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Medical Ethics

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Quote to note

"We never knew how happy we were."

— Citizen of Beslan, Russia where hundreds were killed by terrorists
The New York Times
September 5, 2004

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Ethics for astronauts

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The exploration of space is an uncertain enterprise. Fictional accounts of space exploration are at great odds with the dangerous reality of space flight; the recent tragic deaths of shuttle astronauts are an important corrective to the common view of space flight as a routine undertaking. From a medical standpoint, our fantasies often encourage us to believe that we know more about space flight than we actually do. Despite more than three decades of experience in space, there is a paucity of information about the normal consequences of prolonged low gravity or radiation exposure. Since the majority of U.S. space flights have been of short duration, our accrued knowledge has had little impact. In planning for longer duration flights, our lack of knowledge could be ruinous.

My interest in this topic arises from my work as a member of the Institute of Medicine's Committee on Creating a Vision for Space Medicine During Travel Beyond Earth Orbit.[1] I had the pleasure of reviewing the existing plans for medical care and research for a long duration space mission, such as a trip to Mars, and the greater pleasure of meeting with current and former astronauts and flight surgeons. What was clear is the remarkable dedication and skill of the astronaut corps and the ground staff in charge of their medical care; my remarks should not be construed as criticism of their expertise. However, I believe that NASA's attempt to apply existing clinical and research tenets to what is essentially a unique experience has failed to meet the needs of the space exploration program.

In planning for long duration flights, ethical issues arise in three related areas: the privacy of astronaut medical data, the participation of astronauts in clinical research, and the in-flight clinical care for astronauts.

Given the small number of astronauts and the small number of flights, there is a reasonable concern that the medical data from any individual astronaut may be identifiable. The legal mandates to protect an astronaut's medical privacy were repeatedly cited by NASA as a barrier to collecting data on the human response to spaceflight. The concern is not only a matter of principle, as astronauts evidently fear that identifiable information gathered about their experience before, during or after a mission might have a very undesirable consequence: it might be used to bar them from future missions.

To understand this concern for privacy it is important to understand the relationship between astronauts and flight surgeons. The astronaut corps, like pilots before them, may come to view the flight surgeon as less an advocate than an adversary who has the power to prevent them from flying. The flight surgeon's ability to certify individuals as flight ready may motivate an astronaut to conceal or minimize symptoms. The wariness inherent in this flight surgeon-astronaut relationship is intensified by both the lifelong preparation of the astronauts corps and the intense competition for a small number of missions. The result is that clinical events in spaceflight may not be disclosed to the flight surgeon, and if information is disclosed, the flight surgeon may be prevented by privacy concerns from passing such data on to those responsible for making spaceflight safe.

Let us take as an example the relatively common occurrence of an ileus-like

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syndrome, a paralysis of the intestine, during the first few days in microgravity. This can be discomforting and may cause astronauts to restrict their food intake or to use inappropriate medications such as laxatives. Astronauts might not report these symptoms to their flight surgeons or they might not permit the flight surgeon to report such symptoms, for fear that they indicate an idiosyncratic response to microgravity which might limit their ability to return to space. In this way a "normal" physiological response to microgravity might go unreported and thus inappropriately treated.

How might this systematic pressure to underreport symptoms related to space travel be addressed? In part, the answer lies in reconfiguring the medical privacy laws as they apply to astronauts, perhaps in the form of an administrative structure that better balances the need for confidentiality with the need to create a safe environment for space flight. It may be necessary, given the small number of flights and crew, for the astronauts to cede some medical privacy rights in return for the chance to participate in missions; any changes in the privacy rules should take place after careful consultation with the astronaut corps and the flight surgeons. An additional part of the answer lies in adjustments to the flight surgeon-astronaut relationship, which may not be easy. Shifting the flight readiness aspect of medical care away from the flight surgeon simply passes the buck.

A second and related ethical issue is the participation of astronauts in clinical research. In the current practice, all clinical protocols in which astronauts might participate are reviewed by an institutional review board (IRB) at Johnson Space Center and the Common Rule principles of voluntary informed consent are followed. In my view, application of the Common Rule, the federal regulations that set out the ethical precepts for federally funded research in the United States, fails to recognize astronauts, and space exploration, as unique.

It is reasonable to propose that astronauts have an obligation to participate in clinical data gathering that facilitates the design and maintenance of a safe space flight environment. To apply the standard informed consent procedures to this sort of data gathering implies that astronauts could opt out of activities designed to make space flight safe by declining consent. NASA recognizes this as a problem, and includes a provision in the IRB handbook allowing for astronauts to be taken off missions if they decline participation in protocols deemed important to the mission. The fact that astronauts always consent to participate in all the offered protocols strongly suggests a problem: An IRB should question the effectiveness of a voluntary consent process in which no one ever declines consent. In applying the earthly standards, one of two problems has occurred: either there has been inappropriate pressure, in the form of mission selection, brought to bear on potential research participants, or there has been a category error in calling this sort of data gathering activity research in the usual regulatory sense of the word.

An earthbound example may help suggest a solution. Imagine that the first nuclear power plants are being built and operated. Workers in the plant may have to provide clinical data and clinical samples such as urine and blood in order to monitor their radiation exposure, in order to see if the expected safety precautions are effective, and in order to detect unexpected consequences of their exposure. As more plants are built, and more knowledge is gained about their safety, less monitoring will be needed.

Astronauts are like those workers in the very early plants. Little is known about the risks of the work, and understanding their physiologic responses to the work environment is necessary to protect them from both expected and unexpected risks. Is every activity that leads to such understanding, research in the usual regulatory meaning of the word, such that it should trigger the use of informed consent? I think it is not, in that astronauts ought not decline to participate and still go on the flights, just as the plant workers ought not refuse to participate and still work in the early plants. Instead, I think that an occupational model of health best describes this activity, and that occupation models of data gathering should be used instead of invoking the Common Rule. If the Common Rule procedures continue to be used, and mission selection pressure is applied, then the voluntary nature of the informed consent is in serious doubt.

On the other hand, there will be research protocols designed for astronauts that closely approximate clinical research done in an earthbound setting. Such protocols will involve research on medications or devices that would not be used to make subsequent spaceflights safer or even possible. The purpose of this research would be to examine physiologic variables or to test pharmacologic therapies that would have terrestrial commercial or industrial uses. In this type of research, it is completely appropriate to use the standard informed consent procedures and IRB review, but inappropriate to apply mission selection pressure in order to encourage participation.

The last set of ethical issues raised by long-term space flight is clinical. On long duration flights such as that to Mars, communication with the ground will be limited and delayed, and there is likely to be no possibility of returning mid-flight due to illness. The result is an uncoupling of the sent from the sender; the crew will be on its own in resolving some difficult ethical issues. How should they decide when to use, and when to withhold, advanced medical treatment?

