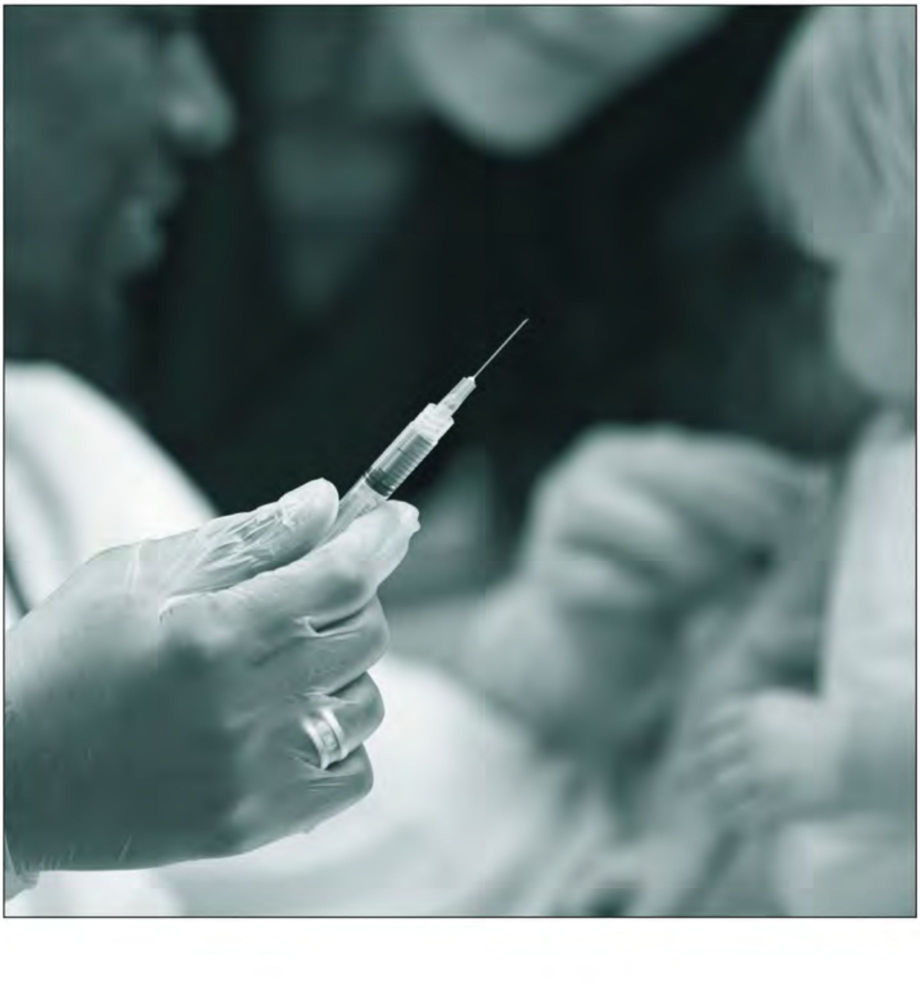
Ethics & Medicine

An International Journal of Bioethics



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PRESS

EDITORIAL

Conflicts of Conscience Matter Because Medicine Matters

C. BEN MITCHELL

Although conflicts of conscience in health care are episodic and relatively rare, they are becoming increasingly frequent as societies become more pluralistic. Refusals by physicians and pharmacists to prescribe emergency and other contraceptives have fueled debate about the role of conscience in health care in the United States. Historically, as University of Chicago physician-ethicist Farr Curlin and colleagues point out, doctors and nurses have not been required to participate in procedures that violated their consciences, e.g., to participate in abortions or assist in suicides. In fact, legislation in states where those practices are legal has more often than not included so-called conscience clauses to protect health care professionals. (though they sometimes seem to be conscience clauses without a conscience)

The growing controversy over emergency contraceptives has led some to criticize conscience clauses. For example, Alta Charo, the out-spoken professor of law and bioethics at the University of Wisconsin at Madison, suggests that the conflict over conscience clauses ‘represents the latest struggle with regard to religion in America,’ and criticizes those who would claim an ‘unfettered right to personal autonomy while holding monopolistic control over a public good.’ Likewise, Oxford ethicist Julian Savulescu declared stridently, ‘a doctor’s conscience has little place in the delivery of modern medical care . . . if people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.’

What Curlin, et al., demonstrate empirically is that physicians themselves are divided about the role of conscience in clinical practice. In their study of more than one thousand physicians (n=1144), they found that most physicians believe it is ethically permissible for doctors to explain their moral objections to patients. That is, 63% thought that explaining their moral objections to certain procedures was not a violation of the physician-patient relationship. Eighty-six percent believed that doctors are obligated to present all options to patients, even those the doctor thinks are morally dubious and 71% thought they should refer a patient to another clinician who does not object to the procedure. Furthermore, 52% reported objections to abortion for failed contraception and 42% objected to prescribing contraception for adolescents without parental consent.

Curlin and colleagues rightly worry that, if their results are accurate, in many cases a patient’s right to informed consent is jeopardized. ‘If physicians’ ideas translate into their practices,’ they say, ‘then 14% of patients—more than 40 million Americans—may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29% of patients—or nearly 100 million Americans—may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments.’ So it is becoming increasingly important that we understand what we are claiming when we claim protection of freedom of conscience.

Having said that, if the protection of one's conscience is an important duty, physicians' and other professionals' consciences count. Legatees of the Hippocratic tradition in medicine should be loath to turn physicians in to 'service providers', patients into 'consumers', and medicine into a commodity. As long as the physician-patient relationship is a covenant to do good and not to harm, the consciences of both physicians and those for whom they care should matter. When the consciences of physicians ceases to matter, medicine will not matter. **E&M**

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CLINICAL ETHICS DILEMMA

WHEN DOCTORS DISAGREE

ANONYMOUS*

Editor's Note: *This column presents a problematic case that poses a medical-ethical dilemma for patients, families, and healthcare professionals. As it is based on a real situation, some details have been changed in the effort to maintain patient confidentiality. In this case, two board-certified ophthalmologists do not 'see eye-to-eye' regarding the importance of a current surgical procedure. The hospital chairman explains his rationale.*

Column Editor: Ferdinand D. Yates, Jr., MD, MA (Bioethics), Professor of Clinical Pediatrics, State University of New York at Buffalo, and Co-chair of Healthcare Ethics Council, Center for Bioethics and Human Dignity at Trinity International University.

Question

Should the chairman of the division of ophthalmology for a community hospital renew a Christian colleague and partner's application for surgical privileges?

