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Medical Ethics

*To be blind to moral dimensions of what human beings do to one another is as much of a handicap as to be visually blind or unable to have memories. But [the former] is a more insidious handicap since it is often not recognized as one. Those who are thus deprived stumble through the world of humans unaware that their perception is flawed—and do untold harm to those whose lives they affect. It is in this category that we must place those who insist that there are no ethical considerations in science or in medicine.**

MEDICINE AND HUMAN VALUES

Medical ethics is not new; the practice of medicine in primitive societies required moral judgments grounded in their respective values. The systematic study and teaching of medical ethics is only now emerging as a major interdisciplinary field. In the last half of the 1970s, suitable textbooks in medical ethics became available for classroom use, signaling a new curricular role. Public awareness surged in 1975 with the New Jersey Superior Court's decision concerning the maintenance or withdrawal of life-preserving treatments of a comatose patient, Karen Ann Quinlan. Six years earlier, however, the Institute of Society, Ethics and the Life Sciences (also known as "The Hastings Center") was founded by an interdisciplinary group of physicians, biologists, philosophers, theologians, lawyers, and social scientists. The Institute developed through a shared concern that advances in medicine, biology, and the behavioral sciences were confronting humanity with enormously difficult ethical dilemmas involving significant social, cultural, and legal implications. Organizers of the Institute believe that ethical and value questions are fundamental and are best pursued in an interdisciplinary fashion.

*Sissela Bok, "The Tools of Bioethics," in *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*, eds Stanley Joel Reiser et al (Cambridge, Mass.: M.I.T Press, 1977), p. 138

A Subject of Irresolution

General principles of personhood and interpersonal love combined with an awareness of moving from fate to choice (see Chapter 1, pp. 6-7) and of concern for substance rather than mere form (see Chapter 7, pp. 147-148) undergird our moral convictions. The presuppositions or axioms expressed in those chapters continue in this chapter on medical ethics. However, additional principles and concepts are needed in medical ethics.

Our purposes in this chapter include: (1) stimulating the readers' moral imagination beyond the convictions taught to them as they were being raised; (2) developing in the reader a greater awareness of the value dimension of medical care; (3) eliciting an appropriate sense of personal responsibility for one's own role in medical decisions; and (4) heightening sensitivity to the inherent ambiguity and pluralism in these matters. We shall not offer neat resolutions or indisputable principles. Instead, we shall explore the irresolutions of some important philosophic concepts and principles in the spirit of "ground work" for further study.

Following the "can do/ought to do" issue that raises the moral aspect, we shall categorize medical ethics as an area within bioethics, note that medical ethics cannot be avoided, and introduce decision making and other issues of communication. The reality of pluralism will again come to the fore as we explore several philosophic issues and some moral dilemmas in medicine.

The "Can Do/Ought to Do" Issue. "Why did you climb that dangerous peak?" asks the curious bystander. "Because it was there!" replies the proud performer. And the public pays homage. One of the fundamental American values now being called into question is the rather strange notion that if something *can* be done it *ought* to be done. The rather silly books listing records of trivial achievements also exemplify this "virtue." The media faithfully covers marathons of any sort—even the riding of a roller coaster a record number of times. "What can be done ought to be done" is thereby further programmed into the population.

Applied to science, this axiom opens the door wide to any procedure, development, invention, or gadget. One consequence of this mentality has been the undisciplined "progress" that has resulted in untold ecological damage. (The ecological issue will be examined in Chapter 16.) Ethically concerned observers of nature, including some philosophers, have become quite vocal in attempts to draw the public's attention to the danger of doing whatever is possible.

Bioethics and Medical Ethics. "Bioethics" is the comprehensive classification of ethical considerations implied by some biological developments such as moral dilemmas about population growth and environmen-

tal quality. Medical or biomedical ethics is the area of bioethics that concentrates on moral questions raised in the practice of medicine; for example, a physician *can* sterilize a retarded teenager, but under what circumstances, if any, *ought* the physician do so? The boundaries of bioethics and medical ethics are not set with finality because they overlap, because of ongoing new developments in the various sciences with implications for bioethics, and because of medical advances. Bioethics as a field attempts to respond to whatever value issues or moral questions are created by new knowledge about humanity in relation to nature. Hence, bioethics remains open to results of human ingenuity and the sorting out of "can do/ought to do" problems.

A BIOETHICAL CREED FOR INDIVIDUALS

1. Belief: *I accept the need for prompt remedial action in a world beset with crises.*
   Commitment: I will work with others to improve the formulation of my beliefs, to evolve additional credos, and to unite in a worldwide movement that will make possible the survival and improved development of the human species in harmony with the natural environment.
2. Belief: *I accept the fact that the future survival and development of mankind, both culturally and biologically, is strongly conditioned by man's present activities and plans.*
   Commitment: I will try to live my own life and to influence the lives of others so as to promote the evolution of a better world for future generations of mankind, and I will try to avoid actions that would jeopardize their future.
3. Belief: *I accept the uniqueness of each individual and his instinctive need to contribute to the betterment of some larger unit of society in a way that is compatible with the long-range needs of society.*
   Commitment: I will try to listen to the reasoned viewpoint of others whether from a minority or a majority, and I will recognize the role of emotional commitment in producing effective action.
4. Belief: *I accept the inevitability of some human suffering that must result from the natural disorder in biological creatures and in the physical world, but I do not passively accept the suffering that results from man's inhumanity to man.*
   Commitment: I will try to face my own problems with dignity and courage, I will try to assist my fellow men when they are

afflicted, and I will work toward the goal of eliminating needless suffering among mankind as a whole.

