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Arthur J. Dyck

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the methods and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health of person which may possibly come from his participation in the experiment.

Articles of the Nuremberg Tribunal¹

The declarations of Nuremberg symbolize and express two significant characteristics of the contemporary situation of medicine: a heightened responsiveness to the needs, wants and rights of patients; a heightened awareness of the increasing difficulty of knowing what is right, and hence of knowing how best to benefit the

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patient and prevent harm. These concerns have arisen within the medical profession itself, but they are shared by the public at large. Technological advances that make it possible to transplant organs and keep the heart and lungs going when the brain is no longer functioning, the ability to diagnose genetic defects while the developing child is still in the womb, the experimentation with techniques that would make it possible to grow babies outside the womb, the rising costs and complexity of delivering health care with its adverse effects on the poor, and the existence of medical experiments that are of no immediate benefit to patients who are subjects, are all facts of modern life known and reflected

upon not only by physicians but also by the public, and by the media that conveys so much of this information to the public.

The past decade has given rise to a flurry of literature that documents and agonizes over moral dilemmas within contemporary medicine. Some of this literature is designed to shock and alarm us. Thus, for example, Pappworth writes a book entitled *Human Guinea Pigs* in which a number of cases are cited as clear deviations from the morality of traditional medical practice.² Within the profession, Henry Beecher, in a widely read essay, discussed cases that he judged to be violations of existing medical codes, and hence unethical.³ One cause for alarm, then, among those who are reflecting upon contemporary medical practice arises from perceived departures from traditional values, including those already embodied in medical codes.

Quite another kind of alarm is being expressed, this by people who tend to assume that technological innovations in medicine and medical science are generally good and ought to be vigorously pursued. Such writers express the concern that traditional values—often the focus is on religious values—continue to stand in the way of medical innovation and progress.⁴ Whereas people used to oppose surgery, blood transfusions, inoculations, etc., now they oppose new definitions of death, transplants, in-vitro fertilization, etc. Some of these writers, therefore, are inclined to call for nothing less than a new ethic that

will clarify the benefits of medical innovation and the necessity of assuming various risks in order to get these benefits.⁵

Decision-Making

Sharp differences of opinion evoke still another kind of reaction to the morally problematic character of contemporary medical decision-making. We see this, for example, in the area of employing a technique like amniocentesis.⁶ To justify the risks of this diagnostic technique to discover whether the child developing in the womb has certain defects, physicians often leave the decision in the hands of the pregnant woman. She is the one who will decide whether she will have an abortion should her developing child be diagnosed as defective. This approach to medical decision-making is one of individualizing those decisions because individuals differ as to whether or when abortion for defective fetuses is morally justifiable.

Sharply contrasting with the tendency to individualize medical decisions is a call for much more stringent regulation of the medical profession, whether by the legislatures, government agencies, and/or the courts.⁷ The desire for more stringent regulation comes from those who wish to see time-honored formulations of moral values enforced. It comes also from those who want to see new values enshrined in medicine: some physicians, for example, seek to have euthanasia, mercy killing, legalized.

Whatever their merit, these responses to contemporary moral dilemmas in medicine are inadequate. They are made without explicitly offering the framework for understanding the relationship between ethical standards and medical practice implied by the policies they advocate. The purpose of this essay is to seek some clarity about the way in which ethical questions arise within medical practice and to suggest a framework for formulating moral policy. Obviously this brief essay will only make a beginning of this dual enterprise.

In characterizing the nature and scope of ethics, it is possible to outline the concerns of this discipline by specifying its three major questions. The major questions of ethics are normative, meta-ethical, and strategic.⁸ Normative questions are raised in an effort to discover the most generally and universally recognizable values that specify the right- and wrong-making characteristics of actions, and the goodness and badness of persons and various states of being. Questions of metaethics have as their concern the understanding of the nature of moral discourse and the processes by which moral judgments and debates are decided, argued, and justified or criticized. Questions of strategy are focused upon the way in which moral decisions are implemented and social policy is formulated and carried out. What we wish to do in this essay is use these three types of questions, that serve to define the nature and scope of ethics, to clarify the nature and scope of ethical

debates concerning contemporary medical practices. Indeed, we wish to indicate how these three types of questions elucidate the nature and scope of medical ethics, both as a sub-specialty within ethics generally and as a set of practical moral issues that arise for both physicians and patients in the pursuit of health and health care.

Normative Questions for Medicine

In her fascinating study of the more universally and generally held human values, Tamara DeBoer found that health was high on the list.⁹ Indeed, one of the effects of improvements in medicine has been to increase the expectations both physicians and the public have regarding the possibility of achieving health and maintaining it. The most startling achievements of medicine, and particularly of public health measures, has come in the form of greatly reduced death rates from infectious and communicable diseases. The decreases in infant mortality that result greatly raise the prospects of longevity.