Case Presentation

As chair of a surgical specialty division in a rural hospital, I was in a difficult position when asked to sign off on the application of a Christian colleague for renewal of cataract surgical privileges. There were four members of our ophthalmology department, and we each were credentialed to perform cataract surgery. The colleague up for renewal was subspecialized in a nonsurgical area of ophthalmology, providing the only access to that important subspecialty in our area, and he was a recognized expert in this area of subspecialization. He had previously learned cataract surgery during an excellent residency completed about fifteen years ago. Following residency, he did a two-year fellowship in the medical subspecialty, and he then joined our staff. During the first two or three years with our group – while building his specialty practice – a significant portion of his patients were in general ophthalmology, thereby generating twenty to thirty cataract surgeries a year. The number of surgeries quickly decreased until, after a few years, he was doing less than ten cataract surgeries a year. He adamantly refused to change the surgical technique he had learned during residency even though profound advancements in cataract surgical techniques were adopted by nearly every cataract surgeon during that period of time. His surgical operating time was routinely in the one to two hour range, rather than the half hour or less operating time of the other members of the staff. In addition, his patients routinely took three months to recover from surgery instead of the three weeks or less which by now was considered standard, and they often needed a stronger prescription in their post-op glasses than was now routine. This long post-op course usually required six to eight office visits instead of the three visits now considered standard. The surgical complication rates and the final visual results, however, were only modestly poorer than averages for the staff as a whole.

To me, it seemed clear that his cataract surgical privileges should not be renewed. Prolonged surgical times added the risk of anesthesia complications; in addition, prolonged vision rehabilitation time with a larger refractive error added significant morbidity. Furthermore, performing so few cataracts each year using an outdated technique betrayed the patient's trust.

Ethical Questions

If we say that brief anesthesia time is important, should only the very swiftest surgeons be allowed to operate? Complication rates vary among surgeons for many reasons, and the process of credentialing only those with the lowest rates may eliminate excellent surgeons who have committed their professional working lives to the surgical care of patients. How much influence should a chairman have in withholding privileges from a colleague who may well be competing with the chairman for surgical patients? Removing cataract privileges might well cause this subspecialist to move out of the area, thereby eliminating access to important vision-preserving care for many other patients. Might sacrificing morbidity for a few patients be worth it to save the vision of many others? Viewed from a more global perspective, the surgical techniques felt to be inadequate in our country remain standard in the underdeveloped areas of the world. Do we Americans have a *right* to superior care?

Resolution

I thought it would be easy to convince my colleague to voluntarily give up cataract surgery. After all, he was spending a great deal of time with every cataract patient both at surgery and in follow-up visits, and he was often under pressure from patients pressing him to explain why their recovery was so much slower than their friends. I pointed out that the morbidity he was causing could be considered a disservice to his patients. I also showed him financial scenarios of his cataract procedures; it was clear that replacing the surgeries with office subspeciality work was expected to generate substantially more income per hour.

He responded by suggesting that according to my reasoning we should identify only the very best surgeon for every procedure and then only credential that one surgeon. He believed that a basic problem with the subspecialty medicine performed in the United States today was the very narrow exposure of many subspecialists to the broader specialty field. To avoid this loss of broader knowledge, he believed that it was important for the subspecialty ophthalmologist to continue doing cataract surgery, a basic procedure for all ophthalmologists. He pointed out that, in the end, his vision results were within an acceptable range. He believed that physicians often chased the latest innovation, only to find a significant shortcoming for some of these procedures later. He also noted that current cataract surgical techniques make subsequent retinal exam more difficult. Why should he be forced to follow the latest trends? In addition, since he was taking his turn with coverage for the emergency room, he felt that ongoing familiarity with the operating suite was important when an emergency case required surgical intervention.

Denouement

I consulted with other ophthalmologists, hospital administrators, the medical director, and attorneys. The hospital board, on combined recommendations, did not renew cataract surgical privileges for the physician. He remains in the community, remains my friend, and continues to provide emergency room coverage. Christian colleagues may disagree, but eventually the patient's best interest must be allowed to dictate the medical process.

Editor's Comment

The goals of medicine may not entirely coincide with the goals of the medicine (surgery) man. Whereas some may opine that the former may be more of an ethereal philosophy, many feel that the goals of medicine should be simultaneously preventative and restorative and that the physician should assist the patient in health maintenance. On the other hand, whereas the goals of the latter (the physician-surgeon) often acknowledge the goals of medicine, they may also be more personally oriented, including a vision of financial gain or personal achievement.

The medical professional must have a specialized body of knowledge and an interactive relationship with the patient. The patient is often not in a position to judge the specialized information offered by the physician; as a protection in health-care delivery, licensing boards, accreditation bodies, and specialized examinations help to assure the competence of the physician. The patient, however, is in a position to judge the results of the procedure based on the patient satisfaction of his or her next-door neighbor. When a physician accepts a patient, he implicitly engages in a covenant of care and a fiduciary responsibility of compassion.

The competent professional physician is observed by both the colleague and the community, and he must indeed learn to serve two masters.

Suggested Reading

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*Editorial note (Dr. Mitchell)

From the makers of **eggsploitation** and ***Lines That Divide***

Anonymous Father's Day

What is it like to grow up not knowing who your father is or if you have any siblings? What is it like to find out that the man you thought was your dad is not your biological father, that your true biological father donated his sperm and is known only by a number? How does it impact your self-perception, the choices you make, and your view of life and the world? Donor-conceived people are demanding answers to these basic questions about their origins, their lives, and their identities.

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GREY MATTERS

When Conscience Meddles with Ethics

WILLIAM P. CHESHIRE, JR., MD

God has given everyone a conscience. -- Dietrich Bonhoeffer[1]

Abstract

The right of conscience is the right of an individual to refuse to do something requested by another on the basis of a deeply-held moral belief. Although debates over rights of conscience in medicine have focused on controversial questions at life's margins, the physician's exercise of conscience also extends to many other areas of care. Conscience is at the heart of the medical profession's commitment to honesty, compassion, and taking responsibility to prevent harm. Conscience in obedience to truth is the bedrock on which rests the moral integrity of the physician, which is essential to the patient's trust.

Objections to a medical professional's right of conscience have been based on flawed reasoning. The argument that physicians should provide any medical service that is legal upon request jeopardizes the moral integrity of the physician who is required to implement interventions he believes to be harmful to patients. Whereas the patient's right to refuse a treatment is nearly inviolable, a patient's right to demand a specific treatment is subject to physician discretion. To compel the physician to act in violation of his or her conscience would be to require that professional to become complicit in an action that he or she believes to be harmful or immoral.

The philosophical appeal to moral relativism is also flawed, because to insist that there is no universal standard of morality in medicine is to assert a truth claim that itself is not empirically verifiable. The absence of consensus on moral issues, on which conscientious people may disagree, does not establish that there exists no truth to be found on those issues. Differing views on ethical dilemmas are inevitable in a pluralistic society and should be welcomed as opportunities for dialogue and discovery. Moreover, to consider the patient's moral beliefs to be worthy of respect rather than arbitrary is to acknowledge the validity of moral beliefs.

Neuroscience, while not possessing a complete theory of conscience, has mapped brain regions underlying moral reasoning. Conscience, which has both innate and cultivated aspects, involves empathy, social awareness, reasoning, memory, and assessment of anticipated consequences. The cognitive capacities that enable conscience are essential to human interactions and growth in wisdom. They are also imperfect. An individual professional's conscience is answerable to the professional community, to humanity, and to God.