5. Belief: *I accept the finality of death as a necessary part of life. I affirm my veneration for life, my belief in the brotherhood of man, and my belief that I have an obligation to future generations of man.* Commitment: I will try to live in a way that will benefit the lives of my fellow men now and in time to come and be remembered favorably by those who survive me.

From Van Rensselaer Potter, *Bioethics: Bridge to the Future* (Englewood Cliffs, N.J.: Prentice-Hall, © 1971), p. 196. Reprinted by permission.

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Medical Ethics Cannot Be Avoided

It is probable that everyone reading this book has consulted a physician. Many employers and schools require a minimal check-up at some time. You may have had surgery, been treated for a "bug," delivered a baby, been tested for glasses by an ophthalmologist, and so on. Occasional involvement with professional medical care has become commonplace in the United States, except for the uninformed or reluctant poor.

Whether or not a person consults a physician reflects the person's values. Whether a check-up is required by an employer, school, or other source; whether a person gets a check-up simply to be in good standing with whoever requires the consultation; whether the person gets a complete examination because of an actual concern for the status of his or her health—the reason doesn't matter. The choice to go to the doctor stems from the individual's values and judgment: "I *ought* to go." Motivations vary, but actually "to go" is a moral choice, an implementation of one's values.

Decision Making. Once a conference with a health care deliverer (physician, nurse, physician's assistant, etc.) is in process, the ethical issues sharpen. The professional can diagnose, recommend, urge, prescribe,

describe alternatives, and offer forecasts, but unless patient incompetence is evident, the decision to take any particular action rests with the patient. The decision-making responsibility is well outlined here:

> 1. The primary decision-making responsibility rests with the patient, so long as he is competent.
> 2. When the patient is incompetent, the socially designated next of kin and other close relatives should be allowed to speak for the patient.
> 3. If the physician has reason to doubt whether the above individuals are representing the patient's best interests, he may choose other individuals to involve in the decision process, or, as a last resort, may make the decision himself; however he assumes the responsibility for demonstrating that his doubts were based on reasonable evidence.
> 4. Any of the above individuals, except the doctor, may opt out of the decision process by being unable to decide or by refusing to take responsibility. In such a case the doctor must seek the opinion of an alternative patient representative (such as a court order or a more distant relative) if there is time, or make the decision himself if there is not. The doctor cannot opt out of the process.
> 5. As a general rule, all the above individuals must act within the usual constraints imposed by society. Where these constraints have become so rigid as to constitute a conflict between society's best interests and the patient's best interests, the case must be decided individually by careful consideration of the consequences.[1]

The patient's decision is based on many values, whether formally considered or not. The physician's recommendations are also interwoven with the physician's own value system, articulated or not. In recommending or choosing a course of action based on medical evidence, physician and patient evaluate such matters as: (1) is living with chronic pain *preferable* to risky surgery? (2) is prolonged suffering *better than* death? (3) is it more *desirable* to relieve present suffering with addictive drugs or to endure pain to prevent the possibility of long-term addiction? (4) *should* valium or a mental health counselor be the treatment?

CHOICES ARE BASED ON VALUES

[E]very medical decision has a value component. The first skill needed by one who takes medical and biological ethics seriously is that of recognizing the evaluative dimensions of cases which otherwise appear to be mundane and value-free. In some medical decisions, to be sure, the value choices may seem utterly trivial. One must have a blood transfusion *if* he *wants* to live—

[1]Howard Brody, *Ethical Decisions in Medicine* 2nd ed. (Boston: Little, Brown, 1981), p. 111.

but the fact that some people, such as Jehovah's Witnesses, value other things more than continuing life in this world reveals that even when the values are so readily assumed, evaluations are still present. Many moral disputes in fact arise because the value alternatives are not recognized and spelled out. . . .

In virtually every medical situation, more than one plausible alternative exists: experimental surgery or standard treatment, salt-free diet or diuretic, psychopharmacological agent or psychotherapy, scientifically trained physician or folk healer. . . . If it is true that more than one plausible alternative exists at some point in the treatment of virtually every patient, then choices must be made based on some system of values.

From Robert M. Veatch, *Case Studies in Medical Ethics* (Cambridge, Mass.: Harvard Univ. Press, 1977), pp. 17, 19.

Robert M. Veatch (b. 1939) earned a Ph.D. degree in ethics at Harvard. Formerly senior associate at The Hastings Center, he is professor of medical ethics at the Kennedy Institute of Ethics, Georgetown University. His writings include Death, Dying, and the Biological Revolution *and several journal and encyclopedia articles.*

The practice of medicine cannot escape value issues. Health care deliverers and patients have moved from fate to choice among options and therefore are participants together in applied medical ethics. A sensitivity to some primary moral problems in medicine enables professionals and patients to make informed decisions. The days of "Do what you think is right, Doctor" are coming to an end as responsibilities for health care are shared significantly with the patient.

Related Issues of Communication. A patient's decision, reflecting values, is linked to the related issues of informed consent and truth-telling. If the patient is to make a sound decision, truth must be communicated effectively; then informed consent can be given by the patient as decisions are made. On further examination, many questions can be raised such as: When is consent informed consent; that is, how much information must be given to a patient before consent is fully informed? Which patients are competent to give consent? When is consent fully voluntary and not

strongly influenced by overwhelming fear? Are doctors ever morally justified in lying to patients? The patient-physician relationship depends significantly on the various answers to these questions.

