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PRESS

EDITORIAL

THE CHRISTIAN HIPPOCRATIC TRADITION IN MEDICINE

C. BEN MITCHELL, PHD

To some people it may seem anachronistic that the aim of *Ethics & Medicine* is to ‘reassert the Hippocratic consensus in medicine as seen through the lens of the Judeo-Christian tradition.’ What is Hippocratic medicine? As Hippocrates once stated, ‘The medical art has to consider three factors, the disease, the patient, and the physician. The physician is the servant of his art, and the patient must cooperate with the doctor in combating the disease’ (*Epidemics*, I, 11). These three factors—the disease, the patient, and the physician—informed the moral responsibilities of a physician. The Oath of Hippocrates was written against the backdrop of the patient’s dis-ease. The patient was sick. He or she had a disease which required the physician’s skills to treat. Treatment of disease might consist of a change of diet, the administration of drugs, or surgery. In the application of therapy, the chief concern was the good of the patient. Above all, the physician was to ‘do no harm’. The patient, not the disease, was the primary focus of the Hippocratic physician’s art.

Over time, the Judeo-Christian tradition helped to refine the Hippocratic tradition. In his recent volume, *Medicine & Health Care in Early Christianity* (Johns Hopkins, 2009), Oregon State University professor of history, Gary B. Ferngren, shows that in classical Greek literature there was little sympathy for the physically impaired or oppressed. Attitudes towards the physically disabled reflected a belief that health and physical wholeness were essential to human dignity, so much so that life without them was not worth living. According to this belief, citizenship, kinship, status, merit, and virtue formed the foundation of claims to human rights or human worth. The basic human worth of orphans, slaves, foundlings, prisoners, and the physically defective was not recognized.

Contrary to these classical views, early Jewish and Christian views of human worth were shaped by the notion that humans were created in the image of God. As Ferngren points out, the doctrine of the *imago Dei* (image of God) was formative in shaping Christian views of humanity, ethics, and ministry. First, the doctrine gave impetus to Christian charity and philanthropy. Just as concern for the poor was an important feature of the Hebrew scriptures, so charity and compassion were regarded as manifestations of Christian love (*agape*) and devotion to Christ. Christians were to imitate God’s love for humans by extending love to a brother or sister made in the image of God (John 13:34-35). True religion was defined, at least partially, as caring for ‘orphans and widows in their distress’ (James 1:27), two classes of vulnerable people.

Second, the doctrine of the image of God provided the ground for the belief that every human life had intrinsic value as a bearer of God’s image and the object of redemption through Christ. This was the basis for Christian repudiation of abortion, infanticide, the gladiatorial games, and suicide.

Third, Christian understanding of the *imago Dei* gave Christians a new perception of embodiment and human personality. Both Greek ascetics and, later, the Gnostics showed no admiration or concern for the body. On the contrary, they despised it and looked forward to the day when they would be released from its prison. The image of God, especially as reflected in the Incarnation, gave rise to notions of a more integrated body and soul, Christ himself being the exemplar. ‘The Christian conception of Jesus as perfect man contributed,’ says Ferngren, ‘to raising the body to a status that it had never enjoyed in paganism’ (p. 102).

Finally, the doctrine of the image of God led to a redefinition of the poor. ‘The human body in all its parts shared in the divine image,’ argues Ferngren (p. 103). This was true of everyone’s body, not merely those of Christians. The poor, sick, and disabled were not to be shunned, but were objects of Christ’s love. ‘Just as God demonstrated in the Incarnation his solidarity with those who suffer, so the members of his ‘body’ must demonstrate their solidarity with the suffering poor’ (p. 104). Celebration of the Eucharist allowed Christians to embrace solidarity with Christ and with all of those made in God’s image. In sum, the image of God, especially as refracted through the prism of the Incarnation, was the basis for Christian compassion and care for those in need.

Together, then, the Christian and Hippocratic traditions offer a robust framework for the virtues of medicine and compassionate care for those who are compromised by illness or disability. The retrieval of those traditions seems a goal worthy of pursuit—for the patient’s good. **E&M**

GREY MATTERS

DOES ALIEN HAND SYNDROME REFUTE FREE WILL?

WILLIAM P. CHESHIRE, JR., MD

Neuroscience opens many fascinating windows into human nature. In the quest to understand human consciousness, volition, and intentionality, there is much to learn from studying even the brain's flaws and failures.

Imagine that it were possible to drive a philosophical wedge between the carrying out of a purposeful act and the recognition of that act as one's own. Would the severing of act from ownership abolish the belief that humans possess free will?

Consideration of an unusual brain lesion shifts that question from the hypothetical to the practical. We recently reported the case of a woman who was startled at dinner when her left hand suddenly began to interfere with her efforts to eat. Each time she brought food to her mouth, her left hand reached up and struggled with her right hand, groped about her face, and even struck her in the cheek. It seemed that her left hand had acquired a mind of its own. This bizarre behavior was explained by an acute stroke in her right parietal lobe visualized by magnetic resonance imaging (MRI).¹ The stroke damaged the connection between the part of the motor cortex that moved the left hand and the parietal cortex that perceived the left hand movements as her own. She had lost the sense of ownership of the hand's behavior. Over time she regained conscious control of her hand but did not fully recover proprioception. Because she could not discern the position of her left hand, the hand continued to make occasional automatic exploratory movements, termed *pseudoathetosis*, to gain a sense of spatial orientation.

The term "alien hand syndrome" refers to a variety of rare neurological conditions in which one extremity, most commonly the left hand, is perceived as not belonging to the person or as having a will of its own, together with observable uncontrollable behavior independent of conscious control. Alien hand syndrome has been described in patients with lesions of the frontal or parietal lobes or their interconnections, especially in the corpus callosum, which joins the left and right cerebral hemispheres, as well as in certain neurodegenerative diseases such as corticobasal degeneration.

The apparently purposeful movements of the alien hand are goal-directed, which distinguishes them from the involuntary spasms of simple reflexes such as chorea or myoclonus. Some patients exhibit intermanual conflict, in which the movements of the left hand oppose the actions executed by the right hand, without necessarily performing the opposite action. For example, one patient put on clothes with the right hand only to pull them off with the left hand.² The hands of another patient struggled with each other as they competed to answer the telephone.³ Another patient tried to turn left while driving, at which point the other hand tried to turn the steering wheel to the right.³ Other patients have exhibited grasping and groping behaviors or compulsive manipulation of tools, opening or taking off eyeglasses, folding the frame, and putting them away, for example.³ While playing checkers, another patient's left hand made a move he did not wish to make. He corrected the move with the right hand, and to his frustration, the left

hand responded by repeating the false move.⁴ These uncontrollable behaviors can be quite distressing to the patient.

Some psychologists have cited the alien hand syndrome as evidence in support of the philosophical position that human free will does not exist. Daniel Wegner, for example, in arguing that all conscious will is an illusion, considers the alien hand syndrome to be an example of the undermining of the experience of volition. The gestures of the alien hand are, in his view, fatal to the idea of mental agency. “The fact is,” writes Wegner, “we find it enormously seductive to think of ourselves as having minds, and so we are drawn into an intuitive appreciation of our own conscious will.”⁴ The absence of awareness of having willed the alien hand to act, such that the patient feels a remote spectator to the actions of the hand which seems to have a mind of its own, leads psychiatrist Raj Persaud also to embrace a deterministic view of human nature. Since the brain is the seat of all our experiences, he argues, then there is “a part of our nervous system which is responsible for our belief that we have free will over our behaviour.”⁵ “The delusion that we are responsible for all our actions,” Persaud concludes, is “one of the prices we had to pay for conscious awareness of ourselves to evolve as a function of the brain.”⁵

Whether one is free to disagree with a deterministic view of human nature is a question on which the very possibility of ethics depends. For if free will is ultimately a delusion and human decisions are reducible to the blind product of material efficient causes, then there could be no reason to argue that one ought to choose to act in a certain way instead of another. Nor would personal decision and moral responsibility be anything more than companion illusions. It would make no sense to appeal to reason as a guide to decisions if all thought ultimately reduces to the irresistible consequence of material causes prodding us as inexorably as lines of computer code.

The evidence, however, has not proved the case for determinism but remains open to various philosophical interpretations, including those that accommodate a view of human nature grounded in free will. Empirical proof of determinism would require a description of the sum of causes leading to a decision alleged to be fully determined. Wegner concedes, however, that, “We can’t possibly know (let alone keep track of) the tremendous number of mechanical influences on our behavior because we inhabit an extraordinarily complex machine.”⁴ So the claim that all decisions are the product solely of material influences, including those inaccessible to investigation or that have not been demonstrated or measured, is a philosophical conjecture that lacks the scientific status of an empirically verified statement.

There is also the problem of how well a mechanistically determined brain could understand itself. If knowledge were attainable only through the material workings of a brain lacking the capacity to reason freely, one could not be certain whether a theory of human action corresponded to reality rather than just reflecting the way the brain happens to be organized.

It is, of course, not surprising to find that there would be an area of the brain possessing knowledge of personal agency if free will truly exists. Loss of the knowledge that one has acted freely, for example, in the case of the patient with a lesion in the right parietal lobe, leads more directly to a diagnosis of the brain’s condition than to a sweeping statement about the nature of reality and free will. The acquired inability to perceive

alien hand behavior as volitional may represent a form of *agnosia*, which means loss of the ability to recognize some aspect of reality despite receiving the specific sensory information. Consider, as an analogy, the patient with a right temporal lobe lesion who, though able to hear, loses the ability to recognize the rhythm and harmony of sounds or experience notes as musical. This agnosia for music is known as *receptive amusia*.⁶ One would be mistaken to conclude that the once heard but now misapprehended Mozart symphony had been an illusion. Unlike the symphony, which other observers could verify as real, conscious free will is subjectively and personally discerned. Agnosia for free will would mean the loss of the sense of agency that normally arises when one freely and purposively acts. In the case of alien hand syndrome, agnosia for free will is limited to particular behaviors of the nondominant hand.

Proponents of determinism might also point out that the alien hand syndrome is proof in principle that the brain has the capacity to generate purposeful actions apart from intentional decision or even conscious awareness and that free will must, therefore, be unnecessary to explain human behavior. It is unclear, however, whether all goal-directed behaviors belong to the same category as alien hand behavior. There would seem to be an important difference between the almost automatic yet complex routine motion of, for example, bringing a cup to one's mouth and the highly intentional, thoughtful and creative act of writing a letter to a family member. The latter could not be done by the most skillful alien hand under the direction of a disconnected motor cortex. To acknowledge that alien hand action is not freely willed would not be to conclude that all nontrivial human action is determined. The findings of functional MRI support such a distinction. In a patient with a right parietal stroke, alien left hand movements correlated with isolated activation by intentional planning systems of the right primary motor cortex, presumably released from conscious control. Voluntary hand movements, by contrast, activated a distributed network involving not only the primary motor cortex but also premotor areas in the inferior frontal gyrus.⁷

Another way to interpret the purposeful yet apparently unintentional behavior of the alien hand would be to suppose that it results from a fragmentary expression of free will. Alien hand movements might be freely generated yet incompletely purposeful, being isolated from other brain regions normally supplying the contextual features of intentional behavior. Released from inhibition by normally restraining subconscious neural influences, such movements would not incur moral responsibility. Cut off from the neural pathways that compose the signature of conscious awareness, the intrusive behaviors of the wayward left hand would go unrecognized as one's own.

As neuroscience probes more deeply into the nature of human thought and behavior, much has been elucidated, and much more awaits discovery. Some of the remaining questions may seem unsettling at first. One such question is how the exercise of free agency might at times occur independently of full conscious awareness. Another is how various unseen external and internal factors influence our choices and habits. In these matters, neuroscience suggests that we are not as free and in control of our actions as we might like to think. Nevertheless, the curious gestures of the alien hand and their ostensibly materialistic philosophical implications have not rendered free will obsolete. The neural traces of freedom, though subtle, are wonderfully consequential.

Our inner thoughts are no doubt more complex than brief self-examination can discern and more conflicted than we might prefer to admit. Discerning the inner turbulence common to all who wrestle with matters of conscience, the apostle Paul wrote, “For I do not understand my own actions. For I do not do what I want, but I do the very thing I hate.”⁸ In this respect, the alien hand syndrome may be an accurate metaphorical portrait of the universal moral condition of humankind, in need, often unknowingly, of the Great Physician to grant us the undivided heart that the prophets of old so earnestly sought.⁹

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CLINICAL ETHICS DILEMMAS

THE NEED TO KNOW: DISCLOSURE OF INFORMATION TO PEDIATRIC PATIENTS

WAYNE R. WAZ, MD

Editor's note: *This column presents a problematic case that poses a medical-ethical dilemma for patients, families, and healthcare professionals. As it is based on a real case, some details have been omitted in the effort to maintain patient confidentiality. This case and discussion point out some of the complexities in treating the minor child. While agreeing with the recommendation, the editor's comment reflects a different paradigm for approaching the issue of a requested confidentiality purposefully withholding information from the patient.*

Column editor:

Ferdinand D. (Nick) Yates, Jr., MD, MA, Acting Consultant in Clinical Ethics, CBHD

Question

Should a nine-year old patient be told about her terminal medical condition?

Case Presentation

An ethics consultation was called for assistance in the case of a nine-year old girl with a two year history of AIDS. At the time of the consultation, her disease had progressed, and it was the opinion of her physicians that she would probably die within the next six months. During the previous two years, she had multiple hospital admissions for treatment of various infections and for poor growth. In addition, she had developed chronic lung disease and required intravenous fluids for nutritional support. More recently, she had developed AIDS nephropathy that had progressed to end stage renal failure requiring daily peritoneal dialysis. She developed pneumonia, and was hospitalized with hypoxia that was compounded by the other aspects of her disease process. At the time of admission, her grandmother (guardian) requested that the patient not be told about the diagnosis of HIV or AIDS, and that information about the predicted terminal course of her disease be withheld from her. Members of the health care team were uncomfortable with this request and asked for an ethics consultation.

Discussion

This case represents a “battle of good intent vs. good intent”. Everyone involved in the care of the patient sincerely wanted to act in her best interests and to optimize her quality of life while minimizing her suffering. However, individual perceptions (medical team and guardian) of her best interests were in conflict over the potential harms and benefits of disclosure of the information. It is helpful not only to summarize each relevant perception of her best interests, but also to acknowledge the relative amount of power

held by each interested party (patient, grandmother, and the medical team) in deciding which party should have decisional authority.

The patient was aware that she had a chronic illness, and she understood that she was experiencing kidney failure. She had spent much of the past two years in the hospital and recognized that her life was different from that of her friends and sibling. The medical team believed that the patient did not know she had AIDS because she had never used this term with family or staff. Furthermore, in the past, when she asked her mother, “What is wrong with me?” her mother avoided use of the terms HIV or AIDS.

Respect for autonomy requires the medical team to provide adult patients with the appropriate information required to make decisions. For minor patients, this is not so clear, and various organizations (see references) have issued statements regarding this particular issue. With some exceptions, the American legal system does not recognize as valid the consent of a minor patient. In this situation, the legal system offered little guidance as there was no legal requirement regarding either disclosure or nondisclosure of medical information to the patient.

Those who work with children recognize that the capacity for medical decision-making does not occur at a fixed point in time, but is a developmental process, that begins in early adolescence. Parents and health care professionals have a duty and responsibility to guide children to adulthood and autonomy. The American Academy of Pediatrics provides guidance (1, 2) for parents involved in the pediatric decision-making process:

- 1) parents should allow children to participate in decision-making commensurate with their development,
- 2) parents should encourage minor patients, to assent to their care whenever reasonable,
- 3) parents and physicians should not exclude adolescents from decision-making without persuasive reasons.

But these guidelines require determination of what level of participation is “commensurate with their development”, when assent is “reasonable”, and which reasons are “persuasive”, calling for the exclusion of minor patients from the decision-making process. In our case, we are forced to decide whether the guardian or the health care professional is best able to answer those questions.

The patient’s mother also had AIDS and was expected to die before her daughter. Because of the mother’s illness, the patient’s grandmother became the legal guardian. In the past, the mother noted that she wanted to tell her daughter about AIDS but did not want to “upset” her. At the time of the consultation, the patient’s mother had developed a severe, terminal encephalopathy and was unable to communicate in any meaningful way. In her role as guardian, the grandmother stated, “It is enough for the girl to know that she has kidney disease, why should you tell her that she is going to die?” The grandmother perceived the need to protect her granddaughter from “bad news” and to make her remaining time as pleasant as possible. Not only was the disclosure of a terminal diagnosis itself something that the patient should be protected from, but the specific diagnosis of AIDS, the potential stigma attached in many parts of society, and the possible realization that the patient acquired the disease from her mother,

were the grandmother's foundational reasons for withholding the information from her granddaughter.

The medical team believed that the patient should be told her diagnosis and prognosis, and that all of her questions about her illness should be answered. The pediatrician was concerned that the patient was already suspicious and uncertain whom to trust; the doctor feared that she might be harmed by the air of secrecy and that continued concealment would be more harmful if/when she ultimately found out her diagnosis. Of particular concern, the setting was a teaching hospital, where the involvement of consultants, students, residents, and support services made it difficult to keep secrets.

To decide on a course of action in this case, it is helpful to consider not only the possible positive outcomes that could result from either disclosure or withholding of information, but also the possible negative outcomes. These options result in four distinct medical-ethical pathways.