Medicine strives for a higher moral standard than can be codified in law, rationalized by philosophy, or pictured by brain scans. Abstract disciplines are detached from the patient as person, but medicine cannot be morally neutral. Medical care is actively concerned with human health and need. The practice of medicine is not merely an exchange of information or a technical procedure but is first and foremost a moral endeavor. The conditions at the bedside — the fact of illness, the act of profession, and

the provision of medicine — define the healing relationship, where patient and physician partner together as moral agents for the patient's benefit. Preservation of the moral integrity of the medical profession is in everyone's interest.

Dissent can be most inconvenient, especially when a lone voice impedes a well-devised plan. Might dissent at times be a moral imperative? Authorized programs, legally-sanctioned policies, or ethically-endorsed guidelines sometimes draw lines that conflict with the deeply-held beliefs of part of the community. They may conflict with the values of a minority, or they may compromise the values of a majority for the sake of an ostensibly greater good. When such conflict moves from discussion and debate to requiring people to act in violation of their most deeply-held moral principles, dissenters may appeal to conscience to justify their nonparticipation.

Conscience, according to the *Oxford English Dictionary*, is "the sense of right and wrong as regards things for which one is responsible; the faculty or principle which pronounces upon the moral quality of one's actions or motives, approving the right and condemning the wrong."[2] The right of conscience is the right of an individual to refuse on the basis of a deeply-held moral belief to do something requested by another. That personal belief may derive its moral authority from reason, religious teaching, professional ethos, or secular sources.

The debate over rights of conscience in health care has often focused on controversial issues at life's margins such as abortion and decisions at the end of life. There are further questions of conscience that arise in the practice of medicine. Should a physician disclose a medical error to a patient who has suffered an adverse outcome?[3,4] Should a physician ever misinform an insurance company with the intent of benefitting the patient?[5] Should a physician prescribe a legal memory-enhancing drug to a student who requests a cognitive boost for the purpose of outperforming other students on a competitive law school entrance examination?[6-8] Should a physician practicing in a jurisdiction where physician-assisted suicide is legal prescribe a lethal drug at the insistent request of a depressed 18-year-old woman who feels that life is unendurable yet has no terminal illness?[9-12] Should a physician, by monitoring vital signs, participate in government-sanctioned torture of a prisoner if other lives are at stake?[13-15]

The obligations and limitations of conscience in health care are a recurring subject of controversy. In support of the long-recognized right of conscience in medicine, physician and ethicist Robert Orr writes, "A health care professional's right of conscience is foundational to the practice of medicine, nursing and pharmacy."[16] One cannot apply scalpel and syringe to flesh and blood without realizing that the practice of medicine is a moral endeavor. Medical technology and the knowledge to apply it in response to illness entail the potential for healing or for harm. Physician and ethicist Edmund Pellegrino writes, "Medicine is a moral enterprise, and has been so regarded since Hippocratic times: that is to say, it has been conducted in accordance with a definite set of beliefs about what is right and wrong medical behavior."[17]

Medical professionals are obligated to evaluate the moral significance and consequences of their actions. Furthermore, the conditions at the bedside – the fact of illness, the act of profession, and the provision of medicine – define the foundation of the healing relationship between physicians and patients which, Pellegrino argues, is necessary to preserve the moral integrity of each.[17] Implicit in the medical encounter is the realization that both the physician and the patient are moral agents. The patient faces decisions about following a healthy lifestyle, whether to take recommended medications or undergo medical tests and procedures, as well as how to live when faced with serious illness. The physician is obligated to respect the patient's autonomy, to enhance the patient's ability to make informed health decisions, to make a concerted effort to relieve suffering and not injure the patient, and to abide by professional ethical standards. Because of the nature of the medical relationship in which the patient is in a position of vulnerability and the physician in a position of greater technical knowledge, power, and authority, the weight of moral obligation rests on the physician, who professes a promise to help the one who is ill. Conscience and the ethic of responsibility, which the physician freely accepts by professing to heal those who are ill, are indivisible.

Ethical dilemmas arise when physicians and their patients differ in their beliefs about the morality of specific medical interventions. Reasonable and well-intentioned people often reach different conclusions on difficult ethical questions. In a morally pluralistic society, universal agreement between physicians and patients is no longer possible, especially in regard to crucial life decisions.

Physicians also differ in their beliefs about the role of professional conscience in medicine. A recent University of Chicago survey of U.S. primary care physicians found that 42% believe that they are never, and 22% that they are sometimes, obligated in medical practice to do what they personally believe is wrong, while the remaining 36% held a middle view.[18] Physicians acknowledging religious belief were more likely than those with low measures of religiosity (58% v. 31%) to conclude that physicians are never obligated to do what they believe is wrong.[18]

In opposition to the right of conscientious objection in medicine, the philosopher Julian Savulescu argues, “A doctor's conscience should not be allowed to interfere with medical care.”[19] Elsewhere, the lawyer Julie Cantor writes that the physician's conscience derives from what she considers to be “the randomness of individual morality” which, in her view, “is a burden that … patients should not have to shoulder.”[20] In opposition to current federal health care conscience protection statutes, Cantor writes, “Physicians should support an ethic that allows for all legal options, even those they would not choose” and “cast off the cloak of conscience when patients' needs demand it.”[20] Both argue that physicians unwilling to provide medical services in situations where those services would be contrary to their moral beliefs should be punished or excluded from the practice of medicine.[19-21] Their arguments demand closer scrutiny.

Skeptical of postmodern moral skepticism, the political scientist James Q. Wilson writes that “most of us have moral sense,” but “some of us have tried to talk ourselves out of it.”[22] In arguing that there can be no universal standard of morality in medicine, Cantor is herself asserting a standard of truth that is not empirically verifiable. The absence of agreement on moral issues, on which conscientious people may differ, does not establish the proposition that there exists no truth to be found on those issues. The rhetoric of moral relativism, as much as the rhetoric of moral intransigence, impedes ethical discourse because it tends to shut down dialogue.

Moreover, the physician who believes his or her own moral beliefs to be arbitrary may be more likely by similar logic to dismiss the patient's moral beliefs as not worthy of genuine respect. Pellegrino wisely exhorts physicians and patients to “recognize where their value systems coincide and where they diverge. In the vulnerable state of illness, patients must be protected against submersion of their value systems without, on the other hand, expecting the physician to sacrifice his own."[17]

Cantor joins other opponents to a physician's right to exercise his or her conscience in asserting that physicians are obligated to provide any and all services that are legal. That assertion, however, is based on the faulty premise that legislation and medical ethics are interchangeable. Laws are binary, whereas medical decisions are discriminatory. Even in the most enlightened nations laws have been enacted that violated basic human rights. Laws change over time and differ from place to place, whereas the physician's responsibility to patients is always and everywhere paramount. It may be technically legal to amputate the healthy limb of a psychologically-disturbed patient who requests such a procedure. Some ethicists even justify such amputation on the basis of the patient's autonomy.[23] Legality alone does not render the procedure harmless or morally correct.

