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Quote to note

"The art of medicine consists in amusing the patient while nature cures the disease."

—Voltaire

Inside

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The ethical challenge posed by surgical innovation

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Surgery, like medicine, is a practice in two important senses. In the broad sense of practice, surgery is composed of communities of individuals who share similar goals and interests, who pursue these interests by employing the same tools and communicate in a common language. Through shared activities and experiences, they come to hold similar beliefs and values. In a more pedestrian sense, however, surgery is a practice in that it is skill based and requires repetition. Even though perfection may elude humans, surgeons rightly aspire to perfection following the adage "Practice makes perfect," since the vehicle for improvement of one's technical skills is to perform the procedure in question repetitively. Both senses of practice are reflected in the notion of standard care.

Standard care involves normative commitments about what is best or appropriate under certain typical conditions. It is not surprising that innovation is regarded with some degree of suspicion, even hostility, in typical clinical settings. Viewing surgery from a vantage point outside the practice, bioethicists often react negatively to reports of novel surgical approaches and complain that they reflect a "cowboy" mentality, which unreflectively criticizes such forays into uncharted clinical terrain.

Coupled with the shocking reports that surgeons are generally unfamiliar with federal requirements for protecting the subjects of research and the mandate and function of local institutional review boards (IRBs),[1,2] the lack of clarity about the domain of innovation in surgery should be a cause for concern.

It might easily be forgotten, however, that not all conditions that are candidates for surgical management can be successfully treated by standard approaches and that many widely employed surgical approaches are less than ideal. Improvements are possible that might minimize morbidity and mortality and yield much better outcomes than are possible with current approaches. Thus, despite the conservative stance of surgeons and the wariness of bioethicists about surgical innovation, innovation is an inevitable and a justified feature of surgical practice. The many significant advances such as open heart surgery, coronary artery bypass graft surgery (CABG) and organ transplantation that occurred without strict adherence to formal research procedures should remind us that Procrustean constraints on innovation in surgery could impede the very goal that drives surgical innovation, namely, improving patient care and outcomes. Like many other advances in patient care, these procedures were introduced through informal and unregulated processes of innovation in which research and practice were combined rather than disjoined. These advances point to the need for a more elaborate

Ethical challenge—*continued on page 2*

Ethical challenge—*continued from page 1*

account of the significant contribution that surgical innovation makes, alongside research, toward improving patient care. Accurately defining the elements and processes of innovation is thus a critical prerequisite for developing nuanced ethics of surgical innovation.

That said, innovation in surgery presents an important set of challenges for bioethics. Since the "Belmont Report,"[3] there has been a tendency to expect that novel techniques or procedures will be framed in a research protocol that undergoes formal review by an IRB. Innovations in medicine or surgery that occur outside this framework are treated as ethically questionable and are sometimes taken as evidence that surgeons cultivate a deep disdain for ethics. This tendency is a byproduct of the dominance of the *research ethics paradigm* (REP) and the way it has shaped bioethical reflection on clinical innovation.[4]

Sound reasons exist to suggest that this paradigm vastly oversimplifies the complex processes of clinical innovation and inappropriately assimilates them into formal research. The development of CABG presents an interesting case. The procedure evolved against a background of limited therapeutic options, underwent technical alteration and improvement as it was employed, and was dependent upon analogous advances in imaging, anesthesia and postoperative care.[5, 6] The processes of selecting patients who might benefit most from the new intervention, standardizing the techniques and resolving technical problems in the application of the procedure could only occur concurrent with experience with the interventions. REP, however, insists that such matters be reviewed beforehand and the structure of review typical of REP cannot effectively monitor the complex processes involved. While scientific knowledge and judgment are certainly involved in surgical innovation, the formal methodology required in a scientific protocol is often not attainable or useful in the early phases of development. In some cases, a significant and complex developmental effort is required to bring a procedure to the point at which formal research is feasible.