The first option is for those involved in the patient's care to agree to keep the information secret (to honor the grandmother's wishes) where this course of action results in a good outcome. In this scenario, a good outcome could be defined as one in which the patient spends her remaining time free of physical or emotional suffering. Such an outcome would be consistent with the grandmother's perception that the patient would not benefit from the bad news, and that the distress created by disclosure would be an unreasonable burden to place on a child with limited time to live. Alternatively, all could agree to keep the information secret, where this plan would lead to a bad outcome. One could imagine the patient curious but afraid to ask questions, trusting those around her but wondering why people were avoiding her concerns. To feel isolated and confused with no understanding about why people were whispering outside her hospital room could certainly be construed as suffering. Or, worse, she could overhear information about her disease accidentally, leading to feelings of anger and mistrust that would be difficult to overcome. In the third option, the medical team and family could agree to disclose the information and the disclosure would lead to a good outcome. It is often said that suffering is pain without meaning. Even at the age of nine, if a child knows that she is dying, she might have very specific things she would choose to do with her life. To allow the patient to openly discuss death, to say her goodbyes, and to have control over her remaining time would be viewed by many as a good outcome. Unfortunately, in the fourth option, disclosure could also lead to a bad outcome. When presented with the diagnosis of AIDS, it is quite possible that the patient may be aware of the social stigma often associated with the disease, and wonder whether she had done anything to bring this on herself. It is likely that once she knew the diagnosis, she would want to know how she acquired the disease, and once she learned it was transmitted by her mother, would feel anger toward and isolation from those she loves.

When analyzing this case, it would have been ideal if we could choose the course that optimized the likelihood of a good outcome while minimizing the likelihood of a bad outcome. But with the information available at the time of the consultation, it was impossible to assign probabilities to each outcome and choose the course with the highest probability of a good outcome. Instead, in considering each of the positions in this ethical case, we acknowledged that either course of action – that is, either informing the patient or withholding the information from the patient – could lead to a bad outcome. We

recognized that it is the person with the most at stake in the outcome, not the person with the best argument for their position, whose position we should honor.

Recommendations

The ethics committee recommended that all reasonable efforts should be made to honor the grandmother's wishes. However, we further acknowledged that if the patient directly asked questions about her diagnosis or prognosis, the health care professionals would not lie or withhold information from her, and, with the grandmother and any other family or other support present, would answer her questions.

Denouement

Because the grandmother's wish was for the patient to die at home, she was discharged from the hospital with palliative care services in place, and died several weeks later. Several months later, one of the attending physicians met with the grandmother, and she stated that her granddaughter died peacefully at home – a “good” death. The patient had not been told, nor had she asked, her diagnosis.

Editor's Comment

Song (3) suggests that confidentiality – requested or demanded – hinges on four important characteristics of the particular medical situation: 1) the magnitude of the harm in question, 2) the likelihood of the harm occurring, 3) the existence of a real or hypothetical 3rd party, and 4) the effectiveness of medical interventions regarding the medical condition. A consideration of each of these items helps to give direction to the ultimate decision regarding whether or not the patient should know her complete diagnosis.

The actual ‘harm’ of this case (as seen by the grandmother) is simply the patient's complete knowledge of her diagnosis. At issue is the juxtaposition of the grandmother's preference – that her granddaughter only has partial information regarding the diagnosis – and the medical team's preference that the patient be fully informed. The medical team's desire to exercise truth and transparency should be applauded. However, it is reasonable to assume that the grandmother has great insight into the patient's level of comprehension and that she knows what the patient can understand regarding her diagnosis. Should the patient inadvertently discover her complete diagnosis, then the grandmother can legitimately explain her protective intent. It is possible that the patient's complete knowledge of her condition could create ‘harm’ regarding her self-vision and thereby negatively impact medical recuperation. She might also have a diminished quality of remaining life due to knowledge of the diagnosis and the stigmata that are often associated with the condition.

Concerning the likelihood of the ‘harm’ occurring, the direct intentionality of the medical team to secure this information is the primary objective, and whereas there may be an unintentional breach, the team can only be responsible for the reasonable day-to-day guarding of the information in the customary form required for routine issues of confidentiality. Regarding the other criterion, in this case, there is a clearly identified

third party (the patient), for whom the medical care would intentionally be the same whether or not she knows her complete diagnosis.

A caring and concerned grandmother, serving as guardian and acting in the best interest of the minor child, should be granted the decision-making authority to determine the level of medical information presented to the patient and the medical treatment plan for the patient.

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ON THE NATURE OF TUBE FEEDING: BASIC CARE OR MEDICAL TREATMENT?

ERIK M. CLARY, MDIV, MA

Abstract

Five years following the Terri Schiavo affair, and almost twenty since the issue of tube feeding first came to the national scene in the case of Nancy Cruzan, the debate over withdrawing this manner of care from patients with severe cognitive impairment continues. One question that frequently arises in the discussion over the ethics of tube feeding involves the matter of categorization—is tube feeding basic or medical care? At its most fundamental level, this question requires an empirical judgment that is distinct from, though not irrelevant to, the ethical question (When, if at all, is it permissible to forego or withdraw tube feeding?). In this article, the nature of tube feeding is considered in light of the evidence that has accumulated in the published literature since the procedure was first reported in 1951. That evidence reveals tube feeding to bear several hallmarks of medical therapy, including its direction toward the sick and not the healthy, the application of medical knowledge and skills, the surgical implantation of a foreign body intended to counter the effects of debilitating disease, and the exposure of the recipient to significant risk of complications directly related to the intervention. It is concluded that tube feeding is properly considered medical care. Arguments for viewing tube feeding as basic care, which generally focus on the nature of the infusate or the personnel required to administer it, are addressed.

With the rapid advance of medical technology in the past century, a host of ethical challenges have arisen for which society has been ill-prepared. One of the more controversial medico-ethical cases in recent memory is that of Terri Schiavo, a patient diagnosed with severe brain damage who received nutritional support for fifteen years up until her estranged husband finally prevailed in his effort to have her feeding tube removed, prompting her death due to dehydration thirteen days later. Among the ranks of those critical of the decision to remove Mrs. Schiavo's feeding tube was Mary Porta, who received national attention by carrying with her to rallies a giant, five-foot Styrofoam spoon.¹ Ms. Porta's point was significant as it reflected a widely held notion that the provision of nutrition and hydration through artificial means constitutes "basic" ("ordinary" or "normal") care. Pope John Paul II was certainly an advocate of this approach to classifying artificial feeding, stating in 2004 that "the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered in principle ordinary and proportionate . . ."²

Are Pope John Paul II and Ms. Porta to be granted their presuppositions concerning the nature of artificial feeding? If they are, then the question concerning tube feeding really becomes one of when, if at all, is it morally permissible to deny a person basic care? If, however, there is a categorical distinction to be made between feeding a person orally

and delivering nutrients tubally—I will argue that while food and water are “basic” in the sense that physical existence cannot be sustained without them, tube feeding is rightly considered medical care—then the issue becomes one of discerning when, if at all, medical treatment may be foregone.³ While the latter analysis will be more admitting of medical considerations in assessing the situation, the need for careful moral reflection is not diminished. The practice of medicine is inherently a moral endeavor, and as such, assigning tube feeding to the category of medical care provides no liberation whatsoever from the obligation to engage in moral analysis.

To be clear, it is not my intention to answer in this work the ethical question, “When, if at all, may tube feeding be foregone or withheld?” My concern, rather, is to clarify what John Frame has labeled in his “triperspectival” approach to ethical decision-making as the “situational perspective.”⁴ That perspective consists of the circumstances in which the moral agent must act that are apprehended through observation and reason. Failure to accurately define the situation jeopardizes the truthfulness, value, and relevance of one’s ethical judgments. When Ms. Porta argues by illustration that tube feeding is like spoon-feeding, or when John Paul II asserts that it is “a natural means” and not “a medical act,” they are both advancing propositions that are foundationally questions of empirical fact. No doubt, they both seek to advance a particular position on the question of moral obligation to tube feed, but they do so operating from what I will argue is a flawed situational perspective. On the question of whether their conclusions on the ethics of tube feeding are correct despite this misstep, again, I offer no particular judgment, as such goes beyond the purpose of this inquiry.

The Experience of Tube Feeding

Prior to the advent of modern medicine, people who lost the ability to breathe or eat and drink simply did not survive. Much has changed in the last century as severely debilitated patients can now be maintained for extended periods of time with assisted ventilation and tube feeding. Tube feeding was initially developed in the 1950s as a means of sustaining premature infants, but over time its use has greatly expanded to other areas of medicine including geriatrics, traumatology, and surgery.⁵ In particular, tube feeding has become a common tool for use in the management of patients with severe cognitive impairment.

Methods for providing nutrition and hydration to the incapacitated patient may be divided into two general categories: enteral and parenteral. Parenteral techniques involve the injection of liquid and nutrients directly into a vein. While intravenous infusion of electrolyte-containing solutions is commonplace, provision of complete nutritional sustenance by intravenous injection, or what is often referred to as hyperalimentation or total parenteral nutrition (TPN), is uncommon, largely for reasons of safety and expense. Complications of TPN, which requires placement of a large-bore, indwelling catheter into a central vein, include incidental puncture of the lung during the procedure, catheter occlusion, and life-threatening infection.⁶ The propensity for infection with TPN is not simply due to the catheter, which provides a portal through which bacteria may gain entrance to the body, but also to a compromise of the barrier that inhibits bacteria from traversing the wall of the gastrointestinal tract and gaining access to the bloodstream. Given such issues, TPN is generally reserved for those patients who are not candidates for enteral feeding.

The simplest method of enteral feeding utilizes an indwelling silastic tube that is inserted through the nostril, down the back of the throat, through the esophagus and into the stomach. In patients with diminished swallowing and cough reflexes, there is substantial risk of the tube being misdirected to the airway (trachea) and thus for the feeding preparation to be inadvertently delivered into the lungs. Even when proper placement of the tube has been clinically verified, pulmonary complications remain a concern as the tube may encourage the movement of stomach contents up into the back of the throat (“gastric reflux”) and into the airway, leading to what is termed “aspiration pneumonia.”⁷ Gastric reflux may also cause erosion of the inner lining of the esophagus, which can be quite painful and can cause internal bleeding and esophageal obstruction. Other reported complications of naso-gastric feeding include nasal bleeding, sinus infection, tube occlusion, and patient agitation that leads to self-removal of the tube, the prevention of which often requires the use of patient restraints.

In an effort to avoid many of the complications of naso-gastric feeding, clinicians often opt for a gastrostomy tube, which is positioned directly across the abdominal wall and into the stomach, thus bypassing the face and oro-esophageal tract. Traditionally, placement of a gastrostomy tube was a major surgical procedure that required general anaesthesia, thus entailing significant risk to physiologically unstable patients, but in 1980, Gauderer and his co-workers described a minimally-invasive, percutaneous endoscopic technique (PEG) performed under light sedation that quickly became the procedure of choice for gastrostomy tube placement.⁸ While the PEG procedure continues to be performed, more recently developed radiologic methods are now preferred, as they do not require endoscopy and can be executed with less sedation.⁹ With the removal of the risks of major surgery and the need for advanced surgical expertise from the treatment algorithm, gastrostomy has become a very common procedure.¹⁰

Even as percutaneous gastrostomy has lessened the frequency of procedural complications, mortality as a direct consequence of the intubation procedure has not been completely eliminated.¹¹ Beyond the peri-operative period, there remain significant concerns related to the use, management, and overall benefit of percutaneous gastrostomy (PG) tubes. Trained in the science of evidence-based medicine, physicians generally seek to base treatment recommendations upon data that attests to the efficacy and safety of the proposed intervention. Over the past two decades, several clinicians have undertaken an evaluation of the practice of tube feeding, resulting in a number of published clinical reports. In 1999, Thomas Finucane and his colleagues from the Johns Hopkins Geriatrics Center conducted an extensive review of the published literature pertaining to tube feeding in patients with advanced dementia.¹² The results of the Finucane analysis and similar investigations have led many clinicians to reconsider the value of tube feeding and, more generally, their overall approach to treating patients with advanced dementia, severe stroke, and other diseases characterized by severe cognitive impairment.

As to some of the more important findings of Finucane et al: first, they noted that in no study was tube feeding demonstrated to reduce the risk of aspiration pneumonia, but in three case-control studies, tube feeding was identified as a risk factor for pneumonia and death. Although a number of patient factors may contribute to this phenomenon, animal studies implicate the gastrostomy itself as a cause of impaired function of the sphincter that prevents gastric reflux.¹³ The propensity for gastric reflux in humans

may be mitigated by slowing the rate of administration, altering the composition of the infusate, and by placing the patient in a semi-erect posture during tube feeding. Yet even with such care, aspiration pneumonia post-gastrostomy remains a significant concern and has led some clinicians to recommend additional surgery in an effort to improve the competency of the gastroesophageal sphincter.¹⁴

Secondly, Finucane and his co-workers discovered that contra the general presumption that artificial feeding will improve nutritional status, the data revealed an inconsistent relationship between tube feeding and body mass. In some cases, they observed, tube feeding improved body condition, but in many chronically ill patients, nutritional therapy was unable to reverse the patient's catabolic state. Even when body condition was stabilized or improved, they noted, the complications generally attributed to malnutrition were not reversed. Specifically, tube feeding did not appear to promote the healing of pressure sores (decubital ulcers) or prevent new ones from occurring. Some investigators have actually reported a predisposition of tube-fed patients to develop pressure sores, theorizing that immobility resulting from patient restraint, combined with increasing edema and urine soiling that are exacerbated by the increase in urine output attributable to improved hydration status, creates conditions under which sores are more likely to develop.¹⁵

Thirdly, the Finucane analysis found insufficient data to support the argument that administration of artificial nutrition and hydration (ANH) improves the general comfort of patients in the last stages of terminal disease. They cite, for example, one prospective study of communicative, non-intubated, terminally-ill patients led by Robert McCann of the University of Rochester School of Medicine and Dentistry who discovered that few of these patients experience hunger or thirst, and those who do can be successfully relieved with small, orally-fed portions of food and fluid or with ice chips and lip lubrication.¹⁶ Robert Sullivan made a similar observation while treating a patient in the latter stages of terminal cancer who declined food and water by all means.¹⁷ Sullivan was motivated by the experience to delve into the scientific literature, where he found corroboration of his clinical observation and biochemical studies to help explain the phenomenon.¹⁸

Survival time is of great importance to interventional analyses. In their review of the medical literature, Finucane and his colleagues found no evidence to suggest that tube feeding prolongs the survival of demented patients.¹⁹ As a matter of explanation for this seemingly non-intuitive finding, they offered several possibilities drawn from various clinical reports. First, they observed that careful hand-feeding will sustain many demented patients as long as tube feeding. Second, they noted that the intubation procedure carries a significant risk of mortality, with estimates in the peri-operative period ranging from six to twenty-four percent. Muriel Gillick, a physician at the Hebrew Rehabilitation Center for Aged in Boston, Massachusetts offers a more direct explanation, commenting that dysphagia, or the inability to swallow, is simply an indication that the patient has entered the latter stages of dementia, which as he notes is a uniformly fatal disorder.²⁰ There are many published clinical reports documenting the mortality rates in patients receiving feeding tubes. One large study, which included 81,105 Medicare beneficiaries receiving gastrostomy during hospitalization revealed a fifteen-percent in-hospital mortality rate and overall mortality rates of twenty-four and sixty-three percent at thirty days and one year post-gastrostomy, respectively.²¹ For most patient mortalities occurring post-gastrostomy, it is the underlying disease that is stated

as the cause of death; yet, in one study of nursing home patients managed with PEG, aspiration pneumonia attributable to gastric reflux was responsible for 13% of deaths.²²

Medical Treatment or Basic Care?

In considering the discussion above, some observations are in order. First, tube feeding is an intervention often directed at patients with incurable, naturally lethal disease that requires the involvement of medical personnel in placing the tube, directing its use, and managing associated complications. Second, substantial risks to the health of the patient attend tube feeding. In some cases, tube feeding may not only fail to achieve the putative goal of prolonging the patient's life, but it may inadvertently hasten death. Though it is often assumed that artificial feeding will serve to nourish the patient and alleviate her suffering, experience suggests otherwise in many cases.²³

As the experience of tube feeding has developed and been reported over time, this mode of care has become increasingly recognized within the medical community as futile when applied in the management of patients with incurable, naturally lethal disease. Witness, for example, the conclusions of Dharmarajan et al., drawn from their recent meta-review of clinical studies dealing with tube feeding in patients with advanced dementia:

Although tube feeding may not be totally futile in all cases, an analysis of the benefits and risks seldom leads to a definite positive result in cognitively impaired individuals . . . In view of the fact that outcomes do not necessarily improve, it is prudent for the health provider to exercise caution in decisions regarding PEG placements in dementia.²⁴

In a similar vein, physicians Lawrence Schneiderman and Nancy Jecker employ the concept of futile care in asserting that “healthcare professionals have no business attempting treatments [tube feeding included] to keep [permanently unconscious patients] alive.”²⁵ The discussion over the futility of artificial feeding simply highlights a significant shift that has occurred within the medical community towards viewing it as a form of medical treatment. Some may wish to argue that this shift largely reflects a change in medical priorities (e.g. an altered formula for medical resource allocation that gives greater weight to global health considerations) or a change in worldview assumptions that deemphasize the traditional sanctity-of-life ethic. Though these factors may certainly be operative in the thinking of some, the empirical warrant in support of the shift is compelling in and of itself. This conclusion is attested to by the fact that, among physicians strongly inclined to implement artificial feeding in dying patients, there is little to no objection to classifying artificial feeding as medical care, but instead, their disagreement with those who view tube-feeding as optional therapy comes primarily over how to balance burden and benefit.²⁶

While physicians have moved towards consensus in classifying tube feeding as medical care, resistance towards such a conclusion persists outside the medical profession—witness, Ms. Porta and her giant spoon. Yet, given the current facts concerning tube feeding, it strikes many as incoherent to hear this method of care likened to spoon-feeding. The latter is a most natural act indicated in times of both health and sickness, and it is generally regarded as both safe and beneficial. Although the spoon is artificial in that it is a fabrication of human design, its use is natural as it simply

facilitates the delivery of food and liquid to the orifice designed for their bodily entrance. Contra tube feeding, with spoon-feeding there is no penetration of tissue or body cavity, no implantation of a foreign conduit, and no bypassing of any portion of the digestive system. Spoon-feeding can be administered by virtually anyone and without specialized instrumentation, unlike tube feeding, which requires the input of both professional expertise and medical resources across the spectrum of usage. Whatever risks to the recipient that may be associated with spoon-feeding are simply those inherent to the natural processing of ingesta and not the spoon itself; whereas the risks with tube feeding are directly related to the implantation, use, or continued presence of the feeding device.

