Future Issues in Bioethics

by Rosemary Flanigan

In reflecting on the future of bioethics, ethicists need to examine the process of doing ethics as they search for moral truths and right action. As increasingly difficult questions are brought before ethics committees, there is a need for more sophisticated strategies that guarantee depth in ethical analysis.

There are two distinct paths one can take in reflecting on future issues in bioethics: one can address *content*—the issues themselves—or *process* —the means of analysis used. Certainly, as technology develops, there will be added items to consider for the *content* of ethics committee meetings; for example, technology advances will save smaller and smaller newborns; sophisticated procedures are saving more grievous burn victims; multiple organ transplants will be more successful as the technology enables infection to be kept at bay, and so on. New content areas of what medicine can do will raise conflicts between a personal ("Please help me, Doctor") and an institutional or social ethic (Can this institution or this society afford to engage in such high tech interventions?) Already, health care reform has led to joint ventures by health care deliverers which promise to be of traditional high quality but at lower cost because duplication is avoided. Nevertheless, there will be a limit to what institutions and society can afford.

In this paper, I will not play the role of prognosticator of future modes of health care delivery. Instead I will explore the challenge for ethics committees in the future. This challenge, I suggest, lies in enhancing the *mode* or *process* of ethical thinking. Questions of separating Siamese twins, of typing gene pools, or of equipping a new subacute unit within the hospital will necessitate increased expertise in ethical reflection.

What does the future presage about increased ethical insight on the part of ethics committee members?

Either/Or Thinking

"Either/or" thinking should not be the usual mode of reflection used by ethics committees. Ethical thinking is the search for moral alternatives for acting and rarely is the choice simply between "good" and "evil" or between two, and only two, possibilities. More often, health care delivery is found within series of alternatives, any one of which has benefit as well as risk, and few of which offer but a single mode of acting to actualize certain values. The very existence of time trials shows that, almost always, protocols can be tried, evaluated, chosen or rejected all the way through the treatment.

What is "either/or" thinking? Remembering that moral decision making takes place only where there is human freedom, then choice has to be possible. "Either/or" choice would clearly delineate two possibilities, no more, and each subsequent choice would have the same duality.

The problem with "either/or" thinking is that too often one views the situation in such a simple light that one begins to justify using human beings as if they were mere means to an end. For example, the use of "either/or" thinking in considering killing in self-defense could easily lead to a purely utilitarian position in which the death of the assailant is merely the means to saving one's own life. Consider the kind of thinking that might occur in such a situation: "This person is trying

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to kill me. I did nothing to warrant such an attack. If I don't fight with all my strength, he will overcome me and I shall be dead. I am fighting with all my might and if I don't kill him, he will kill me. It's *either* his death *or* mine."

The utilitarian model easily assigns more benefit to my own life than to the life of my assailant. In this case, I am fighting literally for my life. After all, it was the attacker's action that placed me in this position. I cannot quit without risking death; he can simply turn on his heel and run if he wants to save his own life. My "benefit" is in saving my own life; I do not wish to exact retribution so that if he turns on his heel and runs away, I shall most probably do the same — in the opposite direction.

However, if the fight continues, justification for "either/or" thinking leads to an understanding that only the perpetrator's death will enable me to reach my "benefit." His death becomes a means to guarantee my own continuing life. Consequently, the assailant becomes an object that stands in my way to life. In this way of thinking, he is not seen as a "man," a "human being" with rights and with dignity, but rather as an object to be removed for my own safety. Only his death can be the means to my life. Such thinking is "either/or."

The principle of efficiency as used by utilitarians allows the "use" of people in the same way that one uses a hammer, a piece of technology, or a pesky gnat's death as a means to one's own wellbeing. When a utilitarian computes benefit, both quantitatively and qualitatively, there exists no anchor that makes humans unique bearers of value. When one thinks like a utilitarian, one engages in a "calculus of pleasure," as Jeremy Bentham projected, but the "pleasure" is subjectively tied to the person (Bentham 1823). Utilitarianism can be Rational Self-interest writ large.

Risk/benefit thinking of a purely utilitarian nature risks the kind of either/or thinking that ethics committees must avoid if they are to respect the dignity of persons in their arguments.

Ethics Committees and Religious/Cultural Issues

There is a growing phenomenon of "transplant culture" today; the American Red Cross gives persuasive speeches on bone, tissue, and organ retrieval and transplantation, encouraging people to fill out donor cards. Instead of having one's wishes expressed on the back of drivers' licenses, an argument is now raised that *not* having expressed a decision regarding organ donation is implicit consent. In such a culture it has been argued that it is wasteful to bury so many replacement parts, a violation of a social ethic. This as an area in which ethics committees do not face a *content* issue as much as they need to understand the role religion and culture play in ethical decision making; thus, it is a *process* issue. Different religious groups and cultures have value anchors that may differ from the norm. Practices such as Jehovah's Witnesses' rejection of blood and blood products must be respected at the same time that medical care is aggressively pursued (Vinicky 1990 and Bamberger 1987).

The religious communities of Japan are ambivalent to take sides around the issue of brain death

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as signifying the death of the person (Hardacre 1994). Again, what one culture accepts easily, another culture does not accept at all. One heart transplant has been done in Japan and the surgeon who was responsible for it was charged with and convicted of murder. The religiously motivated morality that rejects the brain dead as a storehouse of used parts to be employed for others has set its technological wizardry towards

development of an artificial heart (Hardacre 1994).