Innovation, like any process of discovery, requires intuition, experience and a tolerance for ambiguity and uncertainty. It is at home in the flux of everyday patient care and not formal investigation. Scientific research proceeds under methodological constraints from a base of established knowledge toward the goal of hypothesis confirmation or disconfirmation; innovation, however, often occurs in the midst of patient care when clinical opportunity or necessity creates an ethical imperative to respond creatively to these situations. When we recognize that there are innumerable piecemeal modifications of techniques and approaches in the everyday surgical management of patients, the complexity of the task of categorizing and assessing novel interventions becomes apparent.

It is especially important to note that the "Belmont Report" does not require that all novel interventions or procedures be subject to formal research, but only those that are *radically new.* This qualification has important implications for how innovation in surgery might be treated. In addressing the "large gray zone" where surgeons often find themselves, some authors favor an institution-focused approach that involves collaboration between the IRB and the professional oversight of surgical activities that might replace the suspicion and mistrust that currently exists.[7, 8] A prerequisite for such an approach is that a range of critical distinctions is needed before this approach can be successful. We need a well-grounded set of criteria to differentiate at least three types of cases: routine or normal variation; innovation that is beyond routine, not formal research, yet requires review; and innovation that involves research and so requires formal IRB review.

Clarification of the ethical relevance of the various characteristics of the complex process of innovation remains a critical task for bioethical reflection. Until that is accomplished, however, it would be wise to discourage two extreme alternative approaches: first, the wholesale absorption into the REP of the various activities associated with innovation in surgery that share at most a vague resemblance with scientific research, and second, acceptance of the surgical tradition of treating significant changes in technique, even involving medical devices, as mere modifications of practice rather than as research.[9, 10] Neither option is ethically justified since neither allows us to confront the epistemological and ethical complexity of the innovation domain, which is an amalgam of research and practice.

Innovation in surgery presents bioethics with two overlapping domains of concern, the epistemological and ethical. Both need a nuanced analysis that should avoid committing some obvious mistakes. First, prioritizing the ethical concerns in a conventional fashion will thwart confronting the difficult question of whether we intend to protect the individuals as subjects *or* patients. Second, failing to account for the particular clinical circumstances of the patients, the surgeons' capacities, the institutional or practice setting, and the status of the field within which the surgical innovation is being developed will yield an analysis that is potentially as inflexible as the current system. Third, failing to differentiate fully the processes involved in developing an innovative surgical procedure and those involved in implementing novel procedures once developed from both research and practice will impede the ethical assessment of surgical innovation. And fourth, failing to integrate the considerations of epistemology and ethics of surgical innovation will impede meeting the challenges that innovation in surgery poses for bioethics. □

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Ask the ethicist:

Is it physician-assisted suicide?

Question: A 52-year-old physician developed bulbar amyotrophic lateral sclerosis (ALS). A year later, his speech became unintelligible and all nutrition and hydration were delivered by gastrostomy tube. He had constant, intractable drooling unrelieved by medications. He and his wife developed a close relationship with the nurse practitioner in their physician's office and repeatedly discussed their attitudes toward end-of-life decisions. A year later, he became completely dependent on his wife and caretakers for activities of daily living. He made several distressing visits to the emergency room to treat acute dyspnea produced by mucous plugging. During the final clinic visit, in the presence of and at the request of the patient, his wife inquired what dosage of lorazepam would be required to induce a ventilatory arrest. One week later, the nurse practitioner was notified that the patient died peacefully at home.

How should a clinician respond when informed of a terminally ill patient's intended suicide? Is there an obligation to inform a public agency or a psychiatric colleague? By answering the dosing question, did the practitioner engage in physician-assisted suicide?

Response: The answer to the question of whether or not the situation described constitutes physician-assisted suicide is straightforward: It did not. But assuming the case description did not omit key components of this patient's care, the troubling question is: Did it constitute suboptimal medical care?

