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EDITORIAL

# THE INDIGNITY OF 'DEATH WITH DIGNITY'

C. BEN MITCHELL

Despite the valiant efforts of physicians, nurses, and thousands of laypeople, Washington adopted legislation this past November that permits physician assisted suicide (PAS). In doing so, it became the second U.S. state to allow PAS. Oregon has witnessed a decade of rising numbers of assisted deaths since 1998. While it seemed almost inevitable, many professionals, activists, and observers were hopeful that the juggernaut of medicalized killing could be pushed back. Sadly, Americans and other Westerners have convinced themselves that they want to have assistance in ending their own lives whether or not doing so is in the interest of themselves, the government, or the profession of medicine. PAS seems to be more an intuition of late modernity than the conclusion of a carefully reasoned argument.

The founding editor of this journal, Nigel Cameron, observed nearly two decades ago that 'In ancient times, when the Hippocratic physicians who were the founders of modern medicine set their face against taking life as an option in clinical management, the alternatives were drastically limited. Yet their conviction that medicine was about healing was so firm that it remains the cornerstone of medical thinking today'. Or so it was.

Things have changed. Since Nigel wrote those words in 1990, medicine is, generally speaking, no longer governed by the Hippocratic ethos, not viewed as a profession in the traditional sense of the term, and medics have become in the minds of most Americans consumer-animated body plumbers. The patient is the autonomous moral agent and the physician is present to do what the customer wants—even if it means the elimination of the customer. After all, the customer is always right.

Things are about to change again, however. In the American context at least, with skyrocketing health care costs, the pressure to nudge patients toward death sooner rather than later will grow stronger. Consider the case of Barbara Wagner of Eugene, Oregon. Ms. Wagner's doctor prescribed Tarceva, a relatively expensive cancer drug. The Oregon Health Plan refused to pay for the drug, but stated in their letter to Ms. Wagner that the State would pay for comfort care and 'physician aid in dying'. Here is a case where the State is clearly steering Ms. Wagner toward assisted suicide, despite the fact that she does not want to die and her physician says the drug could have significant therapeutic benefits.[1] With the Baby-Boomer generation about to become the largest generation of retirees the world has ever seen, medical costs can only increase in the days ahead—unless something changes.

What is likely to change? Just as the call for assisted suicide has grown louder, so have advances in palliative care and hospice. Pain management has become a subspecialty in medicine. Comfort care with a dual emphasis on both comfort and care has become increasingly more effective. But end of life care—even comfort care—is not cheap. Will palliative care also prove to be too expensive in the near distant future? Will patients be offered the ultimate indignity of either death or abandonment? It seems hard to imagine. But our Hippocratic forebears would have found Barbara Wagner's situation unimaginable. **E&M**

## Endnotes

1 For an interview with Ms. Wagner, see <http://www.katu.com/news/26119539.html?video=YHI&t=a>.

GUEST COMMENTARY

# PLEASING DESIRES OR PLEASING WISHES? A NEW APPROACH TO HEALTH DEFINITION

CARLO V. BELLIENI, MD, AND GIUSEPPE BUONOCORE, MD

## Abstract

*It is difficult for caregivers to have clear awareness of their aim, health, because the present WHO definition of health has widely been criticised as utopian and misleading. It might be helpful to consider health as the realisation of our desires, that is, the possibility of restoring previous skills or to perform skills the average person can perform. Desires differ according to age and possible underlying pathologies; even the possibility of expressing them can be different. So we outline some consequences: 1) health will be attained even in the presence of a disease, if the desire of the patient is not the disappearance of the disease—he/she is aware of the ineluctability of the disease—but is orientated to obtain other gratifications; 2) even nonverbal patients can express desires, so health can be in their range; 3) considering health not as the realization of desires but of wishes may contrast with the principles of justice and non-maleficence, as will be highlighted in the text.*

*Key words*: health, medicine, desire

Recently A. Stark highlighted the limit to medical activity as a hot topic[1]: should medical professionals avoid commercial pressures and fashion-determined requests or impose certain cures? And how can they recognize their true endeavours and goals? B. Brülde recently wrote that medicine has at least seven plausible goals that are irreducible to each other, namely, to promote functioning, to maintain or restore normal structure and function, to promote quality of life, to save and prolong life, to help the patient to cope well with her condition, to improve the external conditions under which people live, and to promote the growth and development of children. This gives room for some concern, he says: it does not seem reasonable, for instance, to improve physiological function or functional ability unless this is expected to have positive effects on quality of life and/or length of life or to improve the quality of life in any respect or by any means.[2] Thus, when we say that physicians should "cure," should they please without limits?

The current World Health Organization (WHO) definition of health is clearly misleading. The sweeping definition of health contained in the Preamble to the Constitution of the WHO, signed in July 1946 and effective in 1948 in accordance with Article 80 of the Constitution, has generated controversy ever since. WHO argues that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[3] This definition, created to oppose the idea of health uniquely seen as "absence of illness," gives room to a clear utopian claim. Health is confused with happiness, and since no one is completely happy, it follows that no one is healthy. Sigmund Freud saw it clearly when, after stopping smoking cigars for health reasons, he wrote: "I learned that health was to be had at a certain cost. . . . Thus I am now better than I was, but not happier."[4] Not only are health and happiness distinct experiences but their relationship is neither fixed nor constant. Having a serious disease is likely to make you less happy, but not having a serious disease does not amount to happiness. Common existential problems—involving emotions, passions, personal values, and questions on the meaning of life—can make your days less than happy or even frankly uncomfortable, but they are not reducible to health problems.[5] To define "health" as "complete well-being" would thus leave us with a "null set" of persons as actually possessing health. As S. Bok states,

> Most people who take themselves to be healthy are surely aware of a variety of minor allergies, aches and pains, mood swings, digestive ups and downs. They would not qualify as exhibiting complete well-being in this sense. Not even seemingly thriving persons without any diseases or impairments could be known to possess complete physical well-being in this sense, much less mental or social well-being."[5]

Thus, the WHO definition makes room for an existential dissatisfaction.[6]

Thus, the question about the nature of health is overwhelming. To answer it, we have to ask: *When do we feel not healthy?* We can easily answer: *When we cannot do something that we used to or something that people commonly do*. For instance, when we can no longer run as swift as we used to, or when a disease inhibits eating food that people commonly eat. To drink, to walk, to eat ice cream, to read a good book; to restore breathing if our nose is obstructed, to restore sight if we are blind or to kill pain if we have a headache—to be healthy is to realize this.

We call these *desires*.

But our aim might be not to restore a previous or an average activity, but to obtain unusual or superior skills. This is the case of *wishes*.

Wishes are born from our will, while desires are inscribed in our personality. Wishes are based upon the affirmation of one's self (e.g., non-altruistic banking of cord blood, which has been discouraged as stem cell sparing by many international committees[7]) or due to external inputs (publicity, fashion) in a sort of "medicine of desires"[8]; or on the supremacy of one part of our being over the others (e.g., taking drugs for sport supremacy though this will be detrimental for the whole organism, or self amputation of arms for non-medical reasons). So we define health as *the possibility of having desires and realizing them,* while we should call "improvement" the aim to realize the wishes.

Only when something (illness, poverty, shyness) prevents the realisation of desires, we are not healthy. Thus, an eighty-year old diabetic patient, who has attained his/her own present goals, might be healthier than a youngster who has failed an exam or is experiencing a heartbreak; or disabled people playing sports successfully are surely making a healthy athletic performance, though they lack one or both legs or may suffer blindness. The meter for health is not doing anything, but what we desire—unless we suffer a desire pathology such as depression.

The possibility of having desires is inherent to humans, from the first steps of life, even when they are not able to express themselves. Who can say that neonates do not have a deep desire for their mothers' presence or milk, though they cannot say nor have a clear conscience of it?

*The awareness that our desires are being realised* is what we call w*ell-being*: in other words, *the awareness of health*. We commonly use this term to describe the possibility of having access to unnecessary things, so that some critics say that our well-being is measured by the garbage we produce. It is a paradox: the maximum well-being would not belong to those who use but to those who simply own without using things. Anyway, getting things about which we do not know what to do cannot produce serenity. A recent UNICEF report on the wellbeing of children in rich countries has caused considerable controversy, as it identified well-being with few specific indicators. "For example, is it valid to use the percentage of children living in single-parent families, or in stepfamilies, as indicators of relationship wellbeing?"[9] Even when we consider elderly wellbeing we can fall in the same flaws: to believe that some social indicators or the presence/absence of illness can give its level.[10]

From this, one consideration derives: *not all operations a physician can perform are curative*. For instance, provoking death, even in the cases law allows; giving anabolic drugs to improve sport performance; heavily modelling bodies following fashion or advisory canons: these are not curative measures, as they regard wishes and not desires. Pharmaceutical firms play their role in this, by creating in some cases new pathologies to sell drugs: it is the so-called "disease mongering" to create needs to sell remedies.[11] Convincing healthy people that they are sick and require medicines can enormously expand the market. Disease mongering can turn ordinary ailments like baldness into medical problems, consider risk factors such as hypertension and osteoporosis as diseases and frame prevalence estimates to increase potential markets. And in medicine there is a true consumerism, for instance in the procreative field,[12] from the assisted reproduction, to the selection of the desired embryo to the huge amount of prenatal exams.[13] These considerations also concern sport medicine: recently D. A. Frenkel wrote: "Doctors' professional duty to athletes should override any duty to the club that hired them, and professional medical opinion should override any caprice of the athlete."[14]

Considering curing as pleasing wishes may contrast the principle of justice, because it is not possible to everyone to obtain the object of such aspirations, and because it leads to a waste in public resources and founds. It can sometimes be also contrary to the principle of autonomy, if our wishes are induced by media propaganda or by fashion, as seldom are. Last, we should wonder if the "wishes medicine" respects the principle of non-maleficence. A study, published in the Annals of Plastic Surgery, reinforces several others that have shown women who have breast enlargements for esthetical purposes have higher suicide risks.[15] Its author, Dr Loren Lipworth, said she believes that some women who get implants may have psychiatric problems to start with, perhaps linked with lower self-esteem or body image disorders. This means that pleasing patients' requests can lead to overriding their actual needs. This can find examples in other fields of medicine, for instance, in the non-clinically justified use of prenatal invasive examination, which can lead to miscarriage, or in that of the mutilations made without a clinical need.

"To cure" is the act that fosters the satisfaction of the desires; other aims, though performed by caregivers and though legitimate, are not health care.

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GREY MATTERS

# TILL WE HAVE MINDS

WILLIAM P. CHESHIRE, JR., MD

> *Nothing is yet in its true form.*
>
> C. S. Lewis*, Till We Have Faces*[1]

A panel of Princeton University scientists recently gathered together to deliberate "whether strong religious belief can coexist with reliance on science."[2] Constraining their definition of truth to "factual human knowledge," the panel, led by professor of molecular biology Lee Silver, posed the provocative question, whether "science has effectively demonstrated that religious beliefs have no place in the rational mind."[2] How one decides that question guides the answer to a related question essential for the Christian physician. How can faith in Jesus Christ coexist with medical science?

Central to newfound confidence in the claim that science has superseded faith is the expanding scientific account not only of nature but also of human nature. At the leading edge of this research, neuroscience is unveiling spectacular discoveries about the brain. Neuron by neuron, the brain is yielding its intimate details to sophisticated neurochemical, neurogenetic and neuroimaging methodologies. The molecular basis of perception, reasoning, decision, faith and belief – every category of thought – has become accessible to the scrutiny of neuroscience. Neuroscience thus offers an increasingly detailed account – in purely physical terms – of mental processes that previously were understood to be within the purview of philosophy, religion and the arts.

Functional magnetic resonance imaging (fMRI), which detects regional increases in blood flow that accompany neural activity, has become a powerful tool to investigate the neuronal architecture of the brain systems underlying specific cognitive functions. Whereas in the past, localizing brain functions relied on the study of patients with brain lesions that happened to destroy those functions,[3] fMRI permits precise, noninvasive, spatial and temporal resolution of psychological processes in the intact, living brain. Brain regions showing increased metabolic activity over baseline will "light up" on fMRI scans. Language, for example, has been mapped in this way, as fMRI studies have shown involvement of the occipital cortex in reading text, the left posterior temporal lobe (Wernicke's area) in comprehending language, the right temporal lobe in assessing context, and the left inferior frontal lobe (Broca's area) in producing speech.[4]

In recent years fMRI has turned to investigating the moral domain. Studies of subjects presented with moral dilemmas have shown that there is no one moral center in the brain.[5,6] Rather, moral thought corresponds to a complex network of complementary cognitive processes traceable to a variety of discrete brain regions. Moral discernment engages systems of sensory decoding and abstract reasoning. Intuitive judgments heed long-term memories' emotional tags. Conscious decision integrates the sometimes competing neural streams of reasoning and intuition in the dorsolateral prefrontal and anterior cingulate cortices, where there exists what C. S. Lewis recognized metaphorically as a liaison between “cerebral man and visceral man.”[7,8] Finally, implementation, planning, and self-control of moral action require healthy frontal lobes.

Religious thought, too, has reclined under the scanner for analysis. Some of the brain correlates of belief and disbelief have recently been identified.[9] Just as for language and moral judgment, investigations have not found any one “God spot” in the brain, as if religious ideas were compartmentalized and detached from other thoughts and concerns.

In an experiment that produced a brain phenomenon apparently indistinguishable from spiritual experience, neuroscientist Michael Persinger applied transcranial magnetic stimulation to the cerebral cortex of healthy volunteers. Even when the subjects were not told that the device was turned on, they reported a mystical sense of another’s presence.[10] Philosopher Patricia Churchland cites that study as evidence that all religious experiences are ultimately neurobiological in cause.[11] However, one synthetic experience in the laboratory does not invalidate the spiritual awareness that many Christians testify has provided them comfort or insight during life’s trials. Artificially inducing what Lewis called a *numinous* sensation[12] by stimulating the parietal cortex no more disproves the existence of the transcendent than would stimulating the occipital cortex and causing the illusion of light disprove the existence of the sun and stars. The intensity of subjective experience in isolation from reason is not necessarily a reliable guide to truth.

If future technologies were to penetrate the brain with even higher resolution and, applying every conceivable biophysical stimulus, still fail to extract an objective sign of mental transcendence, the case for Christianity would not be weakened. Scientific facts, while valid and useful, are not the only ways of knowing about the world. The competence of science is limited to the measurement of phenomena that are quantifiable and consistently reproducible.[13] These include the structure of inanimate matter and predictable patterns of fields of energy. Even here nature conceals subtle details that are permanently incalculable and forever untraceable. Most importantly, the universally human questions of origin, purpose, and ultimate meaning surpass what can be fully answered at the material level. Such questions engage the mind and its capacities for abstract thought, conscience and personal agency, all of which resist a complete explanation in scientific terms. At the patient’s bedside, physicians understand that beyond scientific diagrams, gene maps and charts, there is a further aspect to human nature. The truly spiritual aspect of the human mind may be a gentle whisper, which science, despite its remarkable proficiency, overlooks (1 Kings 19:12, NIV; John 3:8; Heb 11:3).

Prevailing interpretations of neuroscience research presuppose that all brain phenomena are causally determined chains of biophysical events. If truth be established by the volume of data, then a naturalistic appraisal of the human mind would seem to be gaining in acceptance. Frequent comparisons of the brain to the computer reinforce the broader cultural plausibility of a materialistic understanding of human nature. Within that framework, there can be no assurance that the concept of free will, with its weighty implications for personal moral responsibility and autonomy in medical decision-making, has any meaning. Neuropsychologists now debate whether free will might be nothing more than an illusion, since the outcome of a decision can be predicted by changes detectable in the prefrontal and parietal cortices seconds before entering conscious awareness.[14] Alongside increasing optimism in science is a growing skepticism among many contemporary philosophers who ask whether all of consciousness ultimately reduces to an accidental matrix of synaptic impulses.[15-18] According to that view, one's decision to choose the good over selfish interests would be automatically determined solely by antecedent physical forces. Whatever one's reply to Jesus' question, "Who do you say I am?" (Matt 16:15), the materialist recognizes only a reflex, as if belief were equivalent to a yawn.

So impressive is the expanding horizon of neuroscience that Francis Crick, co-discoverer of DNA's double helix, has posited what he called his "astonishing hypothesis," which is, "... that 'You,' your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behaviour of a vast assembly of nerve cells and their associated molecules."[19]

Despite the rhetorical certainty the words, "in fact" seem to imply, Crick's claim is no more than a hypothesis. It is not, of course, a scientific hypothesis, but rather a metaphysical one which exceeds what science can legitimately claim. Crick's sweeping negative assertion that we are *no more than* cells and molecules defies verification, since the scientific method is qualified to describe only what can be empirically observed and quantified. By defining human consciousness exclusively in terms of matter in motion, Crick assumes as a premise the very conclusion that he wishes to reach.

The contributions of neuroscience are necessary, but not sufficient, to explain human thought. A functional neuroanatomical account of moral reasoning broadens the explanation of how one reasons, but it cannot show how one *ought* to reason. Nor can a scientific description limited to factual knowledge about the brain inspire the care of the sick or resolve difficult dilemmas in medical ethics. Less astonishingly, acceptance of Crick's hypothesis would reduce the value one accords to others. A materialistic appraisal of human nature would thus impoverish medicine. The obligations to love one's neighbor (Lev 19:18; Mark 12:31) and serve one another (Gal 5:13) would make little sense if the ethos of health care were based on the lonely view that patients are essentially churning aggregations of molecules.