Robert Orr has pointed out that opponents to a physician's right to conscience also use flawed reasoning in asserting that negative patient autonomy (the right to refuse a recommended treatment) and positive patient autonomy (the right to demand a treatment) are morally equivalent. A well-established tenet of medical ethics is that the patient's right to refuse is nearly inviolable, whereas a patient's right to demand a specific treatment is subject to physician discretion.[24] To compel the physician to act in violation of his or her conscience is to require that professional to become complicit in an action that he or she believes to be immoral.[16]

Savulescu imagines that he has exposed the conscience claim as nothing more than an excuse for selfishness or shirking one's duty.[19] His analysis of conscientious objection in medicine begins with an appeal to the Bard of Avon: "Shakespeare wrote that 'Conscience is but a word cowards use, devised at first to keep the strong in awe.'"[19] More correctly, Shakespeare had his character Richard III utter those words of irony. Here Savulescu bases his ethical position on one of literature's most infamous villains whose Machiavellian rise to power is marked by ruthlessness and treachery. In the play, conscience visits Richard III in a dream as the memory of those he murdered, to which he replies defiantly in the very next verse, "Our strong arms be our conscience, swords our law."[25] Physicians would be well-advised to look elsewhere for a moral foundation for the practice of medicine.

The discipline of philosophy, being detached from patient care, is at a disadvantage in seeking to understand the full meaning of conscience. Sitting back and pondering theoretical arguments is one thing. It is quite another to assume responsibility in medical practice for the consequences of ideas in the application of medical science to the lives of suffering people. Dr. William J. Mayo once commented that "[i]t is easy to philosophize; (quoting Oscar Wilde) the philosopher is the one who bears with equanimity the sufferings of others."[26] Whereas the philosopher's intellect operates within the hypothetical realm of moral neutrality, the physician's conscience must not be indifferent to human need.

The study of the brain may further illuminate an understanding of the conscience. The convergence of neuroscience, behavioral science and moral philosophy is providing fascinating glimpses into the neural basis of moral reasoning.[27,28] The philosopher Patricia Churchland speculates that the phenomenon of conscience amounts to "the negative feeling evoked by emulation of a social action" related to the neuroscientific frameworks that encode feelings of reward and punishment, injunctions and warnings, social emotions such as regret, and theory of mind.[29]

Images of brain function tend to emphasize the perspective that the ability to produce behavior that conforms to ethical rules is the result of neural and molecular mechanisms.[30] The reductionistic approach of neuroscience, looking inward to the brain rather than outward to consider the whole of reality, may seem to suggest that matters of conscience reduce to the firing of a few neurons. A description of conscience restricted to neurology would be as limited as the view that the brilliance of the sun consists in the flash of neurotransmitters in the visual cortex. Such approaches, while informative, are necessarily incomplete. Brain images are descriptive, but they cannot be normative. Colorful images of neural circuits lighting up in response to moral thoughts may lead to more detailed scientific descriptions, but they cannot resolve ethical grey matters or ascertain how one ought to think. Pellegrino asks, "[I]s ethics swallowed by science, by neurology?"[17] Hardly. Rights of conscience, though invisible to brain scans, are palpable in the lives of people.

In 1927, the neuropathologist Constantin von Monakow advanced his theory of biological conscience in which he hypothesized two levels. He proposed that every person has both an innate biological normative filter and a cultural normative filter acquired through learning and social development.[31,32] Cultivation of a healthy conscience requires education, moral reflection, the use of reason, participation in human community, and humility before God. Most religious traditions recognize that conscience at both levels can be morally instructive but also is finite and fallible.

The physician must hold in tension her role as an independent moral agent with that of a medical care provider and a participant in the shared morality of the professional community and society at large. That shared morality is shaped by culture, history, and theological principles. Within these sometimes competing obligations are limits to the right of conscience. The physician is not a law unto herself. The physician has a right of conscience, but she does not have an unqualified right of conscience. Nor does the patient's preference have an unqualified authority over the physician's moral integrity.[33]

Conscience is the impetus that strives for personal moral integrity in harmony with morality writ large. The theologian Dietrich Bonhoeffer writes, "Conscience comes from a depth which lies beyond a man's own will and his own reason and it makes itself heard as the call of human existence to unity with itself."[34] Pope John Paul II reminds us that "it is always from the truth that the dignity of conscience derives."[35] Similarly, Martin Luther King, Jr., asserts plainly that, "[c]onscience asks the question, is it right?"[36]

A health professional's troubled conscience is not necessarily a behavioral problem in need of correction, but it may be a signal to society that something is amiss. Nazi Reichsführer Heinrich Himmler was outraged by what he characterized as the narrow-minded objections of Christian medics to lethal freezing experiments performed on prisoners at Dachau.[37] In such times, physicians should not be surprised by antagonism but must be ever vigiliant to uphold the principles and maintain the standards of their profession.

Preservation of the moral integrity of the medical profession is in everyone's interest. The physician Stephen John Genuis writes, "Professional integrity is not fostered when physicians succumb to implementing perceived harmful interventions toward patients."[38] Physicians who hold to a moral foundation have reason to be truthful, compassionate and self-sacrificing. Conscience also entails the call of accountability. It matters to society how the physician behaves when no one is looking. William Wilberforce writes that, "We shall be called upon to answer for the use which we have made of … the exercise of the nobler and more exalted faculties of our nature."[39]

A conscientious physician also welcomes consideration of diverse perspectives. A well-grounded conscience tolerates disagreement over differences of opinion and is open to dialogue across philosophical and religious lines. People of conscience have not only the right but also the responsibility to share their convictions and their reasoning that leads to their stand on vital moral issues. Such discourse, if offered charitably, can benefit all.

Dr. Charles H. Mayo wrote, "The true physician will never be satisfied just to pass his therapeutic wares over a counter."[26] Conscience in obedience to truth is the bedrock on which rests the moral integrity of the physician, which is essential to the patient's trust.

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In Defence of Selflessness: A Philosophical Analysis of a Central Virtue in Professional Caring Practices

BART CUSVELLER, BNURS, PHD PHIL

Abstract

The virtue of selflessness (unselfishness) does not seem to grip the imagination of many professional nurses. This seems a remarkable contrast to traditional speech in nursing. In this paper, the nature and importance of this virtue is defended as a quality that professional nurses are required to exhibit by the practice of nursing care as such. The nature and structural conditions of professional nursing as a social practice are explored in a philosophical way – using terminology developed by ethicist Alasdair MacIntyre – as well as the importance of selflessness in such a social practice. If one understands professional nursing as a social practice with the well-being of others in need as a central value, there is good reason to believe that a value like selflessness is required by the nature of nursing itself. The interest of the patient may be at peril when sight is lost of the professional virtue of selflessness.

Key words: ethics, virtues, beneficence, selflessness, social practice

Introduction

Background

The face of health care has obviously changed over the last decades. We have come to know new notions such as “advanced practitioners”, cost-effectiveness control, a flurry of research and theories, new strategies for empowerment and influence, and much more. This development could be summarized as one of health care workers becoming more professional. At the same time, some emphasise that such professional development ought to be balanced with compassion and caring (Benner 1998; see also entire thematic sections in *Nursing Ethics* 9 (1999) 3 and 5). The question arises, however: to what extent is it really realistic to balance professionalism with compassion and care? The system of health care delivery sometimes seems to force care professionals in the other direction—that of indifference and formality—resulting in frustration and burnout among committed workers who aim for compassion and care.

