The Future of Bioethics: A New Professor's Reflection

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Doing the right thing is always going to cost you. If you abide by ethical guidelines, that's usually going to get in the way of doing what you actually want to do. Ethics committees and review boards, IRBs, and corporate ethics officers are hurdles to be surmounted by whatever means possible so that you can then get down to business.

As a young professor of Christian ethics at a Catholic college, I'm not surprised that many of my students see taking their required religion and philosophy courses as something to submit to, rather than something to embrace. What I didn't quite expect is how much they see the content of my courses – ethics – in the same way. Perhaps idealistically, I had hoped that my courses in ethics might actually inspire students to *want* to act ethically. What I find more often is that they consider acting ethically as an obstacle to what they are aiming for in life. I can only conclude that the fault is partly mine, though perhaps it also reflects a broader problem for ethicists that we rarely consider: are we actually successful in convincing people and not just other academics? Do we as ethicists actually help our societies to understand and uphold the principles and visions that we espouse? Too often ethicists – especially bioethicists – function solely as troubleshooters after the fact or as urgent responders to dilemmas. I wonder how we can do a better job of functioning *constructively* in shaping an ethical culture.

In spring 2009, as the health care reform debate heated up, I found myself team-teaching a course on health care and social justice with a young health care economist. We had a fascinating meeting of the minds – but were both struck by how little sense our collaboration seemed to make to our students. Students, it seemed, were quick to assume that doing the right thing was always going to carry a steep economic cost, and that the two fields, therefore, were always going to offer conflicting advice. In response, at certain points, we asked the students to consider some ways in which an ethicist and an economist might agree – for example, that providing universal health care was a good thing not only because it upholds human dignity and equality, but also because it could, in the long run, lower health care costs by improving preventive care,

discouraging use of the emergency room for routine visits, and improving overall economic productivity. In addition, we showed them a well-known article from the *Harvard Business Review*, "AIDS Is Your Business," which argues that multinationals operating in Africa can lower their employee expenses by providing their HIV+ employees with antiretrovirals – something which, of course, an ethicist would also applaud – particularly if those companies distributed antiretrovirals even more broadly and invested in local health care infrastructure as well. Yet when we asked students to envision other scenarios in which best practices in ethics and economics might overlap, the idea was still so foreign that they almost couldn't understand the question.

I don't want my students to think that making ethical choices is easy, or even that it is not going to cost them something. However, how can I teach the future medical professionals, researchers, and business people in my classes that ethics can help them, rather than just hinder them, when it comes to providing good medical care, making the next key scientific discoveries, or even achieving economic success?

Perhaps I spend too much time in my classes on pointing out the great heroes, saints and whistleblowers. Certainly they are inspiring, but most of my students don't aspire to be the next Albert Schweitzer or Mahatma Gandhi. In fact, many of the students I happen to teach are first-generation college students, who don't even aspire to a "liberal arts education," but are just aiming at a ticket to the white-collar world. Studying heroism, consequently, may not be the best way to develop ordinary moral virtue.

Instead of holding up ethical paragons, perhaps I should be spending more time on ethical horror stories. There is no doubt that the key bioethics principles make more sense to students when they are familiar with the Tuskegee syphilis experiment or the Nazi programs of euthanasia and medical research. Horror stories are not enough, though. Yes, I want to help my students avoid becoming the next Taliaferro Clarks or Bernie Madoff, but I also want to help them see what it means to be an ethical citizen even when the stakes don't seem quite so high. Yet talking about ordinary ethical behavior doesn't make for very interesting course lectures!

I suppose what I am aiming for, really, is a way to communicate a more eudemonistic ethics – so that my students can believe that ethics and success can go hand in hand – provided one doesn't define that success too narrowly. Of course, virtue is its own reward. However, it can also contribute to more mundane satisfactions: a reputation for respecting patients' wishes is also a vital business asset for any hospital; recruiting volunteers for medical studies is much easier if researchers are known for careful protection of participants' safety; making sure that drug trials include participants of both genders and multiple races is not just political correctness – it also yields results that are

more helpful in the long run by anticipating possible side effects more accurately. It is no coincidence, I tell my students, that some of the most successful businessmen in history have been Quakers, who made great fortunes (in spite of their commitment to simplicity) on the basis of their reputation for honesty and fair prices.