So, if tube feeding bears the hallmarks of medical therapy and physicians are largely agreed on such a designation, then on what basis do others argue to the contrary? Some ethicists may grant that tube feeding has a medical aspect to it, yet still argue for its categorization as basic care. Such arguments often turn on the observation that a layperson can operate a feeding syringe or that the substance being provided the recipient is essentially the same as that delivered through oral feeding.²⁷

That virtually anyone can attach a dosing syringe to a feeding tube and push on the plunger is truly not a matter of debate; however, to argue that this fact somehow mitigates the view of tube feeding as medical care reveals a naïve understanding of medicine in general, and tube feeding in particular. The logic of this argument, which may be termed the “lay-infuser objection,” is that if it can be demonstrated that a layperson can administer a particular treatment, then that treatment is not properly considered medical in nature. Yet the reality is that there is much more to the practice of medicine than the mere administration of treatments. Even if the procedure of inserting the tube, which, no one will argue, constitutes anything other than a medical act, is considered separately from the tube’s subsequent usage, the latter cannot be completely divorced from medical concerns. Post-intubation, there are many issues specific to this form of feeding that require medical supervision and care, including the decision of what to infuse and at what rate, how to prevent or address tube dysfunction, skin infections, self-removal of the tube, and how to recognize and treat life-threatening complications that include aspiration pneumonia and intra-peritoneal deposition of the infusate. As with any prescribed treatment, the supervision of a physician is critical for tube feeding, regardless of who actually administers the feeding.

As with the lay-infuser objection, the argument concerning the nature of the infusate as life-sustaining nourishment suffers from a myopic perspective. First, there is the problem of an exceedingly narrow understanding of what constitutes disease and therapy. Those who advance the “infusate objection” base their case on a distinction between life-sustaining and therapeutic interventions. For example, Kevin McMahon states, “Food and fluids are not themselves therapeutic. Apart from the treatment of some eating disorders, they address no pathology.”²⁸ Similarly, Gilbert Meilaender argues that “All living beings need food and water in order to live, but such nourishment does not itself heal or cure disease.”²⁹ According to their logic, if a patient’s inability to eat arising from esophageal cancer is treated by surgically excising the obstructing tumor, this constitutes medical care. However, if it is treated by delivering food through a surgically-implanted conduit that bypasses the obstruction and a portion of the digestive tract, this somehow falls into a completely different (non-medical) category. What is determinative in this manner of classification is whether the primary disease is being

directly addressed by the intervention. Such an understanding of what constitutes disease is atomistic, as it ignores the reality of secondary pathologies, which may very well be a greater threat to the preservation of life than the primary disease. In the example above, the primary disease is esophageal cancer, but the tumor itself is unlikely to kill the patient. Left untreated, the patient will more likely die from organ failure secondary to the electrolyte disturbances and cellular dysfunction that arise from inadequate intake of fluid and nutrition, which itself is secondary to the obstruction caused by the mass. It may still be said that the cause of death in such case was the primary disease, but only in the sense that it stands at the head of a chain of related pathologies.

Another problem with the infusate objection is the failure to keep in focus the central object of medicine, which is the *patient*. As noted above, the classification system for artificial feeding used by McMahon and Meilaender appears to be more focused on the primary disease of the patient than on the patient herself. Although elimination of primary disease is generally ideal, intervention at that level may not always be feasible or in the patient's best interest; in such cases, intervening at the level of secondary disease may be indicated. Whether the treatment addresses primary or secondary disease, the ultimate concern is that it restores the patient to an acceptable state of health. For the patient with esophageal cancer, the provision of nutrients and hydration through a surgically-implanted tube is, in fact, therapeutic, as it addresses secondary disease.

Conclusion

In summarizing the above discussion, it was observed that a consensus has developed within the medical profession towards viewing tube feeding as medical care, primarily in response to the empirical evidence. The more common objections to viewing artificial feeding as a medical treatment, it was noted, fail largely on account of a faulty conception of the nature of medicine and disease. When advanced in the face of a mountain of contradictory evidence, the effort to retain tube feeding in the category of basic care is apt to be perceived as either irrational or as an effort to force an unwarranted moral conclusion.

Most clearly stated, tube feeding is medical nutrition and hydration (MNH) with the term "medical" addressing not only the manner of delivery, but also the goal of intervention and the attention required to identify and address complications arising from the tube's presence and use. Whether or not tube feeding is obligatory in particular cases, or even as a general rule, such a conclusion should not drive the determination of how the nature of tube feeding is to be classified since that would be putting the cart (moral judgment) before the horse (ethical deliberation). The determination of how to classify tube feeding involves an empirical judgment, and the evidence at hand clearly supports viewing it as medical care. The question of whether or not tube feeding may be rightly withheld in a particular case involves a moral judgment that requires an elucidation and application of the relevant moral norms.³⁰

In presenting the above, it is this author's intention to help eliminate a serious obstacle for many well-intentioned individuals who seek to secure a fair hearing of their views on the matter of tube feeding. There may very well be good reasons for insisting on the moral obligation to provide ANH to patients affected with advanced dementia, PVS, and other severely-debilitating diseases, but if the argument is founded upon or

linked in any substantive way to the proposition that ANH constitutes basic care, it will be difficult to sustain when pitched to those familiar with this mode of care.

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23. These two assumptions underlie John Paul II's argument for viewing tube feeding in principle as "ordinary and proportionate, and as such morally obligatory," ("Care for Patients in a 'Permanent' Vegetative State," 739).
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25. Lawrence J. Schneiderman and Nancy S. Jecker, *Wrong Medicine: Doctors, Patients, and Futile Treatment* (Baltimore: Johns Hopkins University Press, 1995), 12.
26. See, for example, Mark Siegler and Alan J. Weisbard, "Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?," *Archives of Internal Medicine* 145 (1985), 130.
27. Patrick G. Derr, "Why Food and Fluids Can Never Be Denied," *Hastings Center Report* 16 (1986), 30; Eugene Diamond, "Nutrition and Hydration: Patients in a Persistent Vegetative State," *Origins* 33, no. 43 (2004), 743; Kevin McMahon, "Should Nutrition and Hydration Be Considered Medical Therapy?," *Origins* 33, no. 43 (2004), 745; Gilbert Meilaender, "On Removing Food and Water: Against the Stream," *Hastings Center Report* 14, no. 6 (1984), 11. The attempt to retain the category of basic care while acknowledging the necessity of a medical procedure is reflected in McMahon's chosen term for tube feeding: "medically-assisted supply of food and drink." It strikes this author as disingenuous at the least to imply, as does McMahon by his choice of terms, that the patient is receiving a normal meal ("food and drink"). That which is infused through the tube bears no resemblance whatsoever to "food and drink," be it on the basis of visual appearance, physical consistency, nutrient and foodstuff composition, rate of administration, smell, or taste experience (or lack thereof). In common usage, the terms "food" and "drink" also imply an active reception and not passive administration. Furthermore, to say that artificial feeding is "medically-assisted" is a gross mischaracterization as it implies something less than total dependence, which is actually the case.
28. McMahon, "Should Nutrition and Hydration Be Considered Medical Therapy?" 745.
29. Meilaender, "On Removing Food and Water: Against the Stream," 11.
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DIGNITY NEVER BEEN PHOTOGRAPHED: SCIENTIFIC MATERIALISM, ENLIGHTENMENT LIBERALISM, AND STEVEN PINKER

FRANCIS J. BECKWITH, PHD

Sick man lookin' for the doctor's cure

Lookin' at his hands for the lines that were

And into every masterpiece of literature

for dignity...

Someone showed me a picture and I just laughed

Dignity never been photographed

I went into the red, went into the black

Into the valley of dry bone dreams

So many roads, so much at stake

So many dead ends, I'm at the edge of the lake

Sometimes I wonder what it's gonna take

To find dignity

- Bob Dylan, from the song, "Dignity." © 1991 Special Rider Music-

In March 2008, the President's Council on Bioethics published a volume entitled, *Human Dignity and Bioethics*.¹ It consists of essays penned by council members as well as other scholars and practitioners invited to contribute. As one would guess, the idea of human dignity and what it means for bioethics, both in theory and in practice, is the theme that dominates each of the works contributed to this impressive volume. But for those who have been following or participating in the interdisciplinary and multidisciplinary world of secular bioethics during the past fifteen or twenty years, the insertion of the idea of "human dignity," or even the word "dignity," as the anthropological foundation of bioethics is highly unusual. Much of the cutting edge literature in bioethics, with few exceptions, tends to employ the language of modern political theory and contemporary analytic political philosophy and jurisprudence. So, for example, one finds in these cutting-edge works discussions about the meaning and implementation of the principles of autonomy, justice, nonmaleficence, and beneficence, as well as calls for the application of these principles to what constitutes physician neutrality, informed consent, and patients' rights. This project often goes by the name *principlism*. There is, of course, much that this project has contributed to the study and practice of bioethics. For each principle and its application has a long and noble pedigree about which many of us hold a variety of opinions. But what distinguishes principlism from the concept of "human dignity," and what makes this central concern of the council's volume so astounding, is that advocates of principlism typically intend for it to be a means by which a physician, ethics committee, nurse practitioner, general counsel, etc., *need not* delve

into the metaphysical question for which “human dignity” is offered as a partial answer, namely, “Who and what are we, and can we know it?”²

To put it another way, if bioethics commits itself to the idea that “human dignity” is essential to its practice, as the President’s Council suggests, it follows that bioethics must embrace a philosophy of the human person, a philosophical anthropology, if you will, that can provide substantive content to the notion of “human dignity.” But such a suggestion seems to run counter to two ideas that are dominant in the secular academy: (1) Enlightenment Liberalism, and (2) Scientific Materialism.

Enlightenment Liberalism is, roughly, the view that a state that aspires to justice and fairness ought not to embrace one view of the human person as the correct view because to do so would be to violate the principles essential to liberal democracy. This is why the principles central to principlism, such as autonomy and justice, are almost all procedural in their application. That is, when they are applied and practiced correctly, they commit the relevant medical personal and institution to as minimal an understanding of the human person and her good as possible.³ Now, as I point out below, I think that this is actually false. In fact, secular bioethics does commit its practitioners to a substantive understanding of the human person and the human good, one that is as contested and controversial as the so-called “religious” views for which principlism is often thought of as a neutral arbiter.⁴ What I am suggesting here, however, is that this is not how its supporters present, or in some cases understand, their position.

The second idea, *Scientific Materialism*, is, roughly, the view that science is the best or only way of knowing, and that science is committed to methodological naturalism (that science must proceed under the assumption that non-natural entities cannot be items of knowledge that may count against the deliverances of the hard sciences). Therefore, philosophies of the human person that affirm non-material properties like “human dignity” are not items of real knowledge. Thus, such philosophies of the human person, though they may be privately embraced and practiced by individual citizens in accordance with their own religious sensibilities or believed on the basis of utility⁵, none of these philosophical anthropologies may ever serve as the basis on which a society may regulate research and practices of bioethical controversy, such as embryonic stem-cell research, physician-assisted suicide, abortion, or reproductive technologies.

As one would suspect, given these definitions, advocates of Enlightenment Liberalism and Scientific Materialism offer them as neutral and uncontested concepts that provide a fair, impartial, and scientifically respectable foundation for the practice of medical ethics in a pluralistic society of competing worldviews.⁶ Despite their intuitive appeal to many in the academic and professional cultures in which a secular bioethics is dominant, I want to argue that these views are not neutral and uncontested concepts. Rather, they support an account of the common good and the human person that answers precisely the same questions that the so-called contested worldviews, including so-called religious perspectives, attempt to answer. In order to make my case, I employ as my point of departure several comments that appeared in a 2008 article published in *The New Republic*, “The Stupidity of Dignity,” authored by Harvard University psychology professor, Steven Pinker.⁷

Following the lead of bioethicist, Ruth Macklin, who published a 2003 editorial entitled, “Dignity is a Useless Concept,”⁸ Professor Pinker maintains that “dignity” adds nothing of importance to bioethics:

The problem is that “dignity” is a squishy, subjective notion, hardly up to the heavyweight moral demands assigned to it. ...Ruth Macklin... [has] argued that bioethics has done just fine with the principle of personal autonomy—the idea that, because all humans have the same minimum capacity to suffer, prosper, reason, and choose, no human has the right to impinge on the life, body, or freedom of another. This is why informed consent serves as the bedrock of ethical research and practice, and it clearly rules out the kinds of abuses that led to the birth of bioethics in the first place, such as Mengele’s sadistic pseudoexperiments in Nazi Germany and the withholding of treatment to indigent black patients in the infamous Tuskegee syphilis study. Once you recognize the principle of autonomy, Macklin argued, “dignity” adds nothing.⁹

Pinker seems to be making two claims: (I) “Dignity” cannot be adequately defined because it is a subjective notion, and thus cannot serve as a basis for moral judgments, and (II) “dignity” is unnecessary since the principle of personal autonomy can do all the work that dignity is procured by its advocates to handle.

In what follows, I assess each claim as well as some of Pinker’s sub-claims. Although I do not directly offer and defend a particular understanding of intrinsic human dignity (even though I, in fact, believe one view of the human person is correct)¹⁰, I offer several counterexamples and clarifications that rely on what I believe is an understanding of human dignity embraced by many members of the President’s Council on Bioethics. I conclude that the view embraced by Pinker and his allies—and the cluster of ideas that they are convinced is entailed by it—is not the only one that rational reflection has the power and insight to deliver.

I. Dignity is Subjective

Pinker argues that the concept of dignity is too subjective, and thus is relative, fungible, and harmful. On each count, Pinker fails to make his case.

A. Dignity is Relative

Human dignity is relative, argues Pinker, because people and cultures have disagreed on a variety of behaviors and whether or not those who engage in them are acting in a dignified fashion. For example, what constitutes proper dress or culinary practices, whether modesty requires knee-high stockings, or whether licking an ice cream cone in public is a case of bad gastronomic form, are matters of wide and varied opinions across cultures and across time.¹¹ This, according to Pinker, constitutes definitive evidence against the idea that human dignity is intrinsic to the person and thus is not reducible to the flux of unguided nature, historical epochs, and/or social institutions.

This argument can be challenged on at least three grounds: (1) disagreement is not sufficient to reject intrinsic human dignity, (2) disagreement between cultures, ironically, counts against Pinker’s position, and (3) Pinker confuses relative practices

and beliefs about which social indignities may arise with the idea that intrinsic human dignity is a real property had by human beings by nature.

(1) It does not follow from the fact that there are differing understandings of human dignity that there is no such thing as intrinsic human dignity or that no one has authentic or even approximate knowledge of it. The fact that Mother Teresa and Margaret Sanger, for example, had different conceptions of human dignity does not mean that neither one was right. The premise—“people disagree on what constitutes human dignity”—is not sufficient to support the conclusion, “therefore, intrinsic human dignity is either not known or non-existent.” It may, of course, turn out that Pinker is correct. But the mere fact of disagreement cannot logically ground his claim.

(2) Pinker has set down a principle—disagreement about what constitutes human dignity means there is no truth on the matter—that is self-refuting. After all, some of us believe that Pinker’s view is mistaken. We, in other words, *disagree* with Pinker over whether intrinsic human dignity exists and whether any of us can have knowledge of it if, in fact, it does exist. Some of us indeed believe that intrinsic human dignity is real and knowable, whereas others of us, like Pinker, do not. But, according to Pinker’s own principle, disagreement over the question of human dignity means that one ought to believe that there is no truth on the matter. Thus, Pinker himself ought to abandon his own position about human dignity’s relativity as the truth on the matter, since some of us, after all, disagree with it. In other words, his principle is a proposition for which there is no universal agreement, and thus on its own grounds must be rejected. As Hadley Arkes points out concerning a similar argument in support of moral relativism, “My disagreement establishes that the proposition does not enjoy a universal assent, and by the very terms of the proposition, that should be quite sufficient to determine *its own invalidity*.”¹²

(3) Conceptually, Pinker is confusing the “dignity” we often associate with social practices and what they may or may not mean to the community with the idea of dignity as a philosophical or theological concept that refers to an intrinsic property had by human persons from the moment they come into being. The former, no one doubts, is in a sense relative. But as many have pointed out¹³, these social practices are often relative to that which is non-relative. That is, the sorts of practices offered by Pinker as evidence of dignity’s relativity typically acquire their meaning and justification because of their power to actualize and protect deeper and apparently unchanging truths. C. S. Lewis provides several illustrations to make this point:

I know that some people say the idea of a Law of Nature or decent behaviour known to all men is unsound, because different civilisations and different ages have had quite different moralities.