Physician-assisted suicide occurs when a physician (or nurse practitioner or physician's assistant) prescribes a medication with the intention of preempting death from disease. In the case described, lorazepam was previously prescribed, presumably for anxiety or sleep. Even in intentional overdose situations, in healthy individuals, lorazepam is rarely lethal as a single agent. It can, however, contribute to death when it is taken concomitantly with alcohol or other medications.

It is possible that this patient had been prescribed other medications and that the information given by the clinician at the final visit included doses of other medications that would result in a lethal concoction. But providing information does not constitute assisting in suicide. The information about lethal doses is readily available in books, such as *Final Exit* and on the Internet.[1]

Of course, the person described was not a "healthy individual," but someone with advanced ALS. Therefore, it might be asserted that lorazepam could have hastened his death. Possibly, but the assertion would still be off point. This man didn't die from an overdose; he died of ALS.

The clinical perspective illuminates the ethical analysis. ALS is a terminal illness. That means that patients who have it eventually die—of something. Historically, people with ALS died of respiratory failure, often in combination with progressive malnutrition. Increasingly, patients with ALS decide to accept a range of life-sustaining treatments, such as enteral nutrition, as this patient did, and ventilatory support, ranging from nocturnal BiPAP to tracheostomy and long-term mechanical ventilation. But even with all these measures, patients with ALS still eventually die. Therefore, every decision about which treatments to accept for specific complications of ALS—be it antibiotics for a chest infection, a gastrostomy tube or mechanical ventilation—carries with it a corresponding tacit decision that the person must therefore die of *something else*.[2]

Clinicians are duty bound to prolong life and alleviate suffering. In the context of progressive, incurable illness, a plan of care that only addresses which complications to treat and which not to treat is still only half a plan. Clinicians must be able to assist ALS patients and their families in developing an "end-game," a comprehensive plan of care that incorporates the expectation of a peaceful end to the person's life.[3] Absent this full continuum of care planning, it is likely, if not inevitable, that an ALS patient will bounce from emergency to emergency—as did the patient described—and is at high risk of eventually dying in extremis.

I suggest that the question the patient's wife asked the clinician that final visit may have been less about drug doses—the patient was a physician after all. The real meaning of her question pertained to how her beloved husband could die peacefully.

In common with most patients and families who inquire about assisted suicide, this couple almost certainly already possessed the means of hastening death. Even without the probable presence of previously prescribed (or self-prescribed) medications, they could have simply stopped the enteral nutrition and died comfortably within two or three weeks; much sooner if hydration was also curtailed. But if that was unacceptably long or unseemly to them, in addition to prescribed medications, it is quite likely that this couple owned a car and a garage. The same books and Websites that provide information on lethal drug doses remind interested readers that carbon monoxide poisoning reliably results in a painless death.[1]

What this patient and family did not have was a clinician or clinical team that could confidently provide care for them in this very difficult situation through the very end of life. In a health care community of sufficient size and medical sophistication to have an ALS clinic, there is certainly one or more hospice and palliative care programs willing to serve this couple. The absence of a comprehensive plan that encompassed support for the patient and his wife and family through the end of life is a glaring omission.

We are told that the patient suffered with intractable hypersalivation. From a palliative care perspective, physical symptoms are only "intractable" until they are controlled. Hypersalivation is common in bulbar ALS. When medications prove ineffective, other measures may be used, such as surgical salivary gland removal or radiation treatments to induce relative xerostomia.

Requests for assisted suicide represent a medical emergency; after all, a life is at stake. It was not necessary to inform a psychiatrist or public authorities of the request from this patient's wife, but it was necessary to respond in some manner that addressed the patient and family's legitimate fears and current suffering and to develop a comprehensive plan that included a psychological assessment. In this instance, the call should have gone to a clinician

Ask the ethicist—*continued on page 8*

The legal column:

Gestational carriers

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Some infertile couples and individuals are contracting with gestational carriers to assist them in starting or expanding their families. A gestational carrier contracts to carry a biologically unrelated child for someone else. Gestational carriers can be found using law firms, agencies or through private advertising.