With longevity, however, come increases in diseases that affect aging adults, such as cancer and heart disease, diseases which may also be related to our contemporary style of life. It is precisely the increased ability to prolong life that poses what appears to be the most fundamental question of values for the practitioners and recipients of modern medical care. Someone dying from cancer, for example, can be kept alive much longer than ever before. Even patients whose brains are not func-

tioning can be fed and have their hearts and lungs maintained, sometimes for periods of more than two years. Also at the beginning of life, where the ability to perform abortions is coupled with an increasing ability to diagnose various types of fetal deformities, questions about the support of nascent life in the womb also arise. Situations, therefore, exist within contemporary medicine where the increased expectation for health is not always compatible with the very strong desire for maintaining life as long as possible. For as we have noted, there are circumstances under which it is possible to sustain bodily functions under conditions of extremely poor health. At the same time, it is possible to choose to have only healthy infants.

But should health and a certain quality of life be considered a more important value than life itself? Or to put the question another way, is quality of life—a certain state of health and well-being—the dominant value by which we should judge what to do as physicians and what we wish as patients or should life itself be the dominant value? This it seems to me poses one of the most critical and far-reaching issues in the history of ethics and medicine.

A rather startlingly candid editorial in *California Medicine* compares two ethical systems with regard to their understanding of the value of life.¹⁰ One is the Judeo-Christian ethic. This ethic, so the editorial claims, sees life as an absolute value and causes

physicians to prolong and repair life regardless of the cost and circumstances. Alternatively, there is a new ethic that rejects the Judeo-Christian formulation of absolute devotion to life. In the view of the editorial, the adoption of this new ethic is beginning in the practice of abortion where quality of life arguments are used to give the moral justification for abortions, and will extend to various forms of euthanasia. The editorial does not give us a very clear indication as to the range of cases in which killing could be justified by this new quality of life ethic.

Stoicism

This editorial exhibits a very penetrating grasp of one of the most significant moral debates in contemporary medicine. However, it has oversimplified the alternatives considerably. For one thing, it is not true as the editorial alleges, that the quality of life ethic would be a new ethic. Ironically, Christianity had its beginning at a time when the high value it put on individual life distinguished it sharply from other more dominant religious and ethical systems. One such powerful philosophy was Stoicism. The Stoic could definitely justify suicide in circumstances where a person no longer felt life to be worthwhile. For the Stoic, the freedom to exercise rational control over one's own destiny was such a weighty value that it always provided an option to the continuation of one's own life.¹¹

Christianity also found itself

in opposition to the widespread practices of infanticide and abortion that prevailed at the time of its inception. Where Christianity came to dominate, infanticide and abortion came to be seen as evils. Laws to curb such evils came to be enacted.¹² The editorial claims that this legacy of Judaism and Christianity is waning, and an outlook, which as we have noted is more akin to traditional Stoicism, is beginning to take its place. There is no clear evidence to support this assessment of trends.

It's unfair to contrast the Judeo-Christian ethic with the new ethic by arguing that the former is absolutistic and the latter relativistic. This obscures the issue of the difference between an ethic in which life itself is a significant value, and an ethic in which questions of life and death are always questions of the quality of life, so that quality of life and not life itself is the value to be weighed in relation to other values.

Judaism and Christianity have never, except for certain of their sects which espouse absolute pacifism, taken the view that it is never morally justifiable to kill. Capital punishment and self-defense have always had their defendants within these traditions. The just war tradition has developed a whole set of sophisticated criteria designed to constrain rulers and armed forces from killing, but which at the same time state the conditions under which a war waged in self-defense may be just.¹³ In these traditions, therefore, life is looked upon as a good in itself to which

each individual has a right. At the same time, however, this right may be forfeited by those individuals who threaten or rob others of their right to life. The value placed upon life is so weighty that it is not at all easy to justify capital punishment and war. These traditions have especially strong constraints against killing any innocent party, that is, any individual who could in no sense be construed as being an intentional threat or danger to the life of anyone else. Hence the prohibition against infanticide did take an absolute form.

A quality of life ethic does not treat life as a good in itself. Life as a value is always life of a certain kind and the right to life is always subject to question: it cannot be assumed.