But this is not true. There have been differences between their moralities, but these have never amounted to anything like a total difference. If anyone will take the trouble to compare the moral teaching of, say, the ancient Egyptians, Babylonians, Hindus, Chinese, Greeks and Romans, what will really strike him will be how very like they are to each other and to our own. Some of the evidence for this I have put together in the appendix of another book called *The Abolition of Man*; but for our present purpose I need only ask the reader to think what a totally different morality would mean. Think of a country where

people were admired for running away in battle, or where a man felt proud of double-crossing all the people who had been kindest to him. You might just as well try to imagine a country where two and two made five. Men have differed as regards what people you ought to be unselfish to—whether it was only your own family, or your fellow countrymen, or everyone. But they have always agreed that you ought not to put yourself first. Selfishness has never been admired. Men have differed as to whether you should have one wife or four. But they have always agreed that you must not simply have any woman you liked.¹⁴

On the other hand, the philosophical or theological concept of dignity—that it is an intrinsic property had by human persons from the moment they come into being—is not something its defenders claim can be discovered by mere empirical observation of cultural practices, as Pinker seems to think, for he limits his critique to recording just such observations. But, just as the country singer Johnny Lee once sang of his vain search for love in “single bars” and with “good time lovers,”¹⁵ Pinker is looking for dignity in all the wrong places.

According to those who champion the idea of intrinsic human dignity, it is something that we come to know when we reflect upon the nature of human persons, their properties and powers, as well as the goods that contribute to a human being’s flourishing.¹⁶ And yet, much like everything else in which we believe, the idea of intrinsic human dignity is deeply embedded in our cultural, jurisprudential, and religious traditions. Thus, it is sometimes very difficult to understand it apart from the institutions, laws, mores, practices, and beliefs in which the idea of human dignity finds expression, protection, and application.¹⁷ This is why, for example, for most people the parable of the Good Samaritan, the charitable work of Mother Teresa, and Martin Luther King Jr.’s speech at the Lincoln Memorial resonate with them more than Immanuel Kant’s categorical imperative. And yet, human dignity is not reducible to these institutions, laws, mores, practices or beliefs in which and by which it is recognized. For we can think of clear-cut cases in which and by which such institutions and practices have in fact not adequately protected human dignity, such as in the cases of Nazi Germany, Stalinist Russia, and American slavery. This is because human dignity is an intrinsic property had by all human beings by nature. And much more follows from this insight.

Intrinsic human dignity, if it indeed exists, cannot be a degreed property like rationality, intelligence, good looks, height, or weight. For these are accidental properties that by their very nature change, develop, diminish or cease to be actual over time for the human being who has them. But that means that the human being is logically prior to its accidental properties, for the human being subsists as a unified being through all the changes it undergoes. Thus, if the human being is logically prior to its accidental properties, its intrinsic dignity cannot be one of those properties, for an intrinsic property is a necessary condition for the being to be the sort of being that it is. Moreover, if any of the human being’s accidental and degreed properties were the ground of its dignity, dignity would no longer be an intrinsic property that is actualized in any being that exemplifies human nature. It would also mean that we would have to abandon the idea of human equality and draw the conclusion that no two human beings have the same degree of dignity.¹⁸

Because human dignity is not a degreed property, it cannot develop and/or atrophy. For that reason, it is not a material property that has mass or extension. Moreover, because human dignity is intrinsic to every being that exemplifies human nature, it is not the sort of property that is local, in the sense that it depends on the actualization of particular human powers and properties, such as intelligence, good looks, rational faculties, etc. Rather, human dignity is a global property, one that applies to the human being as a whole. That is, human dignity is the property had by the unified entity of a particular sort that maintains absolute identity through change, including the development, growth, and flourishing, as well as the decline and diminishing of her numerous properties and powers. This is why it is difficult to sustain the idea of “human dignity” as an intrinsic property of the whole being if one maintains that the human being is merely a collection of material parts rather than a real unified entity whose parts work in concert for the good of the whole. In sum, its champions claim that human dignity is an intrinsic, immaterial, non-empirical, non-degreed, and essential property had by human beings by nature.

But remember, the second of the two foundational ideas maintained by Pinker and his allies is Scientific Materialism, the view that limits knowledge to the hard and social sciences, which exclude the possibility that we can have knowledge of an immaterial, non-degreed, non-empirical, intrinsic property such as human dignity.¹⁹ As he asserted in his 2003 testimony before the President’s Council on Bioethics:

The idea of humans as possessing some immaterial essence that categorically distinguishes them from animals, I think, is going to come under — is going to become less and less credible, and there will be, I think, a crisis among the religious faiths that depend critically on the assumption that there is some nonmaterial essence....I think there’s going to be a rethinking of ethical issues, such as responsibility and justice and equality, not that it will evaporate....On the contrary, I think they will focus our ethical discussions on what we most value, what we want moral guidelines to do.²⁰

In his 1997 book, *How the Mind Works*, Pinker is more explicit in his commitment to Scientific Materialism:

The traditional explanation of intelligence is that human flesh is suffused with a non-material entity, the soul, usually envisioned as some sort of ghost or spirit. But the theory faces an insurmountable problem: How does the spook interact with solid matter? How does an ethereal nothing respond to flashes, pokes, and beeps and get arms and legs to move? Another problem is the overwhelming evidence that the mind is the activity of the brain. The supposedly immaterial soul, we know now, can be bisected with a knife, altered by chemicals, started or stopped by electricity, and extinguished by a sharp blow or by insufficient oxygen.²¹

And now we see why Pinker’s epistemological and metaphysical commitments limit his analysis of human dignity to wardrobes and eating habits—empirical claims that can be observed and quantified—when in fact the human dignity embraced by its advocates is not that sort of property. This is why, for Pinker, ethics is “what we most value, what we want moral guidelines to do.”²² On the other hand, for the supporter of intrinsic human dignity, ethics is the normative standard by which we assess the rightness of

what we value and what guidelines we want. But this option is not open for Pinker. He is committed to an evolutionary account of ethics that maintains that what we value emerges from inherited behavioral dispositions, though these dispositions, he admits, provide no moral grounds for why an agent ought to behave consistently with those dispositions in the future.²³ So, he offers us an account of morality that is bereft of an account of the duties we may or may not have to obey it.

Ironically, Pinker's suggestion that Scientific Materialism ought to be the metaphysical principle that guides our bioethics violates the first foundational idea that he and his allies embrace: Enlightenment Liberalism. That is, because proponents of Scientific Materialism attempt to answer the same fundamental question that contrary points of view attempt to answer on matters bioethical—who and what are we and can we know it?—a regime, whether political or legal, that proclaims Scientific Materialism as its official position on the nature of human persons and our knowledge about them violates Enlightenment Liberalism's requirement for worldview neutrality. Although he claims in one place that “a free society disempowers the state from enforcing a conception of dignity on its citizens,”²⁴ Pinker nevertheless seeks to shape policy in a direction that recognizes only those views informed exclusively by Scientific Materialism.

B. Dignity is Fungible

According to Pinker, dignity is often set aside or trumped when another good is at stake. He writes:

The Council... treat[s] dignity as a sacred value, never to be compromised. In fact, every one of us voluntarily and repeatedly relinquishes dignity for other goods in life. Getting out of a small car is undignified. Having sex is undignified. Doffing your belt and spread-eagling to allow a security guard to slide a wand up your crotch is undignified. Most pointedly, modern medicine is a gantlet of indignities. Most readers of this article have undergone a pelvic or rectal examination, and many have had the pleasure of a colonoscopy as well. We repeatedly vote with our feet (and other body parts) that dignity is a trivial value, well worth trading off for life, health, and safety.²⁵

Pinker is confusing awkward or embarrassing situations or events—which in our verbal nomenclature we call “indignities”—with a violation of a person's intrinsic human dignity, which, as we have already seen, its proponents maintain is an intrinsic moral property had by human beings by nature. This understanding of human dignity means, among other things, that human beings and their caregivers should treat the human person consistently with his or her own good as a person and not merely as a means to some apparently good end. So, according that understanding, a violation of human dignity would occur if a physician were to *discourage* her patient to undergo a routine pelvic or rectal examination because of the “indignities” described by Pinker. This is because the good of the patient is compromised when he or she willingly abandons her own good in order to avoid a mild indignity that is by its nature not intrinsically immoral.

*C. Dignity is Harmful*²⁶

Pinker maintains that dignity is harmful. That is, of course, an odd thing to say because willing the good of the human person—as human dignity requires—

cannot, by definition, be harmful. What then does Pinker mean? What he means is that throughout human history, governments, and especially religious groups, have committed unspeakable crimes against people in the name of enforcing their version of “dignity” on others. He writes:

Every sashed and bemedaled despot reviewing his troops from a lofty platform seeks to command respect through ostentatious displays of dignity. Political and religious repressions are often rationalized as a defense of the dignity of a state, leader, or creed: Just think of the Salman Rushdie fatwa, the Danish cartoon riots, or the British schoolteacher in Sudan who faced flogging and a lynch mob because her class named a teddy bear Mohammed. Indeed, totalitarianism is often the imposition of a leader’s conception of dignity on a population, such as the identical uniforms in Maoist China or the burqas of the Taliban.²⁷

Pinker is no doubt correct that there are, and have been, despots who employ the language of “dignity” for the purpose of violating the intrinsic human dignity of their citizens. But that’s not an argument against the claim made by many contributors to the council’s report that a human being possesses intrinsic dignity by nature. Pinker is simply making the observation that political and religious leaders sometimes debase language for the purpose of achieving unjust ends. Who disagrees with that?

Nevertheless, a supporter of intrinsic human dignity could find Pinker’s examples to be useful illustrations of what happens when a culture or civilization abandons or does not fully embrace the idea of intrinsic human dignity. In fact, one such supporter, Pope John Paul II, whose name is mentioned in the council’s report over fifteen times, makes this very point in his 1995 encyclical *Evangelium Vitae*:

It is true that history has known cases where crimes have been committed in the name of “truth.” But equally grave crimes and radical denials of freedom have also been committed and are still being committed in the name of “ethical relativism.” When a parliamentary or social majority decrees that it is legal, at least under certain conditions, to kill unborn human life, is it not really making a “tyrannical” decision with regard to the weakest and most defenceless of human beings? Everyone’s conscience rightly rejects those crimes against humanity of which our century has had such sad experience. But would these crimes cease to be crimes if, instead of being committed by unscrupulous tyrants, they were legitimated by popular consensus?²⁸

Thus, the rhetorical trick that Pinker brings to our attention—using the language of “good ends” to justify violating or ignoring a person’s intrinsic dignity--was brought to the world’s attention in 1995 by a Slavic Pope who knows something about what it means for a regime to embrace ideologies that violate human dignity. As a citizen of Poland, he survived the totalitarian adventures of two such regimes: Nazi Germany and the Soviet Union.²⁹

Pinker is certainly right to bring to our attention this disreputable practice of employing the language of dignity as a means to sequester it from one’s policy deliberations. For this reason, let me suggest yet another example, but one often ignored by Pinker and others who embrace similar views on intrinsic human dignity.

Consider the eugenics movement of the 20th century. Its members offered a scientific research program that they were confident would secure certain desirable ends: human excellence, social improvement, and the eradication of a variety of mental and physical pathologies. The eugenicists offered the promise of a brave new future free of misery and disease, one that might fail to be realized if the citizenry stood in the way and continued thinking of the targets of eugenicists as persons with intrinsic dignity. Take, for example, the following comments that appeared in an article published in 1914 in the *Virginia Law Review*:

Could there be general welfare, or would the blessings of liberty to us and our posterity be secured, if there were not restraint upon the human object of the sterilization laws as already passed? Can there be the full blessings of liberty, or full domestic tranquility, if those civilly unfit are allowed to procreate their species and scatter their kind here and there and everywhere amongst our people?...We bestow care upon the breeding of our chickens, horses and cattle; is not the human being worthy of equal care? Nature provides certain immutable laws. It is the duty of our scientists to develop those laws for the benefit of mankind. And if by research it has been found that sterilization will prevent the procreation of idiots, criminals and degenerates, is it not the duty of the legislatures to enact laws which will bring it about? Has it not been for ages an undenied principle that the few must suffer for the good of the many? And when we cause these few to suffer, does it not foster and promote the preamble proclaiming the object of our Constitution?³⁰

Pinker, ironically, offers the same type of rhetorically-charged parade of utopian promises—human excellence, social improvement, and the eradication of a variety of mental and physical pathologies—in order to justify several practices such as embryonic stem-cell research and “therapeutic human cloning.”³¹ He suggests by his comments that researchers and scientists should not take into consideration the moral status of their research subjects or how that research may change the way we think of ourselves, our children, and the other members of our community. Those who think otherwise are labeled “theocons.” Writes Pinker:

[T]heocon bioethics flaunts a callousness toward the billions of nongeriatric people, born and unborn, whose lives or health could be saved by biomedical advances. Even if progress were delayed a mere decade by moratoria, red tape, and funding taboos (to say nothing of the threat of criminal prosecution), millions of people with degenerative diseases and failing organs would needlessly suffer and die. And that would be the biggest affront to human dignity of all.³²

Although Pinker’s language is far more urbane and politically correct than the crude suggestions made by his eugenicist predecessor in 1914, the moral substance is the same: utilitarian considerations, rather than the question of intrinsic human dignity, ought to serve as the basis by which we assess our scientific work on human subjects. Like the 1914 eugenicist, Pinker is asking us to set aside or diminish the question of the moral status of ourselves and our research subjects and focus exclusively on the promised end of eradicating all illness and imperfection.

II. Dignity is Unnecessary

Having dealt with Pinker's claim that dignity is too subjective, I want to now assess his claim that dignity is unnecessary— that the principle of autonomy can do all the work for which dignity has been conscripted by its advocates. Here is Pinker's argument, as I quoted above at the beginning of this article:

Ruth Macklin... [has] argued that bioethics has done just fine with the principle of personal autonomy—the idea that, because all humans have the same minimum capacity to suffer, prosper, reason, and choose, no human has the right to impinge on the life, body, or freedom of another. This is why informed consent serves as the bedrock of ethical research and practice, and it clearly rules out the kinds of abuses that led to the birth of bioethics in the first place, such as Mengele's sadistic pseudoexperiments in Nazi Germany and the withholding of treatment to indigent black patients in the infamous Tuskegee syphilis study. Once you recognize the principle of autonomy, Macklin argued, "dignity" adds nothing.³³

There are several reasons why I do not think this argument works: (1) autonomy presupposes dignity, but is not identical to it, (2) dignity has greater explanatory power than does autonomy in accounting for certain wrongs, (3) non-autonomous human beings can have their dignity violated, and (4) Pinker's view has problems accounting for autonomy as a power had by a rational agent.

A. Autonomy Is Not Identical to Dignity

What if, while on a panel discussion at a meeting of the American Psychological Association, someone turned to Pinker and shouted, "Please sit down and shut up. I am right and you are wrong. And that's that." I suspect that Pinker would find this treatment grossly inappropriate, one not consistent with the sort of respect a man of his accomplishments and stature should be afforded in such a public venue. He would indeed be correct. But why would he think so? Is there something about him that requires others to treat him with respect and deference? Perhaps it is his accomplishments. That seems partly right. But what precisely is it about his accomplishments that demands our respect? It seems to me that they are impressive because they are the consequence of the development of natural gifts that a person with such gifts is morally required to hone and perfect and not to waste on frivolity. After all, if in another possible world Steven Pinker₂ had in fact spent his adult years as a couch potato collecting welfare checks, eating Cheetos, and watching Jerry Springer until he died as an obese loner in a Central Texas trailer park, we would rightfully lament the incredible waste of native abilities that not only disrupted Mr. Pinker's own good but the common good as well. So, we would say that Steven Pinker₂, by living a life of laziness and self-indulgence, did not properly respect himself. He would, by all accounts, have exercised his personal autonomy, and yet he did so in a way inconsistent with the intrinsic purposes of a being of his nature. So, the exercise of autonomy not only cannot adequately ground human dignity; it can be exercised inconsistently with that dignity.

Thus, we would be correct in saying that in a sense one ought not respect people like Steven Pinker₂ who, when given the opportunity to hone and nurture certain gifts waste these potentials in a life of sloth and depravity. But the "respect" not owed here is not the

respect about which defenders of human dignity write. It is a second-order respect that is *earned* by persons who properly employ and nurture those natural talents that are not equitably distributed among human beings (and thus come in degrees and thus cannot be the basis of first-order respect, or human dignity). But the withholding or lavishing of second-order respect on a particular being makes sense only in light of the *sort of being* it is by nature, that is, a being who has certain intrinsic capacities and purposes that if prematurely disrupted by either its own agency or another agent, result in an injustice. So, the human being who wastes his talents is one who does not respect his natural gifts or the basic capacities whose maturation and proper employment make possible the flourishing of talent and skill. That is, the idea that certain perfections grounded in basic capacities have been impermissibly obstructed from maturing is assumed in the very judgment one makes about human beings and the way in which they should treat themselves (as in the case of Steven Pinker₂) or be treated by others (as in the case of the actual Steven Pinker who was told to shut up and sit down). Thus, both Steven Pinker and Steven Pinker₂ possess intrinsic human dignity, even if Steven Pinker objects to our assessment about the grounds by which we should accord him the respect to which he believes he is entitled. And in neither case is the principle of autonomy doing any of the real work.