Either the intended mother's eggs or donated eggs are fertilized in vitro and the resulting embryos inserted into the gestational carrier's uterus. Most gestational carriers enjoy being pregnant and are emotionally satisfied by the experience. Gestational carriers are usually compensated for their services and for the expenses of the pregnancy. A gestational carrier is typically paid about $20,000. Some states prohibit the compensation of a gestational carrier.[1] Contracts in these states may be both illegal and unenforceable. Some states may prohibit compensating a gestational carrier but allow noncompensated arrangements. For example, while New York State prohibits compensation and the surrendering of the child prior to birth, nothing prevents a woman from being an unpaid gestational carrier without a legal obligation to surrender the child prior to birth. There are no states where gestational arrangements are absolutely forbidden.

Gestational carriers are used by heterosexual couples, gay couples and single individuals of both sexes. Some states such as Texas and Florida have statutes that protect only the legal rights of married heterosexual couples.[2] Although there is no central data bank to provide an exact count, approximately 6,000 babies were born in the United States last year using a gestational carrier.

Laws governing the issuance of birth certificates vary by state. Some states allow intended parent(s) to be declared the child's legal parents on the original birth certificate. Certain states have restrictions, and an adoption may be necessary to obtain full legal custody. The use of donated eggs, the marital status of the intended parent(s) or the sexual orientation of the intended parent(s) all may affect their ability to obtain a prebirth parentage order in the state. When donor egg is used, some counties in Pennsylvania will deny the nongenetic mother a prebirth declaration of parentage, forcing an adoption. Some states are recognizing the antiquity of these laws. In a recent decision, the Pennsylvania Appellate Court[3] recognized that a gestational carrier with no genetic relationship to the children she carried should not be declared the children's legal mother. Because of the complexity and variability of state laws, anyone using a gestational carrier should secure proper legal advice.

There are advantages and disadvantages to working with an experienced gestational carrier. An experienced gestational carrier has knowledge of the process, but she may expect higher compensation and additional fees for related pregnancy events. Additional compensation may be required for an amniocentesis, a cesarean section and other medical procedures performed as the pregnancy develops. A first-time carrier will usually request lower compensation. Even when a gestational carrier has medical insurance, the coverage may exclude benefits for claims made for a pregnancy when the insured is acting as a gestational carrier. Fortunately, there are insurance agencies that will provide coverage for gestational carriers; however, this coverage is very costly. For many couples or individuals hoping to start a family, the costs of infertility treatment can be devastating, and, by the time the intended parent(s) begin exploring the option of working with a gestational carrier, financial considerations may be of primary concern, thereby making a first-time carrier a more attractive option.

The gestational carrier's husband also plays a role in the intended parent/gestational carrier relationship. A gestational carrier's spouse will be obligated to undergo clinical and psychological testing pursuant to Food and Drug Administration regulations. He will also be needed to obtain the birth certificate, as his rights, as well as the gestational carrier's rights, will need to be terminated. The support of a gestational carrier's spouse, or partner, is imperative.

It is essential to have the gestational carrier's husband consent to the arrangement and sign the contract. States like Illinois, Texas and Florida will require his consent for the arrangement to be recognized legally. In many other states, like New York, New Jersey or Pennsylvania, the husband of a pregnant woman is presumed to be the father of any child she conceives and delivers during the marriage. If a birth order is not filed by the parties in order to place the intended/genetic father on the birth certificate, the gestational carrier's husband and the genetic/intended father must either sign affidavits denying and admitting paternity, respectively, or a paternity order must be obtained. Leaving the gestational carrier's husband out of the contract is a risky move, given that his consent and cooperation may be required in solidifying the intended/genetic father's legal rights.