To see how this ethic functions, consider the following case of a Mongoloid (Downs Syndrome) child who was deliberately allowed to die.¹⁴ Soon after birth it was discovered that a child, diagnosed as Mongoloid, required surgery. This surgery does involve some risks but is usually successful and permits a child to realize its physical potential. Obviously it does nothing for whatever degree of mental retardation the child would experience as a Mongoloid. Although mentally retarded, Mongoloids are usually happy individuals and may sometimes manage a degree of independence that includes earning one's own living and setting up an independent household. In this particular case, the parents did not give permis-

sion for surgery and their physician acceded to the parents' wishes. He ordered nothing by mouth and fifteen days later the infant was dead.

What kind of argument led the participants to justify infanticide? On the side of the parents there was a strong desire to have a normal child, coupled with a very negative view of mental retardation on the part of the mother who had had some exposure to such children. Both parents did not want the suffering and anguish either of trying to rear such a child or of institutionalizing it. Presumably they also did not wish a life of mental retardation for their child. Whatever other assumptions were made by their physician, there was a strong feeling that institutionalization of an undesirable quality was the only prospect for this child and, given the attitudes of the parents, this was seen quite literally as a fate worse than death. (As it turned out, it was learned later that there are couples in that area who would gladly adopt mentally retarded children. This fact, however, is not essential to understanding quality of life arguments.)

Quality of Life

The essential feature of all quality of life arguments is the proposition that there is such a thing as a life not worth living. Life itself is not what is good: only life of a certain kind, life with a certain degree of intelligence, potential for development, or whatever, is considered valuable. Those who argue in this way will disagree with respect to what it is that

gives life value, how much of it one has to possess in order to have a right to life, and who it is that has the authority to specify that certain individuals will not, for whatever reason, be granted a right to life. Some would restrict the decision as to what qualities bestow value upon life to the individual whose life it is. This view is very hard to maintain, however, because it cannot apply to the very young, the senile, the severely mentally ill or those who have lost their capacity for conscious life. If mercy killing is to be applied in such instances, it cannot be considered voluntary at the time in which people find themselves to be in one of those conditions.¹⁵

Someone may argue that there is really no alternative to a quality of life view. There are occasions when it seems necessary to sacrifice life. One could cite here the declaration of one highly revered patriot when he exclaims "Give me liberty or give me death!" However, this affirmation need not be made from the standpoint of a quality of life ethic. One can take the view that life is a significant good in itself to which every individual has a right and, at the same time, claim that there are other values of great significance to which individuals have a right, such as liberty and justice.

There are situations in which the deprivation of liberty or the perpetuation of injustices are so severe that one might well morally justify risk to one's life and limb in order to increase liberty or decrease injustice. In a situa-

tion of enslavement, for example, there may be a point at which the sacrifice of some lives may bring about the kind of freedom and justice that will greatly reduce suffering and death among the enslaved. Civil disobedience, rebellion, or even revolution may, under certain circumstances, satisfy the criteria involved for waging a just war. Using the just war criteria, the respect for life is never lost. One can never kill in order to improve one's material welfare or happiness. But one may wage war to rectify grave injustices and overcome oppression. The injustices and oppression of slavery can be so great that those who are slaves experience a great deal of premature death, whether as infants or adults deprived of proper care, or as young people or adults so poorly fed and worked so hard that the usual chances for a normal life expectancy are severely reduced.

The right to life, therefore, is fundamentally linked to maintaining and respecting rights to liberty and justice. In the case of the Mongoloid child, the complete deprivation of liberty—the child is not allowed to grow up and decide for itself whether life is worth living—means in that case the complete loss of the right to live. Similarly, where abnormalities such as mental retardation are used to decide the merit of a life, a merit view of justice is brought into play. The merit view of justice does not presume that each individual has an equal right to life, liberty, and the goods of this world, including due process, the cornerstone of

any system of justice. Rather the rights have to be earned in some way.

Ethical or political systems that entertain a merit view of justice are at fundamental odds with the principle of equity. In John Rawls' recent monumental work on justice, he recognizes that certain kinds of inequities, for example differences in income, may be justifiable only if all persons, including those with less income, stand to benefit. From the standpoint of those who see life as a good in itself, life is one of those benefits. From the standpoint of certain quality of life arguments, however, life under certain circumstances is not considered a benefit.

Utilitarian

This brings us to another important normative question. Not only does one's system of ethics hinge on the particular values such as life, liberty, and justice affirmed by it, but also on the mode of moral reasoning employed. One common method of moral reasoning is what is called in ethics utilitarian. A system of ethics that employs only utilitarian reasoning is one in which the rightness and wrongness of actions, and the goodness of persons and of social ends, are all judged by some standard of utility. The rights of individuals to life, liberty, and justice are not presumed. Such rights must be established by their utility.

