her husband, on the grounds that it is unnecessarily risky to put her through two surgical procedures and that he, both as her husband and as one who is affected in important ways by the decision, is an appropriate proxy (and is likely to give the consent you want)?

It is tempting to fall back on the requirements of the law, but that temptation should be resisted as providing the final answer, for three reasons. First, the law does not tell you what you ought to do, morally speaking, in this or other cases: it only tells you what the patient's legal rights are and what may happen to you if you don't observe them. Second, the law itself is not immutable and may change as the result of various social and economic pressures. Third, there is no guarantee that if you don't perform the radical procedure the patient won't later change her mind and hold that you didn't have her fully informed consent. You are probably better off on firm ethical footing (particularly if you think the woman's decision is not one she will stick with).

A utilitarian argument that might be constructed for going ahead with the radical surgery would be partly statistical, partly psychological. The mastectomy offers, in the case of most malignancies, a significantly greater likelihood of survival than does the simple lumpectomy. Most women who lose breasts to surgery adjust to that loss rather well, particularly with the assistance of the various support groups and prosthetic devices available, and most husbands come to accept their wife's disfigurement without it affecting an already stable marriage. You may judge that this woman will not be ultimately happy with the conservative procedure, particularly since it is quite likely to cost her her life; and you may even judge that she has begun to waver as she has had time to think about it. Thus, her happiness, her husband's happiness, and certainly your own satisfaction with the outcome, are all likely to be maximized by ignoring her dissent. At the same time, there seems to be no point in trying to pressure her into consenting prior to surgery, since that would only distress her (and perhaps needlessly, if the biopsy is negative) and since you can most likely get her husband's consent when the need arises. Finally, delaying surgery while she comes (or is brought) around to your viewpoint is medically inadvisable and will upset the surgical schedule of the hospital.

It is interesting to note that opposing deontological arguments can be constructed, depending on how the actions in the situation are described. Consider, for example, the type of argument given by Rabbi Moshe Tendler, who is also a practicing M.D., at a Symposium on Ethical Issues in Human Experimentation in 1972: "It is not necessary in a system of ethics to where I adhere--a biblical system of ethics--to have informed consent if you know for sure, with the best of your scientific and ethical ability to evaluate, that the action is for the benefit of the patient. Just as a man cannot commit suicide under our ethical system, he cannot refrain from benefiting from medical advances and by doing so forfeit his life passively. If indeed a procedure is looked upon as a proper medical procedure, it will be proper to institute it even without informed consent." (quoted by Brody, ibid.,p.66)

On this reasoning, then, *to withhold surgical procedure* which has the best likelihood for preserving life because the patient doesn't want it, *is* viewed as tantamount to *assisting a suicide*, which is prohibited. Thus, the physician on this view would be obligated either to leave the case entirely or to go ahead with the surgical procedure which, in his judgement, is going to be most beneficial to the patient. (And if the surgeon were the only one effectively available to the patient, perhaps the only moral alternative would be to operate without consent.)

On the other hand, a deontological argument which turns on a different description of the surgery, emerges from considering the Kantian grounds for the requirement of informed consent. Kant held that the supreme moral principle was that we should always treat each moral agent "never as a means, but always also as an end as well." The informed consent requirement, an absolute limitation on the physician's powers, is viewed as an expression of this moral law. For the physician treats the patient as a means to his own ends--the preservation of the patient's life--when he does not respect that patient's right to refuse treatment. In this situation, *to proceed with the surgical procedure against the patient's informed and expressed wishes is to fail to respect that person as a moral agent*, charged with a responsibility for self which the rest of us are not empowered to assume.

Review of Background Readings:

While I did say that falling back on the requirements of the law was questionable as a tactic of ethical decision-making, it is not without its merits. The articles by Robert M. Byrn ("Compulsory Lifesaving Treatment for the Incompetent Adult", *Fordham Law Review* 44 (1): 1-36 (October, 1975); reprinted in Thomas L. Beauchamp and LeRoy Walters, eds., *Contemporary Issues in Bioethics*, Encino: Dickenson Publishing Co., Inc., 1978 (pp. 150-161) and Kenny F. Hegland ("Unauthorized Rendition of Lifesaving Medical Treatment", *California Law Review*, 53(3):860-877 (August, 1965); reprinted in Beauchamp and Walters, Eds., *op.cit.*(pp.162-168) present pro and con articles from the perspectives of the law (but with a lot of implicit moral reasoning as well) over the question of whether it is permissible to provide compulsory (i.e., un-consented-to) lifesaving treatment for a competent adult. Both seem to be chiefly deontological in their reasoning, with Byrn more a Kantian and Hegland more in agreement with Tendler.

Byrn's article examines five cases in which "courts, deferring to rights implicit in the American concept of personal liberty, have given priority to patient choice", and five cases in which "various governmental and private interests have been found sufficiently compelling to over-balance patient choice."

The relevant fundamental patient rights that are exhibited as concomitants of the concept of personal liberty are "(1) the right to determine what shall be done with one's body..., and its corollary, the right to acquiesce in imminent and inevitable death..., and (2) the right of free exercise of religion..." There are few compelling state interests which have been held to overrule patient choice in such matters; and Byrn finds "only the state's interests in the welfare of the minor child and the protection of the public from communicable disease" to be proper bases for limiting the competent adult's freedom to reject life-saving medical treatment. Specifically, he rejects the view that the state's interest in preventing suicide, or a paternalistic exercise of the police power, justify such limitation.

Hegland argues, on the other hand, that the "rendition of emergency lifesaving medical treatment on the person of the objecting adult patient is proper"; and that "the law's traditional view of the sanctity of human life and the importance of the individual's life to the welfare of society, deny the individual a right to, in effect, consent to his own death". He argues that "the physician should be allowed to save the patient's life without" a court order, at least in the case of the hospitalized patient.

If you have time, read through the articles (including the two above) on reserve in the Learning Center (42A Farber); but at any rate, think about the case study, issues and arguments, and come to the seminar prepared to hear and participate in further discussion of them.

THE RIGHT TO PSYCHIATRIC TREATMENT

In involuntarily committing a psychiatric patient on the grounds that he constitutes a danger to himself or to others, is there an absolute obligation to provide psychiatric treatment?

DATE, TIME, AND PLACE: Oct.9 , 1978, 12:45-2:15 p.m., 144 Farber Hall

Case Study: THE INVOLUNTARILY COMMITTED PATIENT'S RIGHT TO PSYCHIATRIC TREATMENT (adapted from Wyatt v. Stickney (344 F. Supp. 373 (1972)) and Wyatt v. Aderholt (503 F.2d 1305 (1974)))

This was a class action, originally filed in behalf of patients involuntarily confined at Bryce Hospital, Tuscaloosa, Alabama. "The case began...when a cut in the Alabama cigarette tax forced the state to fire 99 professional, subprofessional, and intern employees, at the Bryce Hospital.... The complaint alleged that the defendants had effected the staff reductions purely for budgetary reasons;... and that as a result of the discharges the patients at Bryce would not receive adequate treatment." The complaint was later amended to question the "overall adequacy of the treatment afforded at the Alabama state mental hospitals." The plaintiffs requested that the Court affirm that "patients confined to a state mental health facility are entitled to 'adequate, competent treatment'."

The defendants alleged that there was no constitutionally guaranteed right to treatment and that the U.S. District Court therefore lacked jurisdiction in the case. But the Court struck down this argument and affirmed that a right to treatment for mental illness is found to be within the purview of the 14th Amendment. Specifically, the Court held that "patients 'involuntarily committed through noncriminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings' are 'committed for treatment purposes' and so 'unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition'." (Wyatt v. Stickney, 374 et passim) The Court also held that the patients in Alabama mental hospitals were being denied their right to treatment, and it laid down detailed and complex standards for adequate care and treatment, ordering the state to provide (i) a humane physical and psychological environment; (ii) qualified staff in numbers sufficient to administer adequate treatment, and (iii) individualized treatment plans.

On appeal, Governor George Wallace argued that "the principal justification for commitment lies in the inability of the mentally ill and mentally retarded to care for themselves. The essence of this argument is that the primary function of civil commitment is to relieve the burden imposed upon the families and friends of the mentally disabled", and inferred from this that the need for care, together with the burden that such placed upon families and friends, justified involuntary commitment for the purpose of custodial care. "The families and friends of the disabled are the 'true clients' of the institutionalization system."

The U.S. Court of Appeals for the Fifth Circuit decided this appeal in Wyatt v. Aderholt. The argument was, in essence that (1) even in those cases where custodial care was all that could be effectively provided for the patient, due to the hopelessness of that patient's condition, certain standards of custodial care had to be adhered to: minimally adequate habilitation and care must be "beyond the subsistence level custodial care that would be provided in a penitentiary". (2) Governor Wallace's argument was rejected:

> "...we find it impossible to accept the Governor's underlying premise that the "need to care" for the mentally ill -- and to relieve their families, friends, or guardians of the burdens of doing so--can supply a constitutional justification for civil commitment. At stake in the civil commitment context...are "massive curtailments" of individual liberty. Against the sweeping personal interests involved, Governor Wallace would have us weigh the state's interest, and the interests of the friends and families of the mentally handicapped in having private parties relieved of the "burden" of caring for the mentally ill. The state interest thus asserted may be, strictly speaking, a "rational" state interest. But we find it so trivial beside the major personal interests against which it is to be weighed that we cannot possibly accept it as a justification for the deprivations of liberty involved.... It is the essence of our holding...that the provision of treatment to those the state has involuntarily confined in mental hospitals is necessary to make the state's actions in confining and continuing to confine those individuals constitutional. That being the case, the state may not fail to provide treatment for budgetary reasons alone."

Review of Background Readings:

In writing about this case, Robert Veatch says: "The first question raised by this case is whether it poses an ethical problem at all." He then goes on to identify as the real problem, "(W)hat the mental health commissioner and the judges ought to do when they realize more funds are needed to provide constitutionally required medical care, but the funds cannot be obtained from the state. The one legal remedy seems to be to release the patients." (Robert Veatch, Case Studies in Medical Ethics, Cambridge: Harvard U. Press, 1977, p. 103). Morton Birnbaum, an M.D. and lawyer, recognized that "To release a mentally ill person who requires further institutionalization, solely because he is not being given proper care and treatment, may endanger the health and welfare of many members of the community as well as the health and welfare of the sick person; however, it should always be remembered that the entire danger to, and from, the mentally ill that may occur by releasing them while they still require further institutionalization can be removed simply by our society treating these sick people properly.... For if repeated court decisions constantly remind the public that medical care in public mental institutions is inadequate, not only will the mentally ill be released from their mental prisons but, it is believed that public opinion will react to force the legislature to increase appropriations sufficiently to make it possible to provide adequate care and treatment so that the mentally ill will be treated in mental hospitals (rather than mental prisons)." (Morton Birnbaum, "The Right to Treatment", Am. Bar. Assn. Journal, 46:499-505 (May, 1960), p. 503) It seems clear that Veatch, and to a lesser extent Birnbaum, see the chief problem in this case to be a political, strategic one.