An intelligently drafted contract executed by all involved parties prior to any medical procedures will address all the above issues. The gestational carrier and her partner/husband should be represented by independent legal counsel. The gestational carrier agreement may or may not be enforceable if delivery occurs in certain states. However, certain aspects of the contract are never enforceable regardless of states laws. For example, a contract may specify that a gestational carrier will have an abortion under certain conditions. Nonetheless, the intended parents cannot force the carrier to have or not have an abortion. If the carrier violates the contract, she can be sued for monetary damages but she can't be compelled to have an abortion. Under U.S. case law a woman has the absolute right to choose.[4] This right extends to complete autonomy over one's body. This right cannot be contracted away. Intended parents also have little control over what the gestational carrier eats and drinks. A gestational carrier relationship is based upon trust and mutual respect and without this, the arrangement is vulnerable.

The court cases regarding gestational carriers are few and primarily involve

***Legal**—continued on page 8*

Ethics and the humanities:
Before I die

By Jenny Downham
New York: David Ficklin Books, 2007, 336 pages

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This wonderful and poignant novel focuses on the last months in the life of Tessa Scott, a 16-year-old British girl with acute leukemia. A spunky teenager whose mood at times plunges into depression and anger, Tessa somehow manages to live her life in spite of the inevitability of her death. Diagnosed at age 12, Tessa makes the decision to give up chemotherapy when she is 16. She spends her remaining months receiving more and more frequent blood transfusions until she's told just 12 days after a transfusion that she already needs another one, that she's "moved nearer the line":

> *It's really going to happen. They said it would, but this is quicker than anyone thought. I really won't ever go back to school. Not ever. I'll never be famous or leave anything worthwhile behind. I'll never go to college or have a job. I won't see my brother grow up. I won't travel, never earn money, never drive, never fall in love or leave home or get my own house. …*

But then she rallies:

> *How long can I stave it off? I don't know. All I know is that I have two choices—stay wrapped in blankets and get on with dying, or get the list back together and get on with the living.*

This list is the backbone of the book and Tessa's lifeline in her last months: 10 things she wants to do before she dies. She wants to become famous, try drugs, have sex, shoplift, spend a day saying yes to every question and fall in love. Her best friend Zoey, a few years older, keeps her busy working at the list, while her father, somewhat ironically, worries about her safety. Ultimately, Tessa falls in love with Adam, the boy next door, whose father not long ago was hit by a car and killed: "It's a wound that connects us," as she puts it. Theirs is a relationship in fast-forward, since from the moment they meet they must deal with the imminence of her death.

"My heart's thumping," Tessa writes after their first kiss. "I feel absolutely alive."

And yet the thought of death lurks, no matter how happy she is. As she explains to Adam: "People think if you're sick you become fearless and brave, but you don't. Most of the time it's like being stalked by a psycho, like I might get shot any second. But sometimes I forget for hours."

The language is lyrical, nuanced with simple, lovely images. In the midst of burying a dead bird with her brother Cal, Tessa is suddenly overwhelmed by thoughts of death:

> *There's earth on my head. I'm cold. Worms burrow. Termites and woodlice come. I try and focus on good things, but it's so hard to scramble out. I open my eyes to the rough fingers of the apple tree. A spider's web quivering silver. My warm hands clutching the stones.*
>
> *But all that is warm will go cold. My ears will fall off and my eyes will melt. My mouth will be clamped shut. My lips will turn to glue.*

When Zoey admits that she's pregnant, Tessa must face the reality that she may not be around to see the baby:

> *I count as I pour water onto the tea bags. Zoey's over three months pregnant. A baby needs nine months to grow. It'll be born in May, same as me. I like May. You get two bank holiday weekends. You get cherry blossom. Bluebells. Lawnmowers. The drowsy smell of new-cut grass.*

And then she realizes just how far away May is, and the pang of how unlikely it is that she'll make it that long strikes her, and us:

> *It's one hundred and fifty-four days until May.*

Tessa's last days are sad and yet heartbreakingly beautiful. Her language—mostly thoughts, as she becomes too weak to speak—transports us into a different realm of reality. We are in her mind, experiencing with her fleeting images, registering bits of conversation. Downham uses more and more white space to illustrate by negation Tessa's weaving in and out of consciousness:

