Editorial:
"Modern" Bioethics

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Inherent in the term "modern bioethics" is the idea that bioethics changes over time and "old-fashioned bioethics" no longer applies. Although core ethical principles may not change over time, peoples' judgment of what is ethical has changed.

Some say that advances in biotechnology have led to changes in our judgment about what is ethical. We now have ventilators, defibrillators, organ transplants, embryonic stem cell research, and the ability to clone life itself. All of these technological advances have created ethical questions that heretofore did not exist.

We are left to ponder some fundamental questions: What is human? What is the value of a human life? Who should decide what is human and what value should be attached to a human life? Who should judge quality of life?

Advances in biotechnology, however, are not solely responsible for modern bioethics. There are other influences in society that impact our perception of bioethics. Language plays a role. Many lay people, for instance, equate the term "vegetative" with "vegetable," thus reducing a person, previously viewed as human, to a mere kernel of corn—with no "quality of life." Although this is a gross mistranslation of a legitimate medical term, it is, nonetheless, how many people understand it, and their understanding has many profound consequences.

There is no question that in the environment of the modern welfare state, many have come to accept a utilitarian ethic—doing what is best for the greatest number. But are utilitarian bioethics ethical?

News media have played a significant role in how we view our society and ethics. The network "news" often contains significant bias in terms of what is covered and how it is covered. It's not "just the facts."

Television dramas are deliberately written to simulate news events that capture the public's attention. On Oct 12, 2005, NBC ran a new episode of *Law and Order*. It just happened to feature a young woman in a vegetative state, whose circumstances were strikingly similar to those of Terri Schiavo. The fictional woman was in a nursing home, surrounded outside by media personalities who were dutifully covering the display of people with pickets and signs, advocating either the right to live, or the right to die.

The fictional character's estranged husband was locked in a fierce legal battle with the young woman's parents—the husband wanting to discontinue her feeding tube, and her parents wanting to continue it. As the husband's car pulled away from the nursing home, it exploded.

The show went on to reveal that the young woman's family had conspired to kill the estranged husband in order to eliminate opposition to continued feeding and hydration of their loved one. Irrespective of the disclaimer that preceded the show—that these were all fictional characters that did not portray any real person or event—it is hard to escape the inference that people who advocate for continued feeding and hydration in such circumstances are not just "wrong," but are really bad people—i.e. "car-bombing terrorists."

Education also influences our view of bioethics. Recently, I attended a seminar entitled: "The Next Case: Medical, Legal, Ethical & Spiritual Issues in a Post-Terri Schiavo World." The seminar was offered under the auspices of the Center for Excellence in End-Of-Life Education Research & Practice. One of the sponsors was a local HMO.

The five speakers comprised three lawyers, one of whom was a judge; a doctor; and a priest. The moderator, who had served as the attorney for the parents of Nancy Cruzan, is currently a fellow at the Center for Practical Bioethics in Kansas City—a program supported by the Robert Wood Johnson Foundation (RWJF). I did not ask about the origin of the name of the center, but I surmised that some bioethics must be deemed "impractical."

The physician speaker was the medical director of a local hospice, and is cochairman of the National Surgical Palliative Care Workgroup of the Robert Wood Johnson Improving Care at the End-of-Life Initiative. He is also a master trainer for the EPEC (Education in Palliative and End-of-Life Care) Project—also funded by the RWJF. At the seminar, we were presented with handouts that listed "Fast Facts" taken from EPERC (End of Life/Palliative Education Resource Center)—yet another RWJF-funded entity. The RWJF, an avid promoter of socialized medicine, was never mentioned by name during the seminar.

One of the "Fast Facts" shared with the audience was: "No studies demonstrate improved quality of life *per se* [with tube feeding]." Upon checking the EPERC website, however, I found that the following words were omitted from the "Fast Fact" in the seminar handout: "[based on] a recent review of the literature...[which was] limited to a few observational studies."

Arguments offered against hydration included the statement that it "interferes with acceptance of the terminal condition." Also,

it was said that "ketones and other metabolic by-products in dehydration [act] as natural anesthetics for the nervous system, causing decreased levels of consciousness and suffering."

Arguments offered for hydration mentioned that it "provides a basic human need"; "may relieve acute thirst"; and "provides a minimum standard of care." The handout also listed some arguments against hydration under the "for hydration" category, presumably for the purpose of "helpfully guiding" attendees to the predetermined "right" decision—to withhold hydration. These arguments "for hydration" included the following: "Does not prolong life to any meaningful degree"; "allows providers to continue efforts to improve comfort and life quality, despite the perception of a poor QOL [quality of life]" (i.e. hydration is apparently viewed as a futile, unhelpful treatment for the patient and merely a "feel good" action for the provider); and "may set precedence [*sic*] for withholding therapies from other compromised patients" (i.e. providing hydration may be so "harmful" to the unconscious, terminal patient that it may be a reason to withhold *therapies* from other compromised, non-terminal patients).

Among the ethical questions left unanswered were these: Does hydration also interfere with a person's or family's "acceptance" of his condition (life unworthy of life?) if he is neurologically impaired but not "terminal"? Is it ethical to induce an abnormal metabolic state for the "purpose" of decreasing level of consciousness and causing death? Or should induced terminal ketosis be viewed as an acceptable "side effect" of "good intentions"? And, are there any circumstances in which death is the only means of providing relief from pain and suffering?

Ultimately, of course, bioethics is about patients, the patient-doctor relationship, and doing what is right for the patient. Patient autonomy and self-determination are fundamental elements of medicine and bioethics. Patients should be free to choose or refuse any medical treatment or procedure.

Unfortunately, outside the arena of self-determination, either in person or via advance directive, we enter the murky, legalistic subjectivities of "clear and convincing evidence," "substituted judgment" (conflicted or non-conflicted), and a court system ill suited to make such personal medical decisions.

Once a bioethical issue arrives in a courtroom, there is only one guarantee—no one will "win." Judges are not immune to the multitude of influences within the bioethical milieu where the culture of life and the culture of death vie for majority approval on a daily basis. Likewise, Congress is ill suited to make bioethical decisions.

Some justify congressional involvement by saying that desperate times call for desperate measures when a life is at stake. Others express outrage that Congress would ever involve itself in a medical decision. Yet, some of the very same people who express such outrage over congressional involvement in an individual medical decision are strangely silent with respect to the pervasive interference in medical decision making by the Medicare program. Congress is responsible, via a plethora of Medicare laws, rules, regulations and policies, for obstructing, impeding, and interfering with nearly every aspect of medical care for millions of seniors on a daily basis.

Physicians must take the lead in reaffirming what is ethical and what is not. Sorting the good from the bad and the ugly in the new, "modern" bioethics requires each of us to reflect on some very historic questions:

What is ethics?

What is truth?

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