By contrast, Thomas Szasz ("Involuntary Mental Hospitalization: a Crime Against Humanity", in James M. Humber and Robert F. Almeder, Biomedical Ethics and the Law, New York: Plenum Press, 1976, the original version appeared as "Science and Public Policy: The Crime of Involuntary Mental Hospitalization" in Medical Opinion and Review, 4:24-35 (May, 1968)) argues that involuntary commitment is always a form of imprisonment even when done protectively and with the availability of treatment aimed at restoring the patient to functional freedom. His reasons are: (1) that 'mental illness' is a metaphor, since it is a diagnosis predicated upon no findings of a "disorder of the physiochemical machinery of the human body"; it is thus "impossible to 'treat' them for any sickness". (2) "The claim that commitment of the "mentally ill" is necessary for the protection of the "mentally healthy" is more difficult to refute, not because it is valid, but because the danger that "mental patients" supposedly pose is of such an extremely vague nature.... (I)f "mental illness" is not a disease, there is no medical justification for protection from disease. Hence, the analogy between mental illness and contagious disease falls to the ground: The justification for isolating or otherwise constraining patients with tuberculosis or typhoid fever cannot be extended to patients with "mental illness." ...,If an individual threatens others by virtue of his beliefs or actions, he could be dealt with by methods other than "medical": if his conduct is ethically offensive, moral sanctions against him might be appropriate; if forbidden by law, legal sanctions might be appropriate." Szasz concludes that the "mental disease" of (an involuntarily hospitalized mental patient)...--unless the use of this term is restricted to demonstrable lesions or malfunctions of the brain--is always the product of interaction between psychiatrist and patient.... A psychiatrist who accepts as his "patient" a person who does not wish to be his patient, defines him as a "mentally ill" person, then incarcerates him in an institution, bars his escape from the institution and from the role of mental patient, and proceeds to "treat" him against his will--such a psychiatrist, I maintain, creates "mental illness" and "mental patients." He does so in exactly the same way as the white man who sailed for Africa, captured the Negro, brought him to America in shackles, and then sold him as if he were an animal, created slave and slaves."

Finally, even when the term "mental illness" is restricted to organic dysfunctions of the brain, Szasz still holds that "when patients with demonstrable diseases of the brain are involuntarily hospitalized, the primary purpose is to exercise control over their behavior; treatment of the disease is, at best, a secondary consideration. Frequently, therapy is non-existent, and custodial care is dubbed "treatment.""

Fundamentally, then, Szasz sees the ethical question to lie not with the question of whether the involuntarily committed have a right to treatment, but with whether involuntary commitment apart from criminal proceedings is morally just. He holds that it only has the appearance of being just through the verbal trick of the metaphor of "mental illness" and the covert appeal thereby to the public right of quarantine. Although he does not explicitly address the case of Wyatt v. Stickney, it seems clear that he would reject both Governor Wallace's line of reasoning and that of the Court -- the former because it is an instance of the utilitarian's willingness to sacrifice the rights of the individual in the pursuit of the common good, and the latter because it is predicated upon what Szasz regards as an unjust imposition of the medical model on one who does not want to be fitted into that model.

We are thus left with two tiers of questions for discussion. (1). Is the classification of a patient as "mentally diseased" and "dangerous to self or others" a legitimate grounds for his or her involuntary commitment? (2). In presuming to involuntarily commit one who has not committed a crime (or who has been found inculpable for a crime committed by reason of insanity), is the utilitarian justification for placing such individuals in simple custodial care as a way of serving both the interests of the state and of families and frinds (a matter of shifting the burden of care efficiently to the state) sound, or should the sorts of deontological considerations involved in the _quid pro quo_ requirement that deprivation of freedom must be offset by the positive opportunity to regain freedom through therapy, limit what can be done to individuals in the name of public interest? Or, is such deprivation of freedom, deontologically viewed, always so great an injustice as never to be justified?

A set of readings for this case and issue (including those abstracted above) is available in the Learning Resources Center (42A Farber); if you have the chance, drop by there and read through some of them. But in any case, be sure to come to the panel discussion to listen and participate.

INVOLUNTARY STERILIZATION

Should nontherapeutic, involuntary sterilization be provided for retarded individuals either on the grounds of controlling the spread of their genetic disorders, or on the grounds that they are not suited for parenthood, or on the grounds of the need to control the effects of sexual behavior of institutionalized individuals?

DATE, TIME, AND PLACE: Oct. 30, 1978, 12:45-2:15 p.m., 144 Farber Hall

Case Study: STERILIZING THE RETARDED CHILD
(adapted from "Case Studies in Bioethics - Case No. 538", in Hastings Center Report 8(2):13 (April, 1978))

"D", a retarded eleven-year-old girl from Sheffield, England, suffering from Sotos Syndrome (cerebral giganticism: characterized by large hands, feet and skull; poor coordination; epilepsy; various endocrine problems; and intelligence ranging from normal to severe retardation with most mildly retarded; inheritability uncertain), is being raised along with her two sisters by her widowed mother in impoverished circumstances. She has been attending a special education school with good success; she is in the normal intelligence range and has a fair academic record and the understanding of a nine-to-ten year old.

Her mother is fearful, now that her daughter has reached puberty, that her daughter might be seduced and have an abnormal baby for which she would then have to care. She thinks her daughter will never improve enough to be a responsible parent. A consultant pediatrician who had taken an interest in the family agrees with the mother's view, and added his concern that the girl's epileptic condition might cause her to harm any child. He has recommended sterilization with parental consent; the mother has discussed the operation with the daughter (who has yet to show any interest in the opposite sex, and who has little opportunity for promiscuity).

However, an educational psychologist at the girl's school strongly opposes the operation and had brought legal proceedings aimed at blocking the surgery by having the girl made a ward of the court. She has the support of the National Council for Civil Liberties and a movement in the House of Commons.

This case involves a confrontation of utilitarian and deontological reasoning. On the utilitarian side is the argument which holds that the chance of genetic abnormality in the offspring of this girl, together with the problems that she may well have, due both to her epilepsy and to the poor prospects of her achieving an adult level of autonomy, in caring for such issue, combine to make the chances of increasing the general welfare by allowing her full reproductive rights lower than by denying them. Even if this girl later experiences distress at being unable to bear children, her distress is more than offset by the peace of mind that the surgery will bring to her mother and by the avoidance of the social burden that public assistance to her for assisting in the care of her offspring (whether deformed or not) would constitute. In addition, the possibility of misery in any abnormal children which she would otherwise bear would be avoided. Such reasoning underlies the famous Supreme Court Decision of 1927 in Buck v. Bell, in which the court found that Carrie Buck, mentally retarded and promiscuous, was "the probable potential parent of socially inadequate offspring, likewise afflicted, that she may be sexually sterilized without detriment to her general health and that her welfare and that of society will be promoted by her sterilization." (Buck v. Bell, 274 U.S. 200(1927))

A first-line deontological argument would hold that there is a human right to reproduce which comes from the more general right to control what is done in and to one's own body; that an 11-year-old is incapable of giving informed consent to the sterilization procedure; that the procedure is not medically necessary; and that an injustice would thus be done to her were she sterilized at this point, because such sterilization would be involuntary and nontherapeutic.

Review of Background Readings:

This case was discussed in the same issue of the Hastings Center Report by LeRoy Walters, Director of the Center for Bioethics of the Kennedy Institute at Georgetown, and Willard Gaylin, President of the Institute of Society, Ethics and the Life Sciences. Neither opposes nontherapeutic, nonvoluntary sterilization in principle; however, each recognizes certain limitations or conditions to be placed on the procedure.

Walters argues for three formal requirements to be applied. (1) There should be a just cause, or strong reason, for the sterilization, since in the absence of a valid consent sterilization is a significant invasion of the body and intrusion into "the sphere of reproductive privacy". (2) Sterilization should be a last resort, since it is irreversible and since equally effective, reversible techniques are available. (3) Due process, or an adequate procedure for representing the interests and rights of concerned parties, must be observed.

Walters found that none of these criteria were met in "D"'s case. First, the evidence concerning the probability of a handicapped child, of "D"'s continued inability to make informed decision concerning reproduction, and of her potential danger to any child, is all inclusive. Further, the party to be benefited by the procedure is not clearly specified, and such is essential

inconclusive

1-9.
Loop

to an assessment of benefits and rights. Second, the proposed sterilization is not a last resort, since no evidence is produced concerning the ineffectiveness or inappropriateness of reversible techniques. Third, due process in such a case where there is no medical indication and where there is likely conflict of interest on the part of the mother, is not to be served by leaving the decision in the hands of the parent and physician. "In cases where the performance of an irreversible, nontherapeutic procedure on a child is contemplated, due process seems to require either the appointment of a guardian for the child or formal approval by an independent review committee."

Gaylin probes into the wider range of issues involved in such cases as these, issues such as the rights of the retarded to have "affection, tenderness, and sexuality...be a fundamental part of their lives...(as partial compensation) for their lack of ordinary intellectual pleasures." He is disturbed by the character of the decision and its reception by most parties as a victory of "good over evil", and identifies a need in the public discussion for some "understanding of the value of sterilization in the mentally retarded." In any such case, once it is established that the mental retardation "is of a degree that precludes the role of parent", the procedure deprives the individual "only of the 'privilege' of conception and, presumably, abortion". It provides that individual new freedoms, and it provides her parents peace of mind. He agrees with Walters that in this case it is too early to determine whether the incapacities to be a mother of this girl will continue; but if they "are still evidenced when she is fifteen..., she, through agents of her care, that is, her family, ought to have the right to exercise the privilege of sterilization."

Thus, Gaylin takes a much more openly consequentialist, if not utilitarian, stance in assessing this case, while Walters views it as requiring a strong commitment to conservatism and procedural safeguards that is typical of the deontologist (although Walters' deontologism doesn't dictate a simplistic proscription against sterilization per se). Their commentaries are brief, and you may have opportunity to look them over, and perhaps some of the other associated readings, before coming to this seminar and listening to and participating in the discussion.

EUTHANASIA AND THE DYING PATIENT

Is there any morally relevant difference between deliberately withholding treatment that would temporarily prolong the life of a dying patient, easing that patient's suffering with analgesics in dosages that are known to shorten life, and deliberately ending a dying patient's life with the injection of a toxic substance, bubble of air, or other means of killing?

DATE, TIME, AND PLACE: Nov. 13, 1978, 12:45-2:15 p.m., 144 Farber Hall

Case Study: TO END THE AGONY
(adapted from Robert M. Veatch, Case Studies in Medical Ethics, No. 106, p. 328 (Cambridge: Harvard University Press, 1977))

Matthew Donnelly, a physicist who had conducted research on the use of X-rays for 30 years, lay dying of progressive skin cancer which had persisted despite removal of part of his jaw, his upper lip, his nose, his left hand, two fingers from his right hand and portions of the skin of his right arm. He was blind, in constant agony, with no further treatment possible except further surgery and analgesia. His predicted life span was about one year with continued surgery, less without.

Of his three younger brothers, he had always felt closest to Harold, who was 36. His pleas for relief were dismissed by the two other brothers, who said that the doctors were doing all that could be done. But for two months he had made explicit pleas to his youngest brother to help him die.

After drinking at several local bars one afternoon and evening, Harold took his .30-caliber pistol to the hospital during the evening visiting hours. While he was there his brother died of a gunshot wound in the temple. At his trial, Harold claimed that he could remember nothing else, including how his brother was shot and killed. His brothers testified against him in the trial.

One of the major areas of disagreement between utilitarians and deontologists is in that of our dealing with dying patients. Deontologists characteristically approach such cases as this by giving an analysis of the various possible acts involved. The most simple deontological analysis, however, applies a rule which requires the physician to preserve life; hence, any action followed by the death of the patient sooner than necessary, is a violation of the physician's prime directive, whether it is an action of omission to treat or an act that is committed. The more sophisticated deontological positions view the motive, or <u>intended</u> result, of one's action as critical in the analysis of what one has done. (There are other factors that enter into the analysis as well. For example, if you are my physician and have agreed to provide me with medical care, and I need and want a certain procedure done in order to prolong my life, and you omit to do it, your omission may be negligent because, in becoming my physician, you agreed to provide me with medically necessary treatments to which I consented; you then undertook a duty which you now have neglected to do -- no matter what your reason for the omission.) If you give me analgesics in quantities which (i) are necessary to relieve my suffering, but (ii) hasten my pending death by depressing respiration, your intending consequence (i) only makes of your act one of simple relief of pain. Had you intended consequence (ii) only, however, your act would be viewed by the deontologist as a deliberate killing, murder in (depending on whether it was premeditated, your state of mind at the time, and so forth) the first or second degree. Of peculiar interest to this position is the claim that there can be two effects of my action, both known to me; but which effect becomes part of my action's description depends on (a) which comes first, and (b) which I intend. Thus, suppose I inject morphine intravenously with the intent of relieving the suffering of Mr. Donnelly, and it does relieve his suffering but hastens his death (shortly thereafter); on this analysis I am not morally responsible (given that this means was necessary to relieving his suffering, etc.) for killing him. On the other hand, if I shoot him in the temple in order to relieve his suffering (as his brother Harold may well have done), and his death and the relief of his suffering may occur simultaneously, I am morally responsible for killing him. With the characteristic deontological rule against killing (innocent) humans, I would properly be held culpable for his death in the latter, but not the former, case (because in the latter case I had intentionally killed him in order to end his suffering, whereas in the former case I had acted to end his suffering with the other foreseen but unintended effect being his death).

