

BIOMEDICAL ETHICS

A Multidisciplinary
Approach to Moral
Issues in Medicine
and Biology

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Bioethics: Then and Now

From the viewpoint of a medical historian looking back at the last quarter of the 20th century, the rise of bioethics as a movement and a discipline is nothing short of remarkable. During this period, an intensive medical and public discourse emerged that identified and debated critical moral dilemmas in medical care and research. The signs of this bioethics "revolution" are all around us. Hardly a day goes by when some moral conundrum of medicine is not aired on the front page, or, even more significantly, on television or the Internet. In our clinical institutions, the impact of bioethics is readily apparent: IRBs (Institutional Review Boards) actively assess the ethics of virtually all proposed human subjects research; the Joint Commission on Accreditation of Healthcare Organizations has mandated that hospitals have a mechanism for resolving ethical dilemmas. Most American medical schools teach medical ethics, and national board exams test candidates for their understanding of key ethical principles. And now, interactive sites on the Internet provide immediate instruction and counsel for vexing ethical dilemmas.¹

This impressive set of activities marks an opportune moment to briefly assess the historical origins of bioethics, as well as its effectiveness in addressing contemporary moral problems in American medicine. As recently as 1970, the world of medicine was sacrosanct; its considerable cultural and political authority made it almost unthinkable that so much in medicine would become open to public debate, and that patients might reclaim authority over medical decisions and practice. In this respect, many observers of the rise of bioethics have declared it a dramatic victory in the name of moral progress.²

Bioethics offered a sharp critique of the insular world of medical research and a paternalistic tradition in medical practice. Among the most powerful triggers for the emergence of bioethics were a series of public revelations of gross abuses of human subjects who had been unknowingly coerced into participation in dangerous, nontherapeutic research. The Tuskegee Syphilis Study, the Willowbrook Hepatitis Study, and a long list of studies identified in anesthesiologist Henry Beecher's heroic 1966 analysis³ are but the most prominent examples of tragic failures within research medicine to respect basic human rights. These and similar revelations exposed a research culture in which the interests of subjects had been fundamentally disregarded in the name of science.⁴ Rising concern about research ethics also pointed to more fundamental questions about the character of medical authority within clinical medicine. Informed consent

soon became the most basic premise for both research *and* clinical care.⁵ The rise of bioethics can only be fully understood in the broader context of the rights-based movements for self-determination in the 1950s and 1960s; these include the civil rights movement, the rise of a new women's rights movement, and the early patient rights activities focused principally on psychiatric issues of civil commitment and the right to refuse treatment.⁶ Bioethics led to a new patient-centered ethic, often advocating patients as genuine participants in their care rather than only the objects of diagnosis and treatment.

Assessing the deeper impact of bioethics in medical and research practice is, however, no easy task. A much-needed fuller assessment would require considerable historical and sociological investigation of a range of variables that are under any circumstances quite difficult to measure. Do patients today really exercise more autonomy over medical decision making? Are research subjects better protected from the intensive and competitive demands of new scientific knowledge? Just as we might assess equity in access to medical care, we might ask if all patients have had equal access to the advantages of new ethical precepts. Is there a socioeconomic gradient? Do better-educated patients, for example, benefit more significantly from informed consent than less well-educated ones? No doubt much changed over recent decades, but there are still significant problems. And indeed, some critics have argued that bioethics, regardless of its progressive intent, has actually had the effect of enhancing medical power over patients and research subjects by legitimate medical institutions and practices. To cite but one example, the consent form—in both research and therapeutic contexts—is often viewed by subjects and patients as but a legal apparatus to protect researchers and physicians from liability.

In short, bioethics as it evolved in the last decades of the 20th century is historically *contingent*; it reflected—and responded to—a series of specific contemporary critiques of biomedical practice and was fundamentally shaped by the social and political conventions of the time in which it emerged. Therefore, the bioethics that emerged in this period may no longer be a particularly good “fit” for the range of moral and ethical dilemmas currently confronting American medicine. Informed consent, the hallmark of bioethics, takes physicians' authority as a given. The prevailing assumption was that if physicians adequately respected patients' autonomy, their considerable authority would pass (through knowledge) back to their patients. Patient autonomy, therefore, rested upon an *a priori* physician autonomy. Bioethics in this form rarely considered the broader social and institutional contexts in which this ethical transaction occurred.