Our Question

There is also a deeper question to be asked, however. This question is “to what extent is a balance of a professional system with compassion and care possible in the first place? To what extent is such a balance an option one can choose and start developing? Are compassion and care required at all by the professional practice of nursing care itself? Or does the practice of care professionals recommend or even require its own balance of professionalism on the one hand and care and compassion on the other? This is not a question of preferences or opportunities but one of structural conditions— i.e., a philosophical question.

Aim

If this is the case, we should perhaps distinguish between the actual caring and compassionate conduct of nurses and the attitude which caring practices themselves require nurses to exhibit in their actual conduct. If we know what is required by caring practices as such, we may know what the balance in professional caring should be like. What is required is to be prepared to show care and compassion in one's professional practice when needed or appropriate. To have a word for it, I will follow traditional speech and call it "selflessness". It is the aim of this paper to ask what the notion of selflessness as a professional attitude for care workers is and to what extent it ought to be expressed in their professional practice.

Outline

To accomplish this, I will first discuss the nature and structure of nursing practice as exemplary for our topic (next section), and, secondly, I will discuss selflessness itself (last section). As this discussion involves the analysis of concepts, argumentations, and structural conditions in nursing, it will appropriately be an exercise in moral philosophy (applied to nursing).

Nursing Care as a Social Practice

Conceptual Framework

In seminal studies (Bishop & Scudder 1990; Gastmans *et al.* 1998; Sellman 2000), nursing care has been described as a 'social practice' in the sense recaptured from Aristotelian moral philosophy by American philosopher Alasdair MacIntyre (1983). One of MacIntyre's purposes was to provide a context in which a virtue ethics could be revived over against attempts in modern philosophy to mould our morality on grounds independent from traditional (Christian) morality, such as human reason, power, or passion. Virtues, in his line of thought, are character traits that enable human beings to achieve the goods of our practices, our lives, and our communities. Whatever the merits of MacIntyre's project (cf. Horton & Mendus 1994), his concept of social practices helps reveal the qualities and components necessary to sustain a social practice like nursing. Therefore, I will follow MacIntyre's understanding of this concept somewhat closely for our purposes here adapted to nursing care.

MacIntyre's definition of a social practice reads as follows:

> By a 'practice' I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partly definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended (MacIntyre 1983, p. 187).

On the most general level, then, a social practice is an organised form of human behaviour usually involving the manipulation of materials of some kind or, more abstractly, '*givens*' of human life. In art, for instance, we work with, say, the givens of beauty, ugliness, and aesthetic potential in materials; in education, we deal with the givens of ignorance, knowledge and intellectual potentials of children; so, in nursing, we deal with vulnerability and dependency. Practices, furthermore, have a certain degree of complexity or structure. We are not able to perform practices simply as we are born, nor do they automatically emerge in us as we mature. For instance, nurses do not care for patients by performing just a single act. Usually they must perform a number of organised, sometimes difficult and time-consuming tasks by following procedures requiring insight, skill and experience. This is already evident in a relatively simple (but really very detailed) procedure such as preparing a syringe for injection.

Goods or Values

On a more specific level, I would single out four characteristics of social practices that are relevant for our discussion of nursing. The first thing to note about such complex activities is that they are performed because it would not be proper for a nurse to follow his or her own whims, preferences, or inclinations. What accounts for the structure of practices is that they are organised around the way one is supposed to manipulate the givens of human existence. One doesn't just do any odd thing with the illness or dying process of a patient. There is something intentional in dealing with those givens—for instance, the intention to alter something undesirable about them, to achieve something desirable in working with them. In other – if more philosophical – words, one intends to accomplish a certain state of affairs. Implied is that this state of affairs is worth pursuing. One values, for instance, having a nice wooden cabinet, or mastering a Mozart sonata, or providing comfort to the incapacitated, and practices cabinet-making, cello-playing, or nursing accordingly. At bottom, then, a practice is organised around the pursuit of something valuable; "a *value*", for short. MacIntyre uses the classical notion of 'goods' (Lat. *Bona*) in this connection: the good of a practice is that which one tries to achieve by performing that practice.

Standards or Norms

The second thing to note about the structure of social practices is that the ways and means of such a complex practice like nursing are usually not self-evident or simply derived from the profession's "body of knowledge". Therefore, practitioners need to learn how to decide which options constitute proper ways of performing their practice. And because performing a practice, as we saw, is centrally about trying to achieve a good or value in dealing with a certain given of human existence, practitioners have to learn to discriminate which options in practice constitute better and worse ways to achieve those values. In other words, the structure of a practice implies upholding *norms* to distinguish between better and worse ways to strive for its values (Wolterstorff 2004). To achieve what is at stake in the soccer game, for instance, one is not allowed to play the ball with one's hands; to paint a decent picture, one has to hold the brush in the proper manner; to know how to attend to a patient with high fever, one respects rules of hygiene. In this connection, MacIntyre uses the notion "standards of excellence": to uphold the standards of excellence of one's practice (or to find better ones) is to excel in accomplishing the values of the practice. Good or professional nursing, therefore, is to uphold the professional norms in order to realise the professional values involved in nursing practice.

Historical and Social Nature

A third thing to note about social practices such as nursing is that they are usually an aggregate of so much insight, skill, and experience that no single practitioner ever starts practicing all new and afresh. One will always respond to and draw from people who have already been performing those practices before. In other words, practices always have a certain *history or tradition*, since most of the givens involved have been with mankind for some time (Cash 1994, Edgar 1993). Hence, part, if not most, of the practice is handed down from generation to generation; one learns them from one's predecessors. What would one make of the game of chess if there were no one around to learn it from? For this reason, but also for the reason that they are by and large performed collectively, practices are not only inherently historical but also *socially* extended. Lawyers, farmers, and nurses have teachers, mentors, colleagues, apprentices, customers, and so on. There will be institutions, authorities, associations and fellowships. Nurses do not learn their practice from a book, they *enter* the (already existing) profession and are *inducted* into the profession's tradition. From that point onwards, they may contribute to the expansion and development of nursing (Edgar 1993).

Internal Goods, Central Value, or Purpose

A fourth and final note about practices is that, obviously, not just any old good or value will do to define and perform a social practice. Usually various values can be achieved by performing a certain practice. Some surgeons become rich, some soccer players become famous, some nurses become satisfied. But is this what their practice is fundamentally about? However one values income, fame, or satisfaction, valuing them is somehow different from valuing the practice for it's own sake. One can become rich, famous or powerful and still not be a real practitioner and do one's job well. This also means that certain values can only be pursued by performing specific practices. Some play chess for the specific sort of experience that only comes with playing a good game of chess; philosophers value the experience that only comes with reading and writing good philosophy; patients call upon nurses for the benefits that are specific for the interventions that constitute good nursing practice.