Nor does the naturalistic methodology of neuroscience adequately account for the scientist behind the experiment whose mind engages nature by drawing inferences and reasoning with inquisitiveness and intentionality. There is, after all, a Crick behind the hypothesis. C. S. Lewis considered naturalism to be self-refuting because it is inconsistent with the validity of reasoning, on which all possible knowledge depends.[20] If mental processes were dictated solely by a deterministic biophysical chain of causation in the brain, then the scientist would have no reason to believe that scientific insights into nature are true and trustworthy rather than just a reflection of the way the brain happens to work.[21] Attempts to explain reason naturalistically end up explaining it away.

Not only must the reasoning mind in some way stand apart from nature to comprehend nature, but the mind that considers science encounters, knowingly or not, signs of a creative Mind behind nature (Psalm 19:1; Rom 1:20). The mere possibility of engaging in scientific investigation depends on the attributes of that Mind. On this point the record of history is instructive, for science as a fruitful and self-sustaining enterprise was stillborn in previous cultures that believed nature to be undirected or the Mind behind nature to be capricious.[22] Modern science emerged in history at a time when Western European culture was steeped in the understanding that the universe is the orderly creation of a rational God. For only a rational God could have authored a coherent universe that scientists can confidently investigate and hope to comprehend.[22] The salient question, then, is not whether religious beliefs have a place in the rational mind but, more properly, what kinds of religious beliefs are rationally compatible with all that is known about nature and the human condition.

If the scientific account has truly displaced rational belief in God, then the Christian faith is empty and futile, the dead perish without hope of afterlife, sins are unforgiven, and those who place their hope in Christ are the most pitiable of people (1 Cor 15:17-19). There is, however, much more than the narrow analysis of naturalism to consider. A worldview purged of theological content casts aside the accumulated wisdom of thousands of years of Western history informed by monotheism, disregards the contemporary discourse concerning the unavoidably transcendent implications of the origin of the universe and its particular conditions finely tuned to support life,[23] and ignores the healing contributions of innumerable healthcare professionals through the ages inspired to serve the sick by their faith in a loving God.[24]

There is a larger view of human nature than is dreamt of in the philosophy of naturalism. Judeo-Christian teaching bases human dignity on the understanding that humankind is created in the image and likeness of God (Gen 1:26). This *imago Dei*, which all men and women bear, is not a scientific notion and thus cannot be defined by physical, genetic or cognitive criteria alone. From a biblical perspective, every human being has value beyond measure (Matt 18:14, 25:40; 2 Pet 3:9). The Hebrew Scriptures declare (e.g., 2 Chron 7:14; Psalm 105:4; Jer 29:13) and the New Testament affirms (e.g., Matt 11:28-30; John 3:16; Rev 3:20), that human beings have the special capacity to enter into a personal relationship with God. This larger view accommodates all that science reveals about human nature. That the human brain is a vast assembly of 100 billion neurons exchanging signals through 160 trillion synapses[25] comes as no surprise to the biblical perspective on humanity as "fearfully and wonderfully made" (Psalm 139:14). To the scientific account the larger view adds hope exceeding anything technology can deliver (John 11:25; 1 Cor 15:22, 51-57; Col 1:27).[26]

This larger view promises that science can never disprove the existence of God. There is no area of brain function off limits to neuroscience, provided the experiments are conducted ethically. Scientific discoveries have hardly put to rest the dialectic between science and faith. On the contrary, they reinvigorate it. Thinking about the brain with all the mind deepens the scientific appraisal. In so doing, it is important to be attentive to unstated philosophical presuppositions regarding the nature of humanity and reality. Rather than question whether science has replaced religion, a better question to ask is, what should be the right relationship of one to the other?

The story of neuroscience is punctuated with reminders that the reality of God is not dependent on human thought, as if His sovereign provision and guidance were the result of human striving or faith the product of sufficient effort to imagine Him clearly. There is assurance in His grace and rest in His presence (Psalms 23, 46:10).

The subject of neuroscience – the human brain – is at once wondrous and wanting. In all of creation nothing more intricate is known. Yet its thoughts are imperfect and its behavior gravely flawed. The mind is not yet in its true form. The renewing of the mind requires communion with the mind of God (Isa 1:18; Rom 12:2), whose thoughts the

Scriptures indicate are vast and profound (Psalms 92:5, 139:17, NIV) and utterly unlike our own (Isaiah 55:8-9). It is unnecessary to ask what kind of science can apprehend the mind of God, as if that were possible. For God, in His mercy, through His Son has bridged the unfathomable divide and invites all people to draw near to Him (Rom 10:6-10). The mind of faith looks to what science has not yet seen (Heb 11:1). Herein lies the hope of seeing God face to face (1 Cor 13:12).

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The views expressed herein are his own and do not necessarily reflect the positions of Mayo Clinic, USA.

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CLINICAL ETHICS DILEMMAS

# Is It Permissible to Forgo Emergent Restorative Surgery in This Case?

DENNIS M. SULLIVAN, MD, MA, AND SUSAN A. SALLADAY, RN, PHD

**Editor's Note**: *The following consultation report is based on a real clinical dilemma that led to a request for an ethics consultation. Some details have been changed to preserve patient privacy. The goal of this column is to address ethical dilemmas faced by patients, families and healthcare professionals, offering careful analysis and recommendations that are consistent with biblical standards. The format and length are intended to simulate an actual consultation report that might appear in a clinical record and are not intended to be an exhaustive discussion of the issues raised.*

**Column editor**: Robert D. Orr, MD, CM, Consultant in Clinical Ethics, CBHD.

## Question

Should we proceed with emergent restorative coronary artery surgery for a patient who gave pre-procedure consent for treatment of complications?

## Case

Sister Bernadette, 84 years old, was admitted to the hospital two weeks ago for elective hip surgery. She has a history of angina and a pre-op cardiac stress test showed significant coronary artery disease, so her hip surgery was postponed. She had a cardiac catheterization and angioplasty[1] of one coronary artery and was discharged. She was re-admitted to the Cardiac Catheterization Lab today for planned angioplasty of a second coronary artery. She signed the consent form, which included standard wording giving consent for other procedures required due to unexpected findings. She was told that risks of today's procedure included emergency surgery, and she consented if surgery became necessary to restore her health.

The angioplasty procedure was done about two hours ago by Dr. Beckett. Immediately after the procedure she had a severe drop in blood pressure, was returned to the Catheterization Lab, re-evaluated, and found to have a ruptured coronary artery. A balloon pump was placed to sustain her vital circulation, and she was immediately transferred to the OR for emergency surgery to repair the damage. She is at this moment on the operating table and the team is ready to begin surgery.

During preparation for surgery she had new-onset generalized seizures, suggesting she has suffered brain damage from lack of oxygen. Though survival of such emergency cardiac surgery is quite common, intact survival in an elderly patient who is exhibiting signs suggestive of brain damage from inadequate oxygen is questionable. There is a reasonable chance that she could survive the crisis, but it is likely that she will be left with some degree, probably severe, of neurological impairment.

When Dr. Beckett was discussing the emergency surgery and serious prognosis with Sister Bernadettte's Mother Superior, he learned that the patient had said in the past that she did not want to be resuscitated or to survive if she should become neurologically incapacitated. Mother Superior confirmed this by phone call to another nun who also knows the patient well.

## Discussion

Withholding life-saving emergency surgery simply because a patient is severely disabled can be discriminatory. Withholding life-saving emergency surgery because a patient's prognosis will most likely include severe impairment, knowing that the patient did not want to live in such a condition, can be morally permissible. Therein lays the moral dilemma.

Surely the heart surgeon's mantra, "No patient should die with bad coronary arteries on my watch," compels Dr. Beckett – Sr. Bernadette is already prepped even as he requests an ethics consultation. For this reason, and because of the ease of repairing the anatomic defect here, it may be difficult for him to consider forgoing corrective surgery.

All members of the care team are virtually certain of an outcome with *some* degree of neurological impairment. The cardiac surgeon seems almost like the hero in a classic tragedy: noble but possessing a tragic flaw (the compulsion to cure). He is driven to proceed, though there is an intuitive sense that this may not ultimately be in the patient's best interests.

Is the request for an ethics consultation at this time disingenuous – thinly disguised self-protection or self-justification? It is impossible to untangle intentions, but the motives of all seem overwhelmingly compassionate: the desire to do what is best for Sr. Bernadette. Hope in the face of the unknown weighs heavily in the emotion of this decision.

One value of an ethics consultation is perspective. Sr. Bernadette had given consent for emergency surgery *to restore her health.* However, at the time she made these comments, she most likely did not envision the current situation, a potential severe cerebral injury and possible unresponsive state. Dr. Beckett has also confirmed that her wishes do not include life at any cost.The original goals of Sr. Bernadette's treatment will most likely not be realized since she is no longer a candidate for hip replacement surgery.

## Recommendations

1) It is not unreasonable to withdraw from the current course of treatment. There is no real ethical distinction between withholding and withdrawing treatment in this case.[2] Either course of action (continuing or not continuing with surgery) is morally permissible.

2) It is important to consider who has the right and responsibility to make treatment decisions. In the patient's present condition, she lacks decision-making capacity, and the healthcare team must rely on a substituted judgment by a surrogate, usually a family member such as a spouse, parent, or sibling. In this case, the religious order to which the patient belongs is very much a family, and they clearly have the moral authority to

act in her best interests. Dr. Beckett has contacted Sr. Bernadette's Mother Superior for additional information about her wishes and values. He should make it clear to her that she is participating in a treatment decision and that she has the right to do so. However, there is great value in shared decision-making. In life and death situations, this ensures that no one person is forced to bear an untoward emotional burden (e.g., uncertainty or guilt).

3) If the surgeon proceeds with the operation and stabilizes the patient's cardiac status, then further neurological consultation and testing (perhaps to include cerebral blood-flow studies) will clarify her prognosis. If extensive neurological damage has indeed occurred, then Dr. Beckett should discuss the findings with Mother Superior, obtain her consent to enter a DNR ("Do Not Resuscitate") order on the chart, and provide expectant management of the case.

## Comments from a Christian Perspective

The determining factor is this case is hope in the face of an uncertain prognosis. The hope that drives the decision to proceed surgically includes an awareness of "erring on the side of life" and faith that God will protect Sr. Bernadette and reveal His future for her.

On the other hand, if extensive neurological damage is present, heroic measures to prolong the patient's life might evidence a form of "Christian vitalism." Christian healthcare professionals may acknowledge God's sovereignty by declining to prolong the dying process.

### Follow-up

The Mother Superior was quite certain that the patient would not consent to surgery that might restore her to a condition of almost certain severe neurological impairment. The ethics consultant believed this was a permissible substituted judgment, and the cardiac surgeon was very willing to forego surgery. The patient was given comfort care and died in a few hours.

### Endnotes

1. An angioplasty is a non-surgical procedure to open up the flow of blood through an artery, either by dilation or by reaming out the obstructing material in the artery.
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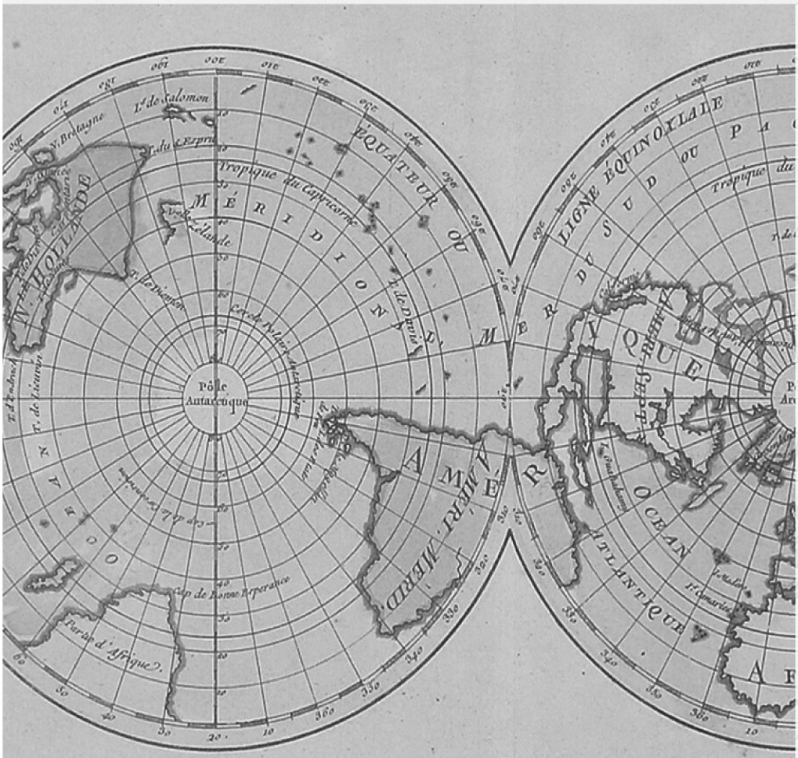

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# ANTI-AGING, RIGHTS AND HUMAN NATURE

THOMAS D. KENNEDY, PHD

## Abstract

*This paper examines the moral arguments offered by the most prominent figure in the anti-aging movement, Aubrey de Grey, and find the arguments lacking. De Grey's understanding of moral rights is confused and incoherent. Furthermore, although his appeal to the "wisdom of repugnance" is intriguing, it too fails. An underlying problem of the moral arguments of the anti-aging movement is their reliance upon a deeply problematic notion of what is natural.*

The name of the prize—The Methuselah Mouse Prize— may at first sound silly, but the cash award is not. The idea behind the prize is that once it has been demonstrated that the days of a mouse can be tripled and, thus, that mice are not doomed to short lives, then we humans will recognize that neither is our own aging inevitable. Once we see that aging can be reversed in mice, we will commit the resources to eradicate aging in humans. Currently we are in a "pro-aging trance," but an old mouse would awaken us from our moral slumbers. As Aubrey de Grey and seven co-authors state in an essay in the *Annals of the New York Academy of Sciences,* "We contend that the impact on public opinion and (inevitably) public policy of unambiguous aging reversal in mice would be so great that whatever work remained necessary at that time to achieve adequate somatic gene therapy would be hugely accelerated."[1] New research and new sources of funding for the research. And then, life extension—first to an average lifespan of one hundred and twenty years, then two hundred years, then, if not to immortality, at least to some five thousand years. Hence, the Methuselah Mouse Prize, to encourage researchers to reverse aging in mice with procedures that can be transferred to humans. The costs are small and the benefits huge; thus the urgency, thus the prize. The total value for extending the life of a mouse—five years is the current benchmark—is now just over one million dollars. That is not play money. Nor is the anti-aging movement a game.

The most prominent figures in the anti-aging movement are not quacks and kooks (whatever that exact distinction is), at least not obviously. They are respected scientists, engineers, and financiers. For example, Ray Kurzweil, the sixty-year-old author of *Fantastic Voyage: Live Long Enough to Live Forever* (Rodale Books, 2004) and, more recently, *The Singularity is Near: When Humans Transcend Biology* (Penguin, 2006) is a member of the Inventors Hall of Fame, a 1999 winner of the National Medal of Technology, a recipient of the $500,000 Lemelson-MIT prize, a "modern Edison" according to *The Christian Science Monitor*. Kurzweil figures that if he can survive another twenty years or so, then his own death is not inevitable; he can be immortal.

There are three bridges to immortality, according to Kurzweil. The "first bridge" currently lies in our hands—eating well, exercising, and maintaining the appropriate health regimen that will get us to the "second bridge," the biotechnological revolution. The third and final bridge to immortality is nanotechnology and artificial intelligence. Kurzweil foresees a day when nanobots will be introduced into our bodies to locate and attack diseases and to reconstruct damaged organs. We *can* live forever. We are living in the midst of the biotech revolution, on the cusp of the nanotechnology revolution. Foreseeable developments in science and technology are making immortality feasible for this generation.

If that sounds too much like science fiction, like the sort of thing a lonely inventor just might dream up after too many hours alone in his lab on long winter evenings, then travel to Cambridge University in England to the *Eagle*, the same pub in downtown Cambridge where James Watson and Francis Crick sipped a proper pint of British ale as they progressed towards figuring out the structure of DNA or, as Watson himself put it, to discovering "the secret of life." Today in the Eagle you meet neither Watson nor Crick but, instead, the poster-boy of the anti-aging movement, and the primary brain behind the Methuselah Mouse prize, Aubrey de Grey, who thinks he's as close to discovering the secret of immortality as Watson and Crick were to discovering their secret in 1953.

De Grey is by training an engineer and an autodidact in biology and genetics, though a brilliant enough autodidact for Cambridge University to have granted him a PhD in biology for a book he wrote on mitochondria. De Grey, however, thinks like an engineer, not a biologist. His formal academic training was in computer science; he was in software design until his company went belly-up. His day-job now is rather unimpressive—he works in a small lab at Cambridge University as the computer support for a genetics research team. But his real work, his mission, lies in "fixing" aging, in approaching the problem of aging the way an engineer would. After much research on mitochondria, in 2000 he suddenly realized that "aging could be described as a reasonably small set of accumulating and eventually pathogenic molecular and cellular changes in our bodies, each of which is potentially amenable to repair."[2]

Since then, de Grey has determined that there are seven distinct components in the aging process—the seven deadly sins of aging, as he put it to *Popular Science*.[3] Discretely address each of these areas and, *voila!*, immortality, or at least a longevity bordering on immortality. For example, *cell loss* is a problem. Despite cells kept in reserve by vital organs, over time a loss of cells impairs the functioning of these organs. But embryonic stem cell technology offers the promise of new editions of these lost cells. Identify the problem; then go to work on it. Another problem is *cell senescence*—cells that have stopped dividing sometimes hang around rather than dying. Some speculate that this may cause neighboring cells to become cancerous. So, we need some way to either kill these cells or encourage them to commit suicide. And so on, with each of the seven deadly sins of aging. Identify the problem, develop the technology to fix it, and one more hurdle on the way to immortality is crossed. (Interested readers can keep up with developments and news about *SENS—Strategies for Engineered Negligible Senescence*—at http://www.sens.org.)