Utilitarians focus on the results of our actions in assessing their moral characteristics. While not denying that intentions and motives have moral importance (the utilitarian would not want to condone the hypothetical killing of Mr. Donnelly by another brother who stood to gain a substantial inheritance sooner by his brother's early death), the utilitarian would see that the death of the patient was inevitable (in the case of the dying patient) and would thus tend to focus on the other considerations involved: the amount of suffering involved for the patient and loved ones; the cost of maintaining the patient; what the wishes of the patient and family are; and so forth. A decision among the various alternative courses of action would thus be dictated by the net effects of each on the balance of good over evil: that course of action which served to maximize good (defined as happiness, pleasure, or whatever, is taken to be the primary (set of) good(s)) would be obligatory. This might, in some cases, involve aggressive therapy, in others keeping the patient comfortable and letting the patient die of "natural causes", in still others heavily sedating the patient and thereby hastening his or her death, and in some actually acting so as to kill the patient quickly. It is this last alternative over which deontologists and utilitarians most frequently part company.

The second issue over which deontologists and utilitarians often differ is over the question of the voluntariness of euthanasia (whether passive or active). Again, a variety of subtle distinctions can be involved, but deontologists of the Kantian variety frequently lay great stock in the satisfaction of the informed consent requirement as a necessary condition for any significant change in the physician's dealings with the patient. Thus, the deontologist views as unethical even a well-intentioned withholding or withdrawal of life-prolonging measures without the patient's knowledge or consent, on the grounds that the necessary condition for such a departure from the normal regimen of therapy lacks the necessary approval of the patient. Hence, the deontologist finds himself morally most comfortable with passive, voluntary euthanasia in the case of a dying patient who chooses not to prolong the dying process; and the deontologist becomes progressively more uncomfortable in moving into involuntary and active euthanasia.

Utilitarians, on the other hand, generally don't value patient autonomy and control as ends in themselves, but see them only as sometimes a means to the end of human happiness. A utilitarian would regard it as ridiculous to view onself as locked into a course of action, no matter how much distress it may cause, because the patient is unable to consent to a change. Had Mr. Donnelly been unable to consent to his brother's shooting him, with the conditions as they otherwise are the utilitarian would in all likelihood regard the shooting as justified and a highly courageous, moral act.

Review of Background Readings:

Veatch presents this case in contrast with two others, involving the death from leukemia of a young adult under intensive care and of a Jehovah's Witness as the result of a refusal of transfusion. He notes that the literature has involved at least five relevant distinctions: that between actions and omissions; that between prolonging the living of a living patient and that between prolonging the dying of a dying patient; that between voluntary and nonvoluntary decisions; that between direct and indirect killing; and that between the interests of some interested parties such as (independent) family members and friends.

Veatch notes that there is difficulty in maintaining a difference between actions and omissions: in the case of actions and omissions that produce death, the result is the same (the party dies); in both cases someone makes a decision that results in an earlier death than would otherwise have occurred; and we hold persons responsible for the resultant deaths in some instances of both cases. Nonetheless, several reasons are traditionally urged for retaining the difference in practice, however difficult to define theoretically.

(1) Acting to hasten death is psychologically different for most people from simply letting death occur. But this may be merely a product of the view that action and omission differ morally. (2) There is a professional obligation of physicians to preserve life. This, however, does not preclude the moral permissibility of someone else being designated the euthanizer. Moreover, it needs to be argued independently that the physician should not be viewed as rather obligated to serve his or her patient's health interests, which might well include on occasion the ending of the patient's life if the patient comes to have a greater interest in death than in life. (3) Legitimization of active killing of patients who are dying in agony might serve as a wedge to legitimate other killing (e.g., of the aged, the mentally ill, those judged undesirable). While a very persuasive argument, one needs to be clear whether the legitimization forseen is psychological or logical. For if it is psychological, independent empirical evidence needs to be provided that such would indeed by the result of the envisoned liberalization: the experience of Nazi Germany may be historically too small a sample, and confounded with too many other variables (such as state control), to yield a reliable prediction. If the claim is that the legitimization is a logical one, it needs to be shown that that is so, particularly if such safeguards are built in as a requirement of voluntary assent to an act of active euthanasia, proceedural reviews, etc. (4) The cause of death is different in the case of letting die from that of killing. This, of course, does not suffice to exonerate any human of responsibility, as when a parent lets a child die by not feeding it. Or to put the matter differently, while there is no difference in the cause of death in a case of passive euthanasia and in the case of a patient similarly afflicted on whom aggressive therapy is being pursued at the time of death, that does not seem to resolve the moral questions. Veatch's discussion of these issues is an air-clearing one, but reaches no final conclusion as to the ultimate permissibility of any or all forms.

A pair of articles by Joseph Fletcher and Leonard J. Weber ("The Control of Death" and "Against the Control of Death", Intellectual Digest, October, 1973, pp. 82-85) present opposing views and arguments. Fletcher's piece turns on the centrality of the value of a life of an acceptable quality, while Weber's makes major use of the notion of the sanctity of (human) life.

Fletcher thus stands in the utilitarian tradition, judging moral matters in terms of the contribution of an act's outcome to human happiness; while Weber stands in the deontological tradition, refusing to view morality as exhausted by considerations of the resultant quantity of happiness, but holding to an absolute value of (human) life itself with the attendant obligation to do nothing that would deliberately cut it short.

Fletcher argues that, all else being equal, active and passive euthanasia are morally indistinguishable; but that passive euthanasia ("letting the patient go") is usually an inferior alternative, since it frequently involves greater suffering and dehumanization than would "taking it into our own hands to hasten death for ourselves (suicide) or for others (mercy killing) out of reasons of compassion." Since "the end, or purpose of both negative and positive euthanasia is exactly the same: to bring about the patient's death", "acts of deliberate omission are morally not different from acts of commission". He argues that even the Hippocratic Oath's injunction to "carry out regimens for the benefit of the sick" and to "keep them from harm and wrong", depending on how we understand 'benefit of the sick' and 'harm' and 'wrong', may make refusing "to welcome or even to introduce death" a violation of that code. (Apparently Fletcher finds it convenient to overlook the troublesome portion of the Oath which reads: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.") Fletcher discusses the way in which the distinction between active and passive euthanasia, and between voluntary and involuntary euthanasia, combine, and one should carefully note the way some of them turn on regarding informed consent as less than absolutely limiting what we may do to another in the name of our conception of his or her benefit.

Weber jumps onto something like this point when he observes that Fletcher's "quality-of-life ethics implies that only some lives are valuable and that only some lives are worthy of this respect that condemns physical violation.... It immediately denies that the _fact_ of human life is sufficient reason for inviolability; it ends by saying that some lives can be taken." Weber holds that actively putting an end to a life, "while done with the best of intentions, is logically part of the view that human life itself is not enough to warrant our respect". However, not fighting death "is fully compatible with the humanistic nature of medicine itself." Weber shows his deontologist's colors rather clearly in maintaining: "There is more to morality than good intentions.... (A)cts have a moral quality, regardless of intention or purpose. By their very nature, actions produce consequences that often enhance or attack the well-being of man. Killing, for example, is a direct attack upon human well-being.... Killing in war, cold-blooded murder, and mercy killing are all different, morally speaking, because the circumstances are different. Yet, there always is evil in the act of killing - the evil of rendering a previously alive person dead - and this evil is the starting point for all considerations of the morality of any kind of killing." Weber ends his argument with an interesting analogy between the ecology movement's decentralization of humans and their purpose in the scheme of nature, with its accompanying ethic of less technological control; and the value of simply ceasing to prolong life medically, as opposed both to prolonging life as long as possible and bringing about death by mercy killing. However, given his previous elevation of human life to the position of highest value, the analogy may strike some as imperfect.

These are profound issues facing the practicing physician, and they deserve careful study and thought. You are invited to partake of the sampling of articles on the subject on file in the Learning Resources Center (42A Farber), and to come to the seminar to hear and participate in a discussion of the issues.

ETHICAL ISSUES IN ABORTION

What, if any, compelling reasons can be given for the view that it is morally wrong for a woman to obtain an abortion of an unwanted pregnancy?

DATE, TIME, AND PLACE: Dec. 4, 1978, 12:45-2:15 p.m., 144 Farber Hall

Case Study: ABORTION FOR THE PURPOSE OF SEX SELECTION
(adapted from a case reported by Theodore Schulman, M.D., at a seminar on abortion held in April, 1978, at SUNY at Buffalo School of Medicine)

You are a specialist in gynecology and obstetrics. A former (twice, for prenatal care) patient of yours, a woman M.D. (pediatrics) in her 40's applies very early in her third (planned) pregnancy for amniocentesis to check for chromosomal aberrations (particularly for trisomy-21). You do the check at the earliest possible date, run the examination of fetal cells quickly, call her in and inform her that she is expecting a perfectly healthy boy.

She then states that they already have two boys and want their third (and last) child to be a girl. She asks for an abortion.

You are about to refuse on the grounds that the reason is trivial, but you hesitate, not wanting to insult a "fellow" physician. She notes your hesitation and first says: "It's still early; the fetus is not yet viable; it's my body and my right to determine the purposes to which it is put." As if having to counter those battle cries were not enough of a task, she goes on to tell you the background for her decision.

She and her husband have already had two boys. In this conception they have employed what few measures exist to influence the sex of the prospective baby (alteration of vaginal Ph being the chief one, short of sperm selection, which they regard as risky). Having a girl is particularly important to them, for they are both researchers in child development and have spent important parts of their careers devising methods for spacing of children, prenatal development, and child rearing that are designed to enhance and accelerate intellectual development. Judging by the results of their two sons, their methods have been highly effective. But they want to try them on a daughter before publishing them or even moving to experiment on a larger population. She insists that these grand designs are the expression of their great love and devotion for their children (and indeed all children), that it has been a lifelong dream of theirs to show in genetically and environmentally controlled experiments the enormous benefits of low sibling pressure, early nutrition, and intensive development and education during the early years. She ends her statement with a repetition of the request for an abortion, so that they can try again for a daughter without overcrowding their family and overtaxing their careers and lives with a long delay in this next step in their "family experiment."

Do you do the abortion? If so, for what reason - that she has demanded one, that her reasons are good, in the name of science?

This case embodies a number of issues centering on the question of abortion. (The adaptation beyond the second paragraph is almost wholly fanciful, although not entirely implausible.) A useful set of questions in terms of which to come to grips with some of these issues follows.

(1) Is, and if so at what point is the fetus a person with a serious right to life?

(2) If, and at those points after which, the fetus is a person with a serious right to life, does the right of the mother to control what is done in and to her person ever take precedence over the fetus' right to life?

(3) If not, or at those points when the fetus is not a person with a serious right to life, should the right of the mother to control what is done in and to her person always be respected (is there ever any rationale for restricting abortions when the fetus is thought not to be a person)?

In answer to (1) there have been a host of positions developed and articulated. For purposes of simplification, let us assume that all parties to the dispute agree on the (partial) definition of the concept of a person as "a being with a serious right to life"; their disagreement is rather over the criteria for application of the term so defined, and as a result over the point in time at which the developing human organism is a person (has a serious right to life). There follows a review of the more influential representatives of these positions in the philosophical literature.