In this connection, MacIntyre introduces the distinction between goods *internal* to a practice and goods *external* to a practice. The acquisition of status, power, or money is external to most practices, because it is not what most practices are intrinsically about. If one values external goods (money, power, status), then one can usually also –and sometimes even better– pursue them by engaging in some other practice. Accordingly, a nurse who is "only in it to pay the rent", has not grasped the central value or purpose of nursing *as such* and hence, MacIntyre might say, will not be a good nurse (cf. Reinders 2000a, p. 201).

Purpose and Moral Nature of Nursing

Accordingly, to define a practice among many others is to identify the central value specific to it. In the case of nursing, we might contrast the central value of nursing with that of another related health care profession such as medicine. Generally, health care professionals foster the health and well-being of people whose capacities to care for themselves or for others are inhibited. This means that the capacities for their activities and functions necessary for daily human life are in some sort of disorder. A way to state the difference between the central values of nursing and medicine, then, is this: Medicine's purpose is to amend disorders or pathological processes (because they have urgent effects on the activities of daily living of patients). For example, the physician treats the fracture in the bone of someone with a broken wrist. Nursing's purpose is to amend the effects those disorders or processes have on the patient's activities and functions necessary for healthy living. For instance, the nurse helps someone with a broken wrist to eat. This central value (or something like it) is definitive for nursing practice (Cusveller 2004). If nurses do not try to achieve that purpose, they are doing all kinds of things, but it will not be nursing.

To posit a short formula, we will say that the central value of nursing practice is to foster the well-being of patients. As such, nursing is to do good to the patient or to serve his health-interests. Even more so, fostering the patient's well-being is traditionally understood not as instrumental to some further value but rather as valuable *in itself*. Nursing practice fosters the patient's well-being as *intrinsically* valuable, that is, for its own sake (Puolimatka 1989, p. 143). Its central value is to be of help to someone else, not to oneself. To help oneself is another practice, but not nursing. This value, i.e., someone else's well-being as intrinsically valuable, is what makes nursing practice as such beneficent in contrast to figure skating, selling cars, or sculpturing. In conclusion, then, this central value is a *moral* one, making nursing care a moral practice or craft rather than an art or a science. (Hence, nursing ethics is "doing your job well" (Reinders 2000b) rather than learning about bioethical issues, moral theories, and ethical decision-making recipes.)

The Virtue of Selflessness

Beneficence, Selflessness and Interest of the Patient

A practice as MacIntyre understands it is a socially and historically shared human conduct with the purpose of dealing with givens of human existence in a normatively conditioned way. Inasmuch as a practice is socially, historically, and normatively extended, its structure is "supra-individual". Nurses can't just do what they like; they follow the rules of the game, the state of the art, the standard of the profession inasmuch as that leads to the central values of the profession (in an innovative way, perhaps –nothing that has been said implies traditionalism). The existence, structure, and development of conditions for practices as such do not depend on individual preferences. So, one does not decide to be responsible as a professional but rather accepts the professional responsibilities inherent to nursing as soon as one becomes a nurse.

In some practices, to be sure, the central value of a practice is to foster *one's own* well-being, as in the sports or arts one practices for fun, the business that one runs for profit, and so on. Yet this is not the case for all practices, and especially not in the practice of nursing. Nursing as such is meant to foster the well-being of the patient. After all, this is what they profess when they take the pledge or accept a code of conduct upon entering their profession— hence the importance of trust and trustworthiness in professional practices (Koehn 1994; Cooper 1988). As professionals, nurses are to foster the patient's well-being in order for the patient to be better off rather than for themselves to be better off. The interests of the nurses themselves involve goods external to their practice, to invoke MacIntyre's terminology once more. Thus, their practice – i.e., their type of work

– is to be directly beneficent towards the patient's well being and disinterested or only indirectly beneficent towards themselves. Their type of work as such – the central value of their practice – has the interest of the patient at heart, not their own interest, even if they may benefit themselves.

Now we are in a position to see the requirement of selflessness in the social practice of professional nursing care. If the profession of nursing has the supra-individual beneficent and disinterested nature I ascribed to it – i.e., serving someone else's interest and not one's own – then this requires of *the professional* to accept this disinterested nature of their profession and embody it in their professional conduct. Even more boldly, entering the profession *entails* accepting and embodying this supra-individual structure. Therefore, as professionals, nurses need to exhibit the inclination or disposition to have a positive attitude toward doing good for others. Becoming a professional requires the willingness to accept and uphold the central value and norms that constitute the structural conditions (or professional responsibility) of nursing. Since nursing care is doing good for others and professional conduct in nursing is beneficent, the professional nurse requires a positive attitude toward doing good for others. This serving attitude, I submit, is the professional virtue of *selflessness.*

Self-Sacrifice or Altruism?

Nothing that has been said so far excludes the possibility that professionals qua individual persons also pursue other values in their work, such as sharing the gospel, earning a living, or achieving work satisfaction. On the contrary, this possibility is left open by distinguishing between the structural conditions of nursing (with the required professional virtues) and the personal intent of nurses. Those external values may be quite legitimate. Qua professionals, then, nurses need to exhibit the virtue of selflessness, but as individual persons they may not. Initially, that is to say, it even seems quite indifferent to the quality of their practice if they also pursue these values, as long as they keep pursuing the central value of their practice as well as they can. Usually nurses get something out of it for themselves and may even have to in order to support themselves. Nothing that has been said implies self-sacrifice.

To put this even stronger, lastly, let me point out that I do not have my eye on altruism. There is a vast body of literature and research on the topic and its diversity and volume make it a daunting task to only begin to cover it. But in this connection, I go with Alasdair MacIntyre's argument that a genuine good (the central value that is pursued in the course of performing a practice) is not really a genuine good when it is understood as a "good-for-me-rather-than-for-others". Nor is it a genuine good when it is understood as "good-for-others-rather-than-for-me". MacIntyre's reason for this position is that the goods of human practices are only genuine goods when they sustain the relationships of giving and receiving constituting our community, as being human means being social beings. The virtue that corresponds to this type of sharing goods, says MacIntyre, is "just generosity", not altruism. In that light, being "self-rather-than-other-regarding" (egoism) misses what is both our good and good for others as much as being "other-rather-then-self-regarding" (altruism). Neither supports the network of mutual caring necessary for human flourishing. What nurses do for patients should be good for themselves, and what they do for themselves should be good for patients. "Self-sacrifice, it follows, is as much of [a] vice, as much of a sign of inadequate moral development, as selfishness" (MacIntyre 2001, p. 160).

Conclusion

Professional selflessness and personal selflessness do not necessarily go hand in hand. Nurses who are *also* "in it for the money" may last long in nursing and even become good nurses. Yet, I would say that there is also a risk in this. As I said, in performing a practice, there are always options – several professional interventions are available. Hence, choices have to be made between those options. And since the options are not always self-evident or determined by the profession's "body of knowledge", the professional's choices will be co-determined by broader considerations about the proper sorts of choices to be made. Cash (1998) calls them "argumentation conditions" when addressing the role of tradition in nursing. And among those broader considerations there will be considerations that do not strictly belong to the profession's body of knowledge, such as personal conviction (Cusveller 1995; Wolterstorff 2004). But if these are not consistent with the central value and norms of the practice the risk is, in the end, that the professional will make choices that are less or even not conducive to the purpose of the practice. In other words, if one personally does not exhibit the virtue of selflessness, then one runs the risk of undercutting the professional virtue of selflessness. And if that happens, the central value of nursing, fostering the well-being of the patient, is at peril.