> *I hear only the fraction of things. Words fall down crevices, get lost for hours, then fly back up and land on my chest.*
>
> *"I'm grateful to you."*
>
> *"For what?"*
>
> *"For not backing off. Most lads would've run a mile by now."*
>
> *"I love her."*

And yet amidst the intense sadness at the end of the book there is hope. It is comforting to imagine that the process of dying can be experienced as a series of memories and dreams, with reality creeping in less and less, the voices of family and friends becoming more muted as the images become stronger, until finally, that's all there is. □

Dialogue:

Medical ethics during war

Professor Gross asks what countries should do if enemies mingled among civilians in a country just outside its borders and from this "protected" location shot rockets into these countries to try to kill their civilians ("Medical ethics during war," *Lahey Clinic Medical Ethics*, Winter 2008). Countries should not be expected, he argues, to accept these foreseeable losses. He suggested that although we have generally held that physicians shouldn't participate in the development of offensive weaponry, they should at least develop nonlethal weaponry, since it may save lives.

Gross's presupposition here is sound. We should not assume that doctors' (and other care providers') traditional medical values always should prevail. Rather, we should reassess this in every new context.

There are, however, good reasons for this previous bright line. Physicians should generally adhere to this previous standard and not participate in the development of offensive weaponry unless certain conditions seem likely, such as nonphysician researchers not being able to accomplish these same ends. This one consideration is the most critical of all, if and when, as Gross suggests, the very survival of one's country and its citizens—or other persons—is at stake.

There are, however, other considerations that may warrant greater moral weight when these conditions aren't present. These include some based on deontological values, such as doctors being able to remain truer to core ethical principles underlying the practice of medicine, acting to heal as opposed to doing harm; and those based on consequences, such as better maintaining patients' trust so that physicians can treat patients more effectively. Whether doctors would lose trust by participating in the development of offensive weaponry is an empirical question and open to debate.

Gross states that military medicine is primarily about not just saving lives, but about salvaging the maximum number of soldiers and returning them to duty. I suggest that in the United States, military medicine is about much more. It is "about" respecting soldiers as individuals and maintaining their health, first, because they warrant this utmost respect in their own right, and, second, so that military physicians can accurately inform their commanders about the unit's health status, and with this information, commanders can best decide what strategies and tactics are optimal.

Military physicians acting to maintain soldiers' trust may be incompatible in some instances with other military interests. An example is the military's respecting soldiers' confidentiality. In the United States, commanders lack absolute, unbridled access to soldiers' medical records. They must justify the information they need and show why it is essential for the military's mission.

As another example, U.S. soldiers *can* refuse treatment, including vaccines and care for common illnesses and life-preserving treatments, unless they are in combat situations and it would jeopardize the mission or put other soldiers at increased risk. In all other contexts, they have merely to resign from the military to be able to do this.

In general, soldiers can "refuse and resign" if their medical need is one that applies to them, individually. An example is a soldier needing chemotherapy to "cure" his or her cancer. If the soldier resigns and refuses treatment that could be highly beneficial or life saving, it may be, however, that he or she will give up other benefits, in addition to remaining in the military, such as subsequent "death benefits" to his or her family. These actual or potential losses are, to an extent, inherently coercive, and thus they reduce the degree to which soldiers can make these decisions as "freely."

Soldiers cannot "refuse and resign," however, when this refusal would affect larger numbers of soldiers as a group. An example is taking vaccines that have been determined necessary by those having the responsibility of making these decisions; if they do not take them, they and the success of the military mission may be at risk. These requirements are part of combat "readiness." Soldiers accept these limitations on their autonomy, implicitly at least, when joining the military.

This exception during combat is necessary ethically, not only due to the need for military "success" and other soldiers' interests. All soldiers and military physicians make an implicit promise to one another when joining the military that their individual interests may be given secondary priority if and when necessary for the military's and society's greater good. That is why, in principle, at least, soldiers are willing to give their lives in the first place. If soldiers could refuse to take vaccines, wear helmets and take other preventive measures, and, as a result, the military mission failed (and the war was lost), this outcome would undermine soldiers' reasons for being willing to sacrifice their lives in the first place—namely, to succeed in a (just) war.