While there is understandable pressure to include the capacity for technologically advanced medical support on any long-term flight, normative guidelines for the use of such equipment should be developed prior to leaving the ground. For example, should mechanical ventilators be included on long duration flights? What would be the criteria for initiating or discontinuing ventilation? How might the crew balance mission needs against medical needs? Traditional wartime triage rules, which distribute medical care based on the ability to return the patient to active duty, might form the basis of a policy, but to adopt such rules requires a prior agreement of the sender and the sent, of the space flight agencies and the astronauts. Might it be better to limit which types of equipment are sent, so that the options are clearer? Given these issues and the likelihood of an international crew with a variety of ethical perspectives on triage, careful attention should be paid to these issues in setting up clinical protocols.

In summary, space exploration and space explorers have unique characteristics that do not easily fit into the existing ethical templates for medical privacy, medical research, and clinical decision making. This is not to say that a new ethics must be devised, but that in this new situation, care must be taken to devise a set of ethical standards that are appropriate to a new environment. □

[1]Ball JR, Evans CH Jr. (eds). Committee on Creating a Vision for Space Medicine During Travel Beyond Earth Orbit. *Safe Passage: Astronaut Care for Exploration Missions*. Washington, DC: National Academy Press, 2001.

An extended discussion of the ethical issues in long duration space flight can be found in the Institute of Medicine Committee's report noted above. However, the author's opinions here are his own and may not reflect the views of the IOM Committee.

Ask the ethicist:

Can an HIV-positive woman be forced to take medicine to protect her fetus?

Question: An ethics consultation was requested when Ms. D., a 28-year-old HIV-positive pregnant woman, refused to take highly-active antiretroviral therapy (HAART). She was five months pregnant and was known to have had HIV for four years that had not progressed to AIDS despite taking no antiretroviral medication. When she became pregnant, her physician strongly urged her to begin HAART and not to nurse the baby because both actions have been shown to significantly lower the incidence of maternal-to-fetal transmission of HIV. She read extensively about this issue and consulted Web sites and friends. She concluded that HAART had a greater chance of hurting her baby than helping it so she refused to start it. She also planned to nurse the baby. She reasoned that she has been feeling well despite her physician's insistence that she take HAART for the last several years. The presentation of objective data of treatment outcomes was unsuccessful in persuading her because she believed that the medical-pharmaceutical establishment was behind the official treatment recommendations and she simply did not believe them. What would you suggest?

Response: This 28-year-old HIV-infected pregnant woman refuses to take HAART and insists on breastfeeding upon delivery, actions that are known to increase maternal-fetal transmission of HIV. When faced with patients who oppose medical advice, clinicians routinely request psychiatry and ethics consultations. The psychiatrist's role is to help the clinicians access decision making capacity; the ethics consultant's role is to help identify and analyze the underlying values at stake and facilitate a decision that respects the values of the parties involved. We assume for the rest of this discussion that despite optimal communication and mediation, the conflict is irreconcilable.[1]

This case raises two ethical questions: 1) should a competent pregnant woman be allowed to refuse lifesaving medical treatment for her fetus? and 2) how does the delivery of the fetus change the moral question?

Can a competent, pregnant woman refuse medical therapy aimed at improving the health outcomes of her fetus? Decision making in health care is guided by the ethical principle of autonomy, the individual's right to self-governance, to make choices about if and when to accept medical treatment and to govern the course of that treatment. Beauchamp and Childress note that respect for a patient's autonomy, however, can be overridden by competing moral considerations: if an individual's choices endanger the public health or potentially harm those who are innocent, others can justifiably restrict the exercise of that individual's autonomy.[2] Some argue that the case turns on whether the fetus has moral rights. Some conservatives argue that the fetus claims moral rights from the moment of conception; others argue that it is not until after birth that the fetus has moral rights. We believe, however, that the critical issue is whether one can force unwanted treatment on a competent, pregnant woman.

The law takes this view. In a famous legal case in 1987, *In re A.C.*, Angela Carder, a pregnant woman with end-stage cancer was forced by a court order to undergo an immediate caesarian delivery to save her fetus's life. Both she and the premature baby died shortly after surgery. Advocates for the surgery argued that since Ms. Carder faced imminent death, all efforts should focus on at least saving one life, that of the fetus. A subsequent appeal was lodged by the American Civil Liberties Union Reproductive Freedom Project to the District of Columbia Court of Appeals which vacated the prior court decision, "concluding that in virtually all circumstances, the pregnant woman—not doctors or judges—should make medical decisions on behalf of herself and her fetus."[3] In the current scenario, Ms. D. remains in excellent health despite her diagnosis of HIV infection. HAART often causes a variety of unpleasant side effects, and compelling Ms. D. to take HAART for the remainder of her pregnancy might impose significantly on her liberty. We believe that any attempts to force her to take HAART are unethical.

Upon delivery, the newborn is a separate and viable human being with moral, constitutional and legal rights. The principle of beneficence urges physicians "to prevent harm from occurring to others," to prevent this newborn from acquiring HIV infection. Administration of zidovudine within 48 hours after birth lowers the risk of maternal-fetal transmission of HIV;[4] nevirapine reduces the risk of HIV transmission during the first 14 to 16 weeks of life by nearly 50 percent.[5] Therefore administering a zidovudine-nevirapine regimen to the newborn is the logical next step in his or her clinical care. Most important, giving the newborn HAART does not infringe on Ms. D.'s autonomy. It, however, infringes on Ms. D.'s parental rights.

In general, the medical and legal establishments recognize the rights of parents to make medical decisions on behalf of their children. However, when a parent's medical decision on behalf of her child is clearly not in the best interest of that child, parental authority may be suspended. In such cases, an independent, temporary guardian is sought to make medical decisions for the child. If a physician can show that a parent is endangering her child's life either by denying medical care or engaging in dubious health practices, the courts may rule in favor of the physician.

Our analysis of this case allows us to conclude that: 1) respect for this 28-year-old, competent, pregnant woman's autonomy dictates that her physicians recognize her refusal to take HAART; and 2) after delivery, the pediatrician may seek judicial intervention to determine the best course of treatment for the newborn.

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Outcome: HAART treatment was not forced on the pregnant woman. The patient did not take HAART and had a Caesarian delivery of an apparently healthy infant. She decided not to breastfeed the infant or have him tested for HIV. □

[1]Stone D, Patton B, Heen S, Fisher R. *Difficult Conversations: How to Discuss what Matters Most*. New York: Penguin Books, 2000. Given the

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The legal column:

Sticker shock—hospital billing and class action litigation

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How much does an overnight stay in a hospital cost? Answer: It depends. For Paul Shipman, a 43-year-old uninsured furniture salesman, a 21-hour hospital stay for a cardiac catheterization and stent was billed at $29,500. Medicare pays $15,000 for the procedure; the state's Medicaid program pays $6,000. Managed care and private insurers reimburse at a variety of rates that hospitals typically will not disclose—but all private insurers pay rates well below the "billed charges" that Mr. Shipman was expected to pay.[1]

Increasingly hospitals are the target of lawsuits alleging that they overcharge patients who are uninsured, engage in unfair billing and collection practices, and fail to provide charity care to patients in need. Nationwide, more than 40 hospital systems and upwards of 500 hospitals have been sued for "gouging the poor." While the legal theories and parties vary, the facts underlying the complaints are fairly uniform: patients who do not have insurance are charged double or even triple the price paid by insured patients; hospitals fail to offer discounts or charity care to low and middle income patients; and aggressive hospital collection practices result in patients losing their homes, having their wages garnished, and landing in jail pursuant to "body attachments," a practice under which a hospital or its collection agent has a patient arrested and jailed for missing a court appearance related to a medical debt.[2]