One of the narrower forms of contemporary utilitarian reasoning is that of judging policies by computing their cost effectiveness. If the utility of a project exceeds

its disutility, it can be justified. Thus in medical literature one finds arguments for aborting deformed fetuses on the grounds that the costs of aborting are so much less than the costs of sustaining the children who would be born.¹⁷ Similarly there are those who argue that the costs of certain kinds of treatment, where the chances of recovery are statistically highly improbable or involve people who are poor risks, may justify withholding treatment from such individuals.

Formalistic modes of normative reasoning are to be distinguished from utilitarian modes in that formalists allege that the rightness or wrongness of actions or practices does not depend solely upon their consequences. Formalists need not, therefore, reject all utilitarian reasoning but see utility as at most one right-making characteristic of actions and practices among others such as justice, truth-telling, gratitude, reparation, etc. One of the most widely respected and regnant formalist systems is that of W. D. Ross.¹⁸

The question no doubt arises in the minds of our readers at this point just how it is that one decides that certain characteristics of actions are right- or wrong-making characteristics, and certain characteristics of things or social ends are good or evil. Closely related to this is the further question as to what individuals and groups speak with authority on moral issues in medicine and what it is that confers such authority. These are questions of metaethics

to which we now turn.

Metaethical Questions for Medicine

There has been, and there continues to be a strong presumption within the profession of medicine that the profession itself provides the best basis for deciding what is right and wrong in questions of medical research and care. Medical ethics in this view is defined, understood, and practiced by medical professionals. Among medical professionals, those with a doctor's degree in medicine carry the most weight. The proposition that a particular group is best qualified to make and to criticize moral judgments pertaining to their own interests and work is not self-evidently true or false. Whether one believes it to be true or false depends in large measure on one's view of the nature of moral judgments and moral decision-making processes.

Books on medical ethics by specialists in ethics do not uniformly presuppose the special expertise of the medical profession to make moral judgments about medical cases. Joseph Fletcher in *Morals and Medicine* does not presume to be doing medical ethics.¹⁹ Fletcher claims that he is dealing with the ethics of medical care and that in so doing he is not dealing with medical ethics, a term usually used for the rules governing the social conduct and graces of the medical profession: "Medical ethics is the business of the medical profession, although certainly it has to fall somewhat within the limits of social obligation."²⁰ Fletcher recognizes

that some professionals would give medical ethics as a professional concern a loftier definition. He cites Dr. George Jacoby as saying that medical ethics deals with "the question of the general attitude of the physician toward the patient: to what extent his duty obligates him to intervene in the patient's interest, and what demands the physician has a right and duty to make upon the patient's relatives in regard to obedience and subordination for the purposes of treatment."²¹ Fletcher notes that Dr. Jacoby nowhere says anything about the demands the patient has a right and duty to make upon physicians. Fletcher then claims that it is this other perspective, namely the patient's point of view, that he tries to take in examining the morals, principles and values that are at stake in medical care.

Despite Fletcher's distinction between an ethics of medical care and medical ethics as professional ethics, his own book is virtually always referred to as a book in medical ethics. When physicians speak of the book in this way, I think it is because they presume that the issues raised by Fletcher are issues for them as professionals: nothing about medical care is outside the expertise of the physician; certainly nothing about medical care is outside the concern of the physician. When ethicists refer to Fletcher's book as a book in medical ethics, they share the assumption that medical ethics is part of ethics generally and that what distinguishes medical ethics

from ethics generally is its concern with the moral questions that arise in and from the practice of medicine.

Thus when Paul Ramsey set out to write a book on patient care entitled *The Patient as Person*, the subtitle is "Explorations in Medical Ethics."²² In the preface to his book, he makes his view of the relation between medical ethics and ethics generally very explicit:

problems of medical ethics are by no means technical problems on which only the expert (in this case, the physician) can have an opinion. They are rather problems of human beings in situations in which medical care is needed. Birth and death, illness and injury, are not simply events the doctor attends. They are moments in every human life.

The question, What ought the doctor to do? is only a particular form of the question, What should be done?

I hold that medical ethics is consonant with the ethics of a wider human community. The former is (however special) only a particular case of the latter. The moral requirements governing the relation of physician to patients and researcher to subjects are only a special case of the moral requirements governing any relations between man and man. Canons of loyalty to patients or to joint adventures in medical research are simply particular manifestations of canons of loyalty of person to person generally.²³

Ramsey has the utmost respect for the moral sensitivity of physicians. Nevertheless, he is not sanguine that the medical profession and its codes will suffice to guide contemporary medicine through its ethical dilemmas:

In the medical literature there are many articles on ethics which are greatly to be admired. Yet I know that these are not part of the daily fare of medical students, or of members of the profession when they gather together as professionals or even for purposes of conviviality. I do not believe that either the codes of medical ethics or the physicians who have undertaken to comment on them and to give fresh analysis of the physician's moral decisions will suffice to withstand the omnivorous appetite of scientific research or of a therapeutic technology that has a momentum and a life of its own.