This is not just a pedagogical challenge, of course. My students' attitudes reflect a broader sense, in our culture, that what ethicists have to say is likely to be obstructionist, abstruse and irrelevant. The task for bioethicists is to move beyond this perception. Of course such a perception is somewhat inevitable, provided that bioethicists continue to fulfill their vital function as watchdogs. But the future of bioethics depends upon training ethicists for the constructive task of ethics, not just the critical. Here we must begin by focusing on the ethical task of helping to identify the shared goals and values we possess. Though it seems simple, the values that are at stake – and the question of how they rank and relate to one another – are not always clear. Next, the ethicist must also serve the task of helping to identify the things that are actually obstructing the achievement of these goods. For example, we say we want good care from our doctors, but we tolerate a billing system and a malpractice system that forces many doctors to spend no more than 15 minutes per patient, thus thwarting the very thing we say we want. Finally, bioethicists must become more involved in suggesting substantive changes: new policies, goals, laws, et cetera. To do this, the field of bioethics must remain deeply interdisciplinary; we need the economists and the medical professionals and the actuaries to help us explore what is possible within the limitations that do exist. For there is that basic principle that we are not obligated to perform those things that are not actually possible.

A more constructive bioethics does not require a revolution in the way we do our work, but a more subtle change in tone and focus. Can we strike a tone that is rigorous and yet not adversarial, so that researchers can see the IRB as an ally in doing good science? Can ethics education for professionals in the field focus less on compliance and more on the big picture? I believe many hospital ethics committees have moved in this direction, and medical professionals are becoming more likely to see an ethics consult as a helpful thing rather than a burden. The overwhelming pace of technology and the challenges of distributing medical care equitably are such daunting problems that guidance from ethicists may even be genuinely welcome in some quarters. In light of these challenges, my hope for the future of bioethics is that we may become and be seen more and more as partners in a joint endeavor to seek genuine wisdom about how to promote the flourishing of our fellow humans and the world we live in. That, I think, might get my students' attention.

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Responses

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The thesis of Laurie Johnston's thought-provoking essay seems to be that the future of bio- and health care ethics should move away from a 'dilemma-centered' approach and focus instead on a more constructive project—and in particular, one which shows that the flourishing of human beings and ethical behavior, instead of being mutually exclusive, actually build on each other. I believe that the general thrust of this thesis is correct, and it certainly indicates how bioethics can contribute something important to health care (and our society at large), but in this response I wish to add some cautions and qualifications.

Even if, somehow, we are able to work with a similar account of the ethical and/or the good life, I worry about leaving the dilemmas behind. We would still have questions, say, about when a human person comes into existence and when a human person has died. We will still ask about what it means to be dishonest with a patient or insurance company, how much of our GDP should be spent on health care, what 'basic' health care means, what constitutes 'aiming at death', and dozens more very important questions which require a very careful, detail-oriented approach. Working with a common understanding of the good and/or of the ethical makes these questions easier to engage, but much work and difficulty nevertheless remain. Ideally, those who take bioethics courses and read bioethics publications will realize that it requires both asking the big questions *and* parsing complex cases and technical arguments in order to address the bioethical issues of our time.

When bio- and health care ethicists do add the big questions to the cases and technical arguments, I agree with Johnston that this must be an interdisciplinary effort. We must bring in the experience of philosophers (especially of biology), theologians, scientists, clinicians, anthropologists, sociologists and more. I was fortunate enough to have taught a course on "The Vocation of the Healthcare Provider" last term with a scientist and a sociologist, and it was a great benefit for both me and my pre-medicine students to have these multiple perspectives engaged. Johnston understandably worries that holding up saints and heroes will frustrate her students who cannot themselves lead such lives, but it is difficult for many to understand how all these ideas and perspectives can work together. I've found that stories of great people go a long way toward both teaching what a coherent practice of the bioethical life looks like, and can inspire people to attempt to live a life that follows a similar path. (Here it might be important to note that God came to us as an embodied person, Jesus, and not as a set of abstract propositions.) It is also important to remember that many of these great people are seriously flawed such that they are

more "human" and able to be identified with.

I also wonder if, given our pluralistic discourse, we will actually be able to identify a eudemonistic approach as the right one in the first place—to say nothing of being able to identify what counts as human flourishing once and if we do. Johnston, for instance, suggests that ethical behavior can produce flourishing given that ethical business practices often make more money for businesses that engage in such practices. But one could argue about whether this actually obtains in most business practices (those who are dishonest and manipulative often fare very well), and whether making money is a helpful way of talking about flourishing. Furthermore, we need to remember that sin permeates the social structures of our health care system such that ethical behavior is often not rewarded in this way. Getting a medical degree often requires a huge amount of debt, and it is often difficult to pay back with the money one makes serving vulnerable populations. This is equally true of many hospitals that attempt to serve the most vulnerable. St. Vincent's was the last Catholic hospital in Manhattan before it was recently forced to close, unable to make enough money due to the very large Medicaid and immigrant population it served. One of the things that bioethics can do is to show that so many of our problems are, in fact, based on social *structures* of sin—and that we cannot pretend to be offering solutions to these problems without addressing this.