U.S. military doctors, in fact, generally "push the envelope" as far as they can to treat soldiers with maximum respect. This phenomenon happened, for example, at the end of the first Gulf War. Servicepersons initially were required to be vaccinated against botulism, though a vaccine hadn't been tested for this use. Testing the vaccine for this purpose would have been "unethical." It was feared that Saddam Hussein could use botulism as a weapon and kill countless soldiers. This vaccine, based on its use in other contexts, also was deemed "safe" relative to this risk.

The highest military authorities in the field, however, believing that Saddam Hussein would not use this biological agent near the end of the war, decided soldiers could, then, take this vaccine voluntarily or refuse it. They did this fundamentally to respect soldiers' autonomy. Their doing so reflected no small commitment to their soldiers, in that this decision opposed the decision made in Washington after long debate that the use of this vaccine should be mandatory, a decision supported by the court.[1]

I favor an alternative to the framework Gross offers, namely, one that involves greater "balancing." According to my preferred model, as the urgency and importance of military needs become less, the importance of other, competing values, such as respecting soldiers' dignity, become greater.[2] This model places more moral weight on respecting individual soldiers' dignity and interests.

This balancing model also applies to the question of military doctors participating in interrogations. Here, Gross

distinguishes between less harmful interrogation practices and those such as severe beating, burning and electric shock, and he argues that physicians' highest duty should be to their country as opposed to the tenets of their medical profession.

A relevant question is empirical: Are "harsher" interrogations "effective" over the short or long term? Claims obviously differ, but a prevalent conclusion, based on limited data and the opinion of some experienced interrogators, is that overall the "best" information is obtained not by harsh methods but by interrogators forming more positive relationships.[3] Regardless of whether harsher methods may be more effective in some cases in the short term, they would likely create more committed enemies in the long term.

Ethically, however, it may be that even if there are slightly greater gains from harsher methods in some cases in the short term, these methods shouldn't be used, though this could result in a greater loss over the short term at least of soldiers' and civilians' lives. Such sacrifices, though profound, may be necessary and morally preferable for the military and society to maintain certain high moral standards. The military, accordingly, precludes use of torture, explicitly, in its regulations.[4]

Participation indirectly or directly in torture, I believe, is morally impermissible not only for military physicians, but for all interrogators. Even if in some cases it could be more "effective," like the use of biological weapons such as botulism, it is inhumane. The price of not using torture may be the loss of some human lives, but this is the price society must be willing to pay to not regress to precivilized practices, as embodied in the statement, "all is fair in war."

Military doctors' moral obligations under this alternative, balanced approach are, in general, more open to conflict, nuanced and complex. Decisions whether to put the military or other competing interests first must in almost every instance be contextualized and, then, separately determined.

This process may result in some outcomes being inconsistent. Decisions may be made, for example, to make the use of a vaccine mandatory at one time, but voluntary later. As these decisions regarding botulism vaccine also illustrate, both the best medical expertise available and the best military intelligence may still leave the bases for these decisions uncertain.

Professor Gross argues that military doctors should analyze each issue independently, as for example, whether a given war is or isn't justifiable. I agree, but take this point one step further and suggest that military physicians, as all other soldiers, should listen to their own consciences in regard to not only whether the war but its means are ethically justifiable. However, there are some acts military doctors and other soldiers should not do even if they personally deemed them justified, such as participating indirectly or directly in torture.

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[1]*Doe v. Sullivan*, 938 F.2d 1370, No. 91-5019, USApp DC 111, July 16, 1991.

[2]Beam TE, Howe EG. A proposed ethic for military medicine. In Beam T, ed. *Textbook of Ethical Aspects of Military Medicine, Volume 2.* Washington, DC: Borden Press, 2004: 851–865.

[3]Intelligence Science Board, *Educing Information/ Interrogation: Science and Art/ Foundations for the Future/Intelligence Science Board Phase 1 Report.* Washington, DC: National Defense Intelligence College, December 2006.