The Nuremberg Code, the Declaration of Helsinki, various "guidelines" of the American Medical Association, and other "codes" governing medical practice constitute a sort of "catechism" in the ethics of the medical profession. These codes exhibit a professional ethics which ministers and theologians and members of other professions can only profoundly respect and admire. Still, a catechism never sufficed. Unless these principles are constantly pondered and enlivened in their application they become dead letters. There is also need that these principles be deepened and sensitized and opened to further humane revision in face of all the ordinary and the newly emerging situations which a doctor confronts—as do we all—in the present day. In this task none of the sources of moral insight, no understanding of the humanity of man or for answering questions of life and death, can rightfully be neglected.²⁴

This does not mean that medical ethics is best left to those trained in ethics only. Ramsey argues that physicians can do medical ethics but not without some training in ethics; similarly ethi-

cists need exposure to the fields of medicine to which their ethical reflections are directed. Above all, Ramsey argues that the medical profession should no longer believe that the personal integrity of physicians alone is enough "to deal with the contemporary quandaries of medical ethics."²⁵

Whereas Ramsey does not become explicit about the metaethical presuppositions that inform his view, a recent essay by Robert Veatch does.²⁶ This essay argues on theoretical grounds that medical ethics should not be the province of medical practitioners only and that medical decisions cannot be morally justified if they are construed as matters of personal opinion. The fact that these decisions of medical care are made by physicians does not by itself suffice to raise them above the level of personal opinion.

In discussing the relationship between medical ethics and ethics generally, Veatch describes a common debate that occurs between those trained in medicine and those who are not. Veatch cites a case where a woman was diagnosed to be dying from cancer. The medical student who presents the case considers it appropriate to tell the woman gently and diplomatically that although the medical staff will do all that it can to treat her condition, it cannot give her assurances that she will recover. The physician who is the student's supervisor and the other physicians participating in the discussion to which Veatch alludes claimed that as physicians they have a unique ethical duty to do no harm to the pa-

tient. The physicians were in agreement that telling the patient she has cancer will harm her and therefore it is wrong to tell her this. Non-physicians discussing this case disagreed with the physicians regarding the factual question of whether the bad news about cancer would adversely affect the patient and also as to whether the decision ought finally to be based on the principle of not harming or on the principle of truth-telling. What raises the metaethical question here is the claim of the physicians that their understanding of moral norms or principles is unique to the medical profession and should be given priority in medical cases over the judgments of non-professionals.

Veatch argues that these physicians were actually claiming that there are specific moral rules applicable in medicine which are valid for physicians qua physicians, and that the general rules and expectations of the larger society may, in specific cases, be justifiably abrogated by them. As Veatch notes, this is an implicit acceptance of a particular metaethical position, namely that of social relativism which argues that to say of an action that it is right or wrong is to say that it is in accord with the mores of one's group. Veatch is quite right in asserting that this metaethical position is not one that ethicists would defend.²⁷ It is a meaningful question to ask whether anything considered right or wrong by one's group is in fact right or wrong. Indeed, it is a growing consensus in contemporary

ethical theory that the peculiarity of moral assertions is precisely that they are assertions that cannot be universalizable.²⁸ In other words, the decision not to tell the truth to a dying patient is one that one would expect any right-thinking person to make if one in fact claims that this is the right decision in cases of this sort.

Personal Relativism

The difficulties of relativistic theories of ethics cannot be thoroughly discussed here but have been elsewhere.²⁹ There is, however, another point at issue that deserves some elaboration. There are those among physicians and this view seems to be quite common, who assume that moral decisions are personal decisions and that physicians can do no more than other human beings when faced with moral dilemmas, which is to search diligently their own consciences. This presumption is also a metaethical position for which the medical literature gives no justification. With respect to this form of relativism, ethical theory is more divided, but at the same time strong objections to plausible alternatives are not hard to find.³⁰ It is enough for our purposes here simply to indicate that one of the working assumptions of some physicians is not one for which they have offered rational and cogent arguments. Where one stands with respect to such an issue makes a lot of difference for one's conception of the nature of medicine as a science and as an art. It goes without saying that those who implicitly or explicitly

adhere to doctrines of social or personal relativism in ethics can more easily justify the private and/or professional nature of medical ethics, feeling no intellectual or moral obligation to know what is discovered by professional ethicists or even what is thought to be right or wrong by the general public except insofar as opinions of the public may represent political and/or legal power to influence decisions by medical practitioners.