Review of Background Readings:

(a) The traditional Judeo-Christian (mostly Orthodox Jewish and Catholic) position has it that the fetus is a person from the point of conception. (Paul Ramsey, a protestant theologian who is mostly in agreement with the traditionalists, places the point of personhood a week or so after impregnation, on the grounds that only then is one beyond the possibility of "twinning"; he thinks it nonsense to speak of one person becoming two persons.) On this view the criterion for being a person involves being an individual human, in the biological sense of being a genetically distinct, unique member of the species homo sapiens, where membership in the species is understood as having the distinctive number and type of human chromosomes (or "something close to it", to handle embarrassing cases like that of the extra Y chromosome male, etc.). This is the position defended by John T. Noonan in his "How to Argue About Abortion" (in Tom L. Beauchamp and LeRoy Walters, eds., *Contemporary Issues in Bioethics*, Encino: Dickenson Publishing Co., Inc., 1978 (pp. 210-217) and assumed by Judith Jarvis Thomson in her "A Defense of Abortion" in *Philosophy and Public Affairs,* 1(1): 47-66 (1971); reprinted in Beauchamp and Walters, eds., *op cit*., pp. 199-209).

(b) Baruch Brody ("On the Humanity of the Foetus," in Robert L. Perkins, ed., *Abortion: Pro and Con*, Cambridge, Mass.: Schenkman Publishing Co., Inc., 1974: reprinted in Beauchamp and Walters., eds., op cit., pp. 229-240) reviews a large number of proposals for where to draw the line between morally relevant personhood and its precursor stage. The thrust of his criticism of the traditional position is that it mistakes the genetic potential of the conceptus for developing distinctive human features for those features themselves, and that the traditional position makes an invalid reference to the presence of personhood on the basis of the presence of that genetic potential. After criticizing other positions, he settles on one of his own. "...(P)roponents of the claim that the foetus becomes a living human being at about six weeks are primarily impressed with the fact that it is about that time that electroencephalographic waves have been noted, and that, therefore, the foetal brain must clearly be functioning after this date. (One main reason) for taking this development to be the one that marks the (point of personhood is that)...it is just this indicator which is used in determining the moment of death, the moment at which the entity in question is no longer a living human being. So, on grounds of symmetry, it would seem appropriate to treat it as the moment at which the entity in question becomes a living human being."

A utilitarian might well reject this criterion, not so much on the grounds of some internal flaw, but on the grounds of its disutility. For, a woman who is regular in her monthly period might go several weeks before she had grounds to suspect pregnancy. She would either be faced with the need to take abortifacent measures -- diethyl silbestrol or dialation and curretage -- or have her pregnancy confirmed or disconfirmed by test (the rabbit test or an attempt at chemically inducing menstruation). This would leave very little time to act before the foetus became a person, even if the results of the test were readily obtainable. The effective period for moral abortion would thus drop enormously, and since the utilitarian is interested in a criterion which maximizes the happiness and welfare of all parties involved, such an early criterion might well seem not consistent with that aim.

(c) The position developed by the U.S. Supreme Court in Justice Blackmun's "Majority Opinion in Roe v. Wade" (410 *United States Reports* 113, Decided January 22, 1973; reprinted in Beauchamp and Walters, eds., *op cit*., pp. 243-247) claims not to involve an explicit criterion for personhood; instead it supposes that the state has an interest in preserving life, which it dates as beginning with viability. But in our limited sense of 'person', to say that after the point of viability there is human life which the state may protect with increasingly strict limitations on abortion, is very close to asserting that the viable fetus has a right to life, and is thus (in our sense, although perhaps not that of the term in constitutional law) a person. The rationale seems to be that viability is the critical point since only after that can one begin to speak of the foetus as independent of the mother, as worthy of separate (because separable) consideration. A very important point about this criterion is noted by Daniel Callahan in his "Abortion and Medical Ethics" (*Annals of the American Academy of Political and Social Sciences*, 437:116-127 (May, 1978)). In Danforth v. Planned Parenthood of Missouri (1976), the Court held that, for purposes of the constitutional law, 'viability' is to be defined as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside of the womb by natural or artificial life-support systems...." As Callahan observes, "But the technological possibilities here are in principle unlimited, subject only to our present lack of skill and knowledge. It is thus not only conceivable, but also likely, that it will soon be possible to keep babies alive outside the womb down to 18 weeks, then 15, and so on. 'Viability' does not, therefore, represent a fixed biological point, but is a function of technical capacity."

In addition, it may be noted that if we seek some sort of consistency between our criteria for personhood in a fetus and our criteria for personhood in the dying patient, treating the criterion of technological viability as sufficient for personhood in the fetus would seem to require treating the same criterion as sufficient for personhood in the individual with a flat EEG who is on a respirator.

(d) Michael Tooley, in his paper "Abortion and Infanticide" (in *Philosophy and Public Affairs*, 2(1):37-65 (1972); reprinted in Samuel Gorovitz *et al*., eds. *Moral Problems in Medicine*, Englewood Cliffs: Prentice-Hall, Inc., 1976 (pp. 297-317), argues that the capacity to desire one's continued existence is necessary for the presence of the right to life and that that capacity in turn requires a concept of one's self as the continuing subject of experiences, a concept of past and future, and self-consciousness (or the capacity for it). He thus places the point of personhood at somewhere around, or even beyond, the first year of life after birth.

Tooley's approach is an interesting one, for several reasons. First, his approach comes out of a typical utilitarian position that frustration of a desire is prima facie evil and thus to be avoided. Second, he insists that connections be made, rather than assumed, between the concepts "person" and "human being". Third, he insists on reasons being formulated for where one wants to "draw the line" which point to a morally relevant difference in those things that fall on one side of the line from those that fall on the other. Fourth, he proposes that what makes for a morally relevant difference in this issue is the possession of a right not to be killed, with that right being grounded in the capacity to desire to continue to exist and the moral principle that it is wrong to frustrate such a desire. Since fetuses and newborns lack the consciousness of themselves as continuing subjects of experiences, and thus lack one necessary requisite of desiring that they continue to exist as the continuing subjects of experiences (which is the desire to live), they cannot be said to have the right to life. (Tooley goes through various contortions to avoid problems with sleeping and unconscious patients.)

(e) H. Tristam Engelhardt ("The Ontology of Abortion", in *Ethics*, 84(3): 217-234 (April,1974); reprinted in Gorovitz et al., eds., *op cit*., pp. 318-334) would seem to be committed to a position as extreme as Tooley's, for he holds that "the rights of the mother regarding abortion are paramount. After all, she is actually the only person involved.... No one else's personal rights are intimately involved: the fetus has no personal rights." This is so, he argues (against the supposed necessity for symmetry between the fetal personhood criterion and the brain death criterion proposed by Brody), because though the fetus has an operating brain (a necessary condition of personhood) it lacks the embodiment of a mental personal life which is present in the sleeping person. In another article ("Viability, Abortion, and the Difference Between a Fetus and an Infant", in *American Journal of Obstetrics and Gynecology*, 116:429 ff., 1973) Engelhardt offers an argument similar to Tooley's but based on the notion that only rational, self aware beings can be of value in themselves and thus have rights (a Kantian position). As a commentator, Howard Brody notes, "...(W)hile things other than end-in-themselves may not have rights in that sense, they may still have very high value and be worth protecting. Thus, while infants are not 'persons' in the strict sense of being rationally self-aware, good child-raising practices demand that we treat them as if they were persons. While not persons in Engelhardt's strict sense, infants occupy the social role of persons and as such have very high social value. Thus, Engelhardt would allow abortion up to around the point of viability, but would prohibit infanticide (and late term abortions, except under extraordinary threat to the mother's life)." (Brody, *Ethical Decisions in Medicine*, Boston: Little, Brown and Co., 1976, p. 517) The argument seems to be a slippery slope type; in order to protect all children who are not persons from undue exploitation, as well as to raise them to become persons, it is important to treat all of them as though they were possessors of rights. For if we don't, many won't develop into persons due to a failure in their developmental dynamic, and that would be a loss of the potential value inherent in beings that can become rational agents. Late term abortions, as well as infanticides, ought to be treated as violations of rights in most cases because it is generally valuable to cast fetuses and infants in the social role of person before the enter the developmental stage in which personhood becomes actualized.

(f) One of Engelhardt's former students, Larry McCullough, a philosopher at the Texas A & M Branch at College Station, argues for a graded conception rights coordinated with a graded notion of the development of the person. If we think of the person in terms of a set of capacities and abilities, and if we reflect on how the law recognizes specific incapacitations and loss of specific rights and responsibilities in mental patients and prisoners, we see how the right of the fetus to life is an increasing matter as the fetus begins to increase in its development of capacities for consciousness, independent existence, suffering of pain, etc. Rather than speak of the right to life as either present or absent, McCullough speaks of it as present to a greater or lesser degree, as commanding a greater or lesser consideration in our determination of the relative weights to be assigned to the fetus' interest in living and the mother's interest in an abortion. (McCullough's paper was presented this past spring before the American Society of Value Inquiry in Cincinnati.)

To the second question raised earlier ("If, and at those points after which, the fetus is a person with a serious right to life, does the right of the mother to control what is done in and to her person ever take precedence over the fetus' right to life?"), Judith Jarvis Thomson answers with a "Yes, sometimes." (See (a) above for her citation.) Thomson weaves a large number of clever (but contrived) examples and arguments together to establish the following conclusions:

(1) A woman may defend her life against the threat to it posed by an unborn child, even if doing so involves its death.

(2) While no given third party must accede to a mother's request that he perform an abortion to save her life, he may.

(3) Having a right to life does not guarantee either the right to be given the use of, or a right to be allowed continued use of, another person's body, even if one needs it for life itself.

(4) If the pregnancy results from a voluntary act, undertaken in full knowledge of the chance a pregnancy might result from it, with a voluntary lack of use of contraceptives, an abortion would be an unjust killing.

(5) The right to an abortion is not a right that the child be killed, if it is possible to detach the child alive.

In sum, then, Thomson's position amounts to a rejection of the view that saying that a fetus has a right to life entails the moral impermissibility of abortion in all cases, or even in all cases in which the life of the mother is not threatened by the pregnancy. The situation that generates the conclusion that abortion is here impermissible is complex and does not consist solely in any one factor, including the fetus' right to life.

Engelhardt's and McCullough's positions may serve as negative responses to the third question raised ("If not, or at those points when the fetus is not a person, should the right of the mother to control what is done in and to her person always be respected?") The same may be true of the Supreme Court's decision in Roe v. Wade, where the Court held that the state could limit the right of the mother to obtain an abortion during the second trimester on the grounds that abortion is statistically riskier than coming to term, and that the state has an interest in protecting the health of the mother that becomes compelling over her interest in obtaining an abortion at the start of the second trimester. Finally, there is an argument that the use of medical resources for abortions on demand where there is not medical or psychiatric reason present is a misuse of those resources, insofar as it takes hospital or clinical facilities and even federal resources away from those whose need for them is medically more justified, it uses friviously the time of physicians and nurses, etc. (This doesn't appear too persuasive unless its proponents are prepared to ban cosmetic surgery, nurses working at jewelry counters piercing ears, etc.)

In your struggles with this issue, perhaps it is wise to keep in mind two comments from individuals who have been involved in various ways in shaping our present policies on abortion. John Hart Ely ("The Wages of Crying Wolf: a Comment on Roe v. Wade", <u>The Yale Law Journal</u>, 82:923-947 (April, 1973); reprinted in Beauchamp & Walters., eds., <u>op cit.</u>, pp. 247-251) suggests that there is an enduring discomfort in even the most liberal position: "Some of us who fought for the right to abortion did so with a divided spirit. We have always felt that the decision to abort was a human tragedy to be accepted only because an unwanted pregnancy was even more tragic." "Abortion is too much like infanticide on the one hand, and too much like contraception on the other, to leave one confortable with any answer; and the moral issue it poses is as fiendish as any philosopher's hypothetical." Daniel Callahan (op cit.) replies: "Perhaps that is the way it should always be--abortion is not the kind of moral issue that is once and for all solved."