The first wave of lawsuits, filed in early 2003, targeted Tenet and HCA (Hospital Corporation of America), national for-profit hospital chains. In December 2003, the Service Employees International Union 1199-New England filed a class action lawsuit against Yale New Haven Hospital and Bridgeport Hospital in Connecticut. Then in mid-June 2004, the lawyers who brought down Big Tobacco began filing federal court class action lawsuits against not-for-profit hospitals and the American Hospital Association (AHA). This coordinated effort, dubbed the Not-for-Profit Class Action Litigation, is led by Richard Scruggs and the Scruggs Law Firm of Oxford, Mississippi, and now includes 39 lawsuits in 20 states with more promised.[3]

The Not-for-Profit Class Action Litigation alleges, among other things, that not-for-profit hospitals have an obligation to provide care at a "fair and reasonable charge"—an obligation the hospitals allegedly violated when they charged uninsured and under-insured patients the "highest and full undiscounted price," failed to notify them of charity care or discounted care, and engaged in aggressive collection practices. According to the complaints, this right to a "fair and reasonable charge" arises from: 1) Section 501(c)(3) of the Internal Revenue Code, and similar provisions of state and local law, which grant tax-exempt status to hospitals; 2) an express or implied contractual obligation to uninsured patients to bill "not more than a fair and reasonable charge" for care; 3) the Emergency Medical Treatment and Active Labor Act (EMTALA), which obligates hospitals that accept Medicare payments to screen all patients who come to their emergency rooms without conditioning emergency care on patients signing agreements to pay "full charges" for care; 4) charitable trust doctrine; and 5) state consumer protection laws.[4] The complaints also allege that the hospitals entered into a "civil conspiracy" with the AHA to conceal and misrepresent the hospitals' billing and collection practices, and charge the AHA with providing "advisory assistance" to hospitals on how to over-bill their uninsured patients and aggressively collect medical debt. The complaints seek a declaration that the hospitals are in violation of the law; a court order requiring the hospitals to change their billing and collection practices; damages, attorneys fees and costs; and "imposition of a constructive trust on hospitals' tax-exempt savings, profits and net assets and revenues in amounts sufficient to provide 'mutually affordable medical care.'"

The initial legal hurdle the Not-for-Profit Hospital Class Action plaintiffs are likely to face is whether the plaintiffs—all former patients at the defendant hospitals—have standing to seek judicial enforcement of any duty to provide discounted and charity care that may exist under the federal and state tax codes. Historically, it is the government that must pursue not-for-profit entities for obligations owed pursuant to the tax code, and a number of tax cases brought by governmental agencies have challenged hospital billing and charity care practices.[5] However, the concept that a patient has standing, through a contract theory or other claim, to challenge a hospital's tax-exempt standing and to obtain damages if the hospital is in violation of tax-exempt law is novel—to say the least.[6]

While the procedural issues may toll the death knell for the Not-For-Profit Class Action Litigation, the lawsuits' complaints that uninsured and underinsured patients paid the "highest and full undiscounted price" accurately describe what had become common industry practice. Until recently, the AHA and hospitals nationwide took the position that Medicare pricing policies, which require that hospitals bill all patients the same charge for each service, meant that the uninsured had to pay full price for their care precluding hospitals from providing discounts or other means of financial assistance for patients.[7] However, in February 2004, Department of Health and Human Services Secretary Tommy Thompson, responding to an inquiry from the AHA, declared that Medicare pricing policies do not—and never have—prohibited hospitals from providing discounts to uninsured patients.[8] Both the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) issued guidance outlining policies that hospitals can use to assist their uninsured and underinsured patients.[9] The CMS guidance document, in the form of a set of questions and answers on charges for the uninsured, states that Medicare regulations and program instructions do not prohibit hospitals from waiving collection of charges—including copayments—to any patient if it is done as part of the hospital's "indigency policy"—which CMS defines as a policy developed and used by a hospital to determine a patient's financial ability to pay for services.[10] It also makes clear that hospitals do not have to file lawsuits against patients, seize their homes or send unpaid bills to a collection agency.

The issue underlying the class action lawsuits—and other lawsuits against for-profit and not-for-profit hospitals—is sticker shock: outrage that hospitals not only charged uninsured patients more than their insured patients, but refused to negotiate some "reasonable" discount or, in appropriate cases, free care. Whatever the merits of the creative legal theories underlying the class action litigation, it is now clear that hospitals can give price discounts and free care to uninsured patients. The AHA has issued new guidelines to help hospitals evaluate their free care, discount and collection policies and practices,[11] and community advocates have issued nine principles to guide patient

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Politics, social priorities and biomedical research: Is the integrity of science being undermined to serve political goals?

This is an edited transcript of a forum presented by the Harvard Medical School Division of Medical Ethics in February 2004. The forum was moderated by Marcia Angell, MD, senior lecturer in social medicine at Harvard Medical School, editor emeritus, New England Journal of Medicine *and author of* The Truth About the Drug Companies: How they Deceive Us and What to Do About It.

Marcia Angell, MD The Union of Concerned Scientists (UCS) an independent organization focusing on technical issues, has recently issued a report[1] charging the Bush Administration with systematically manipulating scientific evidence to support its policy goals. *The New York Times* (Scientists accuse White House of distorting facts. Feb. 18, 2004) described the report this way: "More than 60 influential scientists including 20 Nobel Laureates issued a statement yesterday asserting that the Bush Administration had systematically distorted scientific fact in the service of policy goals on the environment, health, biomedical research and nuclear weaponry at home and abroad." The UCS accuses the Administration of repeatedly censoring and suppressing reports by its own scientists, staffing advisory committees with unqualified political appointees, disbanding government panels that provide unwanted advice, and refusing to seek any independent scientific expertise in some cases. The report cites many examples ranging from suppressing evidence of global warming and industrial pollution; distorting information about condom use versus abstinence to prevent teenage pregnancy and HIV transmission; and stacking government advisory committees with ideologues or members with financial interests in the committee's work.

I have personal knowledge of one of their examples—the Bush Administration's censorship of the National Cancer Institute's (NCI's) Web site. The NCI was instructed to eliminate the information that there is no good evidence that abortions increase the risk of breast cancer, and replace it with the suggestion that there might be such evidence. Scientists at the NCI were outraged at this distortion of the evidence.

The problems that the UCS cites come mainly from the political right and accordingly they serve corporate interests and free market and conservative religious ideologies. But, as the UCS admitted, the right does not have a monopoly on this sort of thing. The left also sometimes distorts and suppresses scientific evidence to satisfy its very different agendas, often to serve what its proponents see as the greater good of public health or greater social equality. One example I am familiar with is the controversy over silicon gel breast implants, a controversy that came mainly from the left and that raged in the early 1990s. You may remember that in the utter absence of any evidence that breast implants caused the diseases they were said to cause, they were pulled off the market. There was a tidal wave of litigation, and women were awarded multimillion dollar jury verdicts. What was in play here was a combination of a form of feminism that sees women as perpetual victims, an anti-industry bias that more or less assumed breast implants were dangerous, and a self-interested plaintiff's bar that was only too willing to exploit the situation.