There is another important implication of metaethical theories like social and personal relativism. If one is a social relativist, there is no way to decide who among differing groups should have the say regarding questions of right or wrong. Personal relativism is also ultimately without a basis for adjudicating disputes among groups or persons. In practice, relativists tend to give the nod in moral decisions to the persons who have the most expertise regarding the factual data relevant to the decisions being made. This means that where the doctors of medicine are considered the experts par excellence in matters of health, they are granted the ultimate power of moral decision-making in medical cases. Veatch refers to this as the fallacy of generalization of expertise. It is a fallacy because, as Veatch and other ethicists generally hold, moral decisions are not based only upon factual matters narrowly defined. Furthermore, the same facts are seen differently from the perspective of various disciplines.

The value of truth for a dying patient may quite justifiably be

perceived quite differently by someone like a minister who may well consider it a great benefit for all concerned if dying persons face the question of their own dying. This kind of benefit may or may not be accepted on purely medical grounds depending upon one's conception of health and of medicine as well as one's conception of the relation between bodily and psychic functions. In any event, the judgment as to whether one ought to reflect upon one's dying is not self-evidently a strictly medical decision, even if the term health is stretched to cover every aspect of a person's well-being. Health so defined becomes the concern of everyone, including a great variety of professionals in addition to those trained in medicine.

Albeit in a very preliminary way, our discussion of metaethical assumptions illustrates some of the ways in which metaethical theories, whether held implicitly or explicitly, influence very practical or strategic questions of moral policy, such as who will be accorded the authority and power to decide moral issues in medical care and how the decisions made will be implemented. In short, metaethical theories have great practical import for moral strategy or policy. This is so because metaethical theory is a theory about the nature of the processes of moral decision-making, particularly of the kind of justification that one offers for one's moral judgments. Metaethics seeks to assess the extent to which such justifications are rational or irrational, subjective or objective, and

private or universalizable. Let us look at some of the practical moral problems of medical decision-making and raise some questions about these in the light of certain meta-ethical criteria.

Questions of Moral Policy for Medicine

Moral policy refers to that portion of the total ethical enterprise in which whatever is known or believed to be true in normative theory as well as metaethical theory is applied to specific moral issues and the methods used to cope with them. Decisions about what is right or wrong, good or bad, are not solely decided, nor ought they to be, on the basis of ethical theory per se. Ethical theory provides one of the essential components of any adequate moral decision, namely a method of moral reasoning.

Moral reasoning about specific moral issues, such as whether to do or to have an abortion, a sterilization, a kidney transplant, etc. has two components: reasoning about general principles as illustrated by our discussion of the difference between formalists and utilitarians; reasoning as to the best processes by which to arrive at a decision. Policy debates, however, hinge not only on the nature of one's moral reasoning but on the perception one has of relevant facts, the kinds of loyalties one has, such as loyalties to one's family, one's ethnic group, one's profession, one's religion, one's nation, etc., and also one's more theological or quasi-theological assumptions about the nature of reality, particularly the nature of per-

sons.³¹ An example of a quasi-theological assumption that greatly influences policy would be that persons are very prone to evil and hence laws and sanctions are very important for preventing evil as compared with an assumption that people are prone to do what is good and interference in their freedom tends to be more harmful than beneficial. Some of the disputes among physicians about the regulation of research often reflect a difference of opinion as to whether individuals doing research are more prone to be influenced by desires for money, advancement, and fame or by the desire to know the truth and benefit humanity. Obviously the direction of one's thinking about policy can be tipped in one direction or another by such considerations.

Wielding power in decision-making depends a great deal upon who has the facts that are relevant to what is being decided. Physicians have a great deal of power in medical cases by reason of their express certification to make diagnoses and engage in intervention where assistance in matters of health is being sought and by reason of the general respect accorded this certification by the public and by other professionals concerned with health and illness, such as ministers, lawyers, judges, politicians, etc. It is also important to note that there are a whole range of occupational roles other than that of the physician involved in medical care. These persons, such as nurses, physiotherapists, counselors, voluntary aides, etc., tend to have a definite-

ly subordinate role in medical decision-making wherever these persons lack an M.D.

There are two strategies, therefore, that serve to secure the power of the licensed physician to have the final say in matters of medical care: one is to perpetuate the notion that the proper knowledge of medicine is conferred by those institutions accredited to grant the M.D. degree; the other is to keep the precious knowledge possessed by the holder of the M.D. within the confines of that profession and to share it as little as possible with any other professional or with the patient.

Sharing of Power

Now we are not arguing that the power and role of expert knowledge per se be diminished or denigrated. The question before us is rather the extent to which the power that comes from possessing such knowledge should be shared and to what extent.