PHILOSOPHIC ISSUES

As we consider several basic philosophic issues related to medical ethics and then some moral dilemmas in medicine, we shall raise many pertinent questions. We shall offer no neat resolutions, because to do so would misrepresent the medical ethics field. You and your physician, and others involved in your health care, will have to reach your own thoughtful conclusions.

As one may expect, many vexing questions face medical ethicists. Although patients and professionals may avoid formal consideration of some of the questions, their assumed answers permeate their chosen moral directions. Let us give attention now to some of the philosophic questions that are linked to moral considerations in medicine.

What Is "Life"? "It's great to be alive!" Perhaps so, but what is it that makes a person alive or "with life"? One answer claims that life exists when a "vital force" is present that distinguishes the entity from inorganic nature. The exact nature of this vital force, however, is elusive; no one seems to know the exact conditions for or ingredients of life throughout nature. Is the vital force different among human beings, parakeets, flowers, and bacteria? Is the vital force a biological essence, a spiritual quality, or a combination of both?

In what sense is it true to say that life is present in a "dead" tree? Is cellular activity in the "dead" tree such that the tree has life in some sense? If there are varying degrees of life present in several trees, what qualifies one tree as "alive" and another "dead"?

What is *human* "life"? Do we look for a biological, spiritual, or mental definition or a combination of the three? What are the implications for "life" if one believes in life after death?

When Does One Become a "Person"? There is no consensus on the nature of "person;" discussions of this issue continue.[2] Yet this is a pivotal matter in decisions related to abortion, care of the profoundly retarded, the senile, and so on. One view is that an individual is a person from the moment of conception until death; the killing of an innocent person at any time between conception and death is murder.

Another view (the "developmental view") makes a distinction between

[2]See "The Concept of a Person in Ethical Theory," *The Monist* 62, no. 3 (July 1979) and Michael B. Green and Daniel Wikler, "Brain Death and Personal Identity," *Philosophy and Public Affairs*, vol. 9, no. 2 (Winter 1980).

human life and a *person.* Human life exists from the moment of conception, but a *zygote* (the fertilized entity not yet implanted at the uterine wall) is not a person. From about two weeks after fertilization until about the end of the eighth week (when brain waves can be detected), the entity is an *embryo,* not a complete person. The *fetal* stage lasts for about the final seven months. Developmentalists disagree as to when the fetus can be regarded as a person: At four months from fertilization when it noticeably moves? At seven months when it may survive on its own outside the mother's womb? At birth? The key to defining "person" among developmentalists is the developmental stage selected for personhood; this is a philosophic judgment.

Other views further qualify "person" among born individuals; not all born human individuals are persons. Proponents of these views have developed several criteria for personhood, such as:

the ability to reason

minimal intelligence

self-awareness (versus mere consciousness)

being an autonomous and free origin of activity (versus a robot-like automaton)

the presence of a soul

a capacity to communicate by any means

the capacity to make basic moral judgments

a sense of the passage of time and of the future

a capability of relating to others

Scholars differ as to which of these characteristics are essential to personhood and the precise meaning of each.

What Is the Value of Life? Many viewpoints take it for granted that life has an intrinsic value. Theologically stated, "life is sacred"; life derives its value from the Creator. On further thought, the question becomes complex. Whether interpreted theologically or humanistically, are we to assume that *all* life is of equal value? Members of the Jain religion are vegetarians, strain their beverages, and sweep their paths as they walk, in order to protect bugs. Having ruled out the sacredness of vegetable life, they value more highly other living creatures. "Life is sacred" means something different to them than to humanists and religious communities that value *human* life most highly.

In the United States we don't eat dogs and cats; in India cows are not food. We eat turkeys and chickens, but not robins and canaries. Swordfish will be on a menu, but not goldfish or guppies. Ancient Romans regarded roses as a delicacy; we use them as ornaments. The President of the United States would receive excellent medical care in a hospital emergency room; would an unshaven recluse be valued such that he would receive the same quality care in the same emergency room? When it comes to the value of

life, we discriminate; we choose the kinds of life that we believe have greatest value. We make these choices among species and within species. With what justification do we assign such contrasting values to the lives of different creatures?

What Is Meant by "The Right to Life"? The belief that life from conception has an intrinsic value or is sacred often exists in conjunction with a "right-to-life" position. In an attempt to get beyond a poster slogan, we can raise the following issues for clarification.

Who or what has a right to life? The bugs protected by the Jains? Cows, dogs and cats, turkeys and chickens, robins and canaries, swordfish, goldfish and guppies, roses, the President and/or the unshaven recluse? Is the right to life an inalienable right? If absolutely so, no exceptions can be made; every living creature must die naturally, without interventions that hasten death. As a result, we would have no meat, fish, poultry as food, or ornamental flowers. If the inalienable right is linked only to persons, we could not kill in self-defense, and the issue of capital punishment would be resolved.

Strictly speaking, few men and women support an absolutist right-to-life position for all human beings. Exceptions are made especially in some occasions of self-defense. However, once an exception is made, the absolute quality is lost. The question is transformed to "under what conditions does a person lose his right to life?" In other words, under what circumstances can one's right to life be waived?

Advocates of lethal self-defense believe that some unjust aggressors have waived their right to life; they may be killed by their victims as a last resort. Proponents of capital punishment believe that with the commission of certain crimes, an individual waives his right to life and may be put to death. Supporters of suicide hold that an individual may waive his own right to life in particular circumstances (e.g., deliberate martyrdom or unbearable terminal illness). By what criteria can the discrimination among creatures or among only human beings be justified with regard to the right to life?