If indeed abortion is a moral issue to be struggled with, you may want to look through the file of articles on it (which includes the above) shelved in the Learning Center (Farber 42A); come to the seminar to hear others who struggle with the issue.

Discussion Notes

SPRING SERIES:

The Hippocratic Oath Vs. the Physician's Social Responsibility

"I will follow that system of regimen which according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.... Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." Oath of Hippocrates (5th Century B.C.)

Traditionally, physicians have taken an oath pledging their skills to the service of the health of their patients. This oath has been historically interpreted in the West to allow the physician absolute freedom in choosing his patients, and access to available resources for treating them, without the necessity of recognizing any moral or professional obligations to distribute either his services or other resources in consideration of the needs of a wider class of humans than those he selects as patients.

With the enormous increase in public support of medical research and education there has come an increased public expectation that physicians will distribute themselves in such a manner that equal access to minimally necessary health care will be assured all citizens of the society, and that the physician will make decisions in the distribution of his services in such a fashion that the goal of general accessibility to health care will be assured.

This series brings into focus the ethical conflicts arising from the perpetuation of this ancient ethic (by both physicians and patients) in a time of egalitarian demands for health care as a general right.

JUSTICE AND HEALTH CARE DELIVERY

Should the physician be compelled to provide a period of service to areas otherwise unable to obtain needed medical services?

DATE, TIME, AND PLACE: Jan.15, 1979, 12:45-2:15 p.m., 144 Farber Hall

Case Study: THE PHYSICIAN AND COMPULSORY PUBLIC SERVICE
(adapted from Robert M. Veatch, *Case Studies in Medical Ethics*, No. 17, pp. 69-72 (Cambridge: Harvard University Press, 1977))

Congressman Gerald Crawford has considered introducing a bill with the following aim:

Every physician educated in a medical school that receives federal funds shall, after his or her one year of internship but before being licensed to practice medicine in any state, serve for two years with a National Health Corps. Compensation will be at the civil service rate for GS-8 ($11,029-14,341 per year). This National Health Corps shall be a division of the U.S. Public Health Service, and shall supply needed medical service to any municipality, county, state, or federal health facility unable to obtain needed medical services, or to any other segment of the population unable to obtain adequate health services.

Congressman Crawford bases his arguments for this bill on two claims: (1) the public subsidizes doctors by providing them with state- and federally-funded education in almost all cases, so that the doctor incurs a debt which should be paid off through public service; (2) there is a right to health care that derives from the right to life, liberty, and the pursuit of happiness. Veatch observes that, given only the first point, "it is hard to see why medical students should not be allowed to buy their way out of the bargain, either by paying their full tuition or by repaying the full loan at the going market interest rates... (But on the second point,) (b)eing given the opportunity to gain the lifesaving knowledge and being licensed by the state to use that knowledge generates a public trust--an obligation to serve the people who are the source of the special opportunity. If such is the basis of the National Health Corps, then it is no more sensible to make public service optional in a time of health crisis than it is to make military service a matter of choice in a time of military crisis."

Review of Background Readings:

Robert M. Sade, M.D., ("Medical Care as a Right: a Refutation," NEJM 285(23):1288-1292) attacks this second point. Sade recognizes but one primary right: the right to one's own life. This right, he asserts, involves three corollary rights: the right to select the goals that one judges to be necessary to self-preservation; the right to choose courses of action to achieve those goals; and the right to dispose of those achievements freely and without the coercions of others. Sade holds that this entails a right to private property, by which he means goods and services which one produces by virtue of his individual effort. The only proper function of government is the exertion of retaliatory force to protect individuals from physical harm, including the expropriation of one's property by others against one's will.

On Sade's view, medical care is a service provided by doctors (and others) to those who wish to purchase it. To speak of a patient as having a right to health care is to speak of the patient as owning the services of some doctor without having earned them or receiving them as a gift from that doctor. And to speak of the state as enforcing the right to health care is to speak of government violating its primary function, which is to protect the doctor (and others) from the deprivation of life and property. Sade takes the extreme position that any governmental intervention in the practice of medicine, whether being forced to join a hospital or group not of his choosing, or being prevented from using a drug he thinks is in the best interests of his patient, or being compelled to make any decision he would not otherwise make, is immoral (unless it is done in the face of a danger posed by that physician's practice to those who purchase it). He draws this conclusion from the points made previously, together with the observation that any outside regulation of his practice forces the physician to violate his fundamental professional commitment of using his own best judgment for the greatest benefit of his patient. He calls for a system that "proscribes the imposition by force (legislation) of any one group's conception of the best forms of medical care." Sade explicitly criticizes the Kennedy-Griffiths bill, the system of socialized medicine in Sweden, and Bill 41 of the 1970 Quebec parliament, as all instances of misdirected governmental control of physicians.

In an article partly devoted to a criticism of Sade's position, Gene Outka ("Social Justice and Equal Access to Health Care," J. Rel. Eth. 2(1):11-32) returns to Congressman Crawford's first point: "...the amount of taxpayer support for medical research and education is too enormous to make any such unqualified case for provider-autonomy plausible." The point may be further extended by holding that the public, by providing funds for the conduct of medical research and the construction and operation of public medical schools, has contracted implicitly with those doctors who choose to benefit in their education and practice from such expenditures of public funds to provide "comprehensive health services for every person irrespective of income or geographic location". Outka argues for a conception of basic needs that parallel's Sade's notion of natural rights, needs which are "assumed to be given rather than...constituted by any action for which the person is responsible by virtue of his or her distinctively greater effort...So very often the advantages of health and the burdens of illness,...strike one as arbitrary effects of the (natural) lottery." The underlying conception of justice with which Outka works holds that goods that are earned by effort are appropriately distributed unequally according to merit, but that goods demanded by essential needs are properly distributed unequally according to need. Outka discusses a number of proposals for such distribution of access to health care, as well as several other conceptions of social justice.

Leon R. Kass ("The Pursuit of Health and the Right to Health", The Public Interest, No. 40, Summer, 1975) cautions against viewing this notion of basic need too broadly: "I would myself guess that well more than half the visits to American doctors are occasioned by deviations from health for which the patient, or his way of life, is in some important way responsible." He cites as instances most cases of chronic lung disease and cirrhosis of the liver, much cardiovascular disease, many gastrointestinal disorders, many muscular and skeletal complaints, venereal disease, nutrition-related problems, various renal and skin problems, most physical traumas, and possibly most cancer occurring in the population above the level where its incidence is lowest. He observes that "All the proposals for National Health Insurance embrace, without qualification, the no-fault principle. They, therefore choose to ignore, or to treat as irrelevant, the importance of personal responsibility for the state of one's health. As a result, they pass up an opportunity to build both positive and negative inducements into the insurance payment plan, by measures such as refusing or reducing benefits for chronic respiratory disease care to persons who continue to smoke." Thus, while the burdens of illness may "strike one as arbitrary effects of the natural lottery", Outka's impression would be a better basis for a social policy based on basic needs if limited to disease that was not the effect of one's own folly or ignorance.

We thus seem to be left with several related questions for discussion at this seminar. (1) Is the ethically proper view of the current profession of medicine captured best under the notion of private enterprise or of civil service? (2) Is there a right to health care possessed by each citizen, and are there responsibilities which go along with that right? (3) Ought Congressman Crawford's proposal,or something like it,be enacted?

If you have time, read over the file of articles (which includes the above) on reserve in the Learning Center (42A Farber); but at any rate, think about the above issues and arguments, and come to the seminar to hear and participate in further discussion of them.

THE ALLOCATION OF SCARCE MEDICAL RESOURCES

Should a totally implantable artificial heart (TIAH) be developed? If so, how should allocation of available units be made?

DATE, TIME, AND PLACE: February 5, 1979, 12:45-2:15 p.m., 144 Farber Hall

Case Study: THE ARTIFICIAL HEART
(adapted from Robert M. Veatch, Case Studies in Medical Ethics, No. 76, pp. 235-236 (Cambridge: Harvard University Press, 1977))

You are a member of the National Institute of Health Artificial Heart Assessment Panel, a group charged with determining the cost, need, feasibility, and desirability of funding an all-out effort to develop a totally implantable artificial heart (TIAH), and with making recommendations of criteria for its allocation in individual cases. You learn that research and development has been going on since 1948, and that hundreds of units have been implanted in animals (but with controls and energy sources external). While development of TIAH's has not progressed to the point that permits testing in humans, perhaps by the early 1980's it will be technically feasible to enter such a testing period.

Development costs to date have been borne by the federal government, and one of the issues to be dealt with is whether to turn over the present level of technology to private industry, or to maintain federal control of the means of production, at least to the extent of contracting out the final product. But even if the TIAH is perfected, the individual unit and installation cost will be high. "Cost estimates range from $15,000 to $25,000 and probably somewhat more for a nuclear-powered heart. It is estimated that there are between 17,000 and 50,000 candidates per year, producing a total cost, conservatively estimated, at between $255,000,000 and $1,250,000,000 per year. This figure would have to be multiplied by the number of hearts needed per person, for it is probable that there will be some mechanical breakdowns. One estimate is that the life span of the heart might be five to ten years." "This is a great deal of money. The entire American national health budget is only approximately $110 billion per year."

If these kinds of costs weren't enough, it should be borne in mind that the same sorts of calculations "should be made for other potential recipients of the approximately twenty-five different kinds of organs and tissues that have now been used in human transplantation, for hemophiliacs, for cancer patients needing chemotherapy, and even for psychiatric patients. The total will certainly far exceed the present national health budget even if it is limited to American cases--a limitation hard to justify."

Furthermore, it is difficult to see how these expenses would be offset by savings elsewhere; in fact, the result may well be an increase in other health problems that are not amenable to present foreseeable technological solutions. For example, there will generally be an increase in both cancer and stroke in that population of individuals whose lives are substantially prolonged with artificial hearts. Frequently, conditions that produce the need for an artificial heart will also produce other health problems which are not solved by the implantation of a substitute heart. Since the majority of health expenses come in the later years, increasing survival time of individuals will more or less automatically be followed by increased health costs per life.

Thus, even if it is technologically possible to meet a range of health care needs, it may not be economically possible. The demands for time, ability and attention of health care professionals, added to these other costs, may well necessitate dealing with the question of individual allocation. How do you as a member of this Assessment Panel decide the macro-allocational question of whether the TIAH should be developed, and what criteria should be recommended for deciding the micro-allocational question of who should receive it?

Discussion and Review of Background Readings:

The Macro-Allocational Question

The traditional Hippocratic ethic has the physicians offering the full scope of his/her skill, including its technological extensions, in the service of the health of those individuals that have been accepted as patients. Hence, on this ethic there would seem to be an obligation to support any technological advance, and any investment in equipment, that offers one's patients a greater chance of survival. On this traditional view, the physician does not have a professional obligation to consider the impact on society of preferring such technological advances. Since the selection of those who are to be one's patients is, under this ethic (and the interpretations of it by the AMA), a morally neutral one that is not constrained by that ethic, it is a matter of no ethical consequence that preferring technological advances in defense of one's patients may result in health care services being increasingly limited to only those segments of the population able to pay for them, or may result in a decrease in other social benefits (like museums, orchestras, libraries) in order to pay for them.

H. Tristam Engelhardt ("The Counsels of Finitude," The Hastings Center Report) argues that the medical profession is irrationally preoccupied with trying to fulfill the striving for immortality, and should in stead recognize that its dedication to the welfare of patients has definite limits. If one views the physician as a human with the normal sorts of human obligations to the general welfare, one sees that the pursuit of extension of the quantity of a patient's life is only one of many obligations that the physician must balance. Implicit in this is a criticism of that imperative to save or prolong one's patients' lives at any cost. On the other hand, Rabbi Moshe Tendler (as reported in Howard Brody, Ethical Decisions in Medicine, Boston: Little, Brown & Co., 1976, pp.   indirectly criticizes an implicit assumption in Engelhardt's position, which is that some lives are of less than infinite value. Tendler's ethics (which he characterizes as a biblical one) seems closer to the traditional Hippocratic attitude towards the patient than does Engelhardt's.