Consider the following case: a man is seriously ill, so ill that there is a high probability that he may die.³² The physician does not convey this to the patient nor does he inform the man's minister of this diagnosis. A nurse, however, connected with the case takes it upon herself to tell the man's minister before he sees the patient of precisely how serious the man's illness is judged to be. The minister, with some trepidation, but with firm resolve, decides to share this information with the patient.

When this incident was reported to a class of graduate students in religion, some of whom were train-

ing for the ministry and some of whom were obtaining higher degrees specializing in ethics, there was considerable criticism of the minister's action. Many felt that the minister should not have taken this upon himself without consulting with the doctor. Indeed some felt strongly that the minister must have the attending physician's consent to talk to the patient about dying. The minister in this instance disagreed sharply. He viewed the man who was in danger of dying as one who was not only paying the physician to carry out whatever duties were incumbent upon him as a physician, but as one who was also paying the minister to carry out his duties. The question as to whether a person who may be dying should reflect upon this possibility or actuality as the case may be is as much a question of the welfare of the patient as the question as to whether discussions of dying will have an adverse physical effect upon a patient. The difficult question as to whether in fact a particular patient will have adverse physical reactions to the topic of death—it appears that this is much less often the case than is supposed—is not the critical question if one's concern about the patient is for that patient's total welfare. A lawyer or a friend or a relative concerned about whether a proper will has been made out, a minister concerned about whether persons have achieved a proper attitude toward their own limited powers as human beings, a nurse concerned with the anxieties of patients who want to know, all raise important considera-

tions about what is beneficial for patients. If physicians are the only ones who know that a given person is dying, the power of what is best for the patient in the light of that fact resides totally with him or with her. Is this the way it ought to be?

One immediate reaction to this question is that it depends upon the particular case that one has in mind. But that response misses the point of the question, which is the question as to whether it is best for attending physicians to make the decision that they indeed will be the only ones who know the prognosis of patients. It is of course the case that many physicians, whether for moral reasons or for others, will share their knowledge of the prognosis of a patient, sometimes only with persons responsible for the care of that patient, sometimes with those persons as well as with relatives and friends of patients, and sometimes with all of these and patients as well. The question is what persons should be involved in the decision about who shares in this knowledge?

Information Controlled

The principle that some knowledge must be shared with patients is well established. We are not therefore talking about totally withholding information from patients or from other persons concerned with patients' care and well-being. Patients, or those who are spokesmen for patients, sign consent forms that include some details about medical interventions that are being contemplated. Surgical interference, for example, re-

quires consent and the necessity for consent is only waived in extreme emergency to save lives where it is not possible to obtain consent in the time required. Furthermore, as indicated in the articles of the Nuremberg tribunal, any procedure considered to be experimental is acknowledged as requiring informed and voluntary consent of the patient or subject. Although this requirement is sometimes violated in spirit or quite literally, nevertheless these violations are considered deviations from accepted norms of medical practice and are subject to censure and negative sanctions. Nevertheless, it is still the case that physicians largely control, on an individual and collective basis, what information is conveyed to patients. They also control, for the most part, what information is conveyed to all others concerned with the welfare of patients.

Now this situation may be seen to be less than optimum in at least two major ways. First of all, the knowledge possessed by physicians by reason of their training is important to know if the patient's welfare is to be served, but it is not the only knowledge that is relevant to the welfare of patients. Secondly, moral decision-making involves a process that includes knowledge of factual information as one of its important components, but not as its only component. The first point involves many interesting questions that we do not have space to discuss here: questions about conceptions of health and disease, and conceptions of what various kinds

of expertise contribute to the enhancement of health, the diminution of disease, and the increase in individual and community well-being. The role and scope of contemporary medicine in enhancing human well-being is not self-evident. Some of its benefits to those whose lives have been saved and lengthened are fairly indisputable, but contemporary medicine with its armament of powerful drugs, its quest for new knowledge through research using humans, does not always engage in practices that are non-controversially beneficial.