B. Dignity Has Greater Explanatory Power Than Does Autonomy

According to Pinker, “[I]nformed consent serves as the bedrock of ethical research and practice, and it clearly rules out the kinds of abuses that led to the birth of bioethics in the first place, such as Mengele’s sadistic pseudoexperiments in Nazi Germany.”³⁴ Although it is true that the Nazi victims were not provided with informed consent, it does not follow that the absence of that informed consent is the reason why the Nazi research was wicked.

After all, suppose we discovered that half of the Nazis’s victims had come to believe Adolph Hitler’s rhetoric and concluded that they were in fact to blame for all that was wrong with Germany. And imagine that some of them willingly became Mengele’s guinea pigs and the remaining went to the gas chambers because of their love for the Fatherland. These courses of action would be entirely voluntary, an exercise of the principle of autonomy. Yet, the reason why these people were gassed was precisely the same reason why the non-voluntary victims were gassed. A bad reason to do evil does not become less of a bad reason simply because the victim voluntarily participates in his own unjustified homicide. Replacing intrinsic dignity with autonomy actually diminishes that wrong, for it turns an intrinsic wrong into a conditional one. So, ironically, if this analysis is correct, it is autonomy and not dignity that is not a necessary condition for assessing the wickedness of these acts. Thus, it is the idea that human beings have intrinsic dignity that best accounts for our understanding of the wrongness of the Nazi atrocities.

C. Non-Autonomous Beings Can Have Their Dignity Violated

Not only can the principle of autonomy not fully account for the wrongness of the Nazi atrocities, it also cannot account for the wrongness of intentionally creating non-autonomous human beings for apparently noble purposes. And it seems that only intrinsic human dignity can do that. Consider this example. Imagine a developmental

embryologist manipulates the development of an early embryo-clone in such a way that what results is an infant without higher brain functions, but whose healthy organs can be used for ordinary transplant purposes or for spare parts for the person from whom the embryo was cloned.³⁵ Given the dominant accounts of moral personhood in the literature—views that claim that a being’s possession of intrinsic value is contingent upon some presently held property or immediately exercisable mental capacity to function in a certain way³⁶—it is not clear how intentionally creating such deformed beings for a morally good purpose is morally wrong. It certainly cannot be that the embryo-clone’s autonomy is violated, since it has not reached a point in its development at which it can exercise autonomy. In fact, the whole point of tinkering with the embryo-clone’s development is so that it will not become autonomous.

Suppose, in response, someone argues that this is morally wrong because the unborn is entitled to his higher brain functions. But as bioethicist Dan Brock argues, “this body clone” could not arguably be harmed because of its “lack of capacity for consciousness.”³⁷ Yet, he concedes that “most people would likely find” the practice of purposely creating permanently non-sentient human beings “appalling and immoral, in part because here the cloned later twin’s capacity for conscious life is destroyed *solely as a means* to benefit another.”³⁸ This intuition, however, only makes sense if the cloned twin is entitled to his higher brain functions. But according to the view embraced by Pinker, the principle of autonomy is adequate for the purpose of determining whether scientific research is ethical. But the pre-sentient fetus is not autonomous. So, the entitlement account does not do the trick if autonomy is the ground of dignity, as Pinker claims. It seems to me, therefore, that what one needs is this sort of principle: it is *prima facie* wrong to destroy the physical structure necessary for the realization of a human being’s basic, natural capacity for the exercisability of a function that is a perfection of its nature. But there are two problems for Pinker if he accepts this: (1) autonomy is totally absent from this account, and thus it shows that the principle of autonomy cannot do the sort of work he claims it can do, and (2) it means that human beings have certain natural ends that are perfections of their nature, an idea at home with the philosophical anthropology embraced by proponents of intrinsic human dignity.

D. Pinker’s View Has Problems Accounting for Autonomy as a Power had by a Rational Agent

According to Pinker, because “all humans have the same minimum capacity to suffer, prosper, reason, and choose, no human has the right to impinge on the life, body, or freedom of another.”³⁹ But according to Pinker’s account of the human person, all our faculties, including the cognitive faculties by which we reason, arrived in their present state as a result of blind non-rational forces combined with natural selection and/or perhaps other material causes.⁴⁰ In that case, what grounds would provide warrant for Pinker to claim that his exercise of his cognitive faculties including his reason is functioning properly? Alvin Plantinga has raised a similar question in what he calls *an evolutionary argument against naturalism*.⁴¹ I will briefly summarize Plantinga’s argument while applying it to Pinker’s case.

Here’s the problem for Pinker: If he provides reasons for his belief that his cognitive faculties are functioning properly he must rely on those very cognitive faculties in order to arrive at those reasons. However, Pinker tells us that all our cognitive

faculties, including his, arrived in their present state as a result of blind non-rational forces combined with natural selection and/or perhaps other material causes. But, as Plantinga points out, “[e]volution is interested, not in true belief, but in survival or fitness.” Thus, “[i]t is . . . unlikely that our cognitive faculties have the production of true belief as a proximate or any other function, and the probability of our faculties’ being reliable (given naturalistic evolution) would be fairly low.”⁴² Thus, “any argument” Pinker “offers” for the reliability of his cognitive faculties “is in this context delicately circular or question-begging.”⁴³ Although it is not *formally* circular in the sense that the conclusion appears in the argument’s premises, it is, writes Plantinga, “*pragmatically* circular in that it purports to give a reason for trusting our cognitive faculties, but is itself trustworthy only if those faculties (at least the ones involved in its production) are indeed trustworthy.” Thus, Pinker or your garden-variety naturalist “subtly assumes the very proposition” he “proposes to argue for.” In other words, “[o]nce I come to doubt the reliability of my cognitive faculties, I can’t properly try to allay that doubt by producing an *argument*; for in doing so I rely on the very faculties I am doubting.”⁴⁴ Thus, one of the grounds that Pinker offers for the principle of autonomy—the minimal capacity to reason—is not an obvious deliverance of reason, since it seems, according to the arguments of Plantinga and several other thinkers⁴⁵, difficult to sustain while embracing a materialist and evolutionary naturalist account of the human person.⁴⁶

III. Conclusion

The idea of intrinsic human dignity as essential to bioethics has come under greater critique in recent years, largely by thinkers such as Professor Pinker, who are committed to Enlightenment Liberalism and Scientific Materialism. They see the prominence of human dignity in the 2008 report of the President’s Council on Bioethics as a threat to the hegemony of principlism as well as the apparent worldview neutrality of Enlightenment Liberalism and Scientific Materialism, both of which are thought by their advocates as supportive of principlism as well as essential to a fair and just liberal democracy in the 21st century.

But, as we have seen, both Enlightenment Liberalism and Scientific Materialism fail to deliver on what their proponents promise. That is, neither one is neutral, and neither one is the only legitimate deliverance of rational reflection.⁴⁷

Endnotes

1. President’s Council on Bioethics, *Human Dignity and Bioethics: Essays Commissioned by the President’s Council on Bioethics* (Washington, DC: www.bioethics.gov, 2008), available at http://www.bioethics.gov/reports/human_dignity/human_dignity_and_bioethics.pdf
2. There are, of course, exceptions to this, such as the Christian principlisms of Scott B. Rae and David B. Fletcher. See Scott B. Rae, *Moral Choice: An Introduction to Ethics*, 3rd ed. (Grand Rapids, MI: Zondervan, 2009); and David B. Fletcher, “Response to Nigel de S. Cameron’s Bioethics and the Challenge of a Post-Consensus Society,” *Ethics & Medicine: An International Journal of Bioethics* 11:1 (Spring 1995)
3. This is especially true of the principles of nonmaleficence, beneficence, and justice. Although they are less procedural than the others, they are nevertheless often presented as largely procedural with minimal substantive content. Consider, for example, how the principle of nonmaleficence is presented by the standard text in the field, *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress, 6th ed. (New York: Oxford University Press, 2009).

On page 149, Beauchamp and Childress write that “the principle of nonmaleficence imposes an obligation not to inflict harm on others.” But, with few exceptions, Beauchamp and Childress are reluctant to say that a fully informed and competent patient may be able to harm herself if she non-coercively chooses a course of “treatment” with which her physician cooperates. For example, they ask us to “consider the actions of physician Timothy Quill,” who prescribed “the barbiturates desired by a forty-five-year-old patient who had refused a risky, painful, and often unsuccessful treatment for leukemia. The woman had been his patient for many years, and members of her family had, as a group, come to this decision with his counsel. The patient was competent and had already discussed and rejected all reasonable alternatives for the relief of suffering.” After briefly mentioning some problems raised by Dr. Quill’s critics as well as Dr. Quill’s lying to the medical examiner in order to minimize his legal liability, Beauchamp and Childress write that they “do not oppose Quill’s act, his patient’s decision, or their relationship.” (Ibid., 183).

4. See Tristram Engelhardt, Jr., “Public Discourse and Reasonable Pluralism: Rethinking the Requirements of Neutrality,” in *Handbook on Bioethics and Religion*, ed. David E. Guinn (New York: Oxford University Press, 2006), 169-198.
5. Writes Steven Pinker: “[E]thical theory requires idealizations like free, sentient, rational, equivalent agents whose behavior is uncaused, and its conclusions can be sound and *useful* even though the world, as seen by science, does not really have uncaused events.... A human being is simultaneously a machine and a sentient free agent, depending on the purpose of the discussion, just as he is also a taxpayer, an insurance salesman, a dental patient, and two hundred pounds of ballast on a commuter airplane, depending on the purpose of the discussion. The mechanistic stance allows us to understand what makes us tick and how we fit into the physical universe. When those discussions wind down for the day, we go back to talking about each other as free and dignified human beings.” (Steven Pinker, *How the Mind Works* [New York: W. W. Norton, 1997], 55, 56) (emphasis added)
6. See Jeffrey W. Bulger, “An Approach Towards Applying Principlism,” *Ethics & Medicine: An International Journal of Bioethics* 25.2 (Summer 2009)
7. Steven Pinker, “The Stupidity of Dignity,” *The New Republic* Vol. 238 Issue 9 (28 May 2008): 28-31.
8. Ruth Macklin, “Dignity is a Useless Concept,” *British Medical Journal* 327 (20 December 2003): 1419-1420.
9. Pinker, “The Stupidity of Dignity,” 28.
10. Francis J. Beckwith, *Defending Life: A Moral and Legal Case Against Abortion Choice* (New York: Cambridge University Press, 2007)
11. “One doesn’t have to be a scientific or moral relativist to notice that ascriptions of dignity vary radically with the time, place, and beholder. In olden days, a glimpse of stocking was looked on as something shocking. We chuckle at the photographs of Victorians in starched collars and wool suits hiking in the woods on a sweltering day, or at the Brahmins and patriarchs of countless societies who consider it beneath their dignity to pick up a dish or play with a child. Thorstein Veblen wrote of a French king who considered it beneath his dignity to move his throne back from the fireplace, and one night roasted to death when his attendant failed to show up. [Leon] Kass finds other people licking an ice-cream cone to be shamefully undignified; I have no problem with it.” (Pinker, “The Stupidity of Dignity,” 30)
12. Hadley Arkes, *First Things: An Inquiry Into the First Principles of Moral and Justice* (Princeton NJ: Princeton University Press, 1986), 132.
13. See, example, Arkes, *First Things*, 134-158; C. S. Lewis, *Mere Christianity* (a revised and amplified edition, with a new introduction, of the three books, *Broadcast Talks*, *Christian Behaviour*, and *Beyond Personality*) (San Francisco: HarperCollins, 2001; originally published in 1952), 5-6; and Timothy Mosteller, *Relativism: A Guide for the Perplexed* (New York: Continuum, 2008), 43-57.
14. Lewis, *Mere Christianity*, 5-6.
15. From the song, “Lookin’ for Love” by Johnny Lee: I spent a lifetime lookin’ for you/Single bars and good time lovers were never true/Playing a fools game, hopin’ to win/Tellin’ those sweet lies and losin’ again./I was lookin’ for love in all the wrong places/Lookin’ for love in too many

places/Searchin' her eyes, lookin' for traces/Of what I'm dreamin' of/Hoping to find a friend and a lover/I'll bless the day I discover,/You - lookin' for love.

16. See, for example, J. P. Moreland, *The Recalcitrant Imago Dei: Human Persons and the Failure of Naturalism* (London: SCM Press, 2009); Patrick Lee and Robert P. George, "The Nature and Basis of Human Dignity," *Ratio Juris* 21.2 (June 2008): 173-193; and John Finnis, *Fundamentals of Ethics* (Washington, D.C.: Georgetown University Press, 1983)
17. See, for example, Alasdair MacIntyre, *After Virtue* (Notre Dame, IN: University of Notre Dame Press)
18. Lee and George, for example, argue that a human being is intrinsically valuable and possesses intrinsic dignity because it is a being with a rational nature, i.e., one that has the basic natural capacity for rationality from the moment it comes into existence. (Lee and George, "The Nature and Basis of Human Dignity"). In making their case they argue that this basic natural capacity is not an accidental property:

On this position every human being, of whatever age, size, or stage of development, has inherent and equal fundamental dignity and basic rights. If one holds, on the contrary, that full moral worth or dignity is based on some accidental attribute, then, since the attributes that could be considered to ground basic moral worth (developed consciousness, etc.) vary in degree, one will be led to the conclusion that moral worth also varies in degrees.

It might be objected against this argument, that the basic natural capacity for rationality also comes in degrees, and so this position (that full moral worth is based on the possession of the basic natural capacity for rationality), if correct, would also lead to the denial of fundamental personal equality.... However, the criterion for full moral worth is having a nature that entails the capacity (whether existing in root form or developed to the point at which it is immediately exercisable) for conceptual thought and free choice—not *the development* of that basic natural capacity to some degree or other. The criterion for full moral worth and possession of basic rights is not the possession of a capacity for conscious thought and choice considered as an accidental attribute that inheres in an entity, but being a certain kind of thing, that is, having a specific type of substantial nature. Thus, possession of full moral worth follows upon being a certain type of entity or substance, namely, a substance with a rational nature, despite the fact that some persons (substances with a rational nature) have a greater intelligence, or are morally superior (exercise their power for free choice in an ethically more excellent way) than others. Since basic rights are grounded in being a certain type of substance, it follows that having such a substantial nature qualifies one as having full moral worth, basic rights, and equal personal dignity.

(Lee and George, "The Nature and Basis of Human Dignity," 190; citation omitted).

19. See, for example, Margaret Urban Walker, "Introduction: Groningen Naturalism in Bioethics," *Naturalized Bioethics: Toward Responsible Knowing and Practice*, eds., Hilde Lindemann, Marian Verkerk, and Margaret Urban Walker (New York: Cambridge University Press, 2009), 1-20
20. Meeting Transcript (6 March 2003), President's Council on Bioethics, available at <http://www.bioethics.gov/transcripts/march03/mar6full.html>
21. Pinker, *How the Mind Works*, 64.
22. Meeting Transcript (6 March 2003), President's Council on Bioethics, available at <http://www.bioethics.gov/transcripts/march03/mar6full.html>. Pinker writes elsewhere: "The foundation of individual rights is the assumption that people have wants and needs and are authorities on what those wants needs are." (Pinker, *How the Mind Works*, 48)
23. "[M]oral emotions are designed by natural selection to further the long-term interests of individuals and ultimately their genes." (Pinker, *How the Mind Works*, 406). Writes Pinker:

Our organs of computation are a product of natural selection. The biologist Richard Dawkins called natural selection the Blind Watchmaker; in the case of the mind, we can call it the Blind Programmer. Our mental programs work as well as they do because they were shaped by selection to allow our ancestors to master rocks, tools, plants, animals, and each other, ultimate in the service of survival and reproduction.

Natural selection is not the only cause of evolutionary change. Organisms also change over the eons because of statistical accidents in who lives and who dies, environmental catastrophes that wipe out whole families of creatures, and the unavoidable by-products of changes that *are* the product of selection. But natural selection is the only evolutionary force that acts like an engineer, “designing” organs that accomplish improbable adaptive outcomes (a point that has been made forcefully by the biologist George Williams and by Dawkins)...

Nature does not dictate what we should accept or how we should live our lives...I do know that happiness and virtue have nothing to do with what natural selection designed us to accomplish in our ancestral environment. They are for us to determine. In saying this I am no hypocrite, even though I am a conventional straight white male. Well into my procreating years I am, so far, voluntarily childless, having squandered my biological resources reading and writing, doing research, helping out friends and students, and jogging in circles, ignoring the solemn imperative to spread my genes. By Darwinian standards I am a horrible mistake, a pathetic loser, not one iota less than if I were a card-carrying member of Queer Nation. But I am happy to be that way, and if my genes don't like it, they can jump in the lake.