## The Moral Case for Anti-Aging

Perhaps the moral case for anti-aging is perfectly obvious. That, at least, seems to be the view of "Righteous Indignation" who wrote in response to the critical comments of the *Technology Review's* editor, Jason Pontin, about Aubrey de Grey and anti-aging:

Posted 2/3/2005 11:20:19 AM by Righteous Indignation

> Subject: A simple fact
>
> Jason Pontin, know that to oppose Transhumanism is to support SUFFERING and DEATH! Period. Transhumanists are morally and rationally right, regardless of the accuracy of their (often quite reasonable) technological assumptions and predictions. Just because there's a chance that we may never win this battle against entropy doesn't mean we should meekly surrender and let ourselves be slaughtered like so many sheep.
>
> What you undoubtedly see as "mature acceptance of the inevitable" is in fact just cowardly, cynical defeatism. I pity you for being trapped in such a depressing, perspectiveless worldview.

Aubrey de Grey is not a moral philosopher, but his mission is driven by moral concerns and commitments. His justification for his war on aging, while substantively the same as that of "Righteous Indignation," is a little more carefully articulated. He appeals to three general moral considerations in making his case: (1) the repugnance of aging; (2) the moral right to make the most fundamental choices about one's life; and (3) the moral right of a healthy human being to keep on living.

De Grey's appeals to rights are seemingly straight-forward. He assumes that there are such things as human rights, apparently natural moral rights, and that chief among these moral rights is the right to life and the right of a healthy human to keep on living. However, he does not interpret these rights the way they might most typically be understood by rights theorists—as negative rights, i.e., as rights to non-interference such that to have the right to life is to have a right to your neither harming me nor interfering with my innocent pursuit of what is required for my life. Understood in this way, the right to make the most fundamental choices about one's life and the right to keep on living would prohibit others from interfering with me as I make fundamental choices and as I keep on living unless I am harming or threatening to harm others in those choices and in my keeping on.

De Grey's interpretation of these rights as positive rights or benefit/entitlement rights, that is to say, *rights to the assistance of others in the acting out of that to which one is entitled*, is based on his rejection of the moral distinction between acts and omissions. Thus, "…there is no moral distinction between action and inaction, in particular between acting to shorten someone's life and not acting to extend it," confirmation of which he finds in "the widespread legal concept of criminal negligence."[4]

Instead, de Grey asserts, "…the right to live as long as you choose is the world's most fundamental right."[5] Again, de Grey:

> The reason we have an imperative, we have a duty, to develop these therapies as soon as possible is to give future generations the choice. People are entitled, have a human right, to live as long as they can; people have a duty to give people the opportunity to live as long as they want to…. If we hesitate and vacillate in developing life-extension therapy, there will be some cohort to whom we will deny the option to live much longer than we do. We have a duty not to deny people that option.[6]

To be human, thus, is to have the right to live as long as you choose. For us—and we may well wonder who the relevant "us" is—to fail to attempt to develop life-extension therapy is to violate the rights of some (future) individuals to choose whether to live longer. We have a duty not to violate this right to choose of these future persons. Therefore, we have a duty to attempt to develop life-extension therapy.

Now there is much that is bewildering in this account and not just because rights talk is, in general, perplexing. But let us assume, for the moment, that there is some fundamental right for each of us to live as long as we choose. Who possesses such a right? Well, *persons* are the best candidates for such rights, and de Grey surely assumes that it is human persons who possess this right, and not members of any other species. But, in fact, this right, if it exists, doesn't belong to just any human persons, it belongs to persons who exist. It does not belong to former persons—my parents have both died and, in dying, they have lost any rights they may have had. Potential persons, that is to say future persons, possess, if any, only potential rights. But de Grey seems to think otherwise. He assumes that it is not just persons and not just *potential* persons who possess the right to live as long as they choose; *possible* persons, those who *might someday exist,* possess this right: "If we hesitate and vacillate in developing life-extension therapy, there will be some cohort to whom we will deny the option to live much longer than we do. We have a duty not to deny people that option."[7]

We have a duty, de Grey maintains, to provide the option to live longer to persons who may exist at some future time, not only to persons, not only to persons and those who are in the process of realizing their potentiality as persons, but to persons and potential persons and *possible persons.* The extension of rights to possible persons, "persons" who may, but just as well may not, someday exist—well, this *is* puzzling. I have no biological grandson of whom I am aware, but to be on the safe-side, let's think about a person who might someday exist, my biological great-grandson. It is possible that someday there will exist a person who is my biological great-grandson, just as it is possible that there will never exist a person who is my biological great-grandson. de Grey seems to think that that this person who may or may not someday exist—my biological great-grandson—has rights against me such that I have an obligation to bring it about that he can choose how long to live should he someday exist. And perhaps, too, the Great Pumpkin, who may or may not exist, has rights you and I have failed sufficiently to attend to.

But de Grey may be wrong about who possesses the fundamental right to live as long as he or she chooses, yet correct about there being such a right. Perhaps this right belongs to all existent persons—not possible persons, not even potential persons, but *actual* persons. Most of us don't recognize such a right, but of course it doesn't follow from that that no such right exists. If there is such a right, notice how different an imperative this yields for us! Why expend any of our resources upon possible persons when there are existent persons and persons in *potentia* who are unable to exercise this right because of our current distribution of resources. If de Grey is correct about this right to choose to continue to live as long as we like, doesn't justice require that our energies be devoted not to the development of life-extension therapies, but to the distribution of life-saving therapies to all those persons whose current choices about how long to live are not realized, in short, to the more traditional understanding of the medical imperative? Even if there were a right to choose to continue to live as long as we like, wouldn't that place anti-aging research near the bottom of our priority list?

Of course the most basic question is this: why should we even assume that there exists a right to live as long as you choose? What would it mean to have such a right? If there are, in fact, rights, and rights not derivative from duties, then I suspect these rights are far less extensive than this one. They are much more like a simple right to life—a right to non-interference and, perhaps, the entitlement right to what one needs to survive for a good while, although not for as long as one might wish to survive. De Grey's first moral appeal, thus, fails, but perhaps his second appeal is the more persuasive.

De Grey claims that even as a child he recognized that aging was something that needed fixing. His language about aging and death is vivid: aging is "repulsive," and death from aging is "barbaric." If you hear echoes of the language of Leon Kass here, that is perhaps not entirely accidental. On his website de Grey writes, "I fully agree with Leon Kass and other bioconservatives"—something that would make Kass and other bioconservatives shudder, I think—"that there is a concept of the 'wisdom of repugnance'—that ultimately what is good and bad is defined by what feels natural and unnatural."[8] What follows from the wisdom of our feeling repugnance when we consider aging and its effects, according to de Grey, is that we should cure aging as soon as possible. De Grey continues, "I consider that saving lives is natural, and conversely that standing by and not doing life-saving research as quickly as possible is repugnant. It's not natural to condemn people to an unnecessarily early death."[9]

Three things in this brief argument call for comment: (1) the moral relevance of the distinction between action and omission; (2) "nature" and its relation to moral norms; and (3) the wisdom of repugnance.

First, let us note de Grey's insistence that in failing to do the life-saving research we "condemn people to an unnecessarily early death." For de Grey there seem to be but two options—we are either killers or we are life-savers. Some of us are guilty of killing innocents by doing something to bring about their deaths; others of us are guilty of killing the innocent aging by failing to do something that would interfere with and prevent aging and death. Again, de Grey: "Roughly two people die every second, worldwide, and more than half of those people die of causes that young people more or less never die of. So we're talking about the fact that aging kills one person a second, it kills a hundred thousand people a day, it kills thirty million people a year. This is a serious number of people. And saving lives is good."[10]

And, of course, killing is not. Again, de Grey: "To stand back and (by one's inaction) cause someone to die sooner, when one could act to let them live a lot longer at no (or even at some modest) cost to oneself or anyone else, is arguably the second most unnatural thing a human can do, second only (and then by a very small margin) to causing someone's death by an explicit action."[11]

We'll come back to this talk of what's *natural* and what is not in just a moment, but first let us concentrate on this acts and omissions issue, and what follows from this, a conflation of duties not to harm others and duties to benefit others. Note that de Grey assumes that there really is very little, if any, moral difference between acting to bring some state of affairs about and failing to act with the result that the same state of affairs occurs. The result is the same in both cases—x occurs—so why think the means by which x is brought about is morally relevant? If two different actions (or omissions) lead to the same resulting consequences, and if the goodness or badness of the action is determined solely by the consequences of the action, then there is no moral difference between the two actions. Thus, if one person a second dies from aging because you and I failed to act to prevent the death, and if Malcolm the murderer kills a person, what's the moral difference between Malcolm and us?

Now there *is* something to this observation if we are talking about *intentions*. Malcolm the murderer intends to kill Anne and, thus, he buys an especially sharp saw. But let us imagine that your Uncle Uriah, the billionaire inventor of the palm printer, who you know has listed you as the prime beneficiary in his will, is coming to visit you. Your bills are weighing heavily upon you and Uncle Uriah is a bit of an old git anyway. So, during dinner, as you notice him beginning to choke on a fish-bone, you excuse yourself to go to the kitchen to re-fill the water glasses, *intending* for the natural act of choking to take its course, though not in your presence. If the intent is to bring about some immoral state of affairs, say Uriah's early death so you can benefit from his billions, it is morally irrelevant whether you intend his death by doing x or by failing to do y. In this case, the facts are such—you know that Uriah is choking, you are trained in applying the Heimlich maneuver, you are the only person there who can save him, you would like for him to die, etcetera—that your omission is the intentional cause of his death. You are guilty.

But is this relevant to the case of aging? Only if it could plausibly be argued that we *intend* for the elderly to age and to die before their time. But that is, of course, nonsense. Most of us probably have no relevant intentions at all with respect to age-related dying. We haven't thought much about the issue. We don't personally know many people who are in the process of age-related dying (unless, of course, we are all in the process). There doesn't seem to be much we could do about the problem. There are many worthwhile things each reader could be doing instead of reading this essay. There are hungry we could be feeding, and lonely we could be befriending. There are parents who would welcome a phone-call, and siblings who could use a message from us. (There are, as well, concertos worthy of being listened to, and sculptures worthy of being attended to, but that is perhaps a different matter.) I was well aware of all this before putting my fingers to the keyboard, but it is preposterous to suggest that I intend for readers not to feed the hungry or befriend the lonely, absurd to think that I intend for you not to contact your family. On almost all of these matters I have no intention at all. My intentions certainly do not run through your actions. Nor do they run through all I do or fail to do.

Now perhaps the more critical distinction is not that of act and omission, but the closely related distinction between foresight and intention. Implicitly, I've suggested that some omissions are acts through which intentions run every bit as much as actions themselves, and that what matters more than whether the act is an action or omission is what the agent is doing in either acting or failing to act, what is going on with the agent and what should be going on with an agent in such circumstances. Of course, some may argue that I bear the moral responsibility for all foreseeable consequences of any action or inaction I consider, and not just for my intentions. There's little that can be done to argue for such a claim, I think; it is more an intuition or assumption. But it is an assumption that has unwelcome implications. If one is morally culpable for all that one foresees, and not just for all that one intends, then there is no moral difference between the suicide and the martyr: the martyr may reasonably expect that her failure to apostatize will result in her death, just as the suicide may reasonably foresee that the handful of pills may kill her, and so, those like de Grey may maintain, each is equally responsible for her death. But, as the philosopher Alan Donagan has pointed out, this position entails that the martyr is not only a suicide, but a persecutor as well, since she foresees that her refusal to apostatize will not only lead to her own death, but she also foresees that her omission of apostatizing will result in the death of a confessor.

This assumption that we are responsible for all the consequences of our actions/inactions that we can foresee is an assumption that moral theory certainly can do without and an assumption that promises to paralyze and cripple the moral agent by the weight it places upon her shoulders. All of us are aware of the inordinate suffering in Africa at this very moment—genocide, hunger, AIDS, war. None of us is, at this moment, doing as much as we might do to address these problems. I don't want to deny that we may, indeed, bear greater moral culpability than we typically acknowledge, but to really believe that I am as responsible for occurrences elsewhere, for events and states of affairs that have no connection to actions over which I have control, is to treat myself as a god, rather than a human, and in the absence of godlike powers to correct what is wrong in the world, what am I to do with that responsibility? How could I not but find it crippling?

Better, I think, to recognize the moral distinction between acts and omissions, intentions and foresight, to acknowledge that we may be differently related to states of affairs brought about by our actions and inactions and those states of affairs that are foreseen, but not caused by us. Better, in short, to recognize that just because we are aware of the large numbers of deaths daily "caused" by aging, we do not necessarily bear responsibility for those deaths. They are not our doing. Now it may be, of course, that we do have some duty to prevent harm and to remove danger to those who are aging, some duties of beneficence. But failure in those duties is not morally equivalent to killing others or, even to failing to save a life that is now before me.

De Grey could, of course, concede this, and argue that although we are not guilty of violating a fundamental moral duty not to harm others, we are guilty of violating a duty to do good to others. Given the low cost to ourselves of developing life-extending therapy, and given the great benefit our success in the development of life-extending therapies might have in the removal and prevention of the harms of aging, perhaps we have a significant duty of beneficence to engage in the development of such therapies. This would be an interesting argument, but it is only as plausible as the claim that age-related harms *are* so significant compared to other harms we might remove or prevent that our energies are well-directed in this area. And why should we think that?

## Nature and Repugnance

A second aspect of de Grey's repugnance argument has to do with what is natural, and perhaps that explains the magnitude of the age-related harms. We can easily imagine arguments against the anti-agers that it is not natural to live to be one hundred and twenty or two hundred years old, and certainly not five thousand years old. De Grey's response is to redefine what is natural: causing someone's death by an explicit action is unnatural, and causing someone to die sooner when one could act with the result that they might live longer is only by a very small margin less unnatural.

Furthermore, de Grey argues,

> It's clearly unnatural for us to accept the world as we find it: ever since we invented fire and the wheel, we've been demonstrating both our ability and our inherent desire to fix things that we don't like about ourselves and our environment. We would be going against that most fundamental aspect of what

> it is to be human if we decided that something so horrible as everyone getting frail and decrepit and dependent was something we should live with forever.[12]

De Grey's appeal exemplifies the "wax nose" character of the arguments that appeal to nature—you can mold and make almost anything you like natural or unnatural. So, for de Grey, it is natural for us to want to fix things that are problems for us, aging is a problem for us, so fixing aging is natural. Likewise, apparently, it is unnatural to cause someone's death by an explicit action as well as to "cause someone to die sooner when one could act with the result that they might live longer." In what sense of "natural" are these natural? How could we tell whether the desire to fix things that are problems for us is natural? Perhaps the desire to have problems fixed *is* natural, but there would appear to be vast numbers of people and even significant periods of time in which the desire to fix problems, as opposed to having them fixed, has, to say the least, not been expressed. By contrast, we would be hard-pressed to find any period of time in which there weren't plenty of folks interested in the "unnatural" act of killing others. So, if what is natural is determined exclusively by numbers, then de Grey has not identified that which is natural. And if what is natural is not determined by majority vote, then how *are* we to determine what is natural?

De Grey's appeal at this point is to the "wisdom of repugnance." Consider aging, "the brutal bombardment by the silent artillery of time", as Abraham Lincoln put it. Isn't our abhorrence, our repugnance at aging, indicative of the unnaturalness of aging and death? Doesn't this repulsion that we feel upon considering aging provide sufficient warrant for declaring war upon aging? De Grey insists that if we will just for a moment step outside our culturally constructed "trance" with respect to aging, we *will* feel repugnance. You and I and a significant number of a large cross-section of groups will respond to aging in terms of moral repulsion. "It's barbaric." "Grotesque." "Revolting." I, myself, find this rather unlikely. Most of us, I think, would feel sympathy for those withering into age-related problems. Most of us, all things being equal, would prefer a rather short period of infirmity prior to our deaths. But do we really think of death as "barbaric" and aging as repugnant? Indeed, what sort of person would?

Well only a person who is alienated from his or her nature as a creature, I think, only a person who thinks of herself as other than her biological self. This is tricky business, but we should say two things here: We are never *only* creatures but we are *always* creatures. What it means to recognize ourselves as creatures is to see that we, like dogs, cats, ferns, and mitochondria have a beginning and an end, that aging and death is a part of normal species functioning for creatures. That aging and death are no more repugnant than eating and being nourished or sex. Furthermore, to think of aging and death as fitting and appropriate to other species, but not to the human species, is to misunderstand human nature and our identities as biological creatures, a misunderstanding that has not bode well for the created order in the past, does not now bode well for the world in which we live, and promises future harm to our wounded world.

Recall the joke about whether God is an electrical, a mechanical, or a civil engineer. Perhaps the repugnance some may feel at a sewer running through a recreational area may lead to designs for a new, improved human body. But that's the engineer's thinking, not the biologist or the naturalist, and the engineer's shudders may tell us much more about him, than about what is natural.