But today we see the authority and autonomy of the provider under attack. Importantly, if patient autonomy was at the center of discussion over the past decades, today physician autonomy seems to be the critical

issue. A brief and perhaps typical clinical vignette illustrates aspects of this problem:

A patient with moderate back pain of relatively short duration comes to see her primary care physician. Following a careful history and physical examination, the physician recommends ibuprofen and rest. He explains that if there is no improvement in the next week the patient should let him know so that they can follow up. The patient asks if she needs an MRI. He explains that it currently isn't indicated, but that if she doesn't improve they can pursue other diagnostic options, perhaps including an MRI. The patient then asks if he is not ordering the MRI now because of financial incentives. The doctor is troubled by this exchange and what it represents about his relationship with his patient.

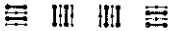
This vignette indicates that forces external to the doctor-patient interaction have altered the character of the relationship. Even though the doctor may believe that he would never compromise a patient's care regardless of financial incentives, his patient is concerned. The quality of trust has been altered, perhaps permanently. The patient worries that the doctor has lost his *authority* to care, and that his autonomous capacity to act in the patient's interest is eroded by new and often hidden rules and financial incentives. Such issues are, of course, not new to managed care. Physicians have always operated under the influence of considerable external (sometimes hidden) incentives. The point here is that bioethics—as it came to be constituted in the 1970s and 1980s—offered little in the way of analyzing such forces, be they economic, cultural or psychological.

As bioethics evolved over recent decades, the central question for health-care providers confronted with an ethical dilemma was typically “what *should* I do?” Today, many of the dilemmas of medical care focus on the question: “what *can* I do?” This question recognizes essential constraints on clinical and moral choices and reflects an important historical shift in assumptions about agency within our healthcare system.

Although the parameters of a new bioethics are far from clear, several broad questions are already clearly apparent.⁷ We will need more empirical research on practices associated with ethics both in patient-provider relationships and in our healthcare institutions and systems. Medical ethics is moving beyond the assertion of critical principles to assess concretely the obstacles that may inhibit our ability to realize them. This agenda requires a wide range of disciplines from clinical caregivers to the humanities and social sciences, as well as stronger assessment of the relationship of health policy to medical ethics. Only a complex dialogue that helps to reveal consensual social and moral values in a diverse culture—a dialogue among experts and the many constituencies doing medical work and seeking medical care—is likely to result in a new and effective medical ethics. In this respect it seems likely that as medicine changes, so too must our medical ethics.

NOTES

1. www.nih.gov/signs/bioethics
2. Rothman DJ. *Strangers at the Bedside*. New York: Basic Books, 1991.
3. Beecher HK. Ethics and clinical research. *N Engl J Med* 1966;274(24):1354-60.
4. Jonsen AR. *The Birth of Bioethics*. New York: Oxford University Press, 1998.
5. Faden RR, Beauchamp TL. *A History and Theory of Informed Consent*. New York: Oxford University Press, 1986.
6. See e.g., Kluger R. *Simple Justice: the History of Brown v. Board of Education and Black America's Struggle for Equality*. New York: Knopf, 1975; Echols A. *Daring to Be Bad: Radical Feminism in America. 1967-1975*. Minneapolis: University of Minnesota Press, 1989; and Filene PG. *In the Arms of Others: a Cultural History of the Right-to-Die in America*. Chicago: I.R. Dee, 1998.
7. Kleinman A, Fox, RC, Brandt AM (eds). *Bioethics and beyond. Daedalus* 1999;128(4).



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Bioethics: Then and Now

Bioethics appeared in the world of medicine in the early 1970s, and as Allan Brandt rightly notes, has grown into a remarkably vigorous discipline. Professors of bioethics exist in most medical schools, courses are taught not only to medical students but to undergraduates, and a continual stream of books and articles is devoted to the topics of the field: death and dying, experimentation with humans, genetics and reproductive technology.¹ I must agree with Brandt that the form it has taken since its beginnings has stressed the relationship between physicians and patients, to the neglect of the structure of the institutions within which that relationship occurs. He proposes that “the bioethics that emerged in this period [from the 1970s until today] might not be a particularly good ‘fit’ for the range of moral and ethical dilemmas currently confronting American medicine.” I will, in this short commentary, explain why bioethics took the route that it did and suggest the route it must take in the coming decades if it is to become a better “fit” in the world of medicine and healthcare.

Brandt correctly identifies the starting point of bioethics’ journey: the “insular world of medical research and a paternalistic tradition in medical practice.” Persons encountered the medical world as patients or, much less frequently, as subjects of research. In both, physicians exercised great power. They held what one scholar called “professional dominance,” that is, they could decide what constituted disease, who might have access to treatment and whether that treatment was only for the patient’s benefit or for the