> *When the imposition of a political or ideological agenda threatens scientific freedom or integrity, science-based policy loses its bearings.*

The panelists we have selected today represent a broad political spectrum and even broader range of experiences.

Joshua Sharfstein, MD, member of the Democratic staff of the Government Reform Committee for Congressman Henry A. Waxman, Democrat of California. As a medical student at Harvard Medical School he published a controversial paper in the New England Journal of Medicine[2] *that found the American Medical Association Political Action Committee had contributed more on average to House of Representatives members who favored tobacco export promotion and the gag rule on abortion counseling and contributed less on average to supporters of handgun control.*

Politics and science have always coexisted. Politicians decide on research budgets, set broad national priorities for study, provide basic ethical guidelines and oversee their implementation. The relationship between politics and science, however, can turn sour. When the imposition of a political or ideological agenda threatens scientific freedom or integrity, science-based policy loses its bearings. The consequences can be measured in cures not found, lives not saved and damage to the public health and environment.

This concern is not hypothetical. In August our staff released a report entitled Politics and Science in the Bush Administration.[3] The report documented misleading statements by the president, inaccurate responses by cabinet secretaries to Congress, altered Web sites, suppressed agency reports, and erroneous international communications. Beneficiaries of this interference were consistently the supporters of the president, including social conservatives and powerful

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***Politics** — continued from page 5*

industry groups. Let me give you a few examples.

In 2002 the Bush Administration dropped three national lead poisoning experts from the national Centers for Disease Control and Prevention's advisory panel that recommended the threshold level of concern for lead in the blood. That threshold had been 10 micrograms per deciliter since the early 1990s, and a number of leading experts believe it should be even lower. In place of these three experts, who have dozens of publications among them, the administration appointed several individuals including William Banner, MD. Dr. Banner has testified on the behalf of the lead paint industry that a lead level of 70 mcg/dl is safe for children's brains. [Gasp from audience.] When I talk about this and I hear a gasp like that, I know there is a pediatrician in the audience! Dr. Banner has no public health experience in lead poisoning, and his claim ignores two decades of research and scientific consensus about the impact of lead on the brain.

Across the federal government, the Bush Administration is pressing agencies to treat abstinence-only education as the most effective way to prevent teen pregnancy and HIV infection. When asked about the lack of scientific evidence to support this position, one of the president's top advisors on welfare responded "Values trumps data."[4]

The Bush Administration is objecting strongly to a report by the World Health Organization (WHO) addressing obesity. The WHO report[5] has found that there is a probable association between soft drink consumption and weight gain. The United States position has been that there is no evidence for this association, and has specifically asked WHO to take out any mention of soft drinks from the report. This position defies the evidence. It defies the U.S. Surgeon General. It defies the USDA dietary guidelines. It even defies the technical document relied upon by WHO, which was coauthored by the leading obesity expert in the CDC.

The scientific community has not kept quiet. Editorials in major medical and scientific journals have decried political litmus tests on scientific advisors, ideological interference with research, and the distortion of information to the public. As the UCS report put it, "Successful application of science has been a large part of the policies that have made the United States of America the world's most powerful nation and its citizens increasingly prosperous and healthy. Although scientific input to the government is rarely the only factor in public policy decisions, this input should always be weighed in an objective and impartial perspective to avoid careless consequences. Indeed this principle has long been adhered to by presidents and administrations of both parties in forming and implementing policies."

There is too much at stake to let a narrow political and ideological agenda—from any perspective—undermine the integrity and credibility of the United States' premier health agencies.

Sally Satel, MD, resident scholar at the American Enterprise Institute[6] in the W. H. Brady Program in Culture and Freedom, staff psychiatrist of the Oasis Clinic in Washington, D.C., and member of the Advisory Committee of the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration. Satel is author of the 2001 book, PC MD, How Political Correctness is Corrupting Medicine *and of the 1999 book,* Drug Treatment, the Case for Coercion. *She is also coauthor of a forthcoming book,* One Nation Under Therapy.

Much of what Dr. Sharfstein has told us and what we read in the UCS report is certainly worrisome. There is no question about that. By no means do they represent the last word on politics and science in this administration but their commentaries are very powerful stimuli for further investigation.

Now, I don't know anything about global warming and wetlands conservation and the other topics mentioned in the UCS report. I think I know a little something about endangered species…that would be me: a Republican psychiatrist, but I do have my own informed opinions about some other areas touched on by the report. To me what they suggest is that there is nothing new under the sun. Ideology has long held sway in many quarters in health and medicine. When facts got distorted, it was wrong then. And when facts get distorted, it is wrong now. It happened before President Bush, but I think in some ways it was less noticeable and I am going to show why I think that is the case.

Let's talk about the composition of boards and committees. Let's take the case of psychologist William Miller, PhD, an addiction researcher at the University of New Mexico. Miller developed a technique called motivational interviewing, which is a very fine therapy for drug addicts and alcoholics, especially those who aren't sure they want to enter recovery. He is a first-rate addiction researcher and excellent methodologist. About once a month in 2000 and 2001, after President Bush had come in, I would get a call from an aide at Health and Human Services (HHS), saying "I have a list of names of people who we're thinking of recruiting to some of these advisory committees. What do you think of them?" Bill Miller was one of the names and I said he is excellent. He is a careful researcher. He is much published, well regarded. The aide said to me, "Did he vote for Bush?" I said I had no idea if he voted for Bush. He asked me what Bill Miller thought about abortion, and I said I had no idea what Bill Miller thought about abortion; he asked me what Bill Miller thought about needle exchange, but still I didn't know what Bill Miller thought about needle exchange. I thought all of these questions were irrelevant and I told the aide that and he said thank you.

Now imagine that a Democratic aide is going to do some vetting and he asks whether you are pro-choice or whether you voted for Clinton. What is the likely answer to be among people in our field? We know that most people in the health services field are liberal or leftist-centered. So, their answers are probably going to be yes, I voted for Clinton and yes, I think abortion rights are fine and yes, I am for needle exchange. So, the opportunity for those kinds of clashes aren't going to come up as much or, I suspect perhaps, those questions aren't even asked because it is safe to assume what the answer will be. I think those are irrelevant questions in a leftist-centered administration. But it is obvious that the opportunity for clashes, when a litmus test is applied, are going to be greater when a Republican administration considers staffing its committees with qualified professionals who may tend to have more liberal pedigrees.

I want to give you another example showing how a shared ideology between the administration and potential appointees can influence the research agenda. I don't know how many of you are familiar with the Center for Substance Abuse Prevention (CSAP)—part of the Substance Abuse and Mental Health Services Administration (SAMHSA) of HHS. It is notorious among substance abuse prevention researchers for funding projects that are often very poorly executed and have little usable data. Some of the staff who oversee the projects have been properly said to be scientifically illiterate. I will just give you one example.