## Endnotes

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# ON REFERRING

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## Abstract

*In this essay, I examine the practice of a physician's referring patients to other healthcare providers for medical treatments the performing of which would violate the referring physician's conscience. I argue that, in some cases, but not all, this practice is ethical. It would not, for example, be ethical in cases in which the treatment that a physician could not bring himself to perform is both itself intrinsically unethical and is known by the referring physician to be intrinsically unethical. The discussion of this topic is deeply enriched by examining the methodology of a recently published study in the New England Journal of Medicine by Curlin et al. that examines physicians' perceived rights and obligations when patients request legal medical procedures to which physicians object on moral or religious grounds.*

## I

There is an art to referring.

Referring's being an art accounts, at least in part, for the substantial difficulties one encounters when attempting to convey to potential consultees what constitutes an 'appropriate referral'. Typically, referral sources' primary requests for consultation with psychiatrists are expressed in terms of referred patients' requiring psychiatric evaluations to gauge whether psychotropic medications are appropriate, either alone or as adjuncts to their existing psychotherapeutic treatment regimens. When patients are sent back to their referral sources without the expected prescriptions or recommendations for medications, this is often viewed as an occasion for disappointment, both for the patients and for the consultees by whom the patients were referred. Patients often expect that, since they were referred specifically for medication evaluations, prescriptions or recommendations for medication should have been the result. This disappointment on the parts of patients often also influences the reactions of consultees. It is not uncommon for consultees to feel, in such instances, that they have referred badly. For, it is commonly believed, at least part of what it means to refer well is for one to receive a certain result, namely, an expected, specific exercise of the consultant's expertise. In the case of a psychiatric referral, this typically means a prescription or a pharmacological recommendation. For the referred patient to return to the consultee with anything less is often viewed as a failure on the part of the consultee; specifically, the consultee in such instances appears to have failed to realize that the patient really was not an appropriate candidate for medication after all and should never have been referred in the first place. Now the consultee must face both the disappointment expressed by the patient in not receiving the treatment that was expected and disappointment in his or her own abilities to assess and to refer well.

These disappointments are, of course, often unjustified. I sometimes explain to consultees that referring well is compatible with more than that one expected (namely, pharmacological) outcome. But then what is it, precisely, to refer well? Certainly not just any referral is a good referral (just as, contrary to what many teachers claim, not just any question is a good question). Suppose that a family practitioner referred all of his patients who suffer from uncomplicated common colds to ear, nose, and throat (ENT) specialists. The family practitioner in such cases would not be referring well. Nor would a family physician be referring well if he did not refer any of his patients with cholesteotomas to ENT specialists. In the former instance, he would be referring when he should not be, and in the latter instance he would not be referring when he should be. In neither case, therefore, is he good at the activity of referring. In neither case would he be referring well.

Now, one might think that referring is really not an 'ethical issue' at all, that it is, instead, merely a 'medical issue'. This frequently made alleged distinction between an issue's being 'merely medical' and an issue's being 'ethical' itself requires extended comment, although not here. Suffice it to say that ethical evaluations, as noted by St. Thomas Aquinas (in the Prima Secunda of his Summa Theologiae, questions 6-17), may be appropriately made for any human act (where a 'human act', as opposed to what Aquinas calls an 'act of the man', is an act that is voluntary and, hence, is an act that involves choice). Consider the act of one's picking up a stick while out taking one's morning walk. Is that act an ethically evaluable act? Can it be rightly said to be either a good act or a bad act? Most certainly it can (as can a surgeon's picking up a scalpel, or an internist's picking one medication over another in order to treat a patient's diabetes). One can see this by asking the question, "Why did the man pick up the stick while out for his morning walk?" The goodness or badness of that act of picking up a stick depends, in part, on the motive for having done so. Were we to find out that the man picked up the stick intending to poke out his neighbor's eye with it in retaliation for a perceived slight, we would certainly think differently about the act in terms of its ethical value, than if we were to find out that the man picked up the stick in order that no one would trip over it. Be this as it may, I intend in this paper to examine cases of referring that no one could fail to recognize as being ethically evaluable (in spite of the fact that it seems clear to me, following Aquinas, that all acts of referring—and, in fact, all voluntary acts involved in the practice of medicine—are ethically evaluable).

## II

There are, broadly construed, two general ways to model acts of referring in medical contexts. The first we will call the 'desire-satisfaction' model, the second, the 'human flourishing' model. According to the 'desire-satisfaction' model, to a first approximation, if a caregiver is unable or unwilling to provide medical services to a patient and these services are available elsewhere, and if the patient expresses or implies a desire for (i.e., in some way requests or hints at) the services in question, then a referral is appropriate. The aim of the referral, in this model, is primarily the satisfaction of the patient's expressed or implied desire. For example, suppose that a generalist has a patient who has an unusual rash. The treatment prescribed mutes the rash but does not ameliorate it. Although the patient looks and feels much better than she did before, a few papules and very minor itching persist. Although satisfied with her treatment up to a point, she is not wholly satisfied. The patient desires to have her skin look and feel like it looked and felt before the outbreak of the rash, and quickly. The generalist has no other ideas about how to treat her, but does not believe the rash will progress. Rather, she judges that, with time, the rash will continue to fade until it is wholly resolved, that no treatment will give the patient the desired outcome as quickly as the patient is expecting and, therefore, that referral to a specialist is not required. The patient, on the other hand, is impatient. She would like to see the rash resolve completely and rapidly. In the end, against her better judgment, the physician refers her patient to a dermatologist for evaluation and additional treatment. She makes this referral solely because her patient desires a degree of satisfaction that she cannot provide.

The 'human flourishing' model of referral is very much unlike this, although it can, and often does, have the same outcome in terms of whether or not, and to whom, referrals are made. Consider again a patient with a different, but again nearly resolved, rash. Suppose that, in this case, the patient does not express a desire for further treatment and, in fact, expressly states that she would not like any further treatment for the rash. However, in this instance, the generalist, knowing something about the lingering adverse effects of this type of rash—effects that the patient herself, for whatever reason, is unable currently to appreciate—tries to persuade the patient that a referral to a dermatologist is in her best interest. The patient eventually gives in, sees the consultant, and receives additional treatment in spite of the fact that she really did not want to see a dermatologist and was content with the degree of improvement previously effected.

Now, whatever one thinks about the tactics that consultees often use to persuade patients to keep appointments with specialists to whom they are being referred, what is important for our purposes is not whether the appointment was kept or the degree of pressure exerted on the patient by the generalist, but the generalist's motivation for making the referral in the first place. In the first instance, the generalist's referral was driven by respect for the patient's expressed or implied desires. In the second instance the referral was driven by considerations involving a perceived optimization of the patient's well-being. Often, of course, these motivations overlap perfectly: patients commonly express or imply a desire to have treatments that conduce optimally to their well-being. But this is not always the case. What does one do when these motivations come apart? Under such circumstances, according to which model of referring ought one operate? Should patients' desires dictate referrals or should caregivers' judgments regarding patient well-being dictate the shape of the referral process?

Notice how this problem is a variation on a very old and quite general one. It is a problem that arises not only in the context of referring, but also in the context of the helping professions more generally: Does one treat patients based on what patients say or imply that they want, or on what they 'really' want (regardless of what they might say that they want), or does one only do what one believes to be good for patients (regardless of what they say that they want or really want), or something else? There are, of course, many and varied complexities in this arena. Certainly, if a patient with an uncomplicated cold persistently expresses desires for a CT scan of his head and treatment with anti-cancer chemotherapy agents—or even antibiotics!—we would not be obliged to satisfy those desires. On the other hand, there appears to be a general consensus on the issue that although it seems clear that it would be in the best interest of adult Jehovah's Witnesses to receive blood products in certain circumstances, that (following an appropriate series of conversations and, perhaps, consultations, together with the proper informed consent) one ought to abide by adult Jehovah's Witnesses' expressed desires not to receive such treatment, even if this refusal results in serious morbidity or mortality. These are cases about which, in today's healthcare climate, most people will agree. What about more controversial cases? Prior to examining such cases, however, we would do well to investigate what, in fact, medical professionals actually say about how they should go about referring.

## III

In a recent article in the New England Journal of Medicine (February 2007), Curlin and colleagues attempted empirically, albeit indirectly (by way of physicians' perceived obligations) to illuminate referral practices among physicians by randomly sampling 2000 practicing U.S. physicians from multiple specialty fields of medicine. According to the authors, "The primary criterion variables were physicians' judgments about their ethical rights and obligations when patients request a legal medical procedure to which the physician objects for religious or moral reasons. These procedures included administering terminal sedation in dying patients, providing abortion for failed contraception, and prescribing birth control to adolescents without parental approval" (p. 593). Sixty-three percent of physicians responded to their survey. Eight-six percent of responders believed it is obligatory that all treatment options should be presented to patients, and seventy-one percent believed it is obligatory that patients be referred to another clinician who would not object to carrying out the requested procedure. What Curlin and colleagues found was that those medical practitioners who were more religious, who were male, and who, in fact, judged certain controversial clinical practices to be immoral were less likely to refer patients to other practitioners.

Curlin and colleagues have provided us with an important new body of data concerning inter alia physicians' perceived obligations to refer patients whose desired treatments violate physicians' consciences. What shall we make of their study and its results? Let us look at the Curlin et al. study itself. There appear to me to be at least the following three concerns about their methodology (concerns not discussed in the section on 'study limitations' at the end of their article): First, the appeal by Curlin et al. to 'terminal sedation'—defined as "administering sedation that leads to unconsciousness in dying patients" (p. 595)—is, at best, confusing and, at worst, profoundly misleading in this context. The concern is simply this: Is terminal sedation to be understood as merely administering sedation that leads to unconsciousness but does not shorten a patient's lifespan, or merely administering sedation that leads to unconsciousness that does shorten a patient's lifespan, or as induced unconsciousness combined with voluntarily stopping food and fluids, as this procedure is frequently characterized in the medical literature? (See for example, Quill et al. [1997]; and, in response, Howsepian, [1998].) Many clinicians might not find voluntary terminal sedation by itself to be morally problematic in terminally ill patients who are experiencing substantial pain and suffering, especially if this sedation does not shorten a patient's lifespan, however many clinicians might find this practice unethical if combined with the intentional withholding or withdrawing of nutrition or hydration for any reason. It would not be surprising if many of the respondents to Curlin et al.'s survey would have wondered what a question about terminal sedation understood, primarily, as not involving the additional withholding of nutrition or hydration, was doing on a list next to 'abortion following failed contraception' and 'prescribing birth control to adolescents without parental approval'. Second, the examples chosen by Curlin and colleagues are almost certain to dictate the results. Suppose, for example, that instead of using examples involving terminal sedation, abortion, and contraception, the examples involved elective amputation requested by fetishes (the chief aim of which is to enhance sexual satisfaction), head transplantation, and female circumcision. I would imagine that, in those cases, significantly greater than those twenty-nine percent of respondents in Curlin and colleagues' study would state that they have no obligation to refer patients to other practitioners in order to perform the procedures that the index clinicians declined to perform.

Call the following principle, the 'Principle of Selective Referral':

> *In at least some circumstances*, it is ethically permissible for medical practitioner S to refrain from referring a patient P to another medical practitioner S* for legal medical procedure X, with the intended purpose of S's referral involving S*'s performing X on P, if referring P to S* in order that S* perform X on P would violate S's conscience.

The negation of the Principle of Selective Referral, we will call the 'Principle of Nonselective Referral'. The Principle of Nonselective Referral, therefore, states:

> *Under no circumstances* is it ethically permissible for S to refrain from referring P to S* for X with the intended purpose of S's referral involving S*'s performing X on P, if referring P to S* in order that S* perform X on P would violate S's conscience.

Consider each of the following medical procedures in turn, in light of these Principles. Suppose that a man, Mr. Peter, approached a surgeon, Dr. Strawson, and said that he has a fetish involving amputation ('apotemnophilia'), that he is aware of the risks and benefits of the amputation procedure in question, since he is a surgeon himself (who is about to retire and is wealthy enough to afford adequate caretaking for the remainder of his life), and that he wishes to have all his limbs severed at their most proximal joints in order to enhance his erotic pleasure during sexual encounters with other amputees. The surgeon being asked to perform the elective fetish-desire-motivated[1] quadrilimbectomy requested by the apotemnophiliac declines to carry out the procedure, thinking that—regardless of whether or not the patient is genuinely consenting to the procedure—it would be, quite simply put, morally insane to perform it. What ought the conscientious surgeon in this predicament do? Ought she say that this is not something that she can, in good conscience, do but that there is a colleague of hers down the street (or in Scotland[2]), a Dr. Frances King, who might help and, subsequently, refer the elective amputation-seeking patient to Dr. King?

Or consider two women patients (or a woman and a man, or two men) approaching a neurosurgeon asking for cephalic exchange surgery. The request is that one person's head be severed and attached to the other person's body and vice versa. The primary reason given for the request is that this arrangement is the way that the couple has chosen to express their love for one another, by giving their bodies to one another in the fullest sense. Further suppose that following a reportedly thorough psychiatric evaluation, no significant psychopathology was detected (by the frequently dim lights of contemporary psychiatry) in either partner. The request itself is not medically unreasonable. Decades ago, the first primate head transplants were successfully performed on a series of monkeys. (White, et al., 1971) (It might or might not be important to note in this context that, given the current state of the art, cephalic exchange transplantations in humans, as is the case with primates, would result not only in bodies that have different heads, but also would guarantee quadriplegia in the cephalic recipients—a kind of 'two-for-one' for those who have an additional strong desire to live their lives paralyzed from the neck down.)

Finally, what about elective female circumcision—not on one's child, but on one's self? The desire here is to extinguish clitoral and labial pleasure once and for all by electively removing one's clitoris and labia minora in their entirety. The stated motivation of the hypothetical patient in this instance is that, after a great deal of reflection, it has been decided that lifelong extinguished sexual desire is preferable to episodic lifelong sexual arousal. In each one of these cases, what ought those physicians do whose consciences would be violated by following through with these requests? Should they refer to colleagues who would proceed where they are unwilling to proceed, or should they not?

Some might judge the examples cited as being unfair or at least unfitting. But why think this? Granted, requests for elective limb amputation—or elective amputation of other body parts[3]—are relatively rare. But the rarity of the requested procedure is irrelevant both to the underlying principle involved, namely, the principlist's 'principle of autonomy'[4], so far as the patient is concerned, and the Principle regarding referring to others what one cannot morally bring oneself to do, so far as the physician is concerned. But it is not, one might protest, simply what one is not herself morally able to do that is at issue. Ex hypothesi the request must also be legal, for that is what generated the quandaries in the first place: patients are requesting legal procedures. But is not amputation legal? Of course it is. How about circumcision, whether male or female? Yes, of course it is. And what about head transplantation? Yes, that too is legal. Or at least it is not illegal.[5] No one has, to the best of my knowledge, ever attempted head transplantation on adult humans. No matter. It is not as if surgical procedures are like medications that must be approved by the Food and Drug Administration in order to be legally prescribed and dispensed: all sorts of innovative surgical procedures have been performed with the informed consent of patients that have never been performed before, outside of standard experimental protocols. Head transplants are just one such innovative procedure candidate. If there are qualified, licensed surgeons willing to perform the procedure and if at least two persons give genuinely informed consent (and other safeguards are in place), then there would be in this instance nothing illegal about pushing ahead.

The issue of legality here, with respect to the aforementioned examples, therefore, is fairly straightforward. There are, however, more complex, controversial, and troubling cases. Not long ago, at the hospital in which I am a Staff Psychiatrist, an issue arose concerning the prescribing and dispensing of sildenifil (Viagra) to patients who are members of certain sexual minorities, namely, to those who are known pedophiles. So here is an uncontroversial 'medical problem'[6], namely, erectile dysfunction. Impotent pedophiles have been asking our medical staff to prescribe for them erectile enhancers. And, in every such case, these pedophiles firmly stated that their intention is not to use their erections in the service of pedophilic sex—an expression of sexuality that, at least currently, is illegal in the U.S. and its territories. Suppose that the physician being asked to prescribe sildenifil does a thorough evaluation, including psychiatric and phallometric evaluations, and judges that although physically not contraindicated (since the sexual minorities in question uncontroversially suffer from erectile dysfunction), since there is a high enough probability that his pedophile patients will (regardless of their repeated denials) engage in child sex, the physician is unwilling to prescribe for them this medication. So, in this case, one's patient's getting erections is not what is morally objectionable but, rather, what is of moral concern is what one suspects that one's patient will do with the erections that he gets. A pedophile's simply having an erection, or one's helping a pedophile obtain an erection, is not itself[7] illegal, rather what the pedophile does with the erection he gets certainly could be. Does not the pedophile have the same right to an erection as anyone else?[8] Well, if you are not willing to take the risk of prescribing a male enhancement aid to a pedophile, maybe your colleague is. Should you be the vehicle by which this 'treatment' takes place? It is, in light of this sort of clinical situation, not at all clear, as stated by Curlin et al., that, "the [medical] profession cannot permit physicians to refuse treatment of the sick on the basis of a patient's . . . sexual orientation" (p. 1891). Pedophilic sexual orientation is but one of multiple sexual orientations that pose serious problems for referral-related decision-making in clinical contexts.[9]

It should come as no surprise that the clinical examples presented in this essay are meant to make the reader uneasy. That, after all, is the point: if one relies solely on examples of medical procedures that a significant part of our culture has already accepted (such as elective abortion, contraception in teens without parental consent, and terminal sedation), then the proportion of those who choose not to refer patients to colleagues who are willing to do what one is unwilling to do is likely to be somewhat small, and the sense of moral outrage (as reflected in the 'Letters to the Editor' regarding the Curlin et al. study) will be aimed at those who believe that there is no obligation to refer in these cases (as opposed to those who feel obliged to refer). With other examples, however—as extreme as they are—the sense of moral outrage might be aimed in a different, in fact, in the opposite direction, namely, at those who would refer their patients to practitioners who are willing to do what the index practitioners are unwilling to do. The extreme nature of the examples is not, after all, unfairly loading the discussion in a direction aiming at non-referral; rather, it is intentionally and quite reasonably loading the discussion in precisely the direction it needs to go, since what is really being highlighted here is not an exploration of what physicians in early twenty-first century America believe they should do when confronted with conscientious objections to medical practices that are, by and large, already an accepted part of American medical practice, but with what, if anything, would dislodge physicians' (real or imagined) allegiance to the Principle of Nonselective Referral. So, the foundational question is whether the Principle of Nonselective Referral is false (and, hence, whether the Principle of Selective Referral is true). Once that question is settled, then the precise circumstances under which selective referral is morally permissible—that is, the precise circumstances under which the Principle of Selective Referral is applied—can be the focus of investigation. As things stand currently, some physicians believe that they endorse the Principle of Nonselective Referral, when in fact it is likely that they do not, in part because the examples of the kinds of medical practices that come into play in this context appear to be precisely the kinds of practices that, although controversial to some degree, are practices that a significant proportion of American medical practitioners not only tolerate, but affirm and endorse (and, correlatively, the kinds of medical practices for which consultants can be relatively easily found).