What Is an Acceptable Quality of Life? "Goodbye To Our Good Life?" is the featured cover story of an issue of *U.S. News and World Report* (August 4, 1980, p. 45). The article reports "The great bulk of this country's people have managed to retain the trappings of a high standard of living: A decent home, good food and clothing, quality education and health care, access to jobs and promotions, and leisure opportunities." Are these "trappings" the standard by which one's quality of life is measured?

A few years ago a television documentary included an interview with a woman confined to an "iron lung" for about 20 years. She was happy, content, able to do many things by orally manipulating various controls and, in her view, had an acceptable quality of life.

Is quality of life measured by moral, biological, psychological and/or economic criteria? Are there levels of quality, and who decides?

When Is Death? Is it possible to pronounce a tree or a person dead only when all cellular life has ceased? If so, quite a period of time would have to elapse between usual reckonings of death and cutting down a tree or embalming a person. On the other hand, the removal of a wanted tree where there is hope of revitalization or the premature burial of a human being is undesirable! At which point is it safe to assume that a person is dead: At heart failure? One year in a coma? When there are no signs of brain activity for one hour, twenty-four hours, forty-eight hours, or _____? A combination of these conditions?

To What Extent Does Humanity Share with God and/or Nature the Responsibility to Begin, Shape, and End Lives? If you have taken an aspirin, cut your fingernails, worn glasses, or taken vitamins, you have intervened in nature. You did not leave it to God or nature to cure the headache, manicure your nails, correct your vision, or manage your vitamin intake. One could argue that wearing clothes, except for protection from environmental nuisances or dangers, is unnatural. The vast majority of civilized men and women accept the principle of intervention in nature; the issue is, to what extent? For therapy? For cosmetic reasons? For control of future human characteristics? As we shall learn later in this chapter, this is a crucial philosophic issue in medical ethics.

If a Practice or Procedure has the Possibility of Abuse, Ought It Be Forbidden? "Doing *this* might lead to *that!*" By itself this degree of caution would prevent any and all changes, developments, and progress. Risks are involved in most situations: a new religion in town *might* create aggressive bigots; allowing ice cream to be served publicly *could* be detrimental to the health of lax diabetics; removing tonsils surgically *may* eventually lead to the disintegration of family life because children forced to go to the hospital may resent their parents; studying philosophy involves questioning what has been taken for granted, which in turn *may* lead to conflicting viewpoints and nuclear war!

We are not suggesting that cautious consideration of possibilities be entirely set aside. We propose instead that the realistic beneficial and harmful probabilities of a practice or procedure be studied with care. We reject the notions that in all instances "A" *must* lead to "D" and that all ventures must be wholly risk free. These faulty notions would have precluded the discoveries of the beneficial uses of fire, the wheel, all surgical procedures, and even initiatives in the risky human relationships we value! Likewise, issues of intervention such as selecting the gender of a child, sterilization, cloning, and suicide can be explored thoughtfully.

Improbable fantasies of "one thing leading to another" as well as ap-

peals to noninterference with "God's Will" in nature are neither convincing nor supportive; after all, left to itself, God's natural environment produces Siamese twins and sustains syphilis. Human medical intervention in these and other "natural" occurrences is usually welcome!

Can Distinctions Be Made Between . . .?

Killing and murder.

> "Then David said to the Philistine (Goliath), 'You come to me with a sword and with a spear and with a javelin; but I come to you in the name of the Lord of hosts, the God of the armies of Israel, whom you have defiled. This day the Lord will deliver you into my hand, and I will strike you down, and cut off your head. . . . ; for the battle is the Lord's and he will give you into our hand.'" (I Samuel 17:45–47)

Is there a contradiction between the Lord's apparent approval of David killing Goliath and one of the Ten Commandments? The consensus of scholars is that no contradiction exists because the accurate translation of the Commandment is "You shall do no *murder*." In fact, "Biblical law distinguishes the following types of homicide: murder, accidental homicide, the goring ox, and justifiable homicide."[3] The ethical issue becomes: By what criteria can a distinction be made between murder (wrongful killing) and justifiable killing? In considerations of abortion, suicide, and inducing death, this issue is especially significant.

Medical aid and medical interference. Surely, one may think, an innoculation against polio is medical aid for everyone. Proven routine assistance that helps prevent disease is routine and clearly beneficial. However, if one's religious convictions prohibit injections, an order to be immunized constitutes intolerable medical interference, a violation of personal rights and liberties.

Another more extreme example is the elderly woman who refused to give permission for the amputation of a leg, although without the surgery she would die. A court declared her incompetent (because of her refusal of relatively safe surgery and her willingness to die), and her leg was amputated. Is this medical aid or is it interference? By what standards can aid be distinguished from interference?

Extraordinary and ordinary means.

> Ordinary means of preserving life are all medicines, treatments, and operations which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience. . . . In contradistinction to ordinary are *extraordinary* means of preserving life. By this we mean all medicines,

[3]J. Greenberg, "Crimes and Punishment," *The Interpreter's Dictionary of the Bible,* vol. A–D, p. 738.

> treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.[4]

This attempt by Roman Catholic theologians at clarification of extraordinary and ordinary means makes it clear that *vitalism,* the prolonging of life no matter what, is not a moral principle of the Roman Catholic Church. We are not aware of any religious or humanistic group in which vitalism is an axiom. However, the "Sacred Congregation" admits to the difficulty, which all persons face, in definitively distinguishing between ordinary and extraordinary means.