As an aside, I should say that as of 2001 Charles Curie became the new director at SAMHSA and he is well aware of some of these problems. But when I was looking into CSAP 10 years ago during the Clinton administration, a $1 million, five-year grant went to something called the West Dallas Community Center. It was for a substance abuse prevention program for young African American men—its goal was to build self-esteem. Now, this self-esteem-building program was necessary according to the West Dallas project director because, as he wrote in his grant, "Scientific colonialism and the institution of racism had defeated young men to the point where they turned to drugs." That doesn't sound very objective for a grant proposal but what about the program? What was the content of that program? Well, part of the self-esteem enhancement curriculum of the West Dallas program included lectures to teach the boys revisionist history, teaching them that Africa was the origin of architecture, mathematics, maritime travel and that white people had tried to deny them this knowledge, deprive them of their source of pride. Pedagogical malpractice aside, did teaching such "history" have any impact on substance abuse prevention? What did the results look like? Unfortunately many students did not either have a pretest or post-test or lacked both, thus change could not be measured. In other words, no results, a complete waste of taxpayer funds.

My point is, where was Representative Waxman when these ill-conceived, clumsily executed studies happened at the CSAP? The answer is no one pulled the alarm because the conceptual bent of the West Dallas project was compatible with CSAP leadership and grant review members' ideology, which is to say an aggressive multicultural agenda that trumped careful planning of the project and its analysis. There is enough politics to go around, right, left, liberal, conservative. I would argue that Representative Waxman missed a few things.

If you ask me whether this political climate is hostile to certain kinds of research, I definitely say yes: consider the current proscription of federal funding for stem cell research on non-designated lines. But I would quickly remind everyone that in the previous political climate there were political and ideological pressures brought to bear as well.

… we should ask not whether science is politicized but if it is democratized.

***David Guston, PhD**, associate professor and director of the Public Policy Program of the Bloustein School of Planning and Public Policy at Rutgers, North American editor of* Science and Public Policy*, and chair elect of the American Association for the Advancement of Science, Section on Societal Impacts of Science and Engineering. His book,* Between Politics and Science, Assuring the Integrity and Productivity of Research *was awarded the 2002 Don K. Price Prize by the American Political Science Association for the best book on science and technology policy.*

Three hundred fifty three years ago, Thomas Hobbes wrote, "Which is the cause that the doctrine of right and wrong is perpetually disputed, both by the pen and the sword, whereas the doctrine of lines and figures is not so because men care not in that subject what be truth as a thing that crosses no man's ambition, profit or lust for I doubt not but, if it had been a thing contrary to any man's right of dominion that the three angles of a triangle should be equal to two angles of a square, that doctrine should have been, if not disputed, yet by the burning of all books of geometry suppressed as far as he whom it concerned was able." Hobbes's observation that science, of which geometry was the paradigm in his time, would be viciously disputed if it "crossed any man's passions, ambition, profit or lust" was of course born out; it strikes me as odd that in some conversations about this, people act very much like Claude Rains character in the movie, *Casablanca*, where he is "… shocked, shocked to find …" We are shocked, shocked to find that politics is going on in and about our scientific establishment.

The question is not whether science is politicized but what are the appropriate institutional channels for political discourse to influence science. Additionally, we should ask not whether science is politicized but if it is democratized.

The founding dean of the Kennedy School, a political scientist named Don K. Price, gave us a template for thinking about the relationship between politics and science. He recognized the spectrum from truth to power and divided this conceptual space between the political enterprise and the scientific enterprise into four "estates," each with different functions.

The scientific estate's function was to pursue truth. Next to it was something that he called the professional estate; its mission was to apply what was found in that scientific estate according to rules that were determined by private organizations and private values. Next along the spectrum was the estate of the professions; the function of the professions was to apply what was learned in those other estates according to public rules. Finally on the end of the spectrum was the political estate that Price fully recognized as being about the pursuit of power. Price developed a two-fold law of responsibility and accountability that ran the transactions among these different estates. He said that the closer you were to the pursuit of truth, the greater autonomy you should have and the closer you were to the pursuit of power, the greater responsibility and democratic accountability you should have. As a normative issue this sits pretty well with most people. We like to think of scientists being able to pursue truth where

***Politics** — continued on page 8*

***Politics** — continued from page 7*

they will. We like certainly to think about people who are capable of exercising power to be subject to democratic accountability.

Yet this spectrum from truth to power runs aground in a couple of places. It misses Hobbes's insight that, at least in the contemporary world, the connection between science and power is much closer than two opposite ends of the spectrum might envision. Price said that what kept this spectrum functioning well in American society was a tradition of treating it with respect. Politicians are supposed to recognize their pragmatic interests in an independent scientific establishment; similarly, the folks who are seeking truth are meant to be contained by a variety of private and publicly promulgated rules.

I think we have to recognize that politics happens in science, in the scientific establishment at all levels, without dismissing it, without suppressing it, without denying it. We need to begin to concentrate on the provision of transparency and accountability in the conduct of this science politics. Finally I think we need to build institutions that attempt to balance political and scientific interests. These are the places that the debate needs to go to in order to transform a fairly unproductive discussion about the politicization of science into a more productive discussion about the democratization of science.

Marcia Angell: I would like to ask Dr. Sharfstein to respond to Dr. Satel: is there really a difference in this administration, as compared to others?

Joshua Sharfstein: I appreciate Dr. Satel confirming the Bill Miller story, that there was an outrageous political litmus test applied to a leading substance abuse expert. Yet she doesn't give a single example of political level distortion of science in the Clinton-Gore administration. I am somewhat perplexed that she somehow concludes it was just as bad because we have reported over 25 well-documented, specific examples of political manipulation of science. We have statements from officials in the Nixon, Ford, Reagan and the first Bush administration either condemning what is going on or saying it is much worse now than it ever was in their time, and we have the statement of 20 Nobel Laureates and many other scientists saying that this is unprecedented. So, there is a lot on one side and there just does not seem to be much on the other.

Dr. Satel mentioned a few specific research studies but I think she is missing the point. There may be good or bad scientific studies in any field that are funded. There may be ones that are terrible in design and funded anyway. Those are scientific issues, within the world of science. That is not political domination of the science. It is not rewriting the conclusions of things. It is a problem within the science. So, I don't consider those in any way to be parallel to political appointees rewriting conclusions of reports and drastically misrepresenting what scientists are doing.

Through balanced types of inquiry, there are ways of creating the kinds of politically relevant, technically competent science advice that we are all looking for.

Marcia Angell: Dr. Satel, do you mean to characterize the difference between the interference in past administrations and the current administration as merely a difference in ideology between the scientific community and the administration?

Sally Satel: I think there are more discrete examples in existence than are being presented today. I don't know how long Dr. Sharfstein spent on his report or how long the UCS spent on their report. These kinds of allegations take an enormous amount of work, hundreds of interviews, maybe even subpoenaing records, looking at old memos, interviewing hundreds of people. It takes a very long time, so I am skeptical of the completeness of their reports. I think that the phenomenon certainly takes place on both sides.

Marcia Angell: Professor Guston, if we reduce the barriers between politics, policymaking, and science, how do we avoid conflicts of interests?