The Need for Strategies for Ethical Analysis

As increasingly difficult questions come before ethics committees for analysis, there is a growing need for more sophisticated strategies that will guarantee depth in ethical analysis. The contrasting strategy of utilitarian versus. deontological thinking is gone forever. Urging participants in the analysis to concentrate exclusively on consequences or exclusively on principles or formal values reinforces either/or thinking. It also introduces a false note in the way ordinary people work through ethical dilemmas.

In training ethics committees, I use three principal strategies: David Thomasma's work-up, Ralph Potter's "boxes," and SASA, a schema for analysis developed by Dr. Hans Uffelmann, a cofounder of the Midwest Bioethics Center and professor at the University of Missouri-Kansas City School and the University of Missouri-Kansas City School of Medicine.[1] Adherence to a strategy, like following a recipe, does not guarantee successful, in-depth ethical analysis; likewise, simply talking over issues, even with highly sophisticated, well-educated thinkers, may miss the mark as easily. Employing a strategy for ethical analysis provides a structure within which the discussion can take place.

David Thomasma, director of the medical humanities program at Loyola University Stritch School of Medicine, distills from the discipline of ethics an essential process of moral reasoning which can be used:

- describe all the facts in the case;
- describe relevant values (of physicians, patients, house staff/hospital staff, family, of the hospital itself and the society it serves, and so on;
- determine principal value clash;
- choose a course of action; and
- defend this course of action based on the values it professes (for example, why was one value chosen over another in this case?)

The advantage of Thomasma's strategy is that it is easy to get one's talking skills around it. The disadvantage occurs in the last step in which nothing normative is offered as a basis for the choice of one value over another, as if simply the best argument provides the best ethical choice. Frequently, much utilitarian thinking allows for an easy conclusion without regard to the dignity of the one/s whose values were not preferred. Consequentialist thinking permits that the minority be "used" as persons. Nothing in the strategy raises such an issue for consideration by the committee.

Another strategy for ethical analysis was devised by Dr. Potter and Talcott Parsons at Harvard when they were developing a structure for examining statements made by churches concerning the morality of the Vietnam War. Since that time, "Potter's Boxes" has developed into a strategy for analysis around health care issues.[2]

Empirical Definition of the Situation	**Assumptions/Beliefs**
Loyalties	**Mode of Ethical Thinking**

Application	**Evaluation**

This strategy has several advantages: 1) it makes overt the assumptions that often lie hidden in ethical analysis and weighs value considerations without the onus of defending them; and 2) it brings into the discussion the loyalties, the primary foci of concern, which lie at the heart of the reasoner and which, again, can weight an argument without the hearer's knowledge. And finally, 3) this strategy forces the one arguing to identify his/her mode of reflection. Such identification makes it easier and clearer to enter the argument by identifying those problems which attach themselves to every mode of ethical theorizing. For example, when one argues from rights, then one can be called to defend whether the right

in question is a positive or a negative right; if one is arguing from relationships rather than from duties, the charge can be raised that the ethical thrust is dependent on a fortuitous stage in a relationship, and so on.

Finally, there is SASA: Sensitize, Analyze, Synthesize, and Actualize. This strategy follows the same kind of thinking used in diagnostic evaluation as performed by a medical practitioner. First, the committee members sensitize themselves by asking "What are the Problems?" They attempt to delineate the "chief complaints" and to define the issues as best as possible. Then comes analysis of the facts relevant to the situation, identifying all relevant medical, social, economic, religious, familial, legal facts and relating them to the ethical issues previously identified and attempting to triage the problem list of ethical issues. Analysis leads to synthesis where the committee addresses what ought to be done. Here the members investigate options, examine risk/benefit ratios, and make a realistic judgment. Finally, the committee actualizes its decision, developing and implementing a plan of action.

Conclusion

However ethics committees will be challenged in the future, they will be expected not only to address issues which may not be foreseeable today but they will likewise be expected to have earned their moral authority as an ethics committee. Such authority is won only through becoming better in doing ethics. But ethics as a science does not simply encourage good argumentation. Clever debaters are not the most valuable ethics committee members. Ethics demands skillful use of argument but from a person who truly searches for the moral truth, for the right thing to do. "To act well as an intelligent human person, one must not only do the right actions, but one must know why such actions are correct to do. Only in such consciousness can a person act by self-direction and be free from external manipulation, at least to the degree possible in the human condition" (LaCroix 1979). The knowing and doing of "right actions" demands more than skills in opposing arguments with clever ripostes.

Endnotes:

1. Hans Uffelmann, PhD, holds a joint appointment as professor of philosophy and medicine at the University of Missouri-Kansas City. He has been honored by the university for "innovation of medical education" award because, since the beginning of the school of medicine in 1971, the first six-year combined BA/MD program in the United States, he has taught clinical ethics there.

2. William G. Bartholome, MD, MTS. was a student of Potter and Parsons during his 1974-1976 residence at Harvard as a Fellow in Medical Ethics. The schematic strategy has been adapted from the original model by Dr. Bartholome. Since 1986 Bill has served on the board of d irectors of Midwest Bioethics Center and has often assisted in ethics committee development where he has employed this strategy.

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