(Ibid., 36, 52). See also, Steven Pinker, “The Moral Instinct,” *New York Times Magazine* (13 January 2008), available at http://www.nytimes.com/2008/01/13/magazine/13Psychology-t.html?_r=1&pagewanted=all

24. Pinker, “The Stupidity of Dignity,” 30.
25. Ibid.
26. Ibid.
27. Ibid.
28. John Paul II, *Evangelium Vitae: Encyclical Letter on the Value and Inviolability of Human Life* (25 March 1995), available at http://www.newadvent.org/library/docs_jp02ev.htm (13 July 2009)
29. George Weigel, *Witness to Hope: The Biography of John Paul II* (New York: HarperCollins, 1999)
30. J. Miller Kenyon, “Sterilization of the Unfit,” *Virginia Law Review* 1 (1913-1914): 461-462, 466.
31. “This spring [2008], the President’s Council on Bioethics released a 555-page report, titled *Human Dignity and Bioethics*. The Council, created in 2001 by George W. Bush, is a panel of scholars charged with advising the president and exploring policy issues related to the ethics of biomedical innovation, including drugs that would enhance cognition, genetic manipulation of animals or humans, therapies that could extend the lifespan, and embryonic stem cells and so-called ‘therapeutic cloning’ that could furnish replacements for diseased tissue and organs. Advances like these, if translated into freely undertaken treatments, could make millions of people better off and no one worse off. So what’s not to like? The advances do not raise the traditional concerns of bioethics, which focuses on potential harm and coercion of patients or research subjects. What, then, are the ethical concerns that call for a presidential council?” (Pinker, “The Stupidity of Dignity,” 28).
32. Ibid., 31
33. Ibid., 28
34. Ibid., 28

35. Carol Kahn offers this proposal in her essay, "Can We Achieve Immortality?: The Ethics of Cloning and Other Life Extension Technologies," *Free Inquiry* (Spring 1989), 14-18.
36. See, for example, David Boonin, *A Defense of Abortion* (New York: Cambridge University Press)
37. David W. Brock, "Cloning Human Beings: An Assessment of the Ethical Issues Pro and Con," in National Bioethics Advisory Commission, *Cloning Human Beings*, vol. 2 (Rockville, MD: The Commission, 1997), E8 (hereinafter, NBAC 2)
38. *Ibid.*, E9.
39. Pinker, "The Stupidity of Dignity," 28.
40. Writes Pinker:

Our organs of computation are a product of natural selection. The biologist Richard Dawkins called natural selection the Blind Watchmaker; in the case of the mind, we can call it the Blind Programmer. Our mental programs work as well as they do because they were shaped by selection to allow our ancestors to master rocks, tools, plants, animals, and each other, ultimate in the service of survival and reproduction.

Natural selection is not the cause of evolutionary change. Organisms also change over the eons because of statistical accidents in who lives and who dies, environmental catastrophes that wipe out whole families of creatures, and the unavoidable by-products of changes that *are* the product of selection. But natural selection is the only evolutionary force that acts like an engineer, "designing" organs that accomplish improbable adaptive outcomes (a point that has been made forcefully by the biologist George Williams and by Dawkins).

(Pinker, *How The Mind Works*, 36)

41. Plantinga, *Warrant and Proper Function* (New York: Oxford University Press, 1993), 216-237.
42. *Ibid.*, 219. Philosopher Anthony O'Hear makes a similar observation:

In the Darwinian view, even our reason is simply an instrument of survival. It was not given to us to unearth the ultimate truth about things but simply to find our way around the savannah well enough to survive and reproduce. That we have a disinterested power to seek and the ability to find the truth for its own sake is as much of an illusion as our faith that our moral sense is truly altruistic and other-regarding. It may, be like our moral faith, a useful illusion, for purposes of survival and reproduction, in that having the illusion may encourage us to uncover facts that aid survival. But it is an illusion none the less, foisted on us by our genes, that we are really engineered by nature to discover ultimate, universally valid truth. Neither our sense nor evolution in general provides any guarantee that what our investigations reveal is the real truth, as opposed to a set of notions useful for a time in the struggle for existence, which of course, leaves a question over the Darwinian notion itself that we are basically survival machines. Is that real truth or merely a notion useful in the struggle for survival? The Darwinian account, seeing our knowledge, as everything else about us, in terms simply of selective advantage, gives us no hope for deciding.

(Anthony O'Hare, *After Progress: Finding the Old Way Forward* [London: Bloomsbury, 1999], 68)

43. Plantinga, *Warrant and Proper Function*, 234.
44. *Ibid.*, Plantinga suggests that the idea of properly functioning cognitive faculties makes the most sense if they were designed by a being for that purpose. That is, "naturalistic epistemology flourishes best in the garden of supernaturalistic metaphysics. Naturalistic epistemology conjoined with naturalistic metaphysics leads *via* evolution to skepticism or to violation of canons of rationality; conjoined with theism it does not. The naturalistic epistemologist should therefore prefer theism to metaphysical naturalism" (Plantinga, *Warrant and Proper Function*, 237). For a response to Plantinga's case, see Branden Fitelson and Elliot Sober, "Plantinga's

- Probability Arguments Against Evolutionary Naturalism,” in *Intelligent Design Creationism and Its Critics: Philosophical, Theological, and Scientific Perspectives*, ed. Robert T. Pennock (Cambridge, MA: M.I.T. Press, 2001).
45. In addition to Plantinga’s work, see William Hasker, *The Emergent Self* (Ithaca, NY: Cornell University Press, 1999); Stewart Goetz and Charles Taliaferro, *Naturalism* (Grand Rapids, MI: Eerdmans, 2008), 25-96; Richard Swinburne, *The Evolution of the Soul*, 2nd ed. (New York: Oxford University Press, 1997); Moreland, *The Recalcitrant Imago Dei*, especially 41-103; J. P. Moreland, *Consciousness and the Existence of God: A Theistic Argument* (New York: Routledge, 2009); J. P. Moreland, “The Argument from Consciousness,” in *The Blackwell Companion to Natural Theology*, eds. William Lane Craig and J. P. Moreland (Oxford, UK: Wiley-Blackwell, 2009), 282-343; Victor Reppert, “The Argument from Reason,” in *The Blackwell Companion to Natural Theology*, 344-390; Keith Yandell, “A Defense of Dualism,” *Faith and Philosophy* 12 (October 1995): 548-66; Charles Taliaferro, “Animals, Brains, and Spirits,” *Faith and Philosophy* 12 (October 1995): 567-81; Ric Machuga, *In Defense of the Soul: What It Means to Be Human* (Grand Rapids, MI: Brazos Press, 2002);
46. I say “evolutionary *naturalism*” to distinguish it from theistic evolution or other understandings of evolution that are non-naturalist. Because it is often mistakenly assumed that evolution is in-principle inconsistent with final or formal causes, many people, including some Christians, have come to believe that evolution per se is a defeater to the belief that the universe is designed. I address this error in Francis J. Beckwith, “How to Be An Intelligent Design Advocate,” *University of St. Thomas Journal of Law & Public Policy* 4.1 (2010). See also Etienne Gilson, *From Aristotle to Darwin and Back Again: A Journey in Final Causality, Species, and Evolution*, trans. John Lyon (Notre Dame, IN: University of Notre Dame Press, 1984) and Francis S. Collins, *The Language of God: A Scientist Presents Evidence for Belief* (New York: The Free Press, 2006)
47. I began working on this paper while I was serving on the faculty of the University of Notre Dame (2008-2009) as the Mary Ann Remick Senior Visiting Fellow in the Notre Dame Center for Ethics & Culture. I would like to thank the Center’s director, Professor W. David Solomon, for allowing me the opportunity to spend the year at Notre Dame free of my ordinary responsibilities at Baylor. I would like to also thank my Baylor department chair, Professor Michael Beaty, for supporting my research leave, as well as the director of Baylor’s Institute for the Studies of Religion, Professor Byron Johnson, for providing me with additional financial support during my year at Notre Dame.

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PHYSICIAN AUTONOMY VS. SELF-REGULATION: YOU CAN'T HAVE ONE WITHOUT THE OTHER

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Abstract:

Physician autonomy is intricately linked with the quality of care and patient protection. Professional autonomy which gives physicians the freedom to exercise their judgment in the best interest of the patient without societal interference is based on the premise that physicians will act competently and will put the wellbeing of the patient ahead of their own personal interest. Since individual physicians cannot always be relied on to be competent and scrupulous, the social contract that gives the medical profession the privilege of autonomy goes hand in hand with the responsibility for effective self-regulation. Governments delegate their regulatory and policing power to the medical profession with the expectation that the profession will fulfill its self-regulatory obligation. For a variety of reasons, the medical profession has done a poor job in this regard and has been accused of complicity and complacency. Largely in response to negative media coverage and public pressure in various countries, the medical profession has undertaken initiatives in recent years to ensure continued physician competence, information sharing among different jurisdictions, increased transparency, greater public participation in the regulatory process, and more vigorous exercise of its policing power. Recertification and revalidation requirements have helped address the issue of competence, but physician conduct still remains a source of concern. The progress toward effective self-regulation has been slow, and greater effort is necessary to allay public concerns in this regard.

Conceptual Background

The Declaration on Professional Autonomy and Self-Regulation adopted by the World Medical Association in October 1987 and revised in 2005 recognizes the “importance of professional autonomy and self-regulation” around the world.¹ The first principle in the declaration enunciates that “the central element of professional autonomy is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients.” Whereas the central element of autonomy is the freedom to exercise professional judgment in the best interest of the patient, the central element of the medical profession’s self-regulatory obligations is policing and punitive action.²

Physicians have long understood that professional autonomy can only be preserved by demonstrating effective self-regulation.²⁻⁵ While physicians place a great deal of emphasis on professional autonomy, they also recognize society’s interest in accountability and protection of patients against negligent, incompetent, and unethical practitioners. The authority of licensing boards, peer review organizations, and credentialing committees to license and regulate physicians stems from an implicit

social contract between the medical profession and society regarding “reciprocal rights and obligations.” The medical profession makes a commitment toward the wellbeing of patients, professional competence, and ethical conduct of physicians. In return, the society confers professional autonomy and “the privilege of self-regulation” upon the medical profession.^{4,5}

Context and Purpose of Self-Regulation

The physician-patient relationship is based on trust² and an assumption of a high level of competence and ethical conduct on the part of the physician. Because of the complexity of medical information, the balance of power in the physician-patient relationship is tilted in favor of the physician. The fact that patients have to rely on the professional judgment and ethical conduct of the physician creates a situation in which patients are vulnerable to incompetent or unscrupulous physicians and at risk for great physical, mental, and economic harm.⁴ To protect the wellbeing of patients, and to safeguard the autonomy of the physician, it is imperative for the medical profession to effectively deal with the small number of incompetent and unscrupulous physicians.⁵ If the medical profession cannot guarantee the former, it stands to lose the latter as well.

Clearly, quality of care is a function of both the competence and the conduct of the provider. That is, the wellbeing of the patient is entirely dependent upon the competence and ethical behavior of the physician. Therefore, the obligations of the medical profession toward society boil down to these two elements. While competence deals with the attainment and exercise of requisite knowledge and skills, conduct deals with the observance and exercise of appropriate ethical and moral principles. Consequently, competence is gauged in terms of explicit standards of knowledge and skill, whereas conduct is assessed on the bases of prevailing societal norms, laws, and a code of professional conduct. Quite simply, the standards of competence, conduct, and quality require the physician to do the right thing for the right person at the right time in the right manner for the right reason.

Adoption of licensing and disciplinary procedures manifestly protects the interests of the medical profession by demonstrating to the society that the profession accords highest priority to the wellbeing of patients and does not tolerate misconduct or incompetence on the part of its members. By appropriately dealing with miscreants among its ranks, the medical profession avoids greater societal involvement in its affairs.^{3,4} Thus, at the heart of regulatory procedures is the need to protect the patient (“first do no harm”) and promote professional integrity. Driven by these needs, the licensing and disciplining mechanisms explicitly assess competence, quality of care, and adherence to a prescribed code of conduct. While quality assurance and patient protection are the primary objectives, these activities also help safeguard the autonomy of the medical profession. With varying degrees of success, licensing and credentialing procedures help ensure entry into the medical profession of only those who are appropriately trained.⁶

By requiring evidence of competence, licensing procedures protect the patients preemptively, whereas disciplinary procedures come into play only after an undesirable event has taken place. Disciplinary actions also serve as a deterrent against future acts of negligence or deviant behavior by setting precedence. At a societal level, licensing

and disciplinary actions are implemented through a two-tiered system of judicial and prejudicial actions. Judicial actions can be taken only by law enforcement agencies, whereas prejudicial actions are the purview of the medical profession. Whereas judicial actions can result in both punitive and compensatory decisions, pre-judicial actions can only be punitive in nature. In other words, judicial actions can do both—punish the wrongdoer and compensate the victim, whereas prejudicial actions can only punish the wrongdoer by, for example, revoking a license.

The Role of the Peer Review Process

Though employed in varying forms in non-hospital settings as well, the peer review process, implemented through medical staff committees, remains predominantly a mechanism to regulate and discipline deviant physicians in hospital settings.⁷⁻⁹ The medical staff peer review committees are designed to address the issue of physician competence, quality, and ethical conduct in the context of hospital care alone.^{10,11} Physicians who serve on hospital peer review committees are protected against discovery and reprisal by state and federal laws including the Health Care Quality Improvement Act (HCQIA) of 1986.^{8,12-19} In the broader context of professional autonomy and self-regulation, however, there are three specific problems with hospital peer review committees. First, these committees operate only within the sphere of hospital care and their actions are generally limited to suspension or revocation of hospital privileges. As such, peer review committees do not have the broader authority to suspend or revoke license to practice medicine. Admittedly, the overall impact on the careers of those disciplined, due to the mandatory reporting of sanctions to the National Practitioner Data Bank, can be quite devastating.^{9, 19} Second, despite the polar opposite assertions of the proponents and opponents of the peer review process regarding the magnitude of the problem, peer review committees have been marred by controversy regarding turf battles and lack of objectivity.^{8-10, 20-24} The opponents of the peer review process and supporters of reduced protections against discovery allege that the peer review process is frequently used to eliminate competition, settle personal scores, and get rid of whistle blowers and “disruptive” physicians.^{8-10, 20-24} Third, aside from the fear of a backlash from those subjected to sanctions, concerns about the escalating cost of malpractice insurance and a misplaced sense of camaraderie allegedly contribute to the environment of looking the other way.³

The Role of Civil Liability

Civil liability, as a mechanism used to hold physicians responsible for incompetent or unethical conduct, is parallel to, and independent of, the activities of the professional regulatory bodies. While the role of medical boards and other professional bodies is to protect the patients and to ensure the competent and ethical practice of medicine, civil liability is used by patients and families to seek compensation for damages and punish the wrong-doers by slapping them with financial liability. The recourse to civil liability on the part of the patient, however, does not absolve the medical profession of its regulatory responsibilities. In fact, the very purpose of self-regulation is to minimize, if not obviate, the need for litigation and civil liability. Thus, civil liability as an avenue to redress patient complaints or to deter future misconduct must not be viewed as a substitute for the obligations of the medical profession toward the wellbeing of patients

and their families. If anything, recourse by patients to civil liability only reflects a failure of the medical profession to effectively fulfill its obligations.

It must also be pointed out that the deterrent effect of civil liability has remained unproven. In fact, there are two serious flaws in the use of civil liability as a mechanism to improve physician behavior or competence. First, it often leads to law suits of questionable merit filed by patients at the inducement of malpractice attorneys and the enticement of large sums of money in the form of compensatory jury awards or out-of-court settlements. Second, for the reasons that will be discussed in the following pages, most of the claims of unethical or incompetent physician behavior do not find their way to an attorney's office or a courtroom.

The Role of Government

The role of government is confined to the delegation of authority to one or more professional bodies and endorsement of their activities. The policing power of the state is transferred to the medical profession through regional or national medical associations or boards of licensure.²⁵ For example, in England the establishment of the General Medical Council under the Medical Act of 1858 transferred the policing and regulatory functions of the state to the medical profession.² The development of protocols and implementation of specific regulatory procedures is left to the representative bodies of physicians. The jurisdiction of professional regulatory bodies, however, is limited in scope to pre-judicial actions that do not extend beyond revocation of license. Only law enforcement agencies have the judicial authority to mete out punitive and compensatory justice involving imprisonment of offenders and financial compensation to patients and families.

In countries where the power to police the medical profession is retained by the state there is still considerable operational involvement of the medical profession and physician representation on committees responsible for oversight, investigation, and regulation. On the other hand, when the policing power is fully delegated to the medical profession, clear boundaries and limitations are imposed by the legislature. For example, in Great Britain the General Medical Council is the statutory body that conducts investigations and holds hearings in cases involving disciplining of physicians. However, the Council has limited autonomy to change its regulations without a change in the law governing the mandate of the Council.²⁶ In the U.S., most of the state licensing boards are granted authority by the state legislature through medical practice acts.²⁷ Consequently, there is a great deal of variation among states in terms of legislated authority and the structure, composition, and resources at the disposal of the licensing board. For example, different state boards may take a different position on the question of whether a physician convicted of shop lifting or tax evasion should also be punished or disciplined by the licensing board.^{3,27}

Frequency of Complaints and Disciplinary Actions

According to a major report published by the U.S. Department of Health and Human Services²⁸, 60-90% of complaints against physicians are filed by members of the general public and predominantly involve issues related to the quality of care. About 14% of cases involve issues related to unregulated physician behavior and are resolved during the intake process before getting to the stage of investigation. Another two-thirds

of complaints are closed during the investigative stage because of a lack of evidence. Additional 20% of cases are dropped at the pre-hearing stage as a result of clarifications provided and agreements made by the accused physician. Consequently, only 1.5% of complaints get to the stage of a formal hearing. Altogether, only 5% of complaints result in some form of disciplinary action.