David Guston: Through balanced types of inquiry, there are ways of creating the kinds of politically relevant, technically competent science advice that we are all looking for. Let me give you a local example. The Health Effects Institute (HEI) is an organization that does this at the interface between the Environmental Protection Agency and the regulated industry with an autonomously run peer review system. In that process, neither side has an interest in overly politicizing the research results and both agree on the review processes. The HEI ends up producing research that fares very well in the regulatory environment. □

[1]*Scientific Integrity in Policymaking: An Investigation into the Bush Administration's Misuse of Science*. Cambridge, MA: Union of Concerned Scientists, 2004. (http://www.ucsusa.org/global_environment/rsi/page.cfm?pageID=1322).

[2]Sharfstein JM, Sharfstein SS. Campaign contributions from the American Medical Political Action Committee to members of Congress. For or against the public health? *N Engl J Med* 1994; 330(1):32–7.

[3](www.house.gov/reform/min/politicsandscience).

[4]Wingert P. Sex education: values trumps data. In Periscope. *Newsweek* 2002;Feb. 11:8

[5]Diet, nutrition and the prevention of chronic diseases. *World Health Organ Tech Rep Ser* 2003;916:i–viii,1–149, back cover.

[6]The American Enterprise Institute for Public Policy Research is dedicated to preserving and strengthening the foundations of freedom—limited government, private enterprise, vital cultural and political institutions, and a strong foreign policy and national defense.

This Medical Ethics Forum was edited by Walter M. Robinson, MD, MPH, Assistant Professor of Pediatrics and Medical Ethics, Harvard Medical School.

Ethics and humanities:

His Brother's Keeper: A Story from the Edge of Medicine

By Jonathan Weiner
Ecco, an Imprint of HarperCollins
New York, 2004, 354 pages

Review by Richard M. Ratzan, MD
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Imagine you are the dean of a medical school, the chief operating officer of a corporation or a skilled programmer for IBM. Imagine yourself any of these and you learn, at the age of 31, that your 29-year-old kid brother has just been diagnosed with amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease). Certainly you would call, commiserate, try to help as much as you can. But would you quit your job, reinvent yourself as a manager of scientists—all strangers to you at the time—working in this and related fields of neurobiology, and embark on a financial and entrepreneurial crusade to try to save your brother?

Jamie Heywood was a 31-year-old mechanical engineer working for the Neurosciences Institute—the prestigious think tank of Gerald Edelman, the 1972 Nobel Laureate in Medicine, in La Jolla, California—when he and his tight Boston family of five, heard the news in the beginning of 1998. He handed in his resignation and began a marathon of activity all geared towards preventing his brother Stephen from becoming the wheelchair-bound shell of a man we see in Stephen Hawkings, the famous astrophysicist with ALS. Leaving California, Jamie sets up a 24-7 headquarters for ALS-related activities in, and later near, his family home in Newtonville, a suburb of Boston. *His Brother's Keeper* is the story of this crusade as told by the Pulitzer-winning science writer, Jonathan Weiner. (It first appeared in *The New Yorker* in 1999 in a shorter version.)

Stephen, the middle son of a South Dakotan therapist and a British professor of mechanical engineering at MIT, was the renegade of the three boys. Jamie and Ben went to MIT and graduated with degrees in engineering, which is the operative world view of this book, since both the Heywoods' father, John, and the author's father, Jerome (at Brown University), are university engineers and the authors of highly technical books, respectively: *Internal Combustion Machine Fundamentals* and *Statistical Mechanics of Elasticity*.

Stephen, a carpenter, was restoring a house in Palo Alto, in December of 1997. He realized something was wrong when he had trouble turning a key. Almost exactly a year later Robert Brown, a neurologist at Massachusetts General Hospital, diagnosed Stephen with ALS. In May of 2000, a neurosurgeon injects Stephen's cervical spinal canal with stem cells (to no effect, but also with no harm). Exactly a year later, Stephen is in a motorized wheelchair with a voice so soft Jamie has to translate for the author.

Between the turn of the key in December 1997 and the wheelchair in May 2001, we watch as the author expertly narrates three stories: Stephen's illness and the Heywood family's reaction to it; his own mother's eerily similar neurodegenerative disease, progressive supranuclear palsy, or PSP (actor Dudley Moore died of PSP in March 2002); and the ongoing development—scientifically, politically and ethically—of gene therapy and what Weiner calls both "regenerative medicine" and "futuristic medicine."

This book creates a rich tapestry from the woof and warp of these narratives and the reader gets the macro and microscopic pictures of all three stories by the last page. Interwoven is the angst of Weiner's mother, Ponnie, as her mind slips and slides into cognitive decay; the history of Guam field research by John Steele on a fascinating variant of PSP (with generous and typically insightful comments by Oliver Sacks); the personal interviews with and revealing profiles of the major players in molecular genetics and "regenerative medicine." There are also literary references to Donne and Kafka, among others. Quite relevantly, when the author relates that a neurologist had told his family that his mother had a rare and incurable disease (Lewy body dementia), Weiner cites John Donne, from the XIIIth Meditation of his *Devotions Upon Emergent Occasions*: "It is a faint comfort to know the worst, when the worst is *remedilesse*." Such references sometimes blind with their clarity, like the inclusion of Kafka's short parable, "An Imperial Message," a 250 word short story that begins, "The emperor, so a parable runs, has sent a message to you, the humble subject, the insignificant shadow cowering in the remotest distance before the imperial sun." Of course the message never makes it past all the obstacles to the humble subject. As a unifying parable of well-intentioned signals gone awry, the parable is brilliant in illuminating the neuropathology of ALS.

The dominant thread throughout, however, is the Heywood story and especially the driving force that is Jamie Heywood. Jamie quickly becomes the focus, the tapestry's overarching pattern as the dynamic ubermensch who oversees (having never been asked) his brother's scientific and clinical care, organizes a new co-operative initiative into the field of ALS research, and coordinates gene therapists, molecular biologists, clinicians, family members and philanthropists at a cost. By story's end, Jamie is separated from his wife. Although we are given signals (paradoxically, the author seems to have gotten them but Jamie, like Kafka's humble subject, did not) by Melinda, Jamie's wife, of the toll such a frenetic life was exacting prior to the separation, we do not get the details of the breakup, just the aftermath of a deserted house. Is Jamie sad? Apparently. Remorseful. No. "When I asked Jamie if looking back he would do anything differently, he said, 'If you ask me would I prioritize Melinda above those life-and-death decisions—no.'"

Stephen, on the other hand, is happily married and playing with his child using hardware and software. How else would the ALS-stricken son and brother of engineers play with his child? And Stephen's response, typed on his keyboard amidst his family, "I FEEL LIKE A KING" says it all about the mind-body drama we have just read.

It is no minor accomplishment that Weiner, amongst the personal, political and medical stories, clarifies almost effortlessly and transparently the mechanics—he is, after all, also the son of an engineer—of gene therapy and the pathophysiology of ALS. His explanation of science is painless and always carefully related to the patient and symptoms at hand. □

Dialogue:

Bioethics in culturally diverse societies

The last two sentences of Leigh Turner's article, "Bioethics in culturally diverse societies" are "Bioethics has its limits." and "Perhaps it is better to recognize these limits than to claim that some method, theory or technique of reasoning, is available that will magically resolve longstanding moral conflicts." (*Lahey Clinic Medical Ethics*, Spring 2004, www.lahey.org/ethics/). I am in complete agreement. Furthermore, it is not merely bioethics that has its limits; there is no method, theory or technique of reasoning available that will resolve longstanding moral conflicts in any area of morality.