> In the past, moralists replied that one is never obligated to use "extraordinary" means. This reply, which as a principle still holds good, is perhaps less clear today by reason of the imprecision of the term and rapid progress made in the treatment of sickness.[5]

The 1980 Declaration proceeds to offer guidelines for making the distinctions; but this effort, in our judgment, does not remove the ambiguities and uncertainties.

The subtle difference between medical aid and interference and extraordinary and ordinary means is that the former issue focuses on whether the intervention itself is *personally valued* as helpful, whereas the latter concentrates on the *professional complexity* of the intervention. For example, a blood transfusion will be regarded as *interference* by a Jehovah's witness and as *ordinary means* by a physician. Or, you may regard your request for $1,000,000 experimental surgery and care that may prolong your life for one year as medical *aid*; those receiving your request may view it as *extraordinary.* The subjective nature of these terms is imprecise and debatable.

Philosophic Pluralism. Philosophic pluralism emerges in its most perplexing and critical forms in medical ethics. The issues discussed in Chapter 2 that led us to philosophic pluralism are important and significant; but the ambiguity surrounding moral dilemmas in medicine are *acute.* A hospital emergency room has an urgency about it that a classroom discussion of freewill versus determinism lacks.

Before we venture into some issues of medical practice, we might reflect for a moment on what we are doing. We are not providing obviously true solutions; we have no method by which the Final Truth on these matters can be established. *We can, however, introduce competing insights and hope to learn to tolerate ambiguity even in acute situations.*

Let us consider only a sampling of medical concerns and their respective

[4]Gerald Kelly, S.J., *Medico-Moral Problems* (St. Louis: Catholic Hospital Assoc., 1958), p 129.
[5]"Declaration On Euthanasia" issued by the Vatican's Sacred Congregation for the Doctrine of Faith, May 5, 1980.

moral dilemmas. Within the scope of this chapter we can develop a modest awareness of the complexity of some moral issues of reproduction, living, dying, and death.

SOME MORAL DILEMMAS IN MEDICINE

Family Planning

An unwanted child, for whatever reasons, begins life with a disadvantage. With varying rationales, contemporary philosophers and theologians agree that planning the number and approximate intervals of children is to the advantage of all concerned. Sharp disagreements arise over the methods of family planning.

Contraception. One view of preventing conception holds that all devices (such as condom or pill) are immoral intrusions into nature, hence "unnatural." Men and women have no right to intervene in the natural process with devices or chemicals. (See Chapter 4 on Thomistic natural law ethics.) Instead, a careful observation of the laws of nature can assist with scheduling intercourse such that conception occurs only as desired; in fertile periods, disciplined abstinence is the natural method of family planning.

A contrasting view values intervention by medically approved devices and chemicals. More accurate, such approaches encourage greater spontaneity between partners and fewer surprise pregnancies. This position views reliable contraceptive devices and chemicals as natural, equating such assistance with the use of eye glasses and aspirin.

Involuntary Sterilization. It is rare that pleas to clothe and feed the poor are coupled with equally strong petitions for effective family planning among deprived people. Even more rarely will a politician or religious spokesperson hint at required sterilization of individuals or groups whose prolific child-bearing aggravates their chronic poverty. The right to have as many children as one wants is in the public's mind an unchallenged axiom that is contrary to notions of involuntary sterilization. In recent years in the United States, an informal belief has arisen that fewer children in a family benefits the family and society in general. However, the federal income tax structure continues to reward taxpayers who have several dependents with increasing tax deductions; no one has seriously proposed a greater tax on parents producing more than a certain number of offspring. To intervene in someone's life through involuntary sterilization or taxing parents for exceeding a recommended number of children presupposes a moral right for authorities to do so; those opposed to such interventions call instead for the treatment of social conditions through acts of justice, not through acts

viewed as being *against* the poor and ignorant. The right to reproduce without restrictions remains supported and intact.

A different view rejects the belief that every man and woman has the inalienable right to reproduce. This view points out that the law already restricts marriage between close relatives or individuals with certain diseases—a nonsurgical form of involuntary sterilization. Because babies are more tolerated now among unmarried persons, such required "involuntary nonsurgical sterilization" could be extended further; subcultures that promote child-bearing for larger welfare checks could be subjected to such sterilization. Forced family planning has come of age for the ignorant, irresponsible, chronically pregnant, retarded, and mentally ill; this view does not question anyone's right to appropriate sexual intimacy, only to unrestricted conception. The alleged right to reproduce without restriction is challenged by this position.

New Methods of Conception. The fertilization of a human egg has, until recent years, been accomplished by means of sexual intercourse. And that's the way it should always be, according to one side of the argument. Humanity has no right to intervene in this natural process of conjugal love; interventions are dehumanizing.

In vitro fertilization. The other side of the debate views human intervention as compassionate assistance to prospective parents who have medical problems preventing conception. On July 25, 1978, Louise Brown was born at Oldham General Hospital in England; her parents had tried for nine years to have a child. British physicians were able to extract an unfertilized egg from her mother's body, place it in a laboratory dish (*in vitro* means "in glass"), fertilize it with her father's sperm, and insert the fertilized egg into her mother's womb for nine month's development.

Objections to the process include not only the charge of a dehumanizing and unnatural intervention, but also murder. In the process, several unsuccessful attempts may result in the discarding of fertilized eggs; if all conceived human life are persons, then it follows that innocent persons have been discarded.