## IV

The Principle of Nonselective Referral has some potentially untoward effects on those who endorse it. Consider, for example, the intentional modification of homosexual orientation in the direction of monogamous heterosexuality. If one does not believe that homosexual orientation ought to be intentionally modified in this way, and if one's patient is asking for such sexual orientation change, then, according to this Principle, one ought to refer one's patient to someone who would be willing to effect this change, regardless of what one might think about the ethics of sexual modification therapies for homosexuals. One might, of course, attempt to neutralize this worry by responding that under no circumstances does there exist an obligation to refer one's patient to a practitioner for a clinical procedure that is futile. And, many have claimed, sexual modification therapy aimed at the sexual reorientation of homosexuals is futile.[10] Yet, Curlin and colleagues ask not only about non-futile options that are to be presented to patients, but all options. This, then, brings us to the third methodological problem with Curlin, et al.'s study, namely, their asking, as one of their three survey questions, 'Does the physician have an obligation to present all possible options to the patient, including information about obtaining the requested procedure?' The problem here is that this alleged obligation is unrealistic in the extreme. No physician has, I dare say, ever done this. It would be so difficult to do, for that matter, that, on this basis alone, it appears clearly to be false that any such obligation exists.[11]

Notice that the standard here is the presentation of all possible options, not merely all options currently available simpliciter, nor even all options currently available, for example, in the U.S., or in California, or in Milwaukee. Still, even if whittled down to all options currently available in Milwaukee, that would be a very long list of options for any single clinical problem, a list so long and difficult to compile that no single practitioner is likely to know how to compile it during a clinic visit, much less to present this list, intelligibly, to his patients. Not only are there multiple allopathic options, some relatively unknown, perhaps because there are only one or two case reports concerning them in the world literature, but there are also multiple homeopathic, osteopathic, naturopathic, chiropractic, and multiple Eastern medicine options, and more. If one stuck only to the allopathic options, one is still saddled with combing an enormous literature (controlled studies, case series, case reports, etc.) in addition to finding unpublished treatment options by talking with multiple allopathic practitioners. The task here is akin to the task of securing informed consent from patients by talking with them about all risks and benefits. Even a more circumscribed discussion concerning the risks and benefits of a certain medication spelled out in something like the Physician's Desk Reference is unrealistic; so much more is a discussion concerning all risks and benefits unrealistic. Yet, eighty-six percent of those in Curlin et al.'s (2007) study stated that they believe that physicians are obligated to present all possible options to patients. Astonishing.

Or is it? Am I being fair here? Clearly, one might respond, what was meant by Curlin and his colleagues, or at least clearly what was understood by the respondents to their survey was that 'all possible' did not really mean 'all possible' or even 'all actual' or even 'all allopathic actual', but something else. But what else? Here is one option: 'all possible' means 'all reasonable, or rational, or non-futile, or good, or appropriate[12] options that I am able to bring to mind at the time', or something close to this. The important issue at this juncture is not how best to specify the precise members of the set of clinical options in question in the context of the survey, but the fact that a modifier of some relevant sort is critically important here and the modifier is not merely one that circumscribes the clinical options geographically, or by philosophical school of medicine, or temporally, or in virtue of some access relation, rather, what appears to be of central importance is some normatively circumscribed range of clinical options. What counts as a reasonable, or rational, or good, or non-futile, or appropriate clinical option is, of course, highly contentious if only because it is based on values about which there are profound disagreements. What one person sees as futile, for example, another will not, not because one does not both see that the procedure or prescription is not making a patient better along some axis of health or other (about which they both can agree), but because they disagree about how the procedure or prescription is or is not contributing to a patient's well-being along other axes of health (about which they disagree), or how the procedure or prescription is or is not contributing to a patient's well-being overall.

Two examples will make the point quite clearly. Consider someone who has a homosexual orientation of some arbitrary degree and who wishes to alter that orientation just enough for him to marry, stay faithful to his spouse for the duration of his life, and father children with his wife. Almost no one would dispute that the psychological sciences are capable, at least in some cases, of delivering what this person wishes. Still, one might respond that any 'treatment' that this individual undergoes will, in fact, never really change his 'sexual orientation' because it will never change this individual's most fundamental sexual attitude toward persons of his own sex. Therefore, one might conclude, the proposed treatment, ultimately, is futile. Further, one might argue, damage is being done to the individual so 'treated' with this 'futile' treatment, since his deepest sexual yearnings along with the satisfactions of those yearnings will be blunted, deformed, crushed, suppressed, bent in a direction opposite to his 'personal nature', twisted in a direction opposite to the vector of his deepest font of self-fulfillment, violating his very core identity. (Oddly, only very few people, perhaps, would say this about pedophiles' sexual identities or the sexual identities of those who, like a patient on whom I consulted a couple of years ago, preferred above all else, sexual contact with dead, plucked, raw, and gutted chickens, or the sexual identities of myriad others with currently less popular, legally unprotected sexual orientations.) A second example: one might claim that a treatment of Persistent Vegetative State (PVS) patients that does nothing more than keep these patients alive in a totally unconscious state is futile, while another might claim that any life-preserving treatment of PVS patients is not futile precisely because such treatment keeps PVS patients alive.[13]

In addition, what one person judges to be a rational treatment, another may not, based, for example, on an evidence-based approach as opposed to an experience-based approach to medical practice, or based on weighing the agreed upon evidence that exists quite differently. There is, after all, substantial debate concerning the worth of 'evidence-based' approaches to medical decision-making (as discussed, for example, in Little [2003], Michaelson [2004], Ryan [1998], and Zwitter [2001]). And even among those who wholeheartedly endorse evidence-based medical practice, there is a lively discussion concerning the nature of evidence, the relationship between evidence and decision-making in specific cases, the value of certain kinds of evidence, etcetera. Finally, there is the highly contentious issue of what 'health' amounts to. The problem is most prominently debated in psychiatry, but it is also apparent in all other branches of medicine. Curlin, Lawrence, and Lantos (May 2007) state that, "the primary goal of medicine . . . is to restore the health of those who are sick" (p. 1891), but what counts as health and sickness is hotly contested in medicine, whether it concerns the level of cholesterol or fasting blood glucose that counts as having dyslipidemia or diabetes, respectively, or whether it concerns the question of transsexualism's (or 'Gender Identity Disorder's') being a disease state (as currently affirmed by the American Psychiatric Association) rather than a robust state of health, as currently argued by many gay, lesbian, and transgendered rights activists.

There is, finally, one other reason for doubting that it is obligatory for physicians to present patients with all clinical options relevant to their cases, even if this were possible, namely, because there is good reason to believe that, if this were done, some patients would, thereby, choose options that they might not have otherwise chosen and that are clearly not in their best interest to undergo. In fact, there is good reason to believe that many patients would choose options that are downright harmful. So, suppose, for example, that oncologists, as a matter of course, presented to their patients the option of treatment with Laetril (laevo-mandelonitrile-beta-glucuronoside)—a 'treatment' that is difficult to obtain in the United States, a 'treatment' that many believe is ineffective, that appears to provide side effect burden without any plausible benefit, but a treatment that has been heralded by some advocates as being a potentially curative agent for some forms of cancer when nothing else will work. There are multiple such 'miracle cure' 'treatments' that, although disputed by most in mainstream medicine, are not disputed by all, and, in fact, are heralded by substantial numbers of those outside of the mainstream. In light of the glimmer of hope that such 'treatments' provide to those who have lost hope, there is very little ability to resist, very little ability critically to analyze 'treatment options' such as these. So, how is the conversation with a patient in this situation supposed to proceed? Should the physician tell the patient about Laetril, only immediately afterwards to say, "I don't recommend Laetril, the studies for its efficacy are not promising . . ." at which point the patient's eyes are likely to glaze over, at which time she hears nothing more that you have said. She'll try it! Why bring it up in the first place? What is the point? Perhaps some principle akin to 'therapeutic privilege' can be brought to bear on this situation and many others (where 'therapeutic privilege' involves one's refraining from dispensing information about diagnoses or treatments that might harm one's patients, including harms received from not acceding to treatments that appear to be in their best interests).

## V

It is important to note that the Principle of Selective Referral is not, of course, a principle of absolute non-referral in those cases in which a practitioner's conscience is being violated. This Principle leaves open the possibility of referring some patients to colleagues who are willing to do what you are, on certain moral grounds, unwilling to do. But, one might wonder, is this a coherent position? Could it ever be ethically appropriate to have someone else do what might be considered to be your medical 'dirty work'? Yes, I believe that it could be. There are some acts that it would clearly be unethical for certain persons to perform, but ethical for others to perform. Roman Catholic priests, for example, because of their vows, are morally prohibited from marrying, but most other Roman Catholics are not so prohibited. Observant Orthodox Jews are prohibited from working on the Sabbath, but gentiles are exempt from this prohibition. According to the

American Psychiatric Association (Section 1.4), psychiatrists should not participate in legal executions, but this does not imply that others should not so participate. In general, someone who has made a promise not to perform certain acts might not at all object to someone else's performing those acts. (Someone who marries one person, for example, promises not to marry anyone else, at least during the time that one remains married to one's spouse. That married individual, therefore, promises not to marry the lady next door, but that does not mean he would object to someone else's marrying the lady next door, or that he would refrain from sending a man over to visit the lady next door for purposes of courtship and eventual marriage, although he would, at that time, not seek this lady's romantic companionship himself.) More generally, some acts that are, in fact, not immoral might be licitly performed by one person, but not by another, since one might firmly, but incorrectly, believe that the act in question is immoral and, hence, refrain from performing it on that basis. Or weaker yet, one might be prohibited from performing a certain action because one believes (wrongly) that what one would be doing is simply likely to be morally wrong, or perhaps one is simply unsure of the morality of one's act, and believes he should not perform it for that reason, while someone else, who knows that the act in question is, in fact, morally right would have no problems performing it. Alternatively, one might believe (truly or falsely) that if one performed a certain action - an action that is known to be moral in itself—one's performing that action at a certain time and place is likely to be an occasion for someone else's doing evil or someone's else's undergoing some other form of harm. A situation like this is described, famously, in the New Testament (I Corinthians 10) in which the Apostle Paul warns those who choose to eat meat sacrificed to idols not to eat such meat (something that, in itself, is not immoral or unlawful) in order not to be a stumbling block for their weaker brethren in the faith. Finally, an otherwise moral action performed by you might convey to others the appearance of evil and, hence, ought not for that reason be undertaken by you, while it might not convey that appearance if performed by someone else.

There will be other cases, however, in which acts are intrinsically unethical and are known to be intrinsically unethical, for which referral would be wholly inappropriate. Elective abortion and homosexual acts are, arguably, examples of such acts. A girl or woman who is asking for an elective abortion (an elective intentional killing of the most dependent, innocent, and vulnerable of human beings) is asking you to be the agent of an act that is arguably so profoundly disordered that not only ought you not provide it, but no one ought to provide it. The same arguably holds true for those individuals who come to therapists looking for affirmation or celebration of their homosexual orientations, guidance regarding how best to engage in homosexual sex, or a closure of their homosexual identities (what Howsepian [2004b] calls, generally, 'homosexualization'). Homosexual sex is, on this view, so profoundly disordered that not only you, but no one, ought to participate in one's patient's further intentional homosexualization. (Mutatis mutandis regarding myriad other 'sexual orientations', sexual acts, and 'sexualizations.'[14]) It would, therefore, be morally prohibited to refer a girl or woman to a healthcare provider who is willing to carry out an intentional elective abortion, with the intended aim of your referral's being that your patient undergoes an elective abortion by the healthcare provider to which she is referred, under any circumstances, or to refer someone to another healthcare provider in order to further the process of one's patients' desired homosexualization, fetishization, or pedophilization under any circumstances. Curlin and colleagues' (February 2007) examples of medical practices are confusing, in part, because they mix acts that many judge to be intrinsically unethical, such as elective abortion, with acts the nature of which are unclear, such as terminal sedation, with acts (such as providing birth control to teens without parental approval) that although not generally believed to be intrinsically unethical, practically speaking, in most instances, would be expected to facilitate what many believe to be intrinsically unethical behavior.[15,16]

The Principle of Selective Referral is, however, much larger in its implications than simply governing how persons with certain, perhaps idiosyncratic, moral convictions practice medicine. Even if one had no moral qualms at all with any current medical practices, the possible evolution of medical culture in the direction of profound violations of conscience is real, if only because, historically, such cultures have arisen and were, but for 'the beauty of our weapons'[17], on the verge of metastasizing to globally distant sites. There is no better example, perhaps, in the twentieth century than the horrors of Nazi medicine, as documented, for example, by Lifton (1986). Those who deny the Principle of Selective Referral would be obliged, in some instances, to refer patients to physicians whose interests, in the grand Nazi medical tradition, involved the systematic degradation, humiliation, and destruction of ethnic minorities in the guise of medical practice. What is needed here is something akin to 'cultural empathy' – the ability to place our culture into the shoes of another. Just as 'but for the grace of God go I', so too, on a grand societal scale, what happened there then could happen here now. The imaginative task is one in which one finds oneself living, at some future time, under a regime that is, currently, subjectively judged to be an evil regime, and in which one's judgments have become transformed at that later time resulting in one's then judging the previously judged evil regime to be good. It is no surprise, for example, and it is robustly consistent with the real possibility of cultural transformation in the direction of further barbarism, that a majority of those psychologists, psychiatrists, and others who are involved in 'genocide studies', are especially intrigued not so much with the architects of genocide, but by the 'foot soldiers'—the ordinary, everyday people who are so easily recruited to carry out the genocidal plans of their leaders. James Waller (2002), for example, painstakingly describes inter alia the social, cultural, and psychological forces at work in the lives of ordinary persons, including patterns of social dominance, dehumanization and projection, group cohesion, mergers of role and person, moral disengagement, 'rational' self-interest, ethnocentrism, and xenophobia that serve as the foundations for the development of extraordinary evil in otherwise ordinary citizens.

Experimental 'medical' procedures should also be mentioned in this context. How, after all, could one deprive patients of experimental 'treatments' that were available and that a patient wanted? What patients 'want', of course, is itself a tricky thing to discern. What is consent, really? When patients are asking for procedures, when do we stop the cascade of inquiries/investigations before stating that, yes, in fact the person asking for the procedure really does want it and is in fact consenting to it? Does everyone need psychoanalysis to get at what one's real desires are? Complexity quickly ramifies at this juncture, for one's 'real' desires might be a profoundly confused admixture of opposing or vague or ambiguous desires. Then what? The discussion, at this level, has the potential either of sliding backwards into massive paternalism—"She does not know what she really wants, but I do"—or forward into unbridled 'autonomy'—"Whatever he says that he wants, if he says it firmly and repeatedly and if it is properly informed, is what he really wants." The critical point is this: if we used the same criteria to decide when someone wants a medical treatment under a Nazi medicine regime as we currently use, almost no one practicing medicine today would deny the Principle of Selective Referral, for should such a regime again take root, some people will voluntarily seek its services in spite of the fact (or, on occasion, because of the fact) that degradation, humiliation, and destruction are precisely what they will receive. If, as recently occurred in Europe, Brend Juergen Brandes voluntarily gave himself up to the German cannibal Armin Meiwes, as advertised, for the purpose of "slaughter and consumption," then it can safely be predicted that many other persons with interests in degradation, humiliation, and destruction—whether recognized by them as conforming to those descriptions or not - will seek out medical practitioners for all manner of degrading, humiliating, and destructive medical treatments and experiments. And if you cannot provide the proper level of degradation, humiliation, and destruction, perhaps a colleague down the street can?

In this light, the Principle of Selective Referral provides a bulwark against tyranny. It is one element of a culture that rightly resists totalitarianism, dictatorship, and genocide. The preservation of the integrity of conscience in the medical domain is, therefore, a prescription for the preservation of democracy, a barrier to fascism and its multi-armed control of its citizens. Curlin, Lawrence, and Lantos (May 2007) may have said it best,

> Conscientious practice in a pluralistic world is messy even when peaceable. Yet the alternative is a society in which physicians are required to forfeit conscience in order to join the profession. Patients will not be well served by moral automatons who shape their practices, without struggle or reflection, to the desires of patients and the dictates of whatever regime is currently popular. (p. 1892)

Just so.