Some would claim that contemporary nursing is actually going in this perilous direction, especially since the traditional Judaeo and/or Christian worldview with which nursing was consistent is now eroded and challenged by other worldviews (Bradshaw 1994; Shelly & Miller 2000). That may well be. In any case, as I have argued elsewhere, nurses are likely to last longer in nursing and become good ones if they personally share the values and norms of the profession. These days, selflessness in particular is as important as ever. It seems to me selflessness is likely to last longer in a nurse when it is supported by commitments and communities of giving and receiving that hold in high regard to "love one's neighbour as oneself". A nurse's worldview, philosophy, or religious commitment is highly relevant to the practice of nursing.

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Decisions, Moral Status, and the Early Fetus

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Abstract

In "Creation Ethics: The Moral Status of Early Fetuses and the Ethics of Abortion," Elizabeth Harman has offered a novel approach to settling the question of the moral status of some fetuses. In the case of an early fetus (one lacking intrinsic properties that convey moral status), Harman maintains that, already lacking intrinsic properties, an early fetus that additionally lacks a future thus lacks moral status. However, Harman argues that this lacking does not figure into rational decision making about aborting one's fetus since the decision to abort determines the fetus's having a future and, in turn, its moral status; thus the decision to abort the early fetus cannot depend on the fetus' moral status. I argue that this is not a tenable position because it implies that rational decision making with regard to aborting an early fetus is impossible. But such a result seems incorrect. Although Harman is correct, and thus in agreement with Marquis and McInerney, that the moral status of a fetus may vary with its potential for life beyond the early stage, one cannot sidestep the question of moral status as an independent question to be settled in order to make a rational decision about aborting an early fetus. The problem is not merely that we might think that decisions do not determine status but that such decisions would not be possible in the first place without begging the question.

Introduction

Rational decision making aims at good choices through the weighing of options, outcomes, reasons, and other relevant aspects of a choice. Sometimes effective rational decision making is inhibited by our circumstances; relevant information is unavailable or a decision requires more time than one has for investigation and contemplation. At other times it is limited by ourselves; a decision is needlessly made in haste or is poorly thought out. Frequently we develop habits of response so that choices are made without explicit decision making. But these habits of response can also lead to mistakes; thus, for one who aims to make good choices (or better choices rather than worse choices) the standards of rational decision making will always be relevant to one's choices.

How does this simplified but commonsense picture of decision making figure into the philosophical debate on abortion? Typically a rational decision of this kind would take into account the moral status (or lack thereof) of the fetus. If the fetus has a moral status, that fact must be accounted for in the decision. If it does not, then moral status need be of no concern.[1] One type of argument for the fetus' having a moral status is based not on its having intrinsic properties that confer moral status but on its having a future. Don Marquis has famously argued that the fetus has a moral status in virtue of its having a future of value (a "future-like-ours").[2] Peter McInerney counters that the fetus does not *actually* have a future-like-ours, the fetus only *potentially* has a future-like-ours. Thus, the relationship between a fetus and its future is different from that of an adult and her future, and so the fetus does not, in virtue of its having a future, have a moral status.[3]

Both positions maintain the picture of rational decision making that I outlined at the start: that the status of the fetus is a determinant in correct decision making about abortion.

In "Creation Ethics: The Moral Status of Early Fetuses and the Ethics of Abortion," Elizabeth Harman has offered a novel approach to settling the question of the moral status of some fetuses that appears to turn this very picture of decision making "on its head."[4] In the case of an early fetus (one lacking intrinsic properties that convey moral status), Harman maintains that, already lacking intrinsic properties, an early fetus that additionally lacks a future thus lacks moral status. However, Harman argues that this lacking does not figure into rational decision making about aborting one's fetus since the decision to abort *determines* the fetus's having a future, and, in turn, its moral status, and so cannot depend on it. In this respect, Harman goes a significant step further than Marquis or McInerney in characterizing the relationship of a fetus to its future. All believe that a fetus's future is relevant to its moral status only if it has an actual future, not merely a potential future. However, while McInerney argues for the mere *potentiality* of a fetus's future on the basis of the characteristics of the fetus, Harman argues for this mere potentiality on the basis of the choice of the parent with regard to aborting it. Does this present a plausible position?

In this essay, I argue that this is not a tenable position because it implies that rational decision making with regard to aborting an early fetus is impossible. But such a result seems incorrect. Although Harman is correct, and thus in agreement with Marquis and McInerney, that the moral status of a fetus may vary with its potential for life beyond the early stage, one cannot sidestep the question of moral status as an independent question to be settled in order to make a rational decision about aborting an early fetus. The problem is not merely that we might think that decisions do not determine status but that such decisions would not be possible in the first place without begging the question.

Harman's Position

Harman understands an "early fetus" as a fetus before it has any "intrinsic properties that themselves confer moral status" (310). After passing the early stage, the fetus will have moral status in virtue of these properties. Those who believe that the fetus has intrinsic properties relevant to moral status from the moment of conception will, of course, not be persuaded by Harman's position. But the difficulty of identifying such intrinsic properties has led many, such as Marquis, to look for other qualities that may confer moral standing. Harman recognizes this potentiality and grants that, while intrinsic properties are sufficient to a fetus's having moral status, they are not necessary; an early fetus may also have some moral status in virtue of having a future. Harman characterizes this in terms of the "Actual Future Principle": "An early fetus that will become a person has some moral status. An early fetus that will die while it is still an early fetus has no moral status" (311). From this Harman denies the view, attributed to previous discussions of abortion, that either all early fetuses have moral status or all lack moral status. Further, she recognizes that "[i]f early abortion requires any moral justification whatsoever, then this is so because the early fetus that dies in the abortion has some moral status." Thus, if some fetuses lack moral status—because they are both early fetuses and they lack an actual future—then no moral justification is required for their abortion. From this she concludes that the very liberal view on abortion—that early abortion requires no moral justification whatsoever—is stronger than previously thought (313).

So stated, Harman's claims seem reasonable. It is plausible to think of a fetus (or human in general) as having some stage in its development in which it lacks intrinsic properties that confer moral status while at the same time recognizing that having a future may confer moral status on the early fetus. Additionally, Harman seems correct in that it is a mistake to regard all early fetuses as having the same moral status. A fetus with abnormalities that will not allow it to fully gestate might well be thought of as having a diminished moral status in comparison to a normally developing fetus. If a scarce resource were needed by both for continued survival, for example, it would seem appropriate to count the normally developing fetus as having a stronger claim on the resource. Finally, if a fetus lacks moral status, then Harman seems correct that moral justification is unnecessary. Moral justification is necessary only when our actions are concerned, directly or indirectly, with things having moral status.