One topic on which we should focus is on the flourishing of human beings *as animals and as a species*. Multiple perspectives can buy into this framework and have a common conversation about it—especially given the empirical data that is available. We might ask, for instance, how our current interns, residents and other physicians are doing out there in the field. Of all the professions, physicians have some of the highest rates of depression, addiction to alcohol and other drugs and suicide. And those they treat are not far behind: despite the monstrous sums of money spent on health care, Americans are a physically unhealthy people (dominated by epidemic rates of obesity, diabetes, and a poor life-expectancy) and a mentally unhealthy people (dominated by various kinds of anti-depressant and other drugs). Furthermore, and despite the widespread availability of contraception, STD rates continue to surge: over 25 percent of New Yorkers now have a sexually transmitted disease.

Despite the fact that almost all of us can see that these problems are serious, our culture forces them out of our public consciousness. We bombard ourselves with images of health, youth, beauty and sexuality—and push those who do not fit this image to the margins of our culture. We continue to buy and consume and have sexual relationships in a way that is disconnected from our own health and the health of others. In addition to raising awareness about the social structures of sin, bio- and health care ethics should also uncover how many of the choices of both physicians and everyday Americans can have a dramatic impact on individual and

communal health. Both are necessary if we are to have positive change in American health care.

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I agree with Johnston: ethicists should function constructively as well as critically. However, there are different social roles of ethicists that shape how an ethicist will be constructive and critical. Distinctions between these roles of ethicists is not explored in Johnston's essay, but it is helpful to see how academic ethicists and clinical ethicists[1] can be and have been both constructive and critical. I will draw on my experience as an ethicist in academia and health care by describing examples of how ethicists might fulfill Johnston's three-part proposal.

First, Johnston proposes that ethicists should help to identify shared goals and values. In academia, ethicists inform ethics education through pedagogy and learning outcomes. Here, one should connect specific learning objectives for a course to learning outcomes of a curriculum (i.e., curriculum mapping). Such learning outcomes should correlate to the social roles for which students are preparing and could include attention to framing shared goals and values. Ethics-related learning outcomes for an undergraduate program will be different, and perhaps more generic, than those for graduate or professional programs. In the master's in bioethics program, our faculty derived many learning outcomes from specific competencies expected in health care ethics.[2] In this design, each course supports students in developing those competencies. In addition, I integrated discussions of the relationships between institutional interests and power,[3] as well as structural violence,[4] into courses I taught, including courses in biotechnology and nanotechnology. This was to help my students – some are future ethicists – in looking beyond quandaries in ethics. The point was less to reach agreement on goals or values *per se* than to prepare students to engage in ethical discourse *about* those goals and values by being able to recognize fundamental factors in ethical issues.

In health care, ethicists align their services to professional practices and delivery of quality health care. For example, the Providence Ethics Center developed ethical components to the professional competency domains of physicians[5] to make explicit the role of ethics and to support the goals of our residency programs.[6] This has a twofold effect: ethics is connected to helping doctors be better doctors (i.e., medical professionals not technicians), and ethics is linked to graduate medical education in an integrative, complementary way not as an "add-on." Moreover, through real-time consultation, clinical ethicists help

providers deal with cases that challenge shared notions of a good society because certain patients (a.k.a., "difficult," "non-compliant," or "hateful" patients), for example, explicitly reject such shared notions.[7] In fact, data show that providers do not always see ethicists as 'obstructionist,' but doctors and other professionals vary in their perceived need for ethics support.[8] This variation may be due to exposure to ethics in professional development and other ways in which individuals have been socialized to ethics and their professional roles.[9]

Two, Johnston suggests that ethicists should help to identify the obstacles to achieving shared goals. Generally, I characterize the contribution of academic ethicists as tending toward hermeneutics whereas the contribution of clinical ethicists as tending toward heuristics. Of course, this is an oversimplification as academic and clinical ethicists both engage in hermeneutic and heuristic work. Academically, ethicists contribute immensely to the development of ethical thought across the gamut of topics. These contributions occur in scholarly work by individuals and collaborative work across disciplines. Without contributions of rigorous scholarly explorations of ethics and various practices and social structures, clinical ethicists would find it impossible to recognize moral meaning and ethical importance in personal and professional relationships. Clinically, ethicists help address issues retroactively, interactively, or proactively through integrated practices such as rounding, consulting and debriefing. For example, over time, moral distress encountered in challenging cases (e.g., those with "non-compliant" patients) affects professional practice and moral sensitivity, and it is often related to external infrastructures or practices that place health providers in morally precarious positions.[10] An adequate ethical response might be, then, a systemic one where an ethicist directly helps identify and ameliorate those causes thereby preventing moral distress and eliminating the build-up of moral residue.