## Endnotes

1. For an especially illuminating discussion concerning the ethics of self-demand amputation, see Tomasini (2006). Some do not conceptualize the desire to amputate healthy limbs, in every case, as a paraphilia (as discussed, for example, in the seminal paper by Taylor and Money, [1976], and as also discussed by Everaerd, [1983]); rather, some of these cases appear to reflect a disorder of identity, similar to Gender Identity Disorder. See, for example, Lawrence, (2006); First, (2005); and Berger, Lehrmann, Larson, Alverno, and Tsao, (2005). The parallel is striking, especially in light of the widespread acceptance in current medical practice of, for example, penectomies in male-to-female transsexuals. Penile amputation is done in these cases because of a perceived mismatch between one's anatomy and one's 'gender identity'. So why not limb amputations when there is a perceived mismatch between one's anatomy and one's more general 'somatic identity'?
2. I parenthetically mention 'Scotland' in this context, because a surgeon in Scotland, as reported by Johnston and Elliott, (2002), chose, in a similar context, electively to amputate the legs of two physically healthy persons who, the surgeons claimed, 'consented' to this procedure.
3. With the exception, perhaps, of penectomies in transsexuals, although whether this is an 'elective' procedure is controversial. While practicing general medicine several years ago, I was asked by a female patient to perform an elective bilateral mastectomy or, if I could not do so, to refer her to a surgeon who would. She worried that, although she had no known personal or family history of breast cancer, and although her breasts showed no current signs of disease, she would prefer not to have breasts so that she would not have to worry about the possibility of having breast cancer in the future. Another patient of mine who had suffered a stroke, who was

not psychotic, and who did not have an identity disorder, asked for amputation of his hemiparetic limbs even though it was explained to him that there is nothing wrong with his limbs but, rather, with his brain. More recently, I evaluated a non-psychotic patient who wanted one of his fingers amputated and placed in a jar, "to remind me of my rage." (He explained that his plan was to focus all of his rage and other bad feelings into that one finger.) This same (young adult) patient wanted all of his teeth pulled so that he might wear specially fashioned dentures with fangs, as he had a long-standing fascination with vampirism.

4. Where a 'principlist' is an adherent to 'principlism'—that widely embraced moral view derived from Beauchamp and Childress's highly influential Principles of Biomedical Ethics. For a richly textured and thoughtfully contextualized historical discussion concerning the 'principle of autonomy' in medical ethics, see Bishop, et al. (2007). Bishop and colleagues correctly point out that, rather than 'autonomy' (in any of its several senses), sometimes patients' require "expert direction" from physicians, as had been dispensed by physicians in ancient Greece: "The ancient physician viewed himself as the protector of the patient – a person who would use his knowledge to advise the patient in ways that would promote health over disease. Indeed, the physician might be expected to push the patient, for his own good, to do something that he might not want to do. . . . Plato's . . . [d]iscussants in Gorgias, his dialogue on rhetoric, use the physician as an example of someone in the position of persuading the patient to do what is of benefit to his health" (p. 165).
5. Of course, if all does not go well, then a malpractice lawsuit might be brought against the surgeon involved, but (if the informed consent process was meticulously followed and if other necessary safeguards were in place) that would be a civil, not a criminal, matter.
6. This needs to be said if only because, as Curlin and colleagues state in reply to those who wrote letters to the Editor of the New England Journal of Medicine (May 2007) concerning their study, the practices of terminal sedation, abortion, and contraception, "are controversial precisely because there is disagreement about whether they are consistent with the goals of medicine" (p. 1891).
7. What, one might ask, would a pedophile want with an erection that he cannot use for pedophilic sex? Many things, it seems: masturbation, for one (either to erotic stimuli involving children or to other erotic stimuli); adult heterosexual sex, for another (not all pedophiles, after all, are exclusively interested in prepubescent children); and, finally, for the feeling one gets simply in virtue of having an erection at desired times. I have had at least one (non-pedophilic, heterosexual) patient tell me that simply having the ability to get an erection, and getting an erection at appropriate times, made him feel whole, feel like a man, even if he never recruited his erection for use in sexual contexts.
8. Pedophilic sex is currently illegal in all 50 United States. Prostitution between adults is not. I have seen at least one erection-impaired patient who admitted obtaining prescriptions for erectile enhancers in California, with the explicit purpose of traveling to one of Nevada's counties in which prostitution is legal in order to frequent his favorite brothel there. For those of us who believe that prostitution is, well, a form of prostitution, whether it is legal or not, are we not ethically permitted, if not obligated, to refrain from filling such patients' prescriptions? Some might claim that situations which occur with greater regularity in this country, namely, persons seeking erectile aides explicitly in order to use their erections for purposes of illegal sexual activity with prostitutes outside of those several counties in Nevada, are, in virtue of their illegality, much easier to adjudicate. And, perhaps, one might claim that if one were practicing medicine in some of those Nevada counties themselves, then the decision would be easier still. But would it? What does the legality of the activity have to do with anything in this context? If the entire State of Nevada, in their collective wisdom, legalized pedophilic brothels, should this really make anyone's decision concerning the prescribing of erectile enhancing medication for the express purpose of having pedophilic sex in these brothels any easier? (I ask 'should', not 'would', because I think I know that, inexplicably, making pedophilic sex-for-sale legal in Nevada would change some clinicians' prescribing practices—in the direction of prescribing a legal medication for a legal purpose for use during legal pedophilic prostitution. Profoundly sad, but, for multiple historical reasons, I think, true.)
9. For a more extensive discussion concerning the ethics of referral in contexts concerning sexual modification therapies, see Howsepian (2004b).

10. The falsehood of this claim is argued by Howsepian (2004a).
11. Robert Veatch (1995) predicts the demise of informed consent because of considerations related to this one. For a response to Veatch, see Howsepian (2006).
12. It is, according to the American Medical Association, the patient's right "to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives." (Section E-10.01, emphasis not in original) It is precisely what counts as 'appropriate' treatment that is at issue. Narrowly defining 'appropriate' merely as what is 'legal' in this context would be absurd, as is discussed in Part V.
13. For discussions concerning those in PVS and other coma-like states, see Howsepian (2006b).
14. Sexual orientations come in many varieties, including orientations toward violent sex, shoes, feces, the elderly, dead chickens, infant children, animals, human corpses, persons of the opposite sex, transsexuals, persons of the same sex, women without limbs, car exhaust pipes, etc. In fact, the American Psychiatric Association officially arguably appears to recognize over 20 sexual orientations including apotemnophilia, asphyxophilia, autogynephilia, bisexuality, coprophilia, exhibitionism, fetishism, frotteurism, heterosexuality, homosexuality, gerontosexuality, klismaphilia, necrophilia, partialism, pedophilia, sexual masochism, sexual sadism, telephone scatologia, toucherism, transvestitic fetishism, urophilia, voyeurism, and zoophilia (as noted in its Diagnostic and Statistical Manual of Mental Disorders, 4th Edition - Text Revision, pp. 566-582). Of course, most of these sexual orientations can be further specified as being heterosexual, homosexual, or bisexual in type. Very recently, in a widely publicized case, a man in California, Mr. Jack McClellan, publicly declared his heterosexual pedophilic sexual orientation. Mr. McClellan's 'coming out' as an avowed law-abiding heterosexual pedophile (i.e., as a pedophile who, although sexually attracted to little girls, had not in the past and had no present or future intention of having sexual contact with little girls) was not warmly received by many of the same people who encourage disclosing other, less socially inflammatory, more politically accepted sexual orientations to friends, co-workers, and family. It is no wonder that there appears to be great reluctance on the part of those advocating for laws that criminalize discrimination on the basis of 'sexual orientation' to say, precisely, what is meant by the term 'sexual orientation' as it appears in the body of the laws proposed. The dilemma appears to be this: to say that by 'sexual orientation' what is meant is simply homosexual, heterosexual, and bisexual orientations is to appear self-serving, narrow-minded, overly conservative, provincial, in fact, discriminatory. While, on the other hand, saying that the concept of 'sexual orientation' embraces a very wide continuum of sexual appetites commits one to including as 'sexual orientations' several 'alternative sexualities' (e.g., many of those sexual orientations endorsed by the American Psychiatric Association) that gay rights advocates, at least for political reasons, might not wish to associate with their political cause. The number and variety of 'sexual orientations' on this continuum are dizzying, and will vary depending on whether one is a 'chunker' or a 'splitter'. On one extreme end of this 'sexual orientation' continuum, for example, Howsepian (2004a) argues that every individual's sexual orientation is sui generis. On the other end are those who, like many in the highly politicized pro-homophile community, implausibly state that there are precisely three sexual orientations, viz. homosexual, bisexual, and heterosexual.
15. Those moral traditions that prohibit one's engaging in 'contracepted acts' do not also prohibit the use of contraceptives simpliciter. The Roman Catholic moral tradition, for example, does not prohibit the use of contraceptives or even being involved in sexual activity while using a contraceptive, but does prohibit, in every instance, 'contracepted acts', i.e., voluntary participation in sexual intercourse whose procreative end is intentionally blocked.
16. The worry in this domain cuts both ways: persons who find homosexuality morally and emotionally disordered might, or at least ought to, be reticent to refer patients for further homosexualization, even if this is explicitly requested by the homosexual patient himself; on the other hand, those who find homosexuality to be just another normal, adaptive sexual orientation, might be (and in my experience, on many occasions have been) reticent to refer patients for full-bodied re-orientation or even partial 'modifications' of their sexuality in the direction of monogamous heterosexuality.
17. "I'm guided by a signal in the heavens. I'm guided by this birthmark on my skin. I'm guided by the beauty of our weapons. First we take Manhattan, then we take Berlin." Leonard Cohen, 'First We Take Manhattan', from "I'm Your Man", 1988.

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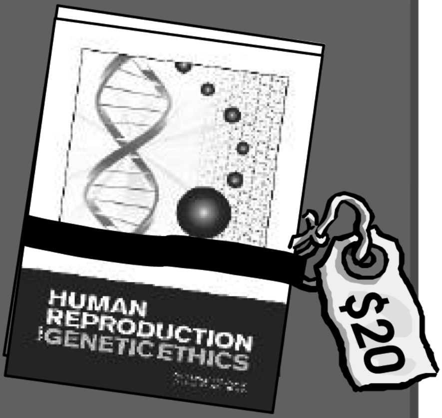
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# ETHICAL DILEMMAS IN TRIAGE: A PERSPECTIVE FROM THE JEWISH PHILOSOPHICAL TRADITION

D. M. S. BODANSKY, BMEDSC (NEUROSCIENCE)

## Abstract

*Triage is a system for deciding which patient to treat first in an acute setting. It divides patients into three groups: those who can wait, those who can be saved with timely treatment and those unlikely to survive despite treatment. This article examines the Jewish ethical perspective on triage as the basis for a clinician's moral approach and to see whether it is concordant with current UK procedure. The Jewish view prioritises patients firstly according to the seriousness of their condition and the ability to save their life. This is broadly similar to usual triage practice. Then, according to the Jewish view, if two patients have similar levels of clinical need, they would be seen on a 'first come, first served' basis. After that, the degree of kinship to the doctor is considered and lastly the patient's social worth. Age is not a factor that is utilised for prioritisation. The Jewish view of triage is therefore based not only on clinical priorities but also considers additional social issues. This approach provides additional layers of prioritisation based on moral factors for the clinician, beyond the simple three levels of need used to triage acute patients.*

## Introduction

It is 4:00 a.m. in a small general district hospital in the North of Scotland. It has been a slow night in the hospital's Accident and Emergency (A&E). Suddenly, the phone goes, informing you, the doctor on duty, that there has been a serious car crash. Two patients, both badly injured and both requiring immediate surgery are on their way and will arrive shortly. To your dismay, you realise that with the personnel and facilities available, you will only be able to operate on one, leaving the other to die.

This article analyses and explains triage and attempts to answer some contemporary ethical questions concerning the practice and application of triage by recourse to traditional Jewish, rabbinic, thought. I use the above example to illustrate the problems involved but use other examples for specific principles. I discuss resource allocation within a wider setting and then focus on triage more specifically. I compare the traditional Jewish view with the procedure used by UK hospitals, to see whether they are compatible or whether there are areas of conflict. There are several questions that I intend to resolve: How can a doctor choose between two patients? What are the criteria that one must consider and utilise to make one's choice? Which take precedence? And finally, which patients come first, all else being equal? The system used to help make these decisions is called 'triage'.

## History

Triage is a system whereby a group of casualties or other patients is sorted according to the seriousness of their injuries or illnesses so that treatment priorities can be allocated between them. In emergency situations it is designed to maximise the number of survivors.[1] The word 'triage' comes from the French *trier*, 'to sort', and that from *tria*, 'three' in Latin.[2] The invention of the triage system is attributed to Dominique-Jean Larrey, a French military surgeon serving in the Napoleonic Wars. [3] His system split patients into three groups, regardless of social class: those with minor injuries who could therefore wait, those who were badly injured but would probably survive if given immediate treatment, and those who were so badly injured that they would die regardless of the help they would receive. Triage concentrated the surgeon's efforts in the middle category.[4]

## Modern applications

Triage is the emergency application of the allocation of scarce resources: How can I best utilise the available resources? In economic terms, this is known as the 'opportunity cost', the sacrifice of alternatives in the production of a good.[5] With £5000 ($10,000), a hospital could afford one coronary artery bypass graft, three defibrillators or 1000 TB jabs. The choice of one comes at the price of the other two options. To treat one patient, comes at the cost of not treating others, either present, or who might enter whilst the doctor is occupied.

We rarely have the luxury of abundant resources and even when we do, there are always areas such as dialysis or available ICU beds that are in short supply. In 1940, when penicillin was first used to treat a patient in the Radcliffe Infirmary, Oxford, they had such small supplies that they recycled penicillin recovered from his urine in a desperate attempt to save his life. The patient died due to insufficient penicillin stocks to combat the Gram-positive infection. Soon afterwards, there was enough to treat one or two patients, but by the end of the war, penicillin was being produced in sufficient quantities to save the lives of many previously unsalvageable patients. However, in those early days with very precious supplies, it would have been agonising to determine who would have had priority if, for example, Roosevelt and Churchill had both fallen ill!

## Macro and Micro Levels of Allocation

Resources are allocated at two levels: at a macro level, with distributing money to different areas and then at a micro level, concerning individuals. In order to balance these demands, it is necessary to work out what level of care a society should aim to provide. Patients may have a basic moral right to treatment, but perhaps society does not need to provide it for them. In America, most sectors of society are expected to provide their own health insurance.

### *Duty to Provide Treatment*

Within Judaism, doctors have a commandment to practise medicine from the Torah (the Old Testament).[6] It explains that if two men fight and one is injured, the aggressor must pay for the other party's loss of earnings and also for him to be healed. There is an expectation that there are qualified people who can heal and they should be paid for their services. It should be noted that although they are doing God's work, they do not have to do it for free.

Judaism believes that when God created the world and nature, He created a framework for doctors to work within. God provides the cure, but expects man to facilitate it. In addition, our Rabbis not only allow, but also command, doctors to heal.[7] Maimonides, a rabbi and physician from the twelfth century, explains in his commentary to the Mishnah (the oral part of the Torah) that the requirement to heal stems from a commandment to return lost items to their owners. Anyone who is able to return a sick person's health must do so.[8] Maimonides also gives various pre-requisites in order for Jewish people to live in a city, one of which is the presence of a competent doctor.

The right to treatment has been established, but the right to health is a greater demand. Basic treatment to save life, and, if possible, to improve its quality, is reasonable and mandatory. The World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[9] The right to health is a much larger request. With limited resources, it might be possible to cure some curable people all the time, or treat most people most of the time, but not all people, all the time. If people have a duty to take care of their health, they have to be able to do it. Society has to be able to accommodate this command.

## *Macro-allocation of Resources*

A doctor's primary duty to heal has been established, but society may make a decision that it is not possible to fund that healing. How does the doctor's command to heal anyone fit in with society's inability to heal everyone? Jewish law is based upon precedents, and I wish to draw upon two classic ones discussing scarce resources to make a distinction.

There are two men staggering through the desert because their vehicle has broken down and they have almost finished their water. One of the men is down to his last water bottle whilst his friend has finished his entire supply. By his calculation, the water bottle is enough to last just him back to town, but if he shares it with his friend, they will both die. He doesn't know whether to share it or keep it for himself. Rabbi Akiva, one of our most famous rabbis rules that he should keep it for himself as his own life takes precedence.[10] He reasons that he is not allowed to sacrifice himself in order to save another based upon "the blood of one person is no redder than the blood of another."[11] The opposing opinion, that is not followed, is that the person must share his water and both die, rather than stand by and let his friend die of thirst.

There are two towns, A and B, on the banks of a river. Town B is downstream of town A. There is just enough water flowing through the river to provide drinking water for both towns but not enough for other uses. There are many Talmudic opinions on what to do, but we usually follow one particular authority. It states that Town A is allowed to use the water not only to drink, but also to wash clothes and for bathing, in order to prevent an outbreak of disease, even if this deprives Town B of its vital supply of drinking water.[12]

The former scenario discusses the decisions of an individual in a life and death situation—'life boat' ethics. The latter shows that a society has more long-reaching concerns and a wider range of consequences to take into account. It needs to ensure not only that its citizens not die of thirst today, but also do not die of disease tomorrow.