However, Leigh Turner takes himself to be providing an attack on the notion of a common morality and I am a leading defender of the view; something is quite puzzling.[1–4] Part of the puzzle is due to the fact that the view that Leigh Turner is attacking is the principlist version of common morality, a view that Beauchamp and Childress adopted in later editions of their book, *Principles of Biomedical Ethics*. This principlist version of common morality has only a distant relationship to the account of common morality that we put forward in *Bioethics: A Return to Fundamentals*.[5]

Common morality cannot and should not be used to settle longstanding moral conflicts in bioethics. Rather, common morality explains why, although there is agreement about the vast majority of moral decisions and judgments, there are some unresolvable moral disagreements. The agreement about the overwhelming majority of moral decisions and judgments, e.g., it is morally wrong to subject a patient to a serious risk of death simply to make money, is overlooked because these kinds of cases are rarely if ever discussed. The relatively few controversial issues, e.g., the moral acceptability of abortion or the use of "medical futility" to discontinue treatment, are widely discussed, and thus are mistakenly taken as constituting the vast majority of moral decisions and judgments. But although the number of unresolvable moral issues is small relative to the number about which there is complete agreement, it is a mistake to think that any moral theory will resolve these longstanding moral conflicts.

Common morality is not a theory; it is the system that people use, usually not consciously, when they make their moral decisions and judgments based on a thoughtful consideration of the facts involved in a specific situation. The correct account of common morality is similar to the correct account of grammar provided by grammarians. These grammarians simply describe the grammatical system that is used, usually not consciously, by speakers of the language when they speak and when they interpret the speech of others. People are speakers of a language if they can understand and can be understood by other speakers of the language. If a grammarian puts forward a description of the grammatical system of a language that is in conflict with the way in which any significant number of speakers use it, that grammarian has put forward a mistaken account.

Philosophers who put forward moral theories that conflict with the moral judgments of any significant number of moral agents, are similarly mistaken. People are moral agents if they can understand what morality prohibits, requires, discourages, encourages and allows and can guide their conduct by it. That is why any accurate account of common morality must allow for unresolvable moral disputes concerning issues about which a significant number of moral agents disagree.

However, although I agree with Leigh Turner about the limits of common morality, we have a significant disagreement about what counts as morality. He says "there is a crucial difference between making normative claims about how humans ought to act and making transhistorical and cross-cultural claims about the empirical status of particular moral practices." He seems to hold that any claim about how humans ought to act is a moral judgment. This is a common mistake of philosophers. Turner seems to offer the following in support of his view that moral practices differ, "Deliberately inflicted violence against the innocent is a staple of human history." That he thinks that inflicting violence against the innocent is a moral practice can only be explained by his acceptance of the view that however any society claims that people ought to act is a moral practice.

When philosophers talk about morality, they are not talking about all of the diverse practices that different societies put forward as guides to conduct. Morality has certain features that they rightly take to be essential. Among these features is that it is inappropriate to make a moral judgment about the actions of a person if he is legitimately ignorant that what he is doing is morally discouraged or prohibited. This distinguishes morality from law and religion, for it is appropriate to make a legal or religious judgment about the actions of a person even if he is legitimately ignorant that what he is doing is legally or religiously discouraged or prohibited. Together with the fact that, unless they are legitimately ignorant of the facts of the situation, it is appropriate to make moral judgments about the actions of all normal adult human beings, this feature of morality has a somewhat surprising implication. The conclusion is that morality cannot be based on religion, for no religion is known to all normal adult human beings. Thomas Aquinas's acceptance of this conclusion explains why he tries to show that the moral views put forward in the Christian Scriptures are the same as those known by natural reason. Neither Aquinas nor I deny that a particular religion may put forward correct moral views, but both of us deny that what makes them correct moral views is that they are put forward by that religion.

Genuine unresolvable moral disagreements are the result of a number of factors, of which two are the most important. The first is a difference in the rankings of the various benefits (goods) and harms (evils). Everyone agrees that death, pain, disability, loss of freedom and loss of pleasure are evils or harms. Everyone also agrees that abilities, freedom and pleasure are goods or benefits. However, within fairly wide limits, rational persons differ in their rankings of these goods and evils. For example, two people suffering from the same painful terminal illness may make different choices, both rational. One may choose to stop life-prolonging treatment in order to avoid the continuing pain, whereas the other may choose to continue life-prolonging treatment despite the pain. Turner is correct that these differences are often the result of different cultural and religious backgrounds, but it is the rationally allowed differences in the rankings of the evils that are directly responsible for the unresolvable moral disagreement.

A second important source of unresolvable moral disagreement are differences about who is included in the group that is impartially protected or protected at all by morality. The group must include all moral agents, those about whom it is appropriate to make moral judgments. If a person denies that any group of moral agents is impartially protected by morality, e.g., women or blacks, he is a sexist or a racist, he is not putting forward a rationally allowed way of being moral. But there is considerable disagreement about who else in addition to moral agents should be included in the impartially protected group. Almost everyone in western societies wants to include infants, but there is considerable disagreement about whether fetuses should

be included. Some people want to include non-human animals, especially highly intelligent mammals such as chimpanzees and dolphins, but others disagree. Like the differences in the rankings of the harms and benefits, this difference about who is included in the group impartially protected by morality is often decisively influenced by cultural and religious factors. However, these cultural and religious factors are only indirectly responsible for the unresolvable moral disagreement; the differences in deciding who besides moral agents should be included in the impartially protected group are what is directly responsible for the unresolvable moral disagreement.

Leigh Turner is correct in claiming that common morality cannot resolve longstanding moral conflicts, but because he equates moral practices with any practices that a society puts forward to guide behavior, he offers mistaken arguments for his claim. Were he to have recognized the distinction between morality and other guides to conduct such as legal or religious guides, he would have been able to support his claim that common morality cannot resolve longstanding moral conflicts without lapsing into what seems like ethical relativism.

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[1]Gert B. Common morality and computing. *Ethics and Information Technology*. 1999;1(1): 53–60. Reprinted in *Readings in CyberEthics*, 2nd ed. Sudbury, MA: Jones and Bartlett, 2004;308–322.

[2]Gert B, Culver CM, Clouser KD. Common morality versus specified principlism: reply to Richardson. *J Med Philos* 2000;25(3):308–22.

[3]Clouser KD, Gert B. Common Morality. In *Bioethics: A Philosophical Overview*. Kushf G (ed). Norwell, MA: Kluwer Academic Publishers, 2004.

[4]Gert B. *Common Morality: Deciding What To Do*. New York: Oxford University Press, 2004.

[5]Gert B, Culver CM, Clouser KD. *Bioethics: A Return to Fundamentals*. New York: Oxford University Press, 1997.