Because *in vitro* fertilization makes possible the current use of donor sperm, donor eggs, substitute females for the period of pregnancy, and perhaps some day a full-term pregnancy in an artificial womb, objections multiply with charges of adultery and disintegration of family life. Frozen sperm, frozen fertilized eggs, and unmarried individuals who want to raise children add further possibilities and occasions of moral resistance.

Artificial insemination. The use of a syringe to deposit semen in the vagina is also supported and objected to along the same lines of argument: those *for* the process see it as medical assistance and one more therapeutic intervention; those against it summon the arguments of unnaturalness and of abuses that defy what God and/or nature intended.

Abortion

Groups favoring abortion do not endorse abortion as just one more method of contraception. Regardless of how early in a pregnancy an abortion takes place, it is medically more risky than the use of contraceptive devices and chemicals. Repeated abortions increase the medical risk to a woman.

Most individuals supporting abortion to some extent or wholeheartedly do not view the human life present during some or all of the nine month's pregnancy as a person. The removal of such human life from a woman's body is similar to the removal of tonsils or the appendix—both also human life but not persons. Supporters have varying views on the stage at which the individual human life becomes an *actual* person. They may agree that each fertilized and unfertilized egg is a *potential* person, but not a complete person with a right to life. They point out that the body itself discards eggs on a regular basis. Unfertilized eggs degenerate, and miscarriages account for abortions of fertilized eggs. As noted in a widely used text:

> Spontaneous abortions, also called miscarriages, occur at a much higher rate than many people realize. It has been estimated that about 33 percent of all fertilized eggs abort before the next menstrual period is overdue. In these cases most women never realize that they are—or were—pregnant. An additional 25 percent of all pregnancies miscarry between the time of fertilization and labor, meaning that almost 60% of all pregnancies end before a viable birth occurs. These abortions and miscarriages occur, of course, without any human intervention.[6]

The body itself aborts human life on a regular basis. According to advocates of abortion, human intervention inducing abortions (like many other medical interventions) supplements what nature is already doing: the discarding of human life, not the murder of persons. Some other defenders of abortion focus on claims of the woman's rights over her own body; the rights of citizens to their individual choices about abortion; the benefits of having wanted, planned-for children; and the value of licensed physicians performing abortions legally and safely. A philosopher has proposed other considerations in the issue of abortion.

> The following factors should then be weighed by the mother before she can be confident that abortion is the right way out of her dilemma, and one she will not come to regret or view with guilt:
>
> whether or not the pregnancy was voluntarily undertaken.
>
> the importance and validity of the *reasons* for wanting the abortion.
>
> the technique to be used in the abortion; the extent to which it can be regarded as "cessation of bodily life support," rather than as outright killing.

[6]James Leslie McCary, *McCary's Human Sexuality*, 3rd ed. (New York: Van Nostrand, 1978), p. 205.

the time of pregnancy.

whether or not the father agrees to the abortion.

whether or not all other alternatives have been considered, such as adoption.

her religious views.

And the father, if he weighs these factors differently, may feel the grief and responsibility differently too and wish to take over the care of the baby after birth.

Abortion is a last resort, and must remain so. It is much more problematic than contraception, yet it is sometimes the only way out of a great dilemma. Neither individual parents nor society should look at abortion as a policy to be encouraged at the expense of contraception, sterilization, and adoption. At the same time, there are a number of circumstances in which it can justifiably be undertaken, for which public and private facilities must be provided in such a way as to make no distinction between rich and poor.[7]

Opponents, who frequently label themselves as "pro-life," view the fertilized egg not only as human life but also as a person or potential person with the right to life from conception to natural death. Abortion by human intervention is unnatural, the killing of the innocent, and therefore murder. They raise a concern for the devaluation of all human life, such that killing elderly people, the mentally ill, and so on could be legally sanctioned along with abortion. Life throughout the continuum from fertilization to death is equally sacred; abortion is immoral.

The choices on abortion before society as seen by one medical ethicist are summed up as follows:

> Only if we can decide where we stand on these issues can we decide where we stand on the morality of terminating pregnancies. In practical policy terms, there are four positions to choose among, and our choice will depend on what we decide about the status and quality of the fetus. (1) We can condemn abortion altogether or, at most, justify it to save the pregnant woman's life. (2) We can favor a limited permissiveness to prevent ill health, to prevent defective babies, or to prevent the product of rape or incest. This is a policy of compulsory pregnancy but with escape clauses. (3) We can approve of abortion for any reasons prior to the ability to survive outside the womb—possibly on the grounds of social needs or some question of justice, although these grounds are not so apparent as they were when we lacked enough labor power and needed lots of soldiers. (4) We can oppose any and all forms of compulsory pregnancy, making the ending of pregnancies, like their beginning, a private or personal matter.[8]

[7]Sissela Bok, "Ethical Problems of Abortion," *Hastings Center Studies*, vol. 2, no. 1 (January 1974); available as Reprint #122 of "Readings" from The Hastings Center.

[8]Joseph Fletcher, *Humanhood: Essays in Biomedical Ethics* (Buffalo, N. Y.: Prometheus, 1979), p. 138.

Shaping Persons

A fairly good rate of success has already been achieved at preselecting the sex of a child. Sperm that create males can be separated quite reliably from those that spark female life; the chosen specimen is then artificially inseminated, and nine months later, the patient has a very good chance of giving birth to a baby of the chosen sex. Not only can a married couple utilize this opportunity, but donor sperm could be used in conjunction with sex selection.