The second point is one that requires some comment. As we noted earlier, the components of moral decision-making and the nature of this process is what a metaethical theory is designed to elucidate. Despite certain variations among theorists in detail, there is a growing consensus in contemporary metaethical theory that moral judgments are rational to the degree that they are factually informed, relatively disinterested, relatively dispassionate, and made in the light of a vivid imagination as to how others are affected by the action or practice being decided.³³ The power and role of factual information we have already illustrated. These other components of moral decision-making merit some clarification. The best examples of disinterestedness and dispassionateness are found in the procedures used to govern judicial processes in the courtroom. Thus judges would not be seen as fit to try their own children or loved ones, nor if they owned stock in a com-

pany, to judge an alleged wrongdoing of that company. We have come, albeit belatedly, to recognize some of the subtleties of racial interest, if not prejudice, and we act accordingly to see that black jurors are involved in the trials of blacks. In a perfect world this would not in principle be necessary but that is not the kind of world that we live in, certainly not with respect to the way our judgments are influenced by our interests and our passions.³⁴

Experiments

The physician-patient relationship is greatly simplified if the relationship is purely between physicians who are committed to constraint from doing any harm to patients and to employing only those therapeutic interventions that can reasonably be expected to improve the conditions of patients. However, many physicians are part of the ceaseless quest of modern medicine for knowledge so that patients can also become subjects in experiments and as such may find themselves at the receiving end of risk-filled interventions that have a low, or even no, probability of benefiting them.

Physicians who also see themselves as scientists cannot be viewed as disinterested parties in the care and welfare of their patients. Because of the great power that physicians have by reason of their knowledge, the requirement of informed consent where the knowledge of the procedures are conveyed by the scientist-physician hardly guarantees that disinterested judgments as to what are justified

risks will be made. This is one of the reasons why procedures for achieving more disinterestedness in decisions involving experimentation have been set up by agencies such as the FDA and NIH.³⁵ Increasingly these agencies are also recognizing that the committees that are to review research before it will be funded by government money should include non-scientists and non-physicians who will help to represent interests that are not primarily those of a medical scientist or even a physician. Such persons may take a harder look at the scientific merit of proposed experiments, but equally if not more important is their role in articulating the point of view and interests of those who are potential subjects in any experiment.

Increasing the representation of interests that are non-medical and non-research oriented not only serves to protect individuals but also serves to determine whether or not certain kinds of medical interventions will create desirable or undesirable social policies. To take one extreme example, decisions to undertake experiments to perfect the technique of in-vitro fertilization, that is of creating and sustaining human life outside the womb, may well be motivated by the physicians' desire to provide children for couples who would otherwise be childless. However, these experiments and their results, while hypothetically beneficial on an individual basis, may not represent a sound social policy. The question of regulation is not one that physicians can be expected

to be disinterested or dispassionate about. By the same token physicians can rightly claim that uninformed lay persons may have their views of this distorted by their passions and interests. The whole purpose of democratic processes from a moral point of view is to achieve a higher measure of disinterestedness, dispassionateness, and vivid imagination. How various parties are affected by one policy or another. To accomplish this, democratic processes seek to maximize participation of diverse interests, or at least to achieve representation of those diverse interests and to establish procedures by which persons and groups are guaranteed due process.

Here we touch on one of the critical strategic moral issues in contemporary medicine. The relations between physicians and patients are not governed purely by the moral conscientiousness of physicians and the sophistication of patients. Groups like the poor and blacks suffer ill health in part because, for various reasons they either do not avail themselves of existing medical care for which they are eligible, or when they do so, they encounter difficulties intentionally or unintentionally perpetrated by persons and modes of care that are not well understood or appreciated, and which may or may not be best for them. Again, this situation is only partially rectified by injecting into the delivery of medical care persons from ethnic and/or minority groups that are not now well represented. There are also larger

policy questions having to do with health education, with alleviation of poverty, with the location and nature of health facilities, and also with the locus and nature of the administrative control of these facilities.

Clearly, our brief essay could only encompass a framework for discussion. There are so many questions that require substantive analysis. Our failure to take up some of these questions in greater detail is not due to a lack of desire but rather to a self-confessed choice that it was important to put some of these questions into a larger framework, a framework suggested by the nature and scope of the ethical enterprise itself. There is no question that the assumption throughout has been that the concerns of the medical profession and of medical ethics as an enterprise are very much the concern of everyone but particularly of ethicists who reflect on the most general nature of ethics and moral decision-making. In no way do we wish to minimize thereby the significance and the benefits of the expertise that comes to us from medicine. We have only suggested ways of thinking and of formulating policy that may increase these benefits for all concerned.

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32. This is an actual case but somewhat changed to hide the identity of persons involved.
33. The clearest formulation of this kind of theory is by Roderick Firth, "Ethical Absolutism and the Ideal Observer Theory," *Philosophy and Phenomenological Research* 12 (1952), pp. 311-345. See also W. K. Frankena, *op. cit.* pp. 94-96.
34. As we noted earlier, policy judgments hinge in part on the loyalties of those who make them. Loyalties are "interests" and "passions." If morality is to be rational, the loyalties must take on the universal perspective at is implied in disinterestedness and dispassionateness.
35. William J. Curran, *op. cit.* 