Oublier Aquinas (It's time to forget Aquinas)

Once again, let me review two problems with common morality approaches in bioethics. First, the common morality is often described as being in "reflective equilibrium." Gert suggests that the common morality provides a "system." The language of reflective equilibrium emphasizes orderliness and stability. One point of my commentary was to suggest that in contemporary social orders we can identify both zones of moral conflict and zones of moral stability. Postmodern theorists typically emphasize the existence of conflict. Principlists and casuists tend to emphasize order and stability. If postmodernists overemphasize conflict, philosophers of the common morality exaggerate the degree of stability and order in contemporary societies. Gert argues that there is agreement about the "vast majority of moral decisions and judgments." I'm not convinced there is agreement on "the overwhelming majority" of moral issues and decisions. Gert suggests there are "relatively few" controversial moral issues. However, any newspaper reader knows that moral controversy surrounds many different topics. Furthermore, these issues are not just of interest to a small cadre of academic specialists. Should the U.S. have invaded Iraq? Is it both legal and moral for the U.S. to detain "enemy combatants" without trial in Guatanamo Bay? Should same sex marriage be both legalized and celebrated? Should governments provide substantial funding for embryonic stem cell research or should research involving embryonic stem cells be prohibited or highly restricted? Should governments fund "faith-based" social institutions? These issues have a moral dimension and "we" do not all agree upon what constitutes appropriate moral decisions and judgments. Caution must be exercised when offering judgments about whether there are "relatively few" or "many" controversial moral issues. This is one area where scholarship by sociologists, anthropologists and other interpreters of societies might make a useful contribution to bioethics. To what extent is there a broadly shared "common morality" in such countries as Australia, Canada and the United States? It is not possible to address such questions simply by offering question-begging claims about what "everyone" thinks.

Second, as I indicate in my commentary, I do not challenge the substance of what many scholars characterize as the common morality. When I note that humans often seem to take pleasure in inflicting harm, violence and suffering, I am not presenting a brief for warfare, genocide or organized famine. Rather, I am suggesting that we need to be skeptical of sunny notions about human nature and the fundamental moral decency of all thinking humans. The last century alone ought to make us skeptical of the notion that humans are generally guided by a beacon of natural reason that prompts them to be honest, trustworthy and respectful of property rights. In short, I am noting problems with empirical claims made by proponents of common morality approaches to moral reasoning. Too often, they make wholly unsupported assertions about the widespread prevalence of common moral intuitions. I wish they would provide some evidence to buttress their claims concerning what "everyone" thinks about pain, death and loss of pleasure. Such experiences might seem like bedrock dimensions of human existence. However, is it accurate to claim that death, pain, loss of freedom and loss of pleasure are always and everywhere experienced as evils or harms? If this claim is inaccurate, proponents of the common morality draw upon a great many mistaken assumptions when they describe what "everyone" thinks. Claiming that "right-thinking" people know the "essential features" of morality seems to offer a tautology rather than an argument.

If I am prepared to suggest that conflict is a part of moral existence and many moral "intuitions" appear to be local, culturally and historically shaped phenomena, am I properly labeled "an ethical relativist"? As I indicate in my commentary, I challenge the "justifications" or "foundations" provided for the common morality. I nowhere suggest that all social practices are equally morally defensible. I might take issue with aspects of the substance of the common morality if philosophers ever clarified in fine detail just what this concept is supposed to include. It is hard to criticize the substance of a concept more often assumed than defended or even described in depth.

Contemporary inhabitants of societies such as Canada and the United States are socially and historically shaped beings. We live at a particular moment in human history. We are enculturated into particular social and cultural traditions. Some of "our" moral norms have longstanding roots and can be found in many different social settings around the world. Other moral norms are of more recent vintage and local provenance. Richard Rorty, Jeffrey Stout and other philosophers with pragmatist leanings think it possible to defend particular social practices and institutions even if the moral norms these practices and institutions embody are not hardwired for all eternity into the human mind. We can say goodbye to Aquinas and his account of natural reason because in the 21st century we inhabit multicultural, multifaith, pluralistic democratic societies where moral agreement is often difficult or impossible to achieve. We should think of the common morality creed in bioethics as more an article of faith than a detailed framework for normative deliberation. □

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The legal column *continued from page 4*

financial assistance policies.[12] Publicly available, well publicized hospital policies on free and discounted care can not only help reduce the cost of care, but alleviate sticker shock. □

[1]Lagnado L. Anatomy of a hospital bill. *The Wall Street Journal* September 21, 2004.

[2]Langnado L. Hospitals try extreme measures to collect their overdue debts. *The Wall Street Journal* October 30, 2003.

[3]See, plaintiffs' counsel website, (www.nfplitigation.com), which provides an updated list of cases, an archive of press releases and other information on the coordinated class action litigation. Other litigation which appears to have been brought by law firms who are not part of the coordinated lawsuits does not appear on the website.

[4]The complaints also allege that the hospitals violated federal and state not-for-profit law prohibitions against profiteering by "private interests," through either "connected" board members and/or physicians whose for-profit businesses are formed and subsidized by the "tax-free" organization.

[5]See, for example, Utah County v Intermountain Health Care, Inc. 709 P.2d 265 (1985) (denying tax exempt status to two not-for-profit hospitals that made "every effort…to recover payment for services rendered and devoted less than one percent of their gross revenues to providing charity care").

[6]Eastern Kentucky Welfare Rights Org. v Simon, 426 U.S. 26 (1976)(class of uninsured patients had no standing to challenge IRS revenue ruling granting hospital tax-exempt status).

[7]Pryor C, Siefert R. Unintended consequences: How federal regulations and hospital policies can leave patients in debt. *The Commonwealth Fund* June 2003.

[8]Letter from Tommy G. Thomson, Secretary of Health and Human Services to Richard J. Davidson, President, American Hospital Association, February 19, 2004, (www.hhs.gov/news/press/2004pres/20040219.html).

[9]Hospital discounts offered to those who cannot pay their hospital bills. February 2, 2004, available at (www.oig.hhs.gov/fraud/ docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf).

[10]Questions on charges for the uninsured. Feb. 17, 2004, available at (http://www.cms.hhs.gov/FAQ_Uninsured.pdf).

[11]Hospital billing and collection practices: statement of principles and guidelines by the board of trustees of the American Hospital Association. (http://www.aha.org/aha/key_issues/bcp/index.html).

[12]Patient financial assistance principles. *Community Catalyst* June 2004.

Ask the Ethicist *continued from page 3*

irreconcilable nature of this conflict, the consultant's job will be to lay out to both parties what she or he believes the societal-ethical consensus is regarding these matters and to lay out for them what the societally acceptable mechanisms are for resolving the conflict.

[2]Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, *4th ed.* New York: Oxford University Press, 1997, p 126.

[3]http://www.aclu.org/ReproductiveRights/ReproductiveRights.cfm?ID=9054&c=30

[4]Wade NA, Birkhead GS, Warren BL, et al. Abbreviated regimens of zidovudine prophylaxis and perinatal transmission of the human immunodeficiency virus. *N Engl J Med* 1998;339:1409-14.

[5]Guay LA, Musoke P, Fleming T, et al. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial. *Lancet* 1999;354:795-802.

Medical Ethics

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