In 1980 a "sperm bank" came to public notice. Using sperm from Nobel-prize winning scientists from the "bank," several women of high intelligence reported their resulting pregnancies. Advocates view this intervention in shaping lives as improving the genetic stock of humanity by freezing gifted men's sperm for current and future insemination of bright women. Assuming that "brighter is better," which in turn can lead to social usefulness, sperm bank promotors see their efforts as humanitarian.

The new science of splicing genes, which control the development of individual cells, is another controversial area. The production of insulin, new foods, and possible cancer cures are among the potential benefits to mankind. However, at least in theory, the creation of new forms of persons (e.g., with very short legs for space exploration and habitation) will be possible in the distant future.

Technologies involving the developing zygote may someday include parthenogenesis (development to birth of unfertilized egg) of a person and cloning (development of many persons identical to a parent).

Shaping persons also comes under the general label "genetic engineering." Ethicists differ on the morality of various aspects of shaping persons with regard to the purposes of such efforts, the standards by which "desired characteristics" are measured, the value and quality of life of any resulting defective people, and whether such nontherapeutic interventions are moral at all!

Other Moral/Medical Issues of Living, Dying, and Death

Repeatedly we discover the same or similar essential philosophic questions being raised about the nature of life itself, the meaning of "person," the value of life, the right to life, quality of life, the extent of human intervention, whether *this* will lead to *that,* and the distinctions between killing and murder, aid and interference, and extraordinary and ordinary means. The conditions and morality of various forms of behavior control, confidentiality, truth-telling, organ transplants, and experimentation are additional issues not so much of reproduction but of medical treatment for the living and the dying.

Death itself raises questions of when death occurs and what it is: an annihilation of a person or a birth to a new plane of personal life? The

rightfulness or wrongfulness of prolonging life of a dying person, of letting nature take its course with a terminal patient, and of inducing death by one's own hand (suicide) or with another's assistance (voluntarily or involuntarily) are dilemmas in daily newspapers, magazines, and on television documentaries and dramas. (See "When Doctors Play God: The Ethics of Life-and-Death Decisions," *Newsweek* cover story, August 31, 1981.)

BENEFITS OF MEDICAL ETHICS STUDY

"I have hated you since you introduced me to issues of medical ethics," was an overstatement by a nurse-colleague to a friend-philosopher. Preferring as little ambiguity as possible and trained for exactness, the world of health care deliverers welcomes the pluralistic insights of medical ethics with mixed emotions. The public at large may react in similar fashion.

But what are we to do? As professionals and layfolk we can stumble through our lives blind to the options, or we can become familiarized with the moral dimensions and major ethical positions of medical care in which we and those we love are or shall be involved. The benefits of understanding the inevitable pluralism include development of our own informed choices as well as respect for the thoughtful, informed choices of those with whom we differ. The framing of laws consistent with the Constitution on these matters will be a persistent challenge for decades to come. It is hoped that our lawmakers, courts, health care deliverers, patients, and moral spokespersons will come to a greater awareness of alternative views so that humanity can move from shallow slogans and responses to informed consciences and choices. We hope this glance at medical ethics will stimulate your interest in further study of these life issues so that you may develop principles and concepts for your use.

A TASK FOR PHILOSOPHERS: CLARITY ABOUT IMPORTANT QUESTIONS

I should like to say at once that if the moral philosopher *cannot* help with the problems of medical ethics, he ought to shut up shop. The problems of medical ethics are so typical of the moral problems that moral philosophy is supposed to be able to help with, that a failure here really would be a sign either of the uselessness of the discipline or of the incompetence of the particular practitioner. I do not want to overstate this point, however. It could be the case that, so far as practical help goes, philosophy is at the stage now at which, not so long ago, medicine was. It has been said that until fairly recently one was more likely to survive one's illnesses if one kept out of the hands

of the doctor than if one allowed oneself to be treated—and this was at any rate true of the wounded on battlefields, because the surgeons' instruments were not sterilized. Yet all the same medicine *has* now progressed to a stage at which it saves lives. The change came when certain *methods* got accepted: I mean, not merely such things as aseptic surgery, but also the application to medicine of the scientific method in general, which meant that firm and reliable procedures were adopted for determining whether a certain treatment worked or not; and also the relation of medicine to fundamental knowledge about physiology and biochemistry, which made possible the invention of new treatments to be tested in this way.

The same could be true of philosophy. There have been great philosophers in the past, just as there were great doctors before the advent of modern medicine; but it is only very recently in the history of philosophy that general standards of rigour in argument have improved to such an extent that there is some hope of our establishing our discipline on a firm basis. By "standards of rigour," I mean such things as the insistence on knowing, and being able to explain, exactly what you mean when you say something, which involves being able to say what follows logically from it and what does not, what it is logically consistent with, and so on. If this is not insisted on, arguments will get lost in the sands. Even now it is insisted on only in certain parts of the philosophical world; you are very likely to meet philosophers who do not accept this requirement of rigour, and my advice to you is that you should regard them in the same light as you would regard a medical man, whether or not he had the right letters after his name, who claimed to have a wonder drug which would cure the common cold, but was not ready to submit it to controlled tests. It is undoubtedly true that many patients will feel much better when they have taken his drug; but since we simply do not know whether it is the drug that has made them feel better, or his personal charisma, or natural causes, he has not contributed to the advance of medicine.