By contrast, the physician who sees his/her duty determined under principles of general social service may well be faced with a moral requirement to forego the development and implementation of costly therapies, at least so long as a basic level of health care has not been achieved for all humans. Applying this egalitarian principle, there would be no question but that development of the TIAH with public funds, and provision of it to only those who can pay by physicians, would be immoral so long as there are substantial segments of the population that lack adequate health care. Even if such distribution were achieved in this country, there would be the problem of the low standard of health care in so many other countries. This line of reasoning has some similarities to one found in support of a no-allocation policy for dealing with situations in which not all who need and want scarce lifesaving medical resources can be provided them. (See the discussion of this view in the following section.) The idea is that there is some sort of unjust elitism involved in developing therapies which are not accessible to all who need them, since to do so involves a commitment of resources (skills and money) at the expense of some for the benefit of others. The standard line of argument against this view (also see below) turns on the view that some merit a greater portion of scarce resources than do others, or on the view that some are sufficiently important to the general welfare to justify allocation to them of extraordinary quantities of resources.

The Micro-Allocational Question

There have been a number of schemes, or principles, adduced for distributing scarce lifesaving medical resources (SLMR). For our present purposes, they may be grouped according to whether they assume a Hippocratic view of the profession of a social service view.

The Hippocratic alternatives: Allocation according to the ability to pay; allocation according to the ability to benefit medically; allocation according to order of application. The first of these, which largely reflects the present system, depends upon viewing entry into the system of health care as a privilege which the patient buys, and is a manifestation of the combination of the Hippocratic ethic with the free enterprise view of the medical profession defended by Robert M. Sade ("Health Care as a Right: a Refutation," New England Journal of Medicine, 285(23:1288-1292 (Dec. 2, 1971)). The second seems to extend a common decision principle that has accompanied the Hippocratic tradition and has been applied as the principle of triage, whereby a physician is enjoined to minister, in the time of a disaster, only unto those that can most clearly benefit from medical treatment. The third alternative combines a kind of random selection (in order of presentation for treatment) with the Hippocratic ethic, and involves no selection among those presenting themselves by any other criteria (except, perhaps, ability to pay or the physician's willingness to accept them as patients).

The social service alternatives: Allocation according to social worth; allocation by lot; allocation according to degree of need; allocation as a form of compensatory justice. The first of these sees the physician in the service of straightforwardly utilitarian goals, where allocation aims at benefitting the greatest number by acting to preserve first the lives of those on whom the most depend. As Veatch puts it illustratively, "...if forced to choose between John F. Kennedy and some hypothetical senile alcoholic who happened to need medical attention on that fateful day in Dallas, some would feel compelled to turn their attention to the President. Treating a mother supporting three small children may seem more compelling than caring for another person without dependents." The second of this group of allocation alternatives reflects the view of the profession defended by Gene Outka ("Social Justice and Equal Access to Health Care," _Journal of Religious Ethics_, 2(1):11-32 (Spring, 1974)), at least in reference to basic or unavoidable, needs. The third suggests an allocation principle to be employed in those cases when a patient's situation is the result of some unjust prior allocation of medical or other resources (as when the patient has been in a "ghetto" -- physicial or educational -- all his life). All of these principles involve viewing the profession as in the service of some social principle, goal or movement that involves a group that is wider or other than that which would most likely be selected by the physician under a Hippocratic ethic.

Finally, some argue that selecting between humans according to criteria of social worth or any other sort is implicitly to make judgements between humans as better or worse than other humans by intentionally selecting some to die, for to do so is to take (or close to taking) the life of an innocent party which is always wrong. Unless individuals select themselves out to a degree that those who are left may all receive SLMR's, this view holds that it as more moral to withhold all SLMR's. "No one should receive such (artificial) hearts until there are enough for all to receive" (Veatch, in reference to a "conscientious thinker, worried over the allocation of the artificial heart paid for by all through government funds").

The thorniness of the decision of what criteria to employ, if any, is rather nicely illustrated in a series of three cases presented by Howard Brody (in _op cit._, cases 41-43). Brody reports that medical sociologists observe that the inclination toward random selection procedures is correlated positively with the absence of information about candidates, and that the inclination toward applying one or another set of criteria is correlated with the availability of additional information. Veatch notes that "Patients whose social characteristics resemble those of the medical staff may get a higher priority", which suggests that the decision on criteria for allocation may be an unavoidably political one.

Anyone who enters the medical profession will be unavoidably faced with both sorts of allocational questions repeatedly. You are urged to take this opportunity to do some thinking and some reading on these issues (a packet of readings is available in the Learning Resources Center (Farber 42A), and to come to the seminar prepared to listen and participate.

Discussion Notes

THE RIGHT TO CONFIDENTIALITY OF PSYCHIATRIC INFORMATION

Should a psychiatrist who knows of information about a patient's psychiatric diagnosis keep such information confidential, even if it indicates that the patient is potentially dangerous to self or society?

DATE, TIME, AND PLACE: Mar. 12, 1979, 12:45-2:15 p.m., 144 Farber Hall

Case Study: THE PSYCHIATRIST AS DOUBLE AGENT
(adapted from "Case Studies in Bioethics: The Psychiatrist as Double Agent," in Hastings Center Report, 4:12-14 (February, 1974))

A freshman medical student, suffering from agitation, anxiety, uncertainty about whether he could continue his studies, acute distress, and on the verge of a disintegrative breakdown, went first to the school psychiatrist and then to a private one. The school psychiatrist had diagnosed him as a latent schizophrenic and had referred him to the private one. The private psychiatrist started intensive psychotherapy in an attempt to avoid hospitalization. The student seemed on the verge of a schizophrenic break, with impaired ability to test the reality of his perceptions of others' intentions, an inclination to interpret the indifferent remarks of others as referring to him, and an apathetic mood combined with grandiose self-appraisal was developing. The private psychiatrist wrote a letter for the student, stating that he was treating him for "emotional problems" and recommending a medical leave. The student succeeded in obtaining the leave at the end of the semester, and withdrew in good standing.

However, the school psychiatrist had entered into his records his own diagnosis of latent schizophrenia. The next fall, when the student applied for readmission with the support of a letter from the private psychiatrist, who stated that he was now medically able of continuing, he was turned down on the sole grounds that he was considered not suitable. Furthermore, he was turned down by every other medical school to which he applied, for when these other schools wrote to his original school, the reason given for his non-readmission was the medical leave with latent schizophrenia. Presumably he was regarded as a high risk, both as a student and as a potential surgeon: about half of those with schizophrenia in remission have another episode, and the power of the surgeon combined with grandiose ideation would pose a serious risk to patients.

While the private psychiatrist recognized that the psychiatric condition might be a valid reason for exclusion from medical school, he questioned whether the school psychiatrist saw the patient in his role as the patient's physician or in his role as representative of school's administration, and whether these two roles could be kept separated. Is it acceptable for a physician on the staff of any organization with which the patient has an independent relationship (as of employee or student) to serve as both the organization's and the patient's agent?

Review of Background Readings and Discussion:

In his discussion of this case in his book, Case Studies in Medical Ethics (Cambridge: Harvard University Press, 1977 (Case No. 19, pp. 76-82)), Robert Veatch points out that there are really three possible conflicting obligations that the school psychiatrist and the private psychiatrist feel: to the patient, to the medical school, and to society in general. On the traditional Hippocratic ethic, the psychiatrist is duty bound to regard as his or her primary obligation service of the interests and needs of his or her patients, and to allow no other obligation to take precedence. This traditional ethic has been somewhat modified to allow physicians to quarrantine carriers of dangerous, contagious diseases, and commit those whose psychiatric conditions make them a clear danger to self and others (although it can be argued that even this relaxation of the physician's primary obligations is objectionable on moral grounds). Such revisions in the Hippocratic code seem defensible, if at all, on the grounds that the physician is responding to the clear, immediate and certain danger to others. By contrast, here the psychiatrist is reacting only to a most probable danger to the health of future patients, and may be representing only the economic interests of the school.

In his commentary on this case in the Hastings Center Report, Willard Gaylin defends the traditional conception of the psychiatrist's primary obligation being to the student. "In order to sustain a relationship in which one individual places his very life in the hands of another, there must be some assurance that the relationship will be governed by its primary purpose: that is, the good of the patient, the preservation of his life, the protection of his well-being. The physician is under oath to 'do no harm.' It is the basis of trust on which the profession of medicine has survived. Any infringement on the inviolability of his contract threatens the whole medical structure.... Had the student only seen the private doctor, he would have been readmitted. The student's problems arose because he had assumed that the school psychiatrist was indeed a psychiatrist, bound by the codes of conduct, oath and ethics of his general profession." Gaylin's argument can be even stronger: it is clear that it is to the benefit of society that schizophrenics (and persons with contagious diseases) receive treatment for their conditions, since that presumably lessens the likelihood of their harming others. But without being able to trust the physician to serve only his interests, the patient whose condition poses a threat to others may well delay or avoid seeking medical help and thereby increase the threat to the general welfare. Hence, a strong case can be made that preserving the traditional Hippocratic ethic does serve the general welfare, at least in regards to the importance of observing strict canons of confidentiality.

At the same time, Gaylin grants that the physician has responsibilities to the future patients of the would-be physician, and that on rare occasion the physician may have to violate his contract with the patient in service of a greater good. "Never should this violation of contract be a matter of diffidence or routine, as is too often the case with 'company' physicians. To use the diagnostic skills of the physician to the detriment of the patient, albeit for a larger good, should be a decision made with the personal agony that always accompanies a moral dilemma." Daniel Callahan has also commented on this case in the _Hastings Center Report_, arguing that while a good case can be made that the school made the correct decision given the information it had about the student, the decision was made in an unjust manner and the information was obtained by the school psychiatrist under what amounted to false pretexts: "the school provided no formal review mechanism for its procedurally arbitrary decision, and nothing remotely approaching due process"; and "it is highly doubtful that, when the student initially went to the school psychiatry, he was informed that 'anything you say to me may be held against you,' which was exactly what turned out to be the case." Callahan sees a difference between the obligations of the psychiatrist and of the medical school admissions committee: the psychiatrist's obligation is either to maintain the confidentiality of the patient or to warn the patient that he may use information disclosed by the patient to his detriment; the admissions committee has obligations to society and future patients (as indeed do the student's instructors), and to other "qualified candidates for medical school (who are not latent schizophrenics and who could be taken but for lack of space)".

In a discussion ("Discussion", _Psychiatric Progress_, 1:2 (September, 1966)) in which the journal invited several physicians to comment on the question, "Under what circumstances, if any, is a breach of doctor-patient confidentiality justified?", a variety of formulations of the principles governing disclosure were given. The one which appealed to the principles of the Hippocratic ethic most skillfully went like this: "The physician's fundamental purpose is to protect the patient. This includes protecting him from himself. It seems, therefore, that a breach is justified when it clearly benefits the patient. Thus it is incumbent upon us to protect him from becoming a murderer, because his act will..._result in penalties and punishment to him_...." Such reasoning might be thought to provide a rationale for disclosing the damaging psychiatric diagnosis to the medical school in the present case, on the grounds that doing so protects the student against a possible future suit for malpractice. However, such appears to be a disguised form of paternalism, in which the physician presumes to act for the patient rather than leave up to the patient the responsibility of acting on the information himself. This points up another feature of the traditional Hippocratic ethic, namely, the incipient paternalism that characterized the patient-physician relationship in that traditional model.