Finally, Johnston proffers that ethicists should actively participate in substantive changes, which can happen locally – in classrooms and at bedsides – and more globally. Ethicists of any ilk can model public discourse on ethically charged issues, and ethicists can engage in public discourse and social reform when needed and in ways correlative to their competencies. There are local, more intimate examples of substantive changes in academics and health care, too. Academic ethicists can identify existing models for integrating exposure to real-world problems and practices that address them into their teaching.[11] For example, I used a grant to integrate a service-based learning module into a course on social justice and bioethics. Clinical ethicists can perform a variety of functions that result in substantive contributions. Although ethics consults are advisory, they can have a profound impact on professionals, patients and families. Some have published data on how ethics consults may limit usage of so-called non-beneficial life-sustaining treatments.[12] Other examples of substantive influence of ethics

in our organization include the development of institutional policies on certain practices such as Donation after circulatory death (DCD), informed consent or refusal, and others. Plus, when it comes to certain organizational decisions, Providence ethicists and mission directors engage in a deliberate process of ethical discernment to assist an organizational leader in making an ethically-sound decision (for example, on whether to continue or close a service line).

In conclusion, ethicists in academic and clinical settings may share visions of ethics in society, but these ethicists do not share the same social roles. However, despite these differences, ethicists in any setting have potentially and ideally a complementary impact that aims at constructive and critical social transformation with a willingness to engage with partners for the betterment of society and the common good.

[1] I will use the term *clinical ethicist* to refer to the ethicist working in non-academic settings. I recognize, however, that there are a myriad of ways an ethicist works outside of academia, for example, as a system ethicist, a regional ethicist, or similar positions. I also recognize, as was the case with my position at the Bioethics Institute of Loyola Marymount University, that some academics function in both clinical and academic settings.
[2] American Society for Bioethics and Humanities, *Core Competencies for Health Care Ethics Consultation*, 2nd edition (Glenview, IL: ASBH, 2011).
[3] Ian Barbour, *Ethics in an Age of Technology*: The Gifford Lectures Volume 2 (San Francisco, CA: Harper San Francisco, 1993).
[4] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkley, CA: University of California Press, 2005).
[5] See Thomas J. Nasca, et al., "The Next GME Accreditation System – Rationale and Benefits," *New England Journal of Medicine*, nejm.org, 10.1056/NEJMsr1200117, published February 22, 2012, accessed February 28, 2012.
[6] John Tuohey and Nicholas Kockler, "The Role of Ethics Education at a Teaching Hospital," *Health Progress*, 2012, forthcoming.
[7] For example, see James E. Groves, "Taking Care of the Hateful Patient," *New England Journal of Medicine*, 1978, 298 (16): 883-887; and Joy D. Skeel and Kristi S. Williams, "Helping Staff Help a 'Hateful' Patient: The Case of TJ," *Journal of Clinical Ethics*, Fall 2005, 16 (3): 202-205.
[8] JP Orlowski, et al., "Why doctors use or do not use ethics consultation," *Journal of Medical Ethics*, 2006, 32:499-502; and Gordon DuVal, et al., "A National Survey of U.S. Internists' Experiences with Ethical Dilemmas and Ethics Consultation," *Journal of General Internal Medicine*, 2004, 19:251-258.
[9] For example, see Christine Grady, et al., "Does Ethics Education Influence the Moral Action of Practicing Nurses and Social Workers?" *American Journal of Bioethics*, 2008 8 (4): 4-11; Johane Petanaude, et al., "Changes in students' moral development during medical school: a cohort study," *Canadian Medical Association Journal*, 2003, 168 (7): 840-844; and Donnie J. Self, et al., "Clarifying the Relationship of Medical Education and Moral Development," *Academic Medicine*, May 1998, 73 (5): 517-520.
[10] Elizabeth Gingell Epstein and Ann Baile Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *Journal of Clinical Ethics*, Winter 2009, 20 (4): 330-342.
[11] For example, see Linda A. Mooney and Bob Edwards, "Experiential Learning in Sociology: Service Learning and Other Community-Based Learning Initiatives," *Teaching Sociology*, April 2001, 29 (2): 181-194.
[12] Lawrence J. Schneiderman, et al., "Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial," *Journal of the American Medical Association*, 2003, 290 (9): 1166-1172.