According to the American Medical Association, in 2002 there were more than 853,000 registered physicians in 182 specialties in the U.S.²⁹ The data reported by the Federation of State Medical Boards (FSMB)³⁰ indicate that in 2007 in the U.S. 2,743 serious disciplinary actions were taken by state medical boards. These numbers translate into 2.92 serious actions per 1000 physicians.³⁰ In 2003, altogether – serious and non-serious actions combined – 5,230 disciplinary actions were reported by all 70 member boards of the FSMB. The number of such actions rose to 5,319 in 2007.³⁰ The scope of information available from other countries in this regard is quite limited. In Australia, the medical board of New South Wales³¹, in accordance with the requirements of the Medical Practice Act, publishes a list of physicians who are currently deregistered as a result of the disciplinary actions taken by the medical tribunal or the supreme court of New South Wales. Currently, the list shows 116 living physicians who are permanently or temporarily deregistered. Some of these physicians can petition to be placed back on the registered after a specified period of time. Additionally, fifteen other physicians are currently under suspension. The medical labor force report of the Australian Institute of Health and Welfare³² indicates that there were 21,182 medical practitioners in New South Wales in 2006, of which 19,726 were listed as clinicians and 1,456 were non-clinicians. Using the above numbers, the rough estimates would suggest that about 0.6% of the total and 0.7% of the clinician medical practitioners are currently deregistered or suspended. Despite the fact that these percentages are clearly underestimation of the number of physicians disciplined by the medical board, since the names of deceased physicians are removed from the list, they serve to illustrate the small fraction of active physicians who were disciplined by the board in the preceding years. Similarly, the Medical Board of South Australia reported a total of 7,240 registered physicians in 2007-08 who provided twenty-one million consultations.³³ During the same period, the medical board received 190 complaints from various sources, of which 61% were filed by patients and relatives and resulted in sixty-five (34%) instances of formal and informal counseling provided to the medical practitioner while five percent of complaints resulted in a formal action being taken against the physician in question.

Accusations of Complacency

The medical profession has long been accused of a “curtain of silence” and a culture of complacency.^{3,27,34} Despite the fact that it is in the interest of the medical profession to weed out the small number of unscrupulous and incompetent physicians, medical boards and peer review committees have done a poor job of self-regulation and protection of whistle blowers.^{3,5,21} Through a number of examples and case reports in a three-part series published in the Washington Post³⁴, the newspaper illustrated the lax procedures and loopholes in the regulatory system that allowed incompetent or even criminal physicians in the U.S. to continue the practice of medicine for years. For example, in the five year period between 1999 and 2004, 972 physicians who had been disciplined in

one state were able to continue the practice of their profession by relocating to another state.³⁴

Observers also suggest that, historically, disciplinary actions taken by regulatory authorities have been quite mild in relation to the seriousness of the offenses reported. For example, a report by Public Citizen - The Health Research Group in the U.S. indicates that 67% of those convicted for insurance fraud and 36% of those convicted in relation to the use and prescription of controlled substances received only non-severe penalties from medical boards.³⁵ Yeon and colleagues³ have suggested that self-interest, “misdirected sense of professional camaraderie,” and lack of explicit standards are responsible for a poor record of self-regulation among physicians. Some^{3, 35} have also suggested that boards of licensure could do a better job in disciplining physicians if they had better funding, staffing, leadership, and a pro-active, investigative approach that takes preponderance of evidence into consideration rather than insistence on evidence beyond a reasonable doubt. In the aftermath of the Harold Shipman inquiry, the department of health in the U.K. has similarly proposed adopting the preponderance of evidence approach rather than the prevailing approach of evidence beyond a reasonable doubt.³⁶

Ethical Challenges and Future Responsibilities

Moral and ethical codes for physicians have existed since the time of Hippocrates, long before medical societies were organized and licensing procedures developed. In modern times, Medical Practice Acts in various countries have helped formalize such codes and have guided the disciplinary and regulatory activities.³⁷ In recent years, concerns about physician competence have been significantly ameliorated in the U.S. and other developed countries by the certification and recertification requirements and the development of Professional Performance Procedures.^{38,39} However, serious concerns linger about the ability of the medical profession to regulate the ethical and moral conduct of physicians.

At the core of this concern is the profession’s inability to develop and implement a code of its “internal morality”⁴⁰ which constitutes a set of shared values rather than “external values” enforced by societal agents such as the legislature and the judicial system. Aside from the persistent issues of sexual misconduct, fraud, alcoholism and substance abuse, many more complex problems have appeared on the forefront of these debates. Ethical dilemmas surrounding assisted suicide, genetic manipulation, early- and late-stage abortion, the use of the “morning after pill”, legalization of marijuana, in-vitro fertilization, and the use of human embryos for stem cell research demonstrate that the boundaries of ethical conduct are not always clear and that medical profession must continue to develop new guidelines and standards in the context of these issues. In the years ahead, the medical profession will not only have to come to grips with many of these issues but will also need to resolve problems that will emerge from new developments in bio-medical research.

Historically, regulatory procedures follow breakthroughs in biomedical research and are developed in response rather than in anticipation of new technologies. To deal with these issues in the future, the medical profession must not rely exclusively on the legislative process and precedence set by court cases. Rather, it would need

to prospectively develop robust and progressive ethical and moral standards to guide physicians in making sound ethical and moral choices in the context of new technologies. Given the medical profession's less-than-passing grade in the effective implementation of its regulatory authority in the past, it is difficult to make a case for expanding its authority to the more complex issues of the future. In fact, the inability of the medical profession to effectively exercise its current regulatory authority lends more credibility to those who are opposed to expanding the medical profession's authority to these more complex challenges of the future.

Ongoing Changes and Future Prospects

In the words of Derbyshire²⁷, all is not bad in the world of medical licensure and self-regulation. A number of national and international cooperative initiatives are currently in progress or in place to develop uniform standards and to share information. In 2003, the General Medical Council in the U.K. and the Medical Council of New Zealand pilot-tested a system for electronic exchange of certificates of good standing among participating jurisdictions. By 2006, fourteen countries and states were exchanging certificates of good standing on thousands of physicians. Eleven other European countries have signed agreements to participate in this program in the near future.⁴¹

Similarly, Healthcare Professionals Crossing Borders (HPCB), a European partnership of professional healthcare regulators, is engaged in developing a common European Certificate of Current Professional Status for participating jurisdictions in Europe.⁴² HPCB has also been exploring the possibility of future information sharing on disciplinary actions. In the U.S., the Federation of State Medical Boards (FSMB) maintains a national database of disciplinary actions to which all state and territorial medical boards contribute information. Now a number of regulatory bodies in other countries are also participating in this system of information sharing.³⁰

There is also a clear trend of greater transparency and public representation in matters related to physician licensing and regulation. In the mid '90s, the General Medical Council in Britain increased the representation of lay persons to 25% of its membership.² In New South Wales, Australia, the medical profession also voluntarily implemented a system of collaborative regulation in partnership with a body of lay people termed the Health Care Complaints Commission. Notwithstanding some earlier reservations in the minds of the medical community, the Commission seems to have worked to the satisfaction of the medical profession as well as the general public.⁴³

In the wake of the Harold Shipman case involving the murder of 250 or more patients by a British family physician over a period of 27 years, regulatory authorities in many countries have changed their systems to promote transparency and greater public accountability.⁴⁴ Laws have been implemented in the U.S. to promote whistle blowing and to provide immunity from lawsuits for those who report incompetent or unethical physicians.^{8-11,25,27} In other countries, regulatory bodies now require physicians to report adverse events that reflect on the quality of care or conduct of their colleagues.⁴⁵⁻⁴⁷

Around the world, regulatory bodies are introducing measures to more effectively assess and revalidate physician performance. As part of these programs, physicians are required to participate in activities that reevaluate their medical knowledge, skills, and attitudes at defined intervals. Practice audits, peer assessments, continuing

medical education, and recertification examinations are essential components of many such programs.⁴⁵ The Canadian Federation of Medical Regulatory Authorities has made revalidation of physician licensure a high priority. The revalidation process requires all licensed physicians “to demonstrate commitment to continued competent performance.”⁴⁶ In the U.S., periodic recertification requirements for physicians have significantly helped in addressing the issue of incompetence. Similarly, making board certification a requirement for granting hospital privileges by credentialing committees has put more pressure on physicians to demonstrate continuing competence in their field. In Britain, the Committee on Renal Disease of the Royal College of Physicians of London has tested, with good effects, the idea of multidisciplinary external audit visits for renal departments. This idea was originally introduced in 1992 by the British Thoracic Society.⁴⁷

Conclusions

In conclusion, physician autonomy and patient safety are intricately linked. There is mounting evidence of improving conditions to address public concerns related to physician competence, conduct, and self-regulation. Licensing authorities in various countries have publicly recognized the importance of lifelong learning and the need for periodic evidence of physicians’ “fitness to practice.”⁴⁸ Revalidation and recertification programs have made significant contributions in allaying concerns about physician competence. Much progress has also been made in identifying and effectively dealing with the small number of unscrupulous physicians. However, concerns persist about a culture of complicity and the need for greater transparency, accountability, and public participation in the medical profession’s self-regulatory activities.

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BOOK REVIEWS

Conflicts of Conscience in Health Care: An Institutional Compromise

Holly Fernandez Lynch. Cambridge, MA: The MIT Press, 2008.

ISBN 978-0-262-12305-1; 376 PAGES, HARDCOVER, \$34.00

Issues of conscience in health care are most often discussed in light of current reproductive technologies. By definition, reproduction includes pre-born human; how one views that life informs one's conscience. In 1973, *Roe v Wade* altered the landscape of medicine as well as American society, polarizing both into camps supportive or objective of legalizing the abortion of zygotic and embryonic babies. It is, then, with a sense of admiration that one picks up Holly Lynch's *Conflicts of Conscience in Health Care*. She begins with uncompromising support for conscientious objectors, seeking to find a "middle ground." Unfortunately, she then undermines her goal by proposing a tedious system of oversight that is neither value neutral nor even-handed to "refusers," morphing what began as a "liberty right" in 1973 into something more akin to an "entitlement right."

In her proposal, Lynch mandates that each state medical licensing board maintain a record of physicians able to provide certain services but refusing to do so based on yet-to-be-determined criteria for conscientious objectors. She also recommends that this board develop and maintain a database of the availability and convenience of specific services in each geographic area. Lynch then suggests that the board selectively issue licenses to "... facilitate the recruitment and long-term maintenance of . . ." (179) those willing to practice in areas where services are considered to be in short supply. If an area does not have a willing provider, she argues that the "last doctor in town . . . [has the] heightened obligation of providing access to the service the patient *desires* . . ." (199, emphasis added), despite potential issues of conscience.

By determining supply based on patient desire rather than need, she co-modifies the physician; the service provided is merely based on a patient's desire or request. A physician becomes no different from any retailer with a sack of wares. Additionally, "health care" is transformed into something other than a quest to return patients to their optimal health (maximal physical functionality with minimal pain). Using the same logic, any specialty in medicine could be regulated: Why should reproductive technologies be any different than urological or plastic surgical technologies? Or further, what protects any service industry?

What makes this book most pernicious, however, is the sleight-of-hand by which the liberty (so-called "negative") right of *Roe v Wade* is transformed into an entitlement ("positive") right. Assuming there should be convenient "...access to services that have been deemed an essential component of basic health care" (152), and since she believes that "...access to pre-coital contraceptives, and potentially to the morning-after pill and abortion services, is in many ways essential to a woman's dignity and freedom from the control of others . . ." (132), Lynch then concludes that "... it may be appropriate to require licensing boards to satisfy patient *demands* for all services that are legally and empirically capable of achieving the patient's *desired* result" (142, emphasis added). In concluding a description of her plan, she tackles the situations in which a physician could be coerced into supplying the desired and requested procedure despite strongly and sincerely held beliefs. The crux, however, is not the refusal of someone's desire; rather, it is not engaging and becoming complicit in a procedure that the "refuser" considers not only immoral but also abhorrent.

Lynch should be congratulated on supporting issues of conscience. However, what begins with laudable goals fails in large part due to assumptions that color her arguments. While attempting to find a compromise between the two camps on such issues as abortion, she has failed to treat physicians with issues of conscience as assiduously as those desiring the service. Failure to discuss the liberty right

of *Roe v Wade* compared to the entitlement right she desires is a major flaw. However, it is a good beginning, and it is instructive in understanding the underlying and deeply held beliefs and biases of some on the pro-abortion side of these issues.

Reviewed by Sharon F. Billon, MA (Bioethics), MD, FAAD who is retired from the private practice of dermatology in Arroyo Grande, California, USA.

Living Gently in a Violent World: The Prophetic Witness of Weakness

Stanley Hauerwas and Jean Vanier; introduction by John Swinton. Downers Grove, Ill.: InterVarsity, 2008.

ISBN 978-0-8308-3452-5; 115 PAGES, PAPER, \$15.00

In *Living Gently in a Violent World*, moral theologian Stanley Hauerwas teams up with L'Arche founder Jean Vanier to reflect on the theological, ethical, ecclesiological, and political lessons to be learned from the mentally disabled—and more specifically from the L'Arche communities in which people with mental disabilities live together with those without such disabilities. This short book is comprised of four essays that emerged from a 2006 conference organized by the Center for Spirituality, Health and Disability at the University of Aberdeen. The director of the Center, John Swinton, adds a brief introduction and conclusion.

In the first essay, “The Fragility of L'Arche and the Friendship of God,” Vanier offers an autobiographical reflection on his forty-two years of living with people with disabilities. He confesses that he “never knew quite where [he] was going” (23), but through it all God has formed the ever fragile and tenuous L'Arche communities and, in the process, has changed many lives, allowing L'Arche to serve as a sign of the gospel. According to Vanier, the gospel presents a vision of “a pyramid of hierarchy . . . changed into a body, beginning at the bottom.” (30) Such is the message of L'Arche. Vanier thus provocatively asks: “Does the church really believe in the holiness of people with disabilities?” (34) He concludes that it is through friendship with the vulnerable that we learn what it means to be a friend of God.

Hauerwas spends the bulk of the second essay, “Finding God in Strange Places: Why L'Arche Needs the Church,” reflecting on the question: “What does L'Arche have to say to the church?” (43) He argues that L'Arche “offers a kind of time, a kind of patience, and a kind of placidness that comes from faithfulness and produces a different understanding of catholicity. That is how L'Arche helps the church find the gospel.” (56-57) Along the way, Hauerwas critiques the contradictions of modernity, such as the fact that “in the United States we now spend between 15 and 17 percent of the gross national product on crisis-care management, which of course has nothing to do with the health of the population.” (52) He concludes that just as the church needs L'Arche, so L'Arche needs the church.

Vanier expresses his concerns about war, peace, and the wall of separation between the powerful and powerless in the third essay, “The Vision of Jesus: Living Peaceably in a Wounded World.” He proposes that the walls that divide humanity are built on fear of meaninglessness, rejection, and weakness. This is precisely why L'Arche is important: it affirms the importance of each individual, accepts those whom others reject, and finds value in weakness. Vanier comments on 1 Corinthians 12 saying, “people who are the weakest and least presentable are indispensable to the church” (74). And such communities are not only indispensable for the church; they also “become a sign of hope for our world . . . that it is possible to love each other.” (75)

Finally, in “The Politics of Gentleness,” Hauerwas uses L'Arche as a political critique of Rawlsian liberalism. According to Hauerwas, one of the problems with liberal political theory is that it has no place for affirming the status of the mentally disabled since its fundamental axiom is “the attempt to secure social cooperation on the basis of mutual advantage for the contracting parties.” (85) On such a political arrangement, however, there is no clear rationale for caring for the disabled. Hauerwas thus

suggests that “the gentle character of the practices constituting the world of L’Arche” are “necessary for any polity that would be about the goods held in common” (92) and therefore provides a political alternative to liberalism. According to Hauerwas, such an alternative is unintelligible without the God of the Christian story.

Those familiar with the work of Hauerwas and Vanier will find in this book variations on a number of familiar themes. Moreover, the usual polemical style of Hauerwas and gentle style of Vanier remain intact, though perhaps Hauerwas is a bit gentler and Vanier a bit more polemical than normal as a result of their mutual interaction. The essays do not build on each other in any obvious way, and readers seeking concrete solutions to the difficult issues surrounding the mentally disabled might find this book a bit too anecdotal and narrativel for their concerns. Nevertheless, the questions raised and the reflections offered on those questions are indispensable for anyone living with, working with, or reflecting on those with mental disabilities. And if Hauerwas and Vanier’s analysis is correct, *Living Gently in a Violent World* will be a valuable resource for the impending day when church is viewed as those peculiar people who don’t kill the mentally disabled among them.

Reviewed by David C. Cramer, MDiv, MA (Philosophy or Religion), who is an Adjunct Professor for the School of Religion and Philosophy at Bethel College, Mishawaka, Indiana, USA.

The Criminalization of Medicine—America’s War on Doctors (Part of the *Praeger Series on Contemporary Health and Living*, Julie Silver, Series Editor)

Ronald T. Libby. Westport, Connecticut and London, UK: Praeger, 2008.

ISBN-13 978-0-313-3453463, 224 PAGES, CLOTH, \$49.95

“Why would the government scapegoat the most humane and caring professional class in society? Perhaps this happened to marginalized groups in society but could it happen to an entire professional class—medical doctors? . . . If so, why would they do so?” (xi) Thus begins this provocative monograph by Ronald T. Libby (Professor of Political Science at University of North Florida and Senior Research Fellow at the Blue Cross and Blue Shield Florida Center for Ethics, Public Policy and the Professions).

Painstakingly researched and grippingly conveyed, Professor Libby quickly lays to rest any conception that this is one more conspiracy theory. He captures our curiosity and compels our belief that, while most doctors may not personally feel the pains of unjust persecution, there are many of us who have experienced these firsthand, or once removed. He contends that politicians, when unable to solve important problems, frequently seek to divert criticism of their own ineptitude to whomever they can successfully blame. (1) In particular, he highlights scapegoating in the war on medical fraud (2), kickback conspiracies (5), and the war on drugs (6).