Henry A. Davidson (in "Professional Secrecy", in Ethical Issues in Medicine, ed. by E. Fuller Torrey, Boston: Little, Brown and Co., 1968 (pp. 190-194); reprinted as "Role of Physician and Breach of Confidence," in Moral Problems in Medicine, ed. by Samuel Gorovitz et al., Englewood Cliffs: Prentice-Hall, Inc., 1976 (pp. 87-90)) argues that the physician's obligation extends beyond protecting the patient to protection of others as well: "...there is the problem of protecting public interest when it means revealing a confidence. If you know that the driver of a school bus is an alcoholic or epileptic, you should report it. Last year 30 people were killed when a bus driver had a heart attack and plunged his bus into the East River in New York City. The driver's physician had known about the bad heart, had cautioned him not to drive, but felt he could not report it to the company since the patient might lose his job. In New Jersey some years ago, six people were killed when a bus driver had a petit mal seizure. The treating doctor knew about the epilepsy, pleaded with the patient to stop driving, but didn't think he ought to report it to the motor vehicle department." Again, one might argue that such disclosures are consistent with the Hippocratic obligation to protect the welfare of the patient, in that the drivers were ar risk for death or injury as a result of accidents caused by their conditions, and were at risk for criminal and civil liabilities for accidents caused by conditions about which they had been duly warned and had concealed from their employers and from the licensing organs of government. Davidson, however, clearly views the responsibility of the physician in this case extending beyond the pale of those persons who are his or her patients, to a much wider group of individuals; in such a conception, the physician is clearly conceived of as a kind of public servant who is obligated to use his relationship of trust with the patient for the benefit of society in general.

Thus, in the specific issues of disclosure of psychiatric information in this case, or the general issue of breaking confidentiality, there are two ways of viewing the issue (1) Does the physician have a moral responsibility to society which on occasion overrides obligations to the patient, or not? (2) Is the physician obligated to act in the stead of his or her patients, when they do not act responsibly in their roles on the information disclosed to them and the advice given them in their dealings with the physician? In regards to this last question, it may be noted that "A few states, such as New Jersey, require that any person who has knowledge of any crime must report such knowledge to the authorities, otherwise he becomes guilty of a crime himself. However, there are no reported cases arising under this statute and it is thus doubtful if it, or statutes similar to it, have ever been enforced. Most states adhere to the more realistic standard of requiring the reporting of certain criminal acts such as gunshot and stab wounds." (Neil L. Chayet, "Confidentiality and Privileged Communication," The New England Journal of Medicine, 275 (18):1009-1010 (November 3, 1966)).

These questions, as well as other related ones, will be discussed in the seminar. You are invited to consult the file of readings in the Learning Resources Center (42A Farber), and urged to come to the seminar to listen and participate in the discussion.

Discussion Notes

INCOMPETENT PRACTICE

Does a member of the health care team have a moral obligation to report instances of incompetent practice which he or she observes? If so, to whom?

DATE, TIME, AND PLACE: April 2, 1979, 12:45-2:15 p.m., 144 Farber Hall

Case Study: THE BLUNDERED DIAGNOSIS AND THE PHYSICIAN'S RESPONSIBILITY
(adapted from Robert M. Veatch, Case Studies in Medical Ethics, No. 33, pp. 113-114 (Cambridge: Harvard University Press, 1977))

You are the resident house officer in a private urban hospital on duty one Friday night, when a married man in his late fifties comes to the emergency room complaining of abdominal discomfort and a temperature. He explains that he has been unable to reach his private physician, who is out of town and who has instructed his answering service to direct his patients to the hospital emergency room.

This man gives a history of a loss of appetite and loss of 30 pounds of weight over the past eight weeks, and complains of a melon-sized mass in the upper left quadrant of his abdomen. When questioned about the condition for which he was being treated by his physician, the man indicates that he had a heart attack in 1968, and has had high blood pressure, but that during his last visit to his physician a week ago, his blood pressure and heart were checked and he was told he was "doing fine". You ask if he mentioned his loss of appetite and weight, and he indicates that he did but that the physician did not examine his abdomen. This is confirmed by the man's wife, although she was not present in the examining room. The doctor had made no arrangements with any other physician to cover for him while he was gone, a common practice on his part despite Medical Board rules requiring staff physicians to provide back-ups.

He is admitted for diagnostic evaluation. Routine lab tests (all that are done in your hospital on the weekend) reveal "a Hgb of 9.1, a WBC of 74,000 (70 percent lymphocytes), and a very low platelet count of 22,000. These values suggested a leukemia-like state."

That night the man spikes a fever of 104°F, and begins to bleed in his gastrointestinal tract. Blood platelet transfusion is begun, but before the cause of the fever can be determined, he dies. An autopsy reveals cancer of the lymph glands, with an enlarged spleen of 200 grams and peritonitis as the immediate cause of death."

You suspect that the private physician has been grossly negligent and would probably be found guilty of malpractice in a law suit. You consider suggesting a suit to the family but are cautioned not to by your attending physician, who tells you of another doctor in the hospital who was sued for libel after reporting a colleague. "This incident had since kept the hospital's Medical Board from taking punitive action against any doctors who failed to provide back-up coverage when not available." You are advised not to get involved and not even to write a letter to the local medical society, for fear of being charged with libel. "'After all,' it (is) pointed out, 'how do you know that (the doctor) didn't know that (the patient) had cancer but thought it would not be in (his) best interest to tell him?'"

Review of Background Readings and Discussion:

Veatch states that "One of the stickier but normally ignored ethical dilemmas in medicine is the problem faced by a member of the health care team who realizes that a colleague has made an obvious error in technique or ethics." That it is normally ignored is perhaps confirmed by the absence of readings in the standard collections on medical ethics on this subject.

Veatch notes that "The Hippocratic oath is first of all an oath of secrecy and loyalty to one's medical colleagues." Thus the dilemma arises, for the oath enjoins the physician to develop trust as both the basis of the patient-physician relationship and as the basis of the collegial relationship between physician and other members of the health care team. When a physician does not live up to the requirements of the covenant with the patient, the colleague who contemplates reporting that breach contemplates breaching another covenant. As Veatch notes, "The dilemmas of the health care team member, especially if that person is a nonphysician, if often between his duty to do what is best for the lay person, who is not necessarily his own patient,...and his need to maintain a cordial, collegial, trusting relationship with his errant colleague. The sociopsychological pressure to 'be a team player' maintaining loyalty to the medical group can be great indeed."

A further complication that Veatch notes is that the question of trust between patient and physician "can be used to justify either intervention to point out a medical colleague's error or nonintervention. On the one hand, the patient's trust--in the entire health care delivery system as well as in the individual physician--can be maintained better if the patient is not informed of the error. On the other hand, the general refusal to disclose errors certainly erodes patient trust."

The third area of complication that is raised by this case is that of the influence on the would-be informer's decision of the fear of reprisal. That is represented in the present case by the threat of a suit for libel, but it can also involve the potential loss of one's job (particularly acute for employees of the hospital, such as nurses), or the potential of loss of good recommendations (as in the case of the medical student on clinical rotation, or even the intern or resident).

In response to this point, it is frequently argued that a nurse or physician in training may lack either sufficient knowledge and skill in assessing the facts of a case to make a fair judgement as to the correctness of some procedure; or because of lack of detailed knowledge of the individual case and its management, or of the "professional judgement" made by the responsible physician, it may be that what appears to be an inexcusable omission is in fact the result of a considered and defensible judgement.

All of the above seem to point to the need for an institutionalized means for patients and colleagues to be able to raise questions about the propriety of a physician's decisions and conduct without either personal risk or necessarily reflecting upon the competence of the physician. One alternative that has been proposed and is being implemented in some hospitals is the so-called Patient's Advocate, or Ombudsman, or Medical Arbitrator, an individual or office charged with impartially receiving and investigating charges of professional misconduct, patient dissatisfaction, or interprofessional disputes. The idea is based upon the notion that it is easier to arbitrate a dispute in which feelings may run high as a disinterested party than as an interested one. Dr. Harry Gordon, Professor Emeritus of Pediatrics and Director Emeritus of the Rose F. Kennedy Center for Research in Mental Retardation and Human Development, Albert Einstein College of Medicine, has been active in developing such a program at the Bronx Municipal Hospital Center, and there is interest in developing a similar office at Meyer Memorial Hospital (The Erie County Medical Center).

The alternatives to institutionalized handling of apparent cases of incompetent practice on a case-by-case basis are: (1) dealing with individual cases through the legal system, with malpractice suits being the patient's chief means of achieving redress; (2) recognition that in medical practice, as in any profession, there is a certain unavoidable measure of error, and treating cases which fall within that measure as regrettable but to be expected. For some cases of mistaken diagnosis or so-called "unnecessary surgery" this second alternative is rather clearly defensible, e.g., it is necessary in order to maximize successful treatment of atypical appendicitis to remove a certain percentage of health appendixes. But it is clearly difficult to achieve a policy whereby one can always judge between necessary and unnecessary errors, and such policies frequently sound to patients like self-serving rationalizations dreamed up by physicians to protect themselves against malpractice suits.

Instead of merely dealing with the problem solely on the individual case-by-case basis, the profession has also taken the route of establishing standards of professional competence in which physicians must qualify to gain the right to practice and must engage in a certain amount of continuing education in order to maintain that right. No doubt such promulgation of professional standards decreases the number of instances of incompetent practice by keeping the physician abreast of developments in his or her field, but physicians do not have to repass competency examinations on a periodic basis. This system also provides no means for dealing with the residue of instances of incompetent practice.

Concerning the question of whether one member of the health care delivery team should report apparently incompetent practice by another, the Hippocratic tradition would seem to yield a clear affirmative only when the patient of the incompetent professional is also a patient of the person who has evidence of the malpractice, and then only if doing so is in the interests of the patient. In the present case, the family of the dead patient are not patients of the house officer; the dead patient cannot be benefitted by exposing the mal-diagnosis; and the Hippocratic pledge of secrecy and loyalty to one's colleagues would be violated by "going public". (The major recourse, of course, is for a private and personal contact with the private physician. Peer pressure can be an effective means of modifying behavior, but it is generally not effective when not brought by one who is regarded as an equal.)

Viewed from the stance of the physician as social servant, the obligation to disclose the error would seem to be clearer. Insofar as one regards himself or herself as having a primary duty to a wider population of individuals than one's own patients, stopping a pattern of incompetent practice on the part of another physician (or other health-care professional) would seem to be required by one's obligation to further the medical welfare of the society at large. Again, though, this is complicated by the dilemma of trying to maintain both the individual patient's trust in his or her physician and the trust of patients as a class in the health care system; it is also complicated by the question of how one's disclosures will affect one's own continued effectiveness in the delivery of health care.

Every physician is bound to encounter the apparent effects of malpractice, or to witness apparent instances of malpractice, in his or her career. You are invited to look over the (small) file of material on reserve in the Learning Resources Center (Farber 42A) and to attend this seminar as a part of your efforts to decide how to deal with the phenomenon of incompetent practice.

NONTHERAPEUTIC MEDICAL EXPERIMENTATION

Is it every morally permissible to conduct an experiment on a patient that does not carry a strong potential of therapeutic benefit to that patient, particularly when the patient is not able to give informed consent?

DATE, TIME, AND PLACE: Apr. 23,1979, 12:45-2:15 p.m., 144 Farber Hall

Case Study: BENEFITTING MENTALLY RETARDED CHILDREN BY GIVING THEM HEPATITIS
(adapted from Robert M. Veatch, Case Studies in Medical Ethics, Case No. 87, pp. 274-275 (Cambridge: Harvard University Press, 1977))

In 1949, endemic hepatitis was recognized in Willowbrook State Hospital, Staten Island, New York, an institution for the care of the mentally retarded. Other infectious diseases such as measles, shigellosis, and various parasitic and respiratory infections, were also prevalent at the institution. In 1954 Dr. Saul Krugman was appointed as a consultant in pediatrics and infectious diseases, and in 1956 he and his associates initiated studies on hepatitis in the hope of developing techniques for controlling the disease in the institution. The average number of residents at any one time was about 5,000 children.