I do not want to give the impression that nobody insisted on rigour in argument until recently; indeed, it was the insistence on knowing what you meant that really got philosophy started. Socrates, Plato, and Aristotle, as well, probably, as some other great men of their time whose works have not come down to us, knew how philosophy ought to be done and made great pro-

gress in it; and there have been other periods in which philosophy in this rigorous sense has flourished; but they have always been succeeded by periods of decline in which a kind of superficial excitement was prized above rigour in argument, and so philosophy got lost. It is very important not to let this happen again. For the true philosopher the most exciting thing in the world—perhaps the only exciting thing—is to become really clear about some important question.

R. M. Hare, "Medical Ethics: Can the Moral Philosopher Help?" in Stuart F. Spicker and H. Tristram Engelhardt, Jr., eds., *Philosophical Medical Ethics: Its Nature and Significance* (Holland, D. Reidel, 1977), pp. 49-50.

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CHAPTER REVIEW

A. Medicine and human values

1. The practice of medicine throughout history has required moral judgments grounded in values; within the past decade, medical ethics has been emerging as a major interdisciplinary field, as evidenced by increasing numbers of textbooks available for classroom use.
2. This chapter explores the irresolutions of some important philosophic concepts and principles in the spirit of "ground work" for further study.
3. A major issue raising the moral dimension of medical care is the "can do/ought to do" issue.
4. Bioethics is the comprehensive classification of ethical considerations implied by some biological developments; medical or biomedical ethics is an area of bioethics that concentrates on moral questions raised in the practice of medicine.
5. The implementation of one's values in judgments and decisions constitutes a moral choice; medical ethics in this sense cannot be avoided by readers of this book, in that each has or will choose to consult a physician at some time or other.

6. Decision making and related issues of communication have value components and are therefore additional issues.

B. Philosophic issues

1. As we consider several basic philosophic issues related to medical ethics, we shall offer no neat resolutions; readers will have to reach their own thoughtful conclusions.
2. The issues include: What is "life"? When does one become a "person"? What is the value of life? What is meant by "the right to life"? What is an acceptable quality of life? When is death? To what extent does humanity share with God and/or nature the responsibility to begin, shape, and end lives? If a practice or procedure has the possibility of abuse, ought it be forbidden? And, can distinctions be made between killing and murder and extraordinary and ordinary means?
3. Philosophic pluralism emerges in its most perplexing and critical forms in medical ethics; although we cannot offer final truths on these matters, we can be introduced to competing insights and, we hope, learn to tolerate ambiguity even in acute situations.

C. Some moral dilemmas in medicine

1. Family planning involves such moral issues as contraception, involuntary sterilization, and new methods of conception.
2. Abortion, shaping persons, and moral/medical issues of living, dying, and death are also vital matters.

D. Benefits of medical ethics study

1. As professionals and layfolk we can stumble through our lives blind to the options we have, or we can become familiarized with the moral dimensions and major ethical positions of medical care in which we and those we love are or shall be involved. We can choose for ourselves, and we may learn to agree to differ with others personally and legally.

SUGGESTED READINGS

Abrams, Natalie, ed. "Newsletter on Philosophy and Medicine."

A publication of the American Philosophical Association (University of Delaware, Newark, Delaware 19711); the eight-page newsletter, published several times a year, includes committee reports, essays, bibliographical information, and announcements of conferences and programs.

Duncan, A. S. et al., eds. *Dictionary of Medical Ethics,* New Revised Edition. New York: Crossroad, 1981.

The second edition of a 459-page dictionary in which more than 70 percent of the contributors are physicians; British experience permeates the brief entries.

Durbin, Paul T., ed. *A Guide to The Culture of Science, Technology, and Medicine.* New York: Free Press, 1980.

An in-depth survey of the literature of the history, philosophy, and sociology of science, technology, medicine, and the expanding field of bioethics. Section III "Bioethics" in Chapter 6 "Philosophy of Medicine" includes a bibliographic introduction to basic sources, reference sources, and journals and series; *a very important bibliographic source.* (The *Hastings Center Report* is one of the important periodicals listed.)

Fletcher, Joseph. *Humanhood: Essay in Biomedical Ethics.* Buffalo, N.Y.: Prometheus, 1979.

The humanistic ethicist who pioneered the field with his *Morals and Medicine* and explored approaches to ethics in his often misunderstood *Situation Ethics* has gathered essays on a wide range of bioethical topics in a most readable manner.

Mappes, Thomas A., and Zembaty, Jane S., eds. *Biomedical Ethics.* New York: McGraw-Hill, 1981.

One of the best of the many current college-level textbooks in the field; clear introductions to each topic, representative views by contemporary scholars (with an introductory synopsis of each selection), and excellent annotated bibliographies concluding each chapter provide the able student with a fine survey.

Reich, Warren T., ed. *Encyclopedia of Bioethics.* New York: Free Press, 1978.

THE reference work in the field!

Ruddick, William, ed. *Philosophers In Medical Centers.* New York: Society for Philosophy and Public Affairs, 1980.

The editor has assembled for the Bioethics Committee of The Society for Philosophy and Public Affairs (New York Chapter) an 82 page booklet of essays by philosophers working in and around two New York medical centers. (Copies are available at a nominal cost from the editor at The Department of Philosophy, New York University, N.Y., N.Y. 10012.)

Shannon, Thomas A., and DiGiacomo, James J. *An Introduction to Bioethics.* New York: Paulist, 1979.

An excellent introduction to selected issues in the area of bioethics along with an overview of the basic medical and ethical dilemmas that have arisen in the field; useful to the citizen for private reading and in basic courses.