On a macro allocation level, a society needs to ensure that all sectors of a society are catered for, to reassure its citizens that it is functioning normally and prevent psychological anguish. It must provide a full range of facilities, because in Judaism, psychological wellbeing is a real tangible concern and is treated with equal importance as physical factors. This is taken from the example of someone with a serious illness. Autonomy would argue that they should be told about the extent of their illness. Jewish law believes that they should not be told the extent of their illness, to prevent them becoming depressed and giving up hope. They should not be told other bad news either, for example, if a family member passes away. Normally they would have a command to sit in mourning for their relative, but they should not even be told about this, to prevent them from sustaining psychological distress. [13]

The basis for choosing one person over another in Jewish law comes from the redemption of captives. This is highly important within Judaism, as in giving them back their freedom you are giving back their lives. In fact, a person must use all his money to redeem a relation. However, the source stipulates that you can only pay a captive's worth and not an excessive amount. This is to prevent encouraging further kidnappings, which will bankrupt the community. To provide for this individual who is in dire need now, the society would have to deprive it of other services and ignore longer-term issues.[14]

We can extrapolate that if we must draw a line when paying a ransom to free a captive, then a fortiori, we must also set a limit on how much society should spend to save the life of a sick person. If limits must be set on what is an excessive financial demand, then perhaps it is not acceptable for Herceptin, an expensive breast cancer treatment, to be provided on the NHS (National Health Service) when other, more basic needs would not be fulfilled for other patients. Taking a more global view, all the ICU beds in the world would not do a society any good unless there were funds to provide defence (e.g. fighter jets) for that society. Therefore, Judaism provides guidance on what would be an acceptable level of funding of health care. Today a body such as NICE (the National Institute for Health and Clinical Excellence) would fit into this context.

The amount spent on treatment and prevention of illness is regulated in Judaism, as treatment, once started, cannot be withdrawn through lack of funding, as this would lead to death.[15] More can be spent on prevention, as long as it is not as an alternative for funding the treatment of patients with existing facilities. One must make sure that both are catered for, to at least an acceptable basic level.

In my first scenario, about the hospital in Scotland, it was only allocated with the resources to deal with one patient at a time that night. Given that constraint, we can examine how the hospital's resources should be utilised when faced with two patients at once, according to Jewish principles.

## *Micro-allocation of Resources*

There is no agreed procedure for triage in the UK. The most commonly used systems are the UK national triage scale and the Manchester Triage System.[16] Both these systems are designed to evaluate patients with respect to their clinical priority. The former uses a five-point scale,[17] and the latter uses a complex series of signs and symptoms to grade each presenting complaint and then discriminate between clinical priorities from a 250-slot priority matrix.[18] After that, the principle of 'first come, first served' is used. There are no additional ethical criteria involved, such as welfare maximisation with younger people coming first prioritised over older people.[19] The Jewish view agrees that someone in more need comes first, as this is in accord with the principle of saving a life. However, the Jewish view is an ethical system, which gives additional priorities, all else being equal.

But why should we even attempt to analyse a modern problem with such an ancient source? It could be that the Jewish Rabbinic view is completely irrelevant to current medical practice. Our current triage systems attempt to rationalise everything and establish a clinical priority to treat a sick person. The discussion goes beyond this to competing views of medicine. All the Jewish sources we have looked at show medicine in broad terms. Judaism has a holistic view that we are treating a person, not an illness.

A comparison can be drawn between the Hippocratic Oath from the fourth century BCE and the Physician's Prayer, written in the twelfth century CE by Maimonides, the physician and rabbi. Kaplan comments on the difference in approach to disease.[20] Hippocrates viewed disease as an enemy, to be fought by the physician with the patient's help—a disease centred model of illness.[21] In contrast, Maimonides wrote that an illness is reflective of the patient's behaviour and acts as a messenger to induce the patient to change his lifestyle—a holistic view. When it comes to treating people, other, wider factors need to be considered, not just the worst case or who arrived for treatment first.

## An Approach from the Jewish, Rabbinic Tradition

Regarding the scenario presented in the introduction above, the two men are on their way to the A&E (Accident and Emergency) unit, and both are probably salvageable if given swift treatment, but there must be some criteria to judge between them. I discuss this decision using criteria established with a Jewish rabbinic perspective, beginning with the most important and working down.

After assessing both patients, it is realised that one can probably be saved, but unfortunately, the other patient has a much worse prognosis. The salvageable patient comes first as this is a simple case of Pikuach Nefesh, the important Jewish principle of saving a life, that overrides almost every other commandment.[22]

The next criterion to consider is what happens if both men have equal injuries. In Judaism, one is not allowed to bypass one mitzvah or good deed to do another comparable good deed. Thus, the physically nearer patient would have priority. [23] The doctor must start treatment on the nearer patient and accept the demise of the other as he is fully engaged and cannot help him. The concept of 'first come, first served' is the doctor's second priority.

These two principles interplay when the salvageable person is further away. The former principle overrides the latter as there is an opportunity to save a life, which is of primary concern so that one may walk past the nearer patient. However, if the nearer, sicker patient is conscious, one could not walk past him. The act of sidestepping him would cause him to despair and that tangible effect could quicken his demise. This is forbidden, as it is doing harm. Instead, it would be necessary to stop and treat him out of kindness and ignore the salvageable person further away as one cannot cause the nearer patient to die more quickly to help the other patient further away.

To alter the scenario slightly, the two men are equally badly injured and arrive simultaneously. When one walks in the room they are equidistant. It is now difficult to discern who should be treated first. The degree of kinship the patient has to the doctor should now be considered. There is a commandment in Judaism not to 'stand aside while your fellow's blood is shed'.[24] The closest level is that of a blood relation and extends outwards in concentric circles. One's family comes first, then neighbours, the community, the city, the nation, and so on. This principle is also used when allocating charity within Judaism.

From a Western ethical perspective, one would think that everyone should be treated equally,[25] but the Jewish view does not believe this is realistic. If one's brother and a stranger came in, one would choose to save one's brother, no matter whom the other person was. Judaism does expect equality of access to services under most circumstances, but perhaps it is simply more honest when it says that it is not always possible to be entirely disinterested in all situations. Nevertheless, this important principle of kinship would not apply frequently in everyday current practice, as most patients would be unknown people from the same locale.

Social worth is the last factor to be considered in the rabbinic tradition. Consideration of this aspect is derived from a Talmudic discussion on the redemption of captives. [26] It starts by reiterating that there are many factors to be considered that would make people unequal in their priority of being redeemed. An example given is if some terrorists were to capture a group of men and women. Women should be redeemed first, not for intrinsic worth, but because of the danger of rape, which makes their captivity unequal to that of the men. The Talmud gives a list of people who take precedence over each other, all else being equal. It mentions that a scholar is redeemed first, then a King of Israel, High Priest, a Prophet and so on. This scale of 'social worth' is not of intrinsic importance, but of social need. A scholar's knowledge would be lost to the world, but a King could be replaced. This definition of social worth is not a preference for the rich and powerful or the king would have been saved first. It is a Utilitarian type of principle which measures the value to society or what would be lost if that person was not saved.

It is important to note that there is a recognition of social worth as a criterion, but not one of age. Current medical practice is to use age as a factor, for example, in kidney transplantation. UK guidelines state that patient survival should be at least five years for kidney transplants, discounting elderly patients.[27] NICE use Quality Adjusted Life Years to decide whether treatments are cost effective. This is a system, which utilises cost benefit to assess the number of years of survival and the patient's quality of life and number of years of survival to establish whether the treatment is worth the cost.

This does not fit with the Jewish concept of life, where young and old are treated equally. According to the Jewish view, life is neither sacred nor precious, but rather every moment is of infinite value.[28] As such, it is not possible to use it as part of a mathematical equation as one cannot divide or multiply by infinity. One minute of infinite value is worth the same as ten years of infinite value; they are both worth infinity. Consequently, a person with one minute to live is to be treated as importantly as a person with ten years ahead of them.

## Conclusion

The public purse has many commitments, such as defence, education and health. Therefore, the individual may have restrictions on his entitlement to any one of these services. Limitless healthcare cannot be made available for any one individual. Judaism believes that society owes a duty to the individual to cater for basic health, but anything beyond this is a decision for that society. The procedure used in the UK for triage establishes a priority based on the patient's condition and clinical need. The Jewish view goes further and establishes additional priorities to help determine who would have greater priority all other factors being equal. It may appear that the factors considered in the Jewish viewpoint are inconsequential as they seldom come into effect. Nevertheless, they provide a logical, ethical and moral framework for triage, in addition to the simplistic criterion of immediate clinical need, based on battlefield situations. However, given the short time usually available and that often further details of the background of the patient are unknown, it is often not possible to use any more sophisticated criteria as to who should come first. Coupled with the limited resources in any A&E unit, the allocation of scarce resources goes beyond simple clinical priority and rests upon the clinician's common sense, experience and judgement, for which a sound ethical system is the basis.[29] The Jewish philosophical position discussed in this essay is compatible with standard triage practice but provides an extra, more holistic societal approach to this problem. It is incumbent on a well-trained doctor to have a well-developed sense of morality and to have a consistent, ethical approach. Whether the doctor's morals and religious perspective are convergent with that of the patient is not part of this discussion. Moreover, the physician should be mindful not to let his personal beliefs interfere with the accepted code of conduct in the society in which he practices.

## Endnotes

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**D. M. S. Bodansky, BMedSc (Neuroscience),** studied on Machon L'madrichim with Bnei Akiva and later at Yeshiva (Shapelles/Darche Noam), Israel. He is currently a third year clinical medical student at Birmingham University, UK.

# BOOK REVIEWS

## Case Studies in Pharmacy Ethics (second edition)

Robert M. Veatch and Amy Haddad. Oxford University Press, 2008

ISBN 978-0-19-530812-9; 336 PAGES, PAPER, $29.95

Years ago, a Christian-Hippocratic commentary argued that physicians should never assist in capital punishment. Separating the ‘black and white’ of medicine has always been essential to the Hippocratic credo. A Pharmacy colleague quickly responded that the same fundamental belief also rings true for her profession (Case 9-8 in the book). That solidarity in the face of assaults on human dignity awoke me from my own dogmatic slumbers. The Healthcare Professions — medicine, nursing, pharmacy, and all their ancillary disciplines — are a sum greater than their individual parts. Veatch and Haddad’s efforts address what is shared among us as the healing professions as well as what is unique to our colleagues in the Profession of Pharmacy.

As its title suggests, the book presents ethical issues in a case-based format with an accompanying discussion of principles. It is comprehensive in scope, but has some shortcomings that affect its conclusions. For instance, one area that has benefited through cross profession-teamwork is Medical Safety. Since human dignity demands attention to improvement in this area, it has received recent attention. Case 1-1 in the book addresses the issue without adequate contemporary details. What about bar code technology? Or, a Pharmacist invited as a colleague on rounds? Both have been proven to decrease medication errors and yet neither is referenced as a truly ethical intervention to be championed in efforts to saves lives. Certain other case scenarios (8-1 and 8-2) confront potential disclosures of serious professional concerns. Neither makes readers aware of PEERS (Potential Error Event Report System), an electronic venue for the confidential reporting of ‘near misses’ before errors take lives. Utilization of the PEERS ‘frame’ changes the ethical responsibilities incurred with such reporting. It is imperative that our worldview lead as we explicitly protect human dignity from unnecessary errors.

The book, like many before, is also hampered by the constricting template of Beauchamp and Childress. Since the postmodern menu precludes consensus on what beneficence and its ‘mantra-like’ partners are, it often makes autonomy its ‘trump card.’ This shortcoming is all the more apparent because in numerous instances (examples on pages 69, 75, 78, 79, 139, etc.) the Hippocratic ethos is mentioned in a positive light. Unlike Beauchamp and Childress, Christian-Hippocratism, however, is not bashful and confronts beneficence and non-maleficence in concrete terms. This book makes a painful disconnect more apparent. Even though North America is populated by an ever decreasing number of schools that hold their students to the Oath and principles thereof, the Oath is mentioned as if it still might bind our broken professions. Why not comment that contemporary case study deliberations are often inconclusive because society and its healthcare workers choose to relegate Hippocratism to the fringes? The sections dedicated to suicide are prime examples of an opportunity to beckon Hippocratic principles to return, but terminal choices in the book are arbitrated more by autonomy.

The scope of this book is right on target. Unfortunately, the framing of ethical issues (e.g. safety, disclosure, and suicide) suffers because essential components are missing.

**Gregory W Rutecki, MD,** who is Director of Medical Education at Mount Carmel Health System in Columbus, Ohio, USA.

## Clinical Bioethics: A Search for the Foundations (International Library of Ethics, Law, and the New Medicine)

Corrado Viafora, ed. Dordrecht, The Netherlands: Springer, 2005.

ISBN-978-1402035920; 192 PAGES, CLOTH, $129.00

Corrado Viafora, a Professor of Moral Philosophy and Bioethics at the University of Padua, Italy, has assembled essays from a clinical bioethics conference which reflect a large and enduring perspective on the origins of clinical ethics and its future. The international flavor, with continental, British and American contributions, is especially appealing. While many of the essays are engaging and well written, others suffer from poor translation and editing. Such unevenness distracts from the overall impact of this volume. Even so, several chapters convey enough fresh thinking to recommend a close, reflective look.

Viafora introduces his collection with a commentary on terms, a way of conveying his sense of the historical movement in bioethics. According to him, 'medical ethics' refers to the 'codification of standards of professional conduct' that remained, for a long time, '"segregated" from larger shifts affecting the rest of culture' and '(b)ioethics' refers to 'the new attention given to ethical issues which fall beyond the boundaries of the physician-patient relationship.' (ix) He voices a concern that bioethics may have become simply a new formula for approaching ethical quandaries and proposes 'clinical bioethics' be used to refer to something more: a synthesis of the procedural approach of applied ethics with a more substantive approach focusing on practical wisdom and an 'adherence to the intrinsic ends of medicine.' (xi)

An essay by David Thomasma examines the relationship of bioethics and post-modernism. Here it is seen that, in our present reality, 'all philosophical systems are suspect' (6) and the idea of a publicly accessible 'good' is in question (9). Even so, surely the traditional goals of medicine are still to be valued. He proposes a way out of this dilemma by recognizing moral pluralism and the liberty interests of all stakeholders in clinical situations, then engaging in careful deliberation using practical wisdom (*phronesis*) in the moral judgments of everyday events.

Edmund Pellegrino takes this a step further by summoning back to the ancient teleological medical ethic, the good of the patient. This great end or *telos* of medicine could be lost under the rubric of modern bioethics. Drawing from Hippocrates, Aristotle, and Aquinas, Pellegrino seeks to define the ends of medicine with the central dictum 'do good and avoid evil.' He suggests that the good is 'quadripartite, healing at four levels of human being and living: the lowest level is the medical good; above that is personal good as perceived by the patient; next is the good of the patient as a human being; and the highest good is the patient's spiritual good.' (25).

Subsequent essays discuss democratic principles in bioethical discussion, communitarian and contextual issues, and anthropological underpinnings of bioethics. Interpretive and deliberative aspects of clinical bioethics are explored. Roberto Mordacci and Henk Ten Have explore the concept of medicine as a practice, concluding that morality emerges out of the 'search for the human good and the goods internal to a practice,' (Mordacci, 108) and that morality is 'a fundamental predicament we are already involved in . . . (e)thical views are articulated and explicated because we are in a moral relationship with other human beings appealing to us.' (Ten Have, 94).

The book concludes with practical pointers on ethical functioning in hospitals and suggestions on how to apply the concepts discussed in ethics committees.

I recommend this book to those who seek a deeper understanding of bioethics as it is rooted in both ancient and recent philosophy and in the practical search for consensus in modern clinical dilemmas. While readers may disagree with some of the authors' conclusions, this collection is helpful when considering the plurality of world views and value systems of both patients and physicians.

**R. Henry Williams, MD, MA (Bioethics), FACP,** who practices internal medicine and chairs the ethics committee at Memorial Hospital, Chattanooga, Tennessee, USA.

# Ethical Practice in Brain Injury Rehabilitation

Joanna Collicutt McGrath. Oxford: Oxford University Press, 2007.

ISBN 978-0198568995; 192 PAGES, PAPER $49.95

As a neurologist and ethicist who helps patients and families make decisions about treatment options, some of which carry grave risks, I am often told by patients that they are not afraid of dying. Dying, however, is much less complex than living for years with severe physical or neurological disabilities.

Much has been written about the beginning and end of life—witness the ongoing stem cell, euthanasia, and abortion wars. Less has been written about the difficult and painful decisions faced by acquired brain injury (ABI) patients and their families. McGrath provides us with a concise, readable overview of issues such persons face, and then outlines a hands-on, interactive process to help all parties arrive at workable solutions.

Professor McGrath brings both her training as a neuropsychologist and Anglican priest along with a giftedness in communication to this discourse; I read through the pages with an eagerness usually associated with a good novel. Despite my background, I found a number of useful pearls and valuable insights into care of patients with ABI and their families.

After a brief introduction, she provides an overview of the types and extent of disabilities patients with ABI face. She then reviews the profound effect ABI has on self-image and perceived image by society. Next, she explores the moral and ethical underpinnings of ethical decision-making. In Chapter Five, she describes her vision of a good rehabilitation practice, and next explains 'A heuristic for managing ethical dilemmas' (112), illustrating the process her center employs in decision-making.