Four times a year for the next 14 years, 12-15 children were admitted into a special research unit. Thus, more than 700 retarded children had infected serum injected to produce hepatitis, with the objective being "to gain a better understanding of the disease and possibly to develop methods of immunizing against hepatitis." The research was initially approved by three review bodies: the Executive Faculty, New York University School of Medicine; New York State Department of Mental Hygiene of the New York State Department of Health; and the Armed Forces Epidemiological Board (one of the funding agencies for the research). Later parts of the study were reviewed and approved by the New York University and Willowbrook State School committees on human experimentation.

Saul Krugman defended the decision to deliberately infect children with strains of hepatitis virus in a letter to The Lancet (May 8, 1971), in response to a letter from Dr. Stephen Goldby (The Lancet, April 19, 1971), who had called the experiments ones"conducted solely for the acquisition of knowledge" and who had charged Krugman with a violation of the World Medical Association's Draft Code of Ethics on Human Experimentation, 1961 (which states, "Persons retained in mental hospitals or hospitals for mental defectives should not be used for human experiments"). Krugman's defense was that "(1) they were bound to be exposed to the same strains under the natural conditions existing in the institution; (2) they would be admitted to a special, well-equipped, and well-staffed unit where they would be isolated from exposure to other infectious diseases which were prevalent in the institution...thus, their exposure in the hepatitis unit would be associated with less risk than the type of institutional exposure where multiple infections could occur; (3) they were likely to have a sub-clinical infection followed by immunity to the particular hepatitis virus; and (4) only children with parents who gave their informed consent would be included."

Review of Background Readings and Discussion:

Daniel Callahan, in commenting on an unrelated case, sets the question for an initial examination of the ethical issues involved in the Willowbrook study. "I have long been troubled by the problem of whether there can be ethically correct decisions within settings which are inherently unjust or immoral, i.e., in those situations where certain kinds of ethical dilemmas would not ordinarily arise but for the fact of distorted or corrupt institutions. In the era of slavery, for example, acute ethical dilemmas used to arise (for some, at least) over the most moral way of separating children from parents when all were to be sold at auction. Obviously the very institution of slavery was immoral. But does that entail that each and every decision made within the *given* context of such an institution was also and equally immoral, regardless of what the decision was?...My answer is "no": correct ethical choices *can sometimes* be made in unjust contexts. But the larger ethical question remains that of the unjust context, which requires correction." (Daniel Callahan, commentator, "Case Studies in Bioethics: the Psychiatrist as Double Agent," *Hastings Center Report* 4 (February, 1974): 12-13; reprinted in Robert M. Veatch, *op cit.*, 79-80) Paul Ramsey ("Children in Institutions", in *The Patient as Person* (New Haven: Yale University Press, 1970), pp. 40-58; reprinted in Samuel Gorovitz *et al.*, eds., *Moral Problems in Medicine* (Englewood Cliffs: Prentice-Hall, Inc., 1976), pp. 129-142) brings this concern to bear on Willowbrook, noting that in Krugman's reports there is an implicit acceptance of the endemic diseases as "natural" (Willowbrook "had endemic infectious hepatitis and a sufficiently open population so that the disease could never be quieted by exhausting the supply of susceptibles" ("Studies with Children Backed on Medical, Ethical Grounds," *Medical Tribune and Medical News* 8 (19):1, 23 (February 20, 1967)), is attacked by Ramsey as undefended: "Nothing is said about attempts to control or defeat the low-grade epidemic at Willowbrook by more ordinary, if more costly and less experimental, procedures... Clearly it would have been possible to secure other accommodation for new admissions away from the infection, while eradicating the infection at Willowbrook building by building.... If this had been an orphanage for normal children or a floor of private patients, instead of a school for mentally defective children, one wonders whether the doctors would so readily have accepted the hepatitis as a "natural" occurrence and even as an opportunity for study." Callahan's principle, that it is possible to make ethical decisions in an unjust context, is implicitly modified by Ramsey with the proviso, "unless one thereby helps to maintain the unjust context".

Veatch is clearly bothered by this aspect of the case: "All things considered, there is the possibility that the patients in a research project such as this, who are undergoing controlled exposure to hepatitis but are receiving high-quality general health care, might be better off than their peers in the general institutional wards.... Is it ethically acceptable to justify an experiment on the grounds that the subject will benefit from the research, when he will benefit from it only because of the social condition in which he finds himself? In this case it is clear that if the residents at Willowbrook received optimum health care and lived in minimally sanitary conditions, the argument that the subjects in the research unit would on balance be better off by receiving the intentional exposure to hepatitis would collapse."

It is difficult to judge retrospectively whether Krugman and associates were, or even honestly thought they were, relatively powerless to proceed with a direct assault on eliminating the source of the infections "building by building". But two lingering doubts remain. First, Krugman admits to an appreciation of the large implications of finding an immunization against hepatitis: "It is unnecessary to point out the additional benefit to the world-wide populations which have been plagued by an insoluble hepatitis problem for many generations." (Krugman, in his letter to The Lancet of May 8, 1971). Second, Ramsey points out that there was already "some evidence from the beginning that gamma globulin provided at least some (temporary) protection... It is axiomatic to medical ethics that a known remedy or protection -- even if not perfect or even if the best exact administration of it has not been proved -- should not be withheld from individual patients. It seems to a layman that from the beginning various trials at immunization of all new admittees might have been made, and controlled observation made of their different degrees of effectiveness against "nature" at Willowbrook. This would doubtless have been a longer way round, namely the"anecdotal" method of investigative treatment that comes off second best in comparison with controlled trials. Yet this seems to be the alternative dictated by our received medical ethics, and the only one expressive of minimal care of the primary patients themselves."

A possible and plausible interpretation of the Willowbrook studies sees them as resulting from physicians (i) viewing themselves as under a primary obligation to a wider population than those who are their direct patients, and (ii) dedicated to providing that wider population with the best, most reliable scientific knowledge in service of its interests and needs. Obtaining such knowledge requires the use of controlled clinical trials (thus, the administration to some subjects of various doses of gamma globulin and the withholding of any from others, who served as controls; thus the administration of gammas globulin to a group of subjects and then their division into two groups, one of controls and the other of subjects fed hepatitis virus "in concentrations estimated to produce hepatitis with jaundice in half the subjects tested" (Ramsey, op cit.)). The infected patients are described thusly: "The liver became enlarged in the majority, occasionally a week or two before the onset of jaundice. Vomiting and anorexia usually lasted only a few days." (Krugman, et al., "Infectious Hepatitis: Detection of the Virus during the Incubation Period and in Clinical Inapparent Infection," New England Journal of Medicine 261 (15):(October 8, 1959)). We now know, points out Ramsey, that "cirrhosis of the liver results from infectious hepatitis more frequently than from excessive consumption of alcohol". Thus, while "their exposure in the hepatitis unit would be associated with less risk than the type of institutional exposure where multiple infections could occur" (Krugman, letter to The Lancet, op cit.), one must be quite sure that there were no alternatives to that institutionalization save the ones provided by the study in order to accept the deliberate infection with hepatitis as the least risky alternative (acceptance of which seems necessary to regarding the experiment as therapeutic as well).

One of the major sources of Ramsey's opposition to non-therapeutic experiments on children and other populations that are incapable of giving fully voluntary, informed consent, is just that: they are subjected to experimentation on the authority of others who provide "proxy consent" for the risks of the experiment. Ramsey contests whether the consent of a parent to such nontherapeutic exposures to risk is a valid substitute for the (impossible to obtain) consent of the child. His view seems to be that parental consent is constrained to decisions on what will benefit children; that while an adult may validly consent to participating in a nontherapeutic experiment, none may so consent for another (save one who has been empowered as a real proxy by that other).

Richard A. McCormick ("Proxy Consent in the Experimental Situation", in Perspectives in Biology and Medicine, 18 (1):2-20 (Autumn, 1974)) examines the notion of parental consent to therapy and finds that "it is morally valid precisely insofar as it is a reasonable presumption of the child's wishes, a construction of what the child would wish could he do so... (And, T)he child would wish this therapy because he ought to do so. In other words, a construction of what the child would wish (presumed consent) is not an exercise in adult capriciousness and arbitrariness, subject to an equally capricious denial or challenge when the child comes of age.... To see whether and to what extent this type of moral analysis applies to experimentation, we must ask, Are there other things that the child ought, as a human being, to choose precisely because and insofar as they are goods definitive of his growth and flourishing? Concretely, ought he to choose his own involvement in nontherapeutic experimentation, and to what extent?.... (I)f we can argue that a certain level of involvement in nontherapeutic experimentation is good for the child and therefore that he ought to choose it, then there are grounds for saying that parental consent for this is morally legitimate and should be recognized as such." (McCormick does not notice that the converse of this consequent is that 'parental *dissent* to nontherapeutic experimentation is morally legitimate and should *not* be recognized'.) McCormick then argues that there is a duty, arising from our nature as social beings, to further the good of health in others; "to share in the general effort and burden of health maintenance and disease control is part of our flourishing and growth as humans. To the extent that it is good for all of us to share this burden, we all *ought* to do so. And to the extent that we *ought* to do so, it is a reasonable construction or presumption of our wishes to say that we would do so. The reasonableness of this presumption validates vicarious consent (to participating in nontherapeutic experimentation)."

However, McCormick also recognizes that there is a limitation on what may be consented to under this principle. "(W)hen a particular experiment would involve no discernible risks, no notable pain, no notable inconvenience, and yet hold promise of considerable benefit, should not the child be constructed to wish this in the same way we presume he chooses his own life, because he *ought* to? I believe so." When he addresses the question of which experiments are permitted under these strictures, McCormick notes "that the notions of 'discernible risk' and 'undue discomfort' are themselves slippery and difficult, *and probably somewhat relative*"(my emphasis). Although he does not spell these out, the kinds of relative considerations he has in mind are presumably those natural conditions of the background situation in which the child exists; so that while it would be impermissible to expose a normal child in a suburban home to hepatitis, relative to the risks inherent in the natural situation at Willowbrook, such exposure might (as Krugman has argued) involve a positive gain in the risk/benefit ratio for such a child. (It is surprising, then, to find McCormick seeming to exempt children who are institutionalized from what is implied by the foregoing. However, the essence of what he urges for such children is extra special care, that their disadvantaged condition not tempt us to regard them as "lesser human beings" and thus presume to impose even greater burdens on them (as we do on nonhuman experimental animals).)

McCormick's position may be seen as an attempt to escape between the horns of the dilemma of the physician who feels equally strongly the obligation to protect his or her patients from harm, and the obligation to further the general welfare. For, McCormick reads that latter obligation into the patient, and argues that, within limits, it is moral to expect patients (and other humans) to participate in nontherapeutic experimentation. The physician who holds to only one horn, the Hippocratic ethic, will have none of this; the physician who holds only to the other horn, the ethic of social responsibility and service, will not be particularly bothered by situations in which an individual's welfare *must* be subordinated *if* the general welfare is to be served. The Willowbrook studies (which also involved, by the way, the development of a highly effective measles vaccine) stand as an exemplar of the kind of situation that produces the widely divergent moral judgements incipient in these two ethical traditions: and the comment of Robert H. Moser, editor of the *Journal of the American Medical*

Association (editorial in vol. 277:432 (1974)) to the question of whether we are ever justified in the use of children in experimentation, needs to be seriously questioned: "It is an insoluble dilemma. All one can ask is that each situation be studied with consummate circumspection and be approached rationally and compassionately." For, the danger in that approach, as Callahan notes, is that we focus only on the question, what is the moral thing to do in this situation? and lose sight of the questions, Is this situation itself moral? and If not, can I do anything about it?

Physicians engaged only in providing therapeutic medicine may well think themselves rendered immune to confronting these dilemmas by their choice against actively doing research. Howevery, they stand to serve as beneficiaries of such research, and the question of whether it is moral to use knowledge gained by questionably moral means, thereby tending to perpetuate whatever patterns of ethically questionable experimentation has produced those advances, is one that every physician may have to grapple with. You are invited to look through the file of articles on reserve in the Learning Resources Center (Farber 42A) and to come to the seminar as a participant-observer.