[4]Department of Defense Instruction, Number 2310.08E June 6, 2006: Medical Program Support for Detainee Operations.

Response: In his provocative book, *Not a Suicide Pact: The Constitution in a Time of National Emergency*, U.S. Federal Judge Richard Posner reminds his readers: "the idea that torture is a cruel and ugly practice …confuses torture as a routine practice of dictators…with torture as an exceptional method of counterterrorist interrogations." "It is especially odd," he continues, "to issue an unqualified condemnation of a practice that almost everyone accepts the necessity of resorting to in extreme situations."[1]

If you disagree with Posner, then there is no need to read on. You will believe, as does Professor Howe, that participation in torture is wrong for physicians and interrogators alike. But if you agree with Posner and you are a physician, then you face a very hard dilemma: How can you expect other people to do the dirty work? And dirty work it is, make no mistake about that.

The only way to condemn physicians' involvement is to believe that the advantages of torture (and you have to believe that there are advantages if you accept Posner's claim) are outweighed by the damage done to medicine if physicians lend a hand to interrogators. The only way to support physicians' involvement is to believe that their expertise is absolutely essential. These are difficult claims to ascertain, but there are some relevant points to consider.

Physicians aiding interrogators may cast a pall over the medical profession just as interrogators cast a pall over the military profession. But will physicians aiding interrogators in Langley, Va., undermine another physician's ability to inspire trust and heal his patient in Chicago? It does not seem likely. On the other hand, effective interrogation requires medical participation. Human rights organizations make this claim explicitly when they charge medical workers with the duty to disrupt interrogations by withholding their services. Obviously, they disagree with Posner. But if you agree with Posner, and understand that it is impossible to conduct interrogations without medical assistance, then there are no grounds to let physicians wash their hands of torture. □

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[1]Posner RA. *Not a Suicide Pact: The Constitution in a Time of National Emergency.* New York: Oxford University Press, 2006:83.

Ask the ethicist*—*continued from page 3

skilled in palliative care, or better still, an urgent referral to a hospice or palliative care team.

Outcome: Attempts to control the patient's drooling and secretion clearance problems with anticholinergic drugs, botulinum toxin and radiation therapy were unsuccessful. His physician was knowledgeable about palliative care treatment in ALS patients, and was unaware of the patient's use of lorazepam for unintended purposes. □

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[1]Humphry D. *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying.* Eugene, OR: Hemlock Society; 1991.

[2]Ascher S, Jordan J. *So Much, So Fast.* West City Films, Inc., 2007.

[3]Mitsumoto H, Rabkin JG. Palliative care for patients with amyotrophic lateral sclerosis: "Prepare for the worst and hope for the best." *JAMA* 2007;298(2):207–216.

Legal*—*continued from page 4

those who have sued for custody. To date, no gestational carrier has ultimately won the legal right to visit or keep the child. □

[1]In the New England area, New Hampshire and New York prohibit gestational carrier arrangements for a fee. See N.H. Rev. Stat. Ann. Sec.168–15 (1990) and New York Domestic Relations Law, Article 8. Surrogate parenting contracts (Secs. 121–124).

[2]*Florida Statute 63.212(1)(i) and See* Tex. Fam. Code Ann. § 160.701–.707 (Vernon 2002), §§ 160.751–.763 (Vernon Supp. 2005).

[3]*J.F. v. D.B.*, NO. 221 WDA 2005, NO. 1256 WDA 2005, NO. 1266 WDA 2005, SUPERIOR COURT OF PENNSYLVANIA, April 21, 2006.

[4]*Roe v. Wade*, 410 U.S. 113 (1973).

Medical Ethics

Lahey Clinic Medical Ethics **encourages reader participation. We welcome comments for our "Dialogue" column and invite submission of ethical dilemmas for "Ask the ethicist." Send correspondence and requests for complimentary subscriptions to David Steinberg, MD.**

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