McGrath concludes with eighteen complex but realistic case studies. She relates the first six studies at length, the next six at moderate depth, and the final six studies in outline. All studies are designed to serve as bases for ethics discussions, suitable for use in various settings. The dilemmas are multi-layered, messy, and defy simplistic solutions.

On the other hand, before you rush to order your copy, a few caveats:

1) This is primarily written for a British audience. It mentions a number of British laws in passing, assuming the reader is familiar with these laws, and does not mention applications in other cultures or settings. The only other country's systems noted (only negatively in passing) is the United States.

2) A brief glossary is included. These definitions could easily have been included within the text, obviating the need to flip back and forth from text to glossary.

3) McGrath assumes a democratic decision-making process should be employed in the rehabilitation unit—including an equal vote by all staff members—prior to patient admission, discharge or treatment changes. It is not transparently obvious why this is so, and many would be interested in her rationale for this approach.

On balance, this is an excellent book, illuminating, fun to read, and likely useful for trainees in all areas of rehabilitation and ethics.

**Robert E. Cranston, MD, MA (Bioethics), FAAN,** who is a Clinical Associate Professor at University of Illinois College of Medicine (Urbana-Champaign) and currently chairs the Neurology Division and Ethics Committee for Carle Clinic Association and Carle Foundation Hospital in Urbana, Illinois, USA.

## Bioterror and Biowarfare

Malcolm Dando. Oxford England: Oneworld Publications, 2006.

ISBN 978-1851684472; 256 PAGES, PAPER, $15.95

In Malcolm Dando's text, one is quickly struck with the historical perspective on the use of biological weapons before they became a major concern for most readers – about the time of 9/11 and the subsequent anthrax scares. It is enlightening, in a sadistic way, that these 'weapons' have been available for use by armies across the globe for many years. Though most biological warfare, according to the author, began with World War I, many of these agents were identified as far back as 1876. The author provides a comprehensive list of such pathogens, including one of the first microorganisms – anthrax – discovered by Koch in 1876.

Malcolm then explores the subsequent and more intense usage of these organisms from World War II through 2004. He then looks into the world of biotechnology which, with a more effective mode of distribution, may make these virulent organisms an even greater threat to mankind now than in the past. The impact of the biotechnology revolution is not a simple issue since many (if not most) third world countries who tinker with these microbes are unfamiliar with the potential for self-destruction and the scope of destruction possible with their use.

On several occasions, the author refers to guidelines which have been in place for many years outlining the appropriate use of these organisms. These have been generally ignored by the world at large, perhaps primarily due to the inability to enforce the guidelines upon individual countries or groups of terrorists most likely to use these weapons.

Malcolm concludes his text with thoughts on possible uses of these agents in attack scenarios of today. He also proposes wise, but more unenforceable, guidelines that all countries and 'handlers' of these agents should follow.

A concern for this reviewer is the paucity of information concerning the ethics of the supply and distribution of these agents. Many of the mentioned microorganisms, currently without useful purpose outside of bioterror, can be (at least partially) controlled through vaccines and other healthy practices. The ethical issues which need to be addressed surround the delivery and distribution of organisms from countries that have ready and safe access and control over their use to others that desire to use them reputably but may not have adequate control measures. Withholding these organisms and the possible biotechnological issues which might result should be further developed in the text rather than adding to a compilation of useful, but nearly unenforceable guidelines.

Though the book seems to be a well documented history of microorganisms which can be used for bioterror or biowarfare, it provides no specific answers as to what to do with this knowledge.

**Ronald D. Crock, MD, FACP, MA (Bioethics),** who is an Associate Professor of Internal Medicine and Associate Program Director at Canton Medical Education Foundation in Canton, Ohio, USA.

## Beyond Method: Philosophical Conversations in Healthcare Research and Scholarship

Pamela M. Ironside, Ed. Madison, WI: The University of Wisconsin Press, 2005.

ISBN 0-299-20824-9; 308 PAGES, PAPER, $26.95

Beyond Method begins with an introduction that is a complex description of the philosophical underpinnings of research methodologies. This sets the tone for the remainder of the book which is a difficult read for one not well versed in the basics of philosophy and the language of philosophy. Before utilizing this book as a text or reference, a basic understanding of the following concepts is necessary: epistemology, hermeneutics, phenomenology/phenomenological, Gadamer, Heidegger, realism, idealism, Descartes/Cartesian, Socrates. The book proposes to address interpretive research methodologies while presupposing that not all research methodologies involve interpretive components. I would argue that even the simplest quantitative measure has to have an interpretive meaning. In that way, the book could falsely reassure some researchers that interpretation could be avoided by steering clear of hermeneutics, phenomenology or narrative analysis.

Though a target audience is not specifically identified, the editor writes, ‘Gathering the voices of scholars from across disciplines and around the world into converging conversations, this volume provides substantive paths to thinking in which researchers, students, and clinicians in healthcare and the human sciences can continue to inquire into complex human phenomena while keeping possibilities in play.’ (xviii) The emphasis of the Western philosophical school of thought in the essays is quite dramatic. Though the influence of Heidegger, Gadamer, Merleau-Ponty, and Popper on qualitative research methodologies cannot be denied, alternative/non-Western ways of understanding data would be a beneficial addition to research thought.

The necessity of attention to context is mentioned throughout the essays, and there seems to be a false sense conveyed that recognizing and labeling a characteristic or an experience is enough to adequately or completely attend to context. A striking departure from that approach is present in Kathryn H. Kavanagh’s (Chapter 2) treatment of the phase of interpretation that involves naming phenomena, which she calls, ‘representing.’ She paints a vivid picture of the necessity for contextualization, while not downplaying the danger of misrepresentation. She also does not downplay the difficulty inherent in researcher/outsider understanding from a different cultural perspective. This chapter is most helpful in the process of iteratively and reflexively checking themes, categories, and names of phenomena to ensure responsible representing.

This volume of essays may be helpful to advanced qualitative researchers however, it is not a ‘how-to’ manual for health care researchers planning qualitative research methods.

**Claretta Yvonne Dupree, RN, PhD**, who is an assistant professor at The Medical College of Wisconsin in the Dept. of Pediatrics, Hospital Medicine Section, and is also the Director of Research for the Palliative Care Program at the Children’s Hospital of Wisconsin, USA.

## Evangelicals in the Public Square: Four Formative Voices on Political Thought and Action

J. Budziszewski with David L. Weeks, John Bolt, William Edgar, and Ashley Woodiwiss; afterword by Jean Bethke Elshtain. Grand Rapids, MI: Baker Academic, 2006.

ISBN 978-0801031564; 224 PAGES, PAPER, $20.00

Readers of this journal know that, in recent decades, evangelicals have chosen to engage in the public debate about the moral and social issues of our time, including those bearing on bioethics. What theological framework can they employ to guide their reflections in bioethics? Political philosopher J. Budziszewski of the University of Texas at Austin capably analyzes four recent theologians he considers formative of contemporary evangelical political thinking. These include three Calvinists, Carl F. H. Henry, Abraham Kuyper, Francis Schaeffer, as well as the Anabaptist theologian John Howard Yoder. The book includes responses by contemporary evangelicals who are specialists in the work of each of these theologians. Henry is represented by David L. Weeks of Asuza Pacific University, Kuyper by John Bolt of Calvin Theological Seminary, Schaeffer by William Edgar of Westminster Theological Seminary, and Yoder by Ashley Woodiwiss, at Wheaton College at the time of this writing, now of Erskine College. This work grows out of a conference held in 2003 sponsored by the Ethics and Public Policy Center, but it is much more coherent than would be expected in a collection of conference proceedings.

Budziszewski believes that an ‘adequate political theory’ must contain at least three elements:

> (1) an *orienting doctrine*, or guide to thought, explaining the place of government in the world as a whole; (2) a *practical doctrine*, or guide to action, explaining in broad but

> practical terms how Christians should conduct themselves in the civic realm; and (3) a *cultural apologetic*, or a guide to persuasion, explaining how to go about making the specific proposals of those who share the other two elements to those who do not. (18-19)

Evangelical political theory, according to Budziszewski, must be faithful to what makes evangelicals distinctive, which is a commitment to Scripture and its relevance and applicability to the issues of life. Unfortunately, evangelicals fall victim to two major problems in their application of Scripture to social and moral issues, what Budziszewski calls 'projective accommodation' and 'inflationary strategies.' 'Projective accommodation' is the tendency to accommodate 'Scripture to one's own political views by reading those views into the Biblical text.' (21) This is seen in the American revolutionaries' repudiation of monarchy by an interpretation of I Samuel 8. (Obviously, a much more recent example would have been preferable.) 'Inflationary strategies' refers to the practice of drawing more out of Scripture than is warranted by the text. An example of this is 'to assume that the details of God's code for ancient Israel reflect the divine blueprint for all civil law,' a strategy represented in 'its most pronounced form in . . . theonomy,' as developed by R. J. Rushdoony and others.

'Although evangelicals are rightly committed to grounding their political reflection in revelation, the Bible provides insufficient materials for the task. This is what I have called the evangelical dilemma.' (30) Budziszewski proposes that evangelicals need to engage more fully with the doctrine of 'general revelation,' the deliverances of human reason as it reflects on our experience in the world. This is genuine revelation, he argues, because it comes from God and depends on His ordering both of the world and of the human intellect. Ultimately, Budziszewski is arguing for an acceptance of natural law by evangelicals. This approach is a staple of Roman Catholic moral theology and is endorsed by the Reformers as well. An evangelical when he did the original work for this book, Budziszewski in 2004 entered the Roman Catholic Church.

Budziszewski's analyses of the four thinkers he considers in this book are fair-minded, respectful, and illuminating. He levels common criticisms at all four thinkers. All of them 'are ambivalent about the enduring structures of creation and about the reality of general revelation,' 'are ambivalent about the ordained work of the state,' and 'slip into projective accommodation and inflationary strategies.' None of the four presents an orienting doctrine, a practical doctrine, or a cultural apologetic that is adequate to the task of grounding an evangelical political theory.

If Budziszewski is correct, there is a great deal of theological work to be done by evangelicals before they can expect to make a genuine, positive contribution to social ethics, and perhaps, to bioethics.

**Reviewed by David B. Fletcher, PhD**, Department of Philosophy, Wheaton College, Wheaton, Illinois, USA.

## Gender, Power, and Persuasion: the Genesis Narratives and Contemporary Portraits

Mignon R. Jacobs. Grand Rapids, MI: Baker Academic Press, 2007.

ISBN 978-0-8010-2706-2; 272 PAGES, PAPER, $21.99

If you have ever pondered the relational dynamics of the various personalities of the book of Genesis, you will find Mignon Jacobs' book *Gender, Power, and Persuasion* fascinating. In it Jacobs attempts to 'color outside the lines,' examining the dynamics of deception involving several relationships in the book of Genesis – dynamics that are often only incidental to the traditional interpretations.

Writing from a modern, feminist perspective, Jacobs evaluates deception and persuasion as elements of power in relational dynamics. Her analysis of relationship networks illuminates subtle interpersonal dynamics often overlooked. She describes the 'anatomy of deception,' and uses it to demonstrate that even the 'deceived' is an active participant in the deceptive process and consequently that no one in such relationships is utterly powerless. Five narratives are examined through the conceptual window of gender, power, and persuasion. Beginning with Genesis 2-3 and the Divine-human-creature dynamics centering on the serpent's deception, Jacobs moves to the female-male relationship of deception between Abraham, Sarah, Pharaoh and Abimelech regarding Sarah's status. The male-male dynamic is that of Isaac and Jacob and their mutual roles in deception. Female-female dynamics of power are examined in the triangular relationships of Sarah and Hagar with Abraham, and of Rachel and Leah with Jacob. The use of deception to gain power is illustrated in the relationship of Judah and Tamar. In the final section, Jacobs demonstrates that these same relational dynamics of power, deception, and persuasion still operate in contemporary culture.

But Jacobs' book is also a potent portrayal of the power of presuppositions in textual interpretation. Her analysis of the Divine-human relationship in Genesis 2-3 includes no reference or allusion to Genesis 1. While Genesis 1 contains no substantial relational dynamics, it is foundational to a proper understanding of the creation narrative. Such disregard for Genesis 1 skews her analysis of the relationship of Creator to creature, elevating the human relative to the marginalized Creator. Likewise, her intensely microscopic perspective of individuals marginalizes 'the Deity' whose story it is. He is outside her field of vision, lost from view.

Jacobs' approach to Scripture is critical rather than believing, creating a distance from the text and resulting in a tone that is cold and calculating. Her substitution of the term 'the Deity' for all references to God further enhances this sense of distance. Indeed, her portrayal is very 'deistic' – the Deity who initiated His plan now sits on the sidelines calling out emergency plays to achieve His goals. This Deity is not the *Mysterium Tremendum,* nor a god who 'knows the end from the beginning,' but is a god who is always instituting emergency solutions for 'unexpected' human circumstances.

Jacobs' book is an insightful analysis of the relational dynamics of well-known Biblical characters enabling us to appreciate them as real persons with real struggles not different from our own. However, by over-magnifying the unfulfilled lives and personalities of the individual characters she disregards the overarching motif of the creation-fall-redemption story. We are left with a portrait of fallen humanity helplessly enmeshed in deception in their pursuit of power, rather than a fallen humanity rescued from such entanglement by their Creator-Redeemer-King.

**Reviewed by Susan M. Haack, MD, MA (Bioethics), FACOG**, who a consultative gynecologist at Hess Memorial Hospital and Mile Bluff Medical Center in Mauston, Wisconsin, USA.

## Belmont Revisited: Ethical Principles for Research with Human Subjects

James F. Childress, Eric M. Meslin, and Harold T. Shapiro, Editors. Washington, D.C.: Georgetown University Press, 2005.

ISBN 978-1-58901-062-8, 279 PAGES, PAPER $29.95

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created in 1974 and, after much deliberation (including four days at the Smithsonian Institution's Belmont Conference Center), released its recommendations in April, 1979. The Belmont Report, after 25 years, is reconsidered in this book by authors prominent in bioethics, economics, law, medicine, medical ethics, philosophy, public health, public policy, and sociology. Three of these authors — Albert R. Jonsen, Patricia King, and Karen Lebacqz — served as members of the National Commission, while Tom L. Beauchamp was assigned the task of writing the original document.

The authors of the Belmont Report described three principles that should govern research with human subjects: respect for persons, beneficence, and justice. Are these all that should be required of human research? Are these three the most important considerations in conducting human research now? The authors, in stand-alone chapters, have a variety of views.

Jonsen and Beauchamp provide the historical context for the Belmont Report, as well as a good number of details regarding its creation. Beauchamp takes pains to describe how the work he and James F. Childress did in delineating how their four principles of medical ethics and how they differ from the work of the Commission. He concludes that the Belmont Report is both principlist and casuist.

Chapters by Capron; Faden, Mastroianni, and Kahn; and Shapiro and Meslin reflect on the use (or lack of use) of Belmont by subsequent government-appointed bodies: the President's Commission, the Advisory Committee on Human Radiation Experiments, and the National Bioethics Advisory Commission.

Eric J. Cassell offers a thoughtful essay on how both medicine and the Belmont principles have changed over 25 years. He concludes with the case of a 49-year-old woman who dies of recurrent breast cancer even while the wound for her hip surgery is healing and her kidneys are 'doing well.'

Lebacqz calls for modifying autonomy with covenant, and including the requirement for '*attention to power differentials and to the liberation of the oppressed*' (105-7). Churchill would prefer a re-formulation of autonomy as the guiding first principle, built on a base of 'respect for persons.' (117) Levine tackles beneficence, while justice is addressed by King.

Susan Sherwin, using her feminist lens to critique Belmont, declares, 'Only when research programs are made accountable to all segments of the population can we be confident that subjects and citizens are treated ethically.' (162) She then contradicts herself by stating in her last note that her call for diversity only extends so far: '. . . it allows specific exclusion of those who are committed to discriminatory social programs, as they do not support the underlying ethical principles at issue.' (164)

Reducing bodies to organ systems may make information more manageable; reducing ethics to principles may make distributive justice more transparent. Yet, according to Evans, many scholars feel such reductionism in ethics does not capture the moral life. The Belmont Report is a good place to begin as well as to revisit, but we do not have to live there forever.

**Reviewed by D. Joy Riley, MD, MA (Bioethics),** who serves as the Executive Director of the Tennessee Center for Bioethics and Culture in Brentwood, TN, USA.

# HUMAN REPRODUCTION and GENETIC ETHICS

Volume 15:1 Spring 2005

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Dr. Boon Chin Heng - *Ivymed International Pty Ltd., SINGAPORE*

**Assisted Procreation and its Relationship to Genetics and Eugenics**
Dr. Mariella Lombardi Ricci *Professor of Bioethics, Faculty of Theology of Northern Italy, Turin; Università del Sacro Cuore, Rome (affiliated to the University of Turin), ITALY*

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**Archimandrite Makarios Griniezakis[1] and Deacon Nathanael Symeonides[2]**
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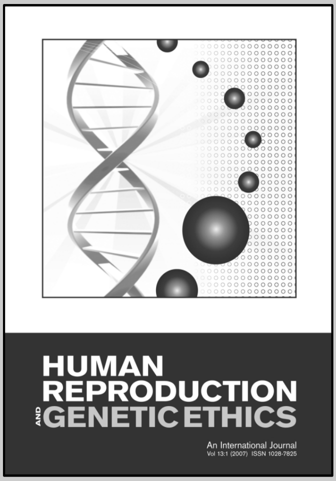

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