Chapters cover Oxycontin and its peculiar targeting by the DEA as a purportedly uniquely dangerous and seductive opioid (chapter 2), outlier billing physicians—assumed to be fraudulent (chapters 3 and 4), anti-kickback laws twisted by an aggressive prosecutor to destroy innocent naïve doctors and advance his own professional and political career (chapter 6), and DEA abuses in targeting responsible, compassionate pain doctors in opioid sting operations (chapters 7, 8, and 9). He particularly highlights Richard P. Kusserow, head of Health and Human Services from 1981 to 1992 (32), as a prototypical “junkyard dog” whose sole intent was to “cut burgeoning costs of Medicare and Medicaid by discouraging physicians from treating patients.” (32) As Inspector General, he employed inept auditors, “instituting a merit pay/bounty system that required all agents in the IG’s office to meet conviction and monetary quotas in order to qualify for pay increases.” (33) He coached investigators and prosecutors to obtain convictions through intimidation and plea bargains with the threat that consequences to non-capitulating physicians would be magnitudes harsher. (41, 42)

Libby concludes by opining that doctors are easy political targets. Media love to caricature the rich, arrogant, corrupt physician who is brought down to size by the dogged pursuit of the idealistic government servant. (182) His final sober word of warning: “In order to end the government’s current war on doctors it will be necessary for medical associations to launch a national campaign to demand an end to the unjust prosecution of physicians.” (183)

Reviewed by Robert E. Cranston, MD, MA, FAAN, who is an associate clinical professor (Neurology) at University of Illinois College of Medicine, a hospital ethicist at Carle Foundation Hospital in Urbana-Champaign, and medical director for medical subspecialties at Carle Clinic in Urbana, Illinois, USA.

More Humane Medicine: A Liberal Catholic Bioethics

James F. Drane. Edinboro, Edinboro University of Pennsylvania, PA: 2003.

ISBN 0-972-75300-1; 399 PAGES, PAPERBACK, \$24.95

This book comes with a warning to those who hold strictly pro-life positions since the author describes himself as a representative of “Liberal Catholicism.” Situating his position in the field of bioethics by pitching it against “Conservative Catholicism,” James Drane signals that his book sits uneasily with anyone who takes a strong anti-abortion and anti-euthanasia stand – and also with the teaching of Rome regarding contraception.

Adopting a historical approach, the author reviews past traditions of thinking about life and death, primarily with a focus on the natural law tradition. After Roman Catholic natural law tradition is explored and criticised, the author reviews classical natural law thinking, much of which he appreciates. That said, however, Drane does not seem to have much time for the radical views advocated by Plato in *The Republic*. Rather, he appears to side with Aristotle who took issue with Plato’s view that a doctor should “facilitate” the patient’s death when the patient is chronically ill and unable to contribute to the good of the state or “his own development.” Euthanasia as a last resort in order to relieve unbearable pain is another matter, he argues, suggesting that “if pain relief is not effective” and the patient “is dying in agony,” then it might—exceptionally—be justifiable directly and intentionally to kill the patient.

On abortion, Drane would justify abortion to save the mother’s life (a position which might be adopted even from a strong pro-life perspective), but he would justify abortion if the foetus were destined for a life of disability and suffering. This position is surely indefensible from a strict pro-life position. After all, suffering in various forms is a part of the human condition and who is to say that the foetus would not be glad to live if given a chance? Many disabled persons cherish life despite physical or mental suffering. More importantly, from a Christian perspective, human life is not ours to take. Most everyone wants to avoid suffering, and, of course, it is the doctor’s role to seek to alleviate suffering – but not by any means. For Christians, human life is sacred. Moreover, in the Hippocratic tradition, a doctor does not relieve suffering by eliminating the sufferer.

Taking issue with Rome in particular, Drane includes a former paper in which he takes issue with Pope Paul VI’s anti-contraception encyclical *Humane Vitae* of 1968. Following the publication of this paper, Drane was suspended from his Roman Catholic priesthood. However, most Roman Catholic lay people in Europe and Northern America would side with Drane on this issue.

Drane also presents a convincing argument for not regarding the use of the condom as a means of contraception when it is used in order to avoid HIV transmission. He does so using a variation of the so-called double effect argument. On this line of reasoning, if the intention is to avoid HIV transmission, then the contraceptive use of the condom should be regarded as a mere side-effect. Moreover, so it is argued, it is a justifiable side-effect given the importance of avoiding HIV transmission. As he observes, arguing thus is surely to adopt a pro-life position. This is especially true in those parts of the world where people have poor access to medication to hold back the disease.

Overall, Drane's book is well worth the read, although the reader may well disagree with many of his conclusions. Whether the reader agrees or disagrees, however, he or she will encounter some thought-provoking arguments.

Reviewed by Agneta Sutton, PhD, who lectures in bioethics and sexual ethics at Heythrop College, University of London.

The Ethics of Surgical Practice: Cases, Dilemmas, and Resolutions

James W. Jones, Laurence B. McCullough, and Bruce W. Richman. New York: Oxford University Press, USA, 2008.

ISBN: 978-0195321098; 360 PAGES, PAPER, \$24.95.

There is something unique about the discipline of surgery—a practice that invades a person's body, removes and rearranges the pieces, and purports to leave the person better than before. The relationship between the patient and surgeon is a *sui generis*. Attempts to describe or delineate the appropriate conduct of surgeons in merely legal or contractual terms—or even strictly in terms of other medical professions—are inherently flimsy. Analogies to similar relationships are bound to ring false to the experienced ear. Yet the idea of a surgical ethics is one that has yet to be fully explored.

This is only the second book to be written on 'surgical ethics.' The first was *Surgical Ethics* (Oxford University Press, 1998) edited by Laurence B. McCullough, James W. Jones, and Baruch A. Brody. The first of its kind, *Surgical Ethics* was a collection of chapters consisting of collaborations between various ethicists and surgeons, and it reads like a standard textbook in ethics.

This latest offering from James W. Jones, Laurence B. McCullough, and Bruce W. Richman is more 'surgeon-friendly.' Organized in a format familiar to most in clinical practice, each chapter consists of several scenarios with each presenting an ethical question and five possible answers. After each case, there is a brief overview of the key issues at stake followed by an explanation of why each of the possible answers is not as satisfactory as the one right answer. While this format is likely to irritate the non-medical reader, it is perfect for the practicing surgeon since it resembles exactly the Surgical Education and Self-Assessment Program published by the American College of Surgeons for board review. Since each chapter was previously published in *The Journal of Vascular Surgery* or *Surgery*, it is an individual morsel easily consumed by itself.

The first chapter is a 'Primer on Surgical Ethics,' which briefly and fairly contrasts the binary logic of day-to-day surgical thinking with the nuances and shades of gray present in most ethical discourse. The goal of this book is to show how the two can and should co-exist in the practice of the contemporary surgeon. The seventy-one cases are divided into seven chapters: 'Informed Consent and Disclosure,' 'Professional Self-Regulation,' 'Innovation and Research,' 'Conflicts of Interest and Conflicts of Commitment,' 'The Ethics of Surgery as a Business,' 'Challenges to Medical Professionalism: Assaults from Within and Without,' and 'End of Life Issues.' Against the 'there are no right answers' mantra of post-modernity, these authors offer up right answers to tough ethical dilemmas by mining the professional ethical codes of Hippocrates, John Gregory, Thomas Percival, and the AMA. They give primacy to virtue ethics, stressing the importance of integrity, compassion, self-effacement, and self-sacrifice in the life of the surgeon.

The beauty of this book is that it speaks in the language of surgeons as well as ethicists. The level of clinical detail in the cases allows each to hit the resident or practicing surgeon very close to home. The ethical analysis, while brief, shows a broad familiarity with the ethics literature. Furthermore, there are many references to episodes in surgical history, grounding the discourse in an historical context—a strategy endearing to the heart of every surgeon. This establishes a framework that most practicing surgeons, whether agnostic, Hindu, Muslim, Jew, or Christian, can relate to and use to inform their surgical practice. This collection of cases and analyses goes a long way in laying the foundation for a generation of surgeons who must cultivate the virtues necessary to care faithfully for the surgical patient.

It should be mandatory reading for every surgery resident as well as attending surgeon. In addition, medical students and students of bioethics will gain tremendous insight into the practice of surgery by working through this book.

Reviewed by Christian J. Vercler, MD, MA (Bioethics, Theological Studies), currently a fellow in plastic surgery at the Harvard Combined Plastic Surgery Training Program in Boston, Massachusetts, previously served as a Clinical Ethics Fellow at the Emory Center for Ethics at Emory University in Atlanta, Georgia, USA.

Design and Destiny: Jewish and Christian Perspectives on Human Germline Modification (*Basic Bioethics Series*)

Ronald Cole-Turner, Editor. Cambridge, MA and London, England: The MIT Press, 2009.

ISBN 9-7082652-533010; 237 PAGES, CLOTH, \$58; PAPER, \$23

Since the completion of mapping of the Human Genome Project, there has been a proliferation of books detailing the ethical quandaries that these new genetic technologies pose for us, including issues such as stem-cell research, cloning, and reproductive technologies. Some of these technologies push traditional boundaries, force us to think carefully both ethically and religiously in terms of what is or is not acceptable, and even challenge what it means to be human. Ronald Cole-Turner has written a couple of excellent books dealing with some of these issues from a religious perspective, and in this volume he continues to add significantly to the body of scholarly work on the subject. This book contains nine essays written specifically on the topic of germline modification from the perspective of the Christian and Jewish faiths, focusing as well on the Catholic tradition. A number of these scholars have published widely in the area of genetics and ethics already and are quite well-known, including James J. Walter, Lisa Sowle Cahill, and Celia Deane-Drummond.

This book is well worth reading for anyone, especially scholars, interested in medical ethics in general and genetics in particular. It is extremely well-organized, nicely written, thorough, and informative. One of its unique features is that it focuses on one particular issue – germline modification – allowing an in-depth exploration that is often, of necessity, lacking in other such books. The possibility of altering our DNA in a way that would be passed on to future generations creates considerable controversy, and the authors do not pass lightly over the controversies.

The manuscript is also helpful in that it provides a number of different religious lenses from which to assess the issue of germline modification. While there are some differences in their approaches, each writer nicely illustrates the unique insights that his/her particular religious tradition contributes to the debate. The volume as a whole contributes to the discussion on the resources religious traditions can provide in the field of emerging genetic technologies, the concept of human nature, the role of God, and the potential social impact of embracing such technologies. It also provides a variety of possible religious responses with regard to this technology that include outright rejection, support with some modifications, and virtually unequivocal acceptance.

Since the majority of the contributors support some aspects of germline modification, those readers with a more conservative viewpoint might find some of the essays unsettling, particularly when their religious tradition is being utilized to support something as controversial as ‘designing our children.’ However, this book is a must-read for those who are interested in ethics and genetics, are willing to consider religious perspectives on germline modification, and are willing to be stretched with regard to their views.

Reviewed by Donna Yarri, PhD (Religious Studies), who is an Associate Professor of Theology at Alvernia University in Reading, Pennsylvania, USA.

The Ethics of Hospital Trustees

Bruce Jennings, Bradford H. Gray, Virginia A. Sharpe, Alan R. Fleischman, editors.
Washington, D.C.: Georgetown University Press, 2004

ISBN 1-58901-015-9; 284 PAGES, HARDCOVER, \$64.95

Based on original research and task force meetings with leading experts from across the United States, *The Ethics of Hospital Trustees* is comprised of a series of essentially free-standing essays directed at various aspects of a major decision-making group in health care – hospital trustees. Thirteen chapters, divided into three sections, address legal and social context, ethical perspectives, and decisions and systems in the practice of trusteeship.

While all are scholarly articles, they are written with varying degrees of audience appeal. Some articles are quite engaging, others are fairly dry, but all are informative. The ten-page introduction is well-worth reading and is a good overview for the essays. (If you read this book, don't skip the introduction.) Not only does it set the table for the upcoming articles, it also directs us to watch especially for the principles which the editors define as fundamental to ethical trusteeship: 1) fidelity to mission, 2) service to patients, 3) service to the community, and 4) institutional stewardship.

Much of the book's material focuses on not-for-profit hospitals with one chapter devoted to Catholic hospitals and systems. In the latter, the author does an exceptional job of delving into the complex inter-relationships between Catholic hospitals and secular institutions vis-à-vis how far a mission-driven, religiously based institution can bend without losing its essential qualities, explaining formal and material cooperation, immediate and mediate material cooperation, duress and proportionality in the process.

Two chapters are authored by Bradford Gray and Linda Weiss from the New York Academy of Science and derive from a survey study of ninety-eight individual hospital trustees in New York State. Their quotations and analyses from these trustees and CEOs are both highly informative and readable.

Overall, though, my favorite chapter was written by William F. May and addresses money, mission, and medicine. While he directs his comments to the way trustees function, much of what he says also applies individually to nurses, teachers, administrators, and physicians. Pithy one liners such as "The practitioner in the helping professions must respond not simply to the client's self-perceived wants but also to his or her deeper needs" (146), "teaching is slow boring through hard wood" (147), and "money . . . vulgarizes, distracts, corrupts, distorts, excludes, and thus endangers the integrity of the professions . . . [even though it] is a useful but unruly servant" (149) rolled around pleasantly on my tongue and in my head.

I enjoyed this good book which covered an important area that previously had poor coverage. The asking price of \$65 seems a bit steep, but Amazon.com can improve nicely on the MSRP.

Reviewed by Robert E. Cranston, MD, MA, FAAN, who is an associate clinical professor (Neurology) at University of Illinois College of Medicine, a hospital ethicist at Carle Foundation Hospital in Urbana-Champaign and is medical director for medical subspecialties at Carle Clinic in Urbana, Illinois, USA.

Between the Dying and the Dead: Dr. Jack Kevorkian's Life and the Battle to Legalize Euthanasia

Neal Nicol and Harry Wylie. Madison, WI: The University of Wisconsin Press, 2006.

ISBN 978-0-299-21710-8; 273 PAGES, HARDCOVER, \$27.95

Dr. Jack Kevorkian stands as one of the most recognizable public villains of past decades. “Dr. Death” made headlines in his quest to legalize assisted suicide, and his name continues to be thrown around to describe people and policies related to the issue. *Between the Dying and the Dead* provides a window into his life.

The work begins close to the present time, describing the case that led to Kevorkian's imprisonment. It then turns back the clock to relate Jack's life story from the beginning. The rest of the book follows this format, detailing aspects of his childhood, education, research, and imprisonment. It includes several informative and interesting details, some shedding important light on his understanding of suffering (such as his parents' flight from the Armenian genocide of World War I [25-31] and his mother's painful battle with cancer [112-114]) and others merely interesting (such as Jack's failed attempt at producing a film based on Handel's *Messiah* [125-130] or his unfruitful business venture into the realm of professional sports merchandize [210]). Nicol and Wylie follow Jack through his trials and ultimately imprisonment. Published in 2006, the book ends before Kevorkian's parole in 2007.

Nicol and Wylie are two of Kevorkian's closest companions. This relationship leads to interesting stories and inside information, but those looking for a somewhat-neutral biography will be disappointed. The authors clearly side with Kevorkian's practices, and they play the ‘misunderstood hero’ card too often. Jack is portrayed as smarter than all of his teachers and hopelessly misunderstood by the wider medical community; he is a man “ahead of his time” (253). His ideas struggle in the public's eyes because they “require too much of an emotional leap for many people to accept” (260). The elitism also turns its attention to religion, giving it patronizing treatment and accusing it of being one of the main reasons Americans have reacted negatively to death-related research and change (at one point, he turned to military application for an experiment with cadaver blood because he was sure that the army wouldn't be “held hostage by religious objections” as apparently the medical community and the public were [110]). As is often the case, the great strength of the book emerges from the relationship between its authors and its subject, which also leads to several weaknesses.

Words matter, and both Kevorkian and his biographers recognize this. Jack renamed his suicide machine “mercitron” instead of his original “thanatron” (Greek for ‘death machine’) (143). The practice of “medicide” is hailed in the book as if using a different word in place of “assisted suicide” or “euthanasia” would change the debate. The question remains if it will. Kevorkian, Nicol, and Wylie insist that the tide is changing, and this book attempts to paint a soft picture of “Dr. Death” and reframe the question on what exactly happens when one person either helps another die or actively kills them.

Reviewed by Jacob William Shatzer, MDiv, who serves on the staff of the *Kairos Journal* and lives in Louisville, Kentucky, USA.

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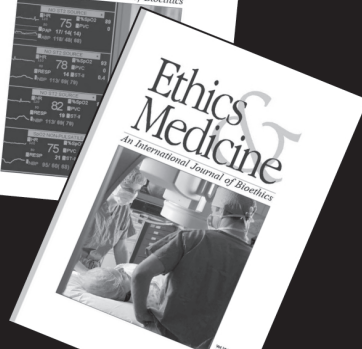
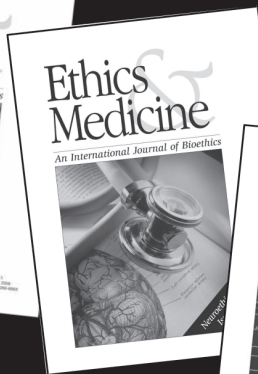
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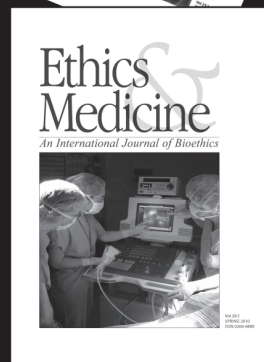
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