Harman's position is remarkable, however, for its inclusion of the parent's aborting the early fetus as a means by which the early fetus can lack an actual future (314). If, in contrast, the parent will not abort the early fetus and nothing else will prevent the fetus from surviving past the early stage, then the fetus has an actual future and, thus, has moral status. The claim is remarkable because it includes the future intentional behavior of the parent towards the early fetus as one of the criteria for whether the early fetus has an actual future and, thus, has moral status. Understandably, a fetus with fatal abnormalities might be said to lack an actual future and so lack moral status; hence, one can abort it. Its lacking an actual future does not result from the parent's intended actions. But for a fetus to lack an actual future, and hence moral status, as a result of one's decision to abort it is another matter. If moral status is relevant to such decisions in the first place, then the account has troublesome results for any sort of rational decision making about aborting the early fetus. To frame this concern in terms of the disagreement between Marquis and McInerney: Can the parent's decision to abort make an actual future into a potential future?

Decisions about the Early Fetus

Suppose the temporal range of rational decision making for aborting an early fetus spans from t_0 to t_n, with t_x being some time among this range. After t_n, the fetus will have aged past the early stage. On Harman's view, what determines an actual future, as opposed to a potential future, is the decision that will be in effect at t_n. Thus, as a parent changes her mind about an abortion from t_1 to t_2 to t_3, the moral status of the fetus does not change since its standing is fixed by the decision that will be in place at t_n. Consider an early fetus that will survive the early stage except for intervention by abortion, and suppose the pregnancy is in all other ways morally unambiguous. I'll term this kind of early fetus an "ideal early fetus." By "morally unambiguous" I mean that the fetus is not threatening the life of the mother, is not the result of a rape, and so forth. An ideal early fetus will therefore have an actual future if and only if the parent decides not to abort it. Consider the following result:

> (1) Making the rational decision to abort or not to abort an ideal early fetus at t_x depends on the moral status of the ideal early fetus.
>
> (2) The parent's rational decision to abort or not to abort that will have been made by tn determines the moral status of an ideal early fetus.

> Therefore, (C1) making the rational decision to abort or not to abort at t_x depends on the rational decision to abort or not to abort that will have been made by t_n.

The inference is valid, but if we instantiate to time t_n, then (C1) becomes problematically circular. The problem is not that a rational decision made in the present depends on a rational decision to be made in the future. That is reasonable and perhaps common. The problem is that the decision at t_n is the very type of decision that is contemplated at t_x, so what is true of t_x —that is, its dependence on answering t_n—is also true of t_n. So a rational decision cannot be made since making the decision depends on the decision that is being made.

(1) is an instance of straightforward principles of rational decision making and morality. First, a rational decision must take into account those features that are relevant to making a good choice. Second, the moral features of a choice are relevant to a good choice. Given that the early fetus in this case is ideal, the only objective features relevant to a good choice is the fetus's moral status or lack of moral status; thus, moral status determines which choice is good and so determines the rational decision. This is not to claim that the ideal early fetus has moral status, only that the rational decision depends on settling the question of its having or not having moral status.

(2) follows from Harman's claim that the actual future of the fetus determines its moral status and the assumption that the fetus is an ideal early fetus. Since an ideal early fetus will survive unless aborted, it follows that the decision of the parent will determine its having moral status or not having moral status.

On the surface, the problem of circularity is apparent. If the decision to abort depends on first settling the question of moral status, but the question of moral status is settled by the decision to abort, then the decision cannot be made rationally. Harman is well aware of the potential for circularity. She states:

> In other cases of difficult decision, it is natural to approach the decision by first recognizing what attitudes one ought to take toward the relevant elements of the situation and then deciding on the basis of these attitudes what to do. The pregnant woman cannot do this. She cannot first determine what attitude she ought to take toward the fetus and then decide whether to abort the pregnancy. The decision she makes will determine what attitude she ought to take (317).

On the face of it, this denies (1) by asserting (2). So why accept (2)? Harman's defense of (2) seems to be based on the Actual Future Principle in the following way:

> (3) The parent's rational decision to abort or not to abort that will have been made by t_n determines whether the ideal early fetus has an actual future.
>
> (4) An ideal early fetus has moral status if and only if it has an actual future.
>
> Therefore, (C2) the parent's rational decision to abort or not to abort that will have been made by t_n determines the moral status of an ideal early fetus.

(3) is clearly true: given that an ideal early fetus will survive unless it is aborted, abortion determines its having an actual future. But (4) is problematic not because it may not be true but because (4) depends on showing that the early fetus lacks moral status in the first place. If an ideal early fetus is the kind of thing that, by itself, lacks moral status but its having an actual future endows it with moral status, then indeed the decision to abort or not to abort is a decision that determines moral status. But Harman hasn't given

an argument that the early fetus, independent of the question of an actual future, has no moral status. She has only granted that it lacks *intrinsic properties* that might confer moral status. To respond that it has no moral status, by itself, because the decision to abort determines moral status would be to respond with just what needs to be argued. That a decision may affect moral status does not mean it does not also depend on moral status. The two are not mutually exclusive.

Consider, as an analogy, a variation of Thomson's famous violinist case. The sickened violinist requests the use of my kidneys, and I, among his many fans, volunteer and end up being chosen. Because I have decided to help out, the other volunteers are sent away. But at the last moment, I get cold feet and wish to no longer help him. It might be thought that in these circumstances my decision to help gave rise to an obligation to help him (since my decision led to other potential helpers being dismissed); whereas, had I not decided to help I would not have any obligation. But the conclusion that my decision determines my obligation, however, rests on the fact that prior to the decision I had no obligation in the first place. In other words, the question of moral status and relevancy must first be established prior to the decision to know how my decision can affect moral status.

It is certainly not obvious that an early fetus has moral status. But this has to be settled before one can accept a denial of (1) in favor of (2). The novelty of Harman's position is its attempt to bypass this matter, to show that we need not worry about the question of moral status given the actual future principle (320). In some cases this seems correct. If a parent knows that the early fetus will die of an abnormality, then she does not have to worry about whether the early fetus has moral status—either in virtue of intrinsic properties or something else—since it lacks an actual future independent of any actions of hers. But this same reasoning cannot work in cases of decision making about an ideal early fetus without having first established the lack of moral status.

One might object as follows: Hasn't Harman been explicit about her assumption that at a certain time the fetus lacks moral status, i.e., the early fetus. It is not, therefore, her aim to argue that it lacks moral status. Rather, she argues that a decision to keep the early fetus confers moral status on what otherwise has none. Likewise, the decision not to keep it implies that it maintains its lack of moral status. Thus, she argues, the decision does not depend on moral status but in fact decides it.

This objection has two problems. First, what Harman has explicitly assumed is not that early fetuses lack moral status but that early fetuses lack the *intrinsic properties* which are sufficient but not necessary for conferring moral status. (The early fetus is thus defined.) It is an open question whether they have moral status by some other means. Absent an argument that early fetuses do lack moral status —alternatively, that having an actual future is a necessary feature for early fetuses to have a moral status—the decision of the parent to abort cannot function, as she purports, to determine moral status.[5] Second, if Harman's position were indeed that the early fetus (but for the decision to maintain the pregnancy) lacked moral status, not just instrinsic properties, then it is not clear what the point of her argument is for the very liberal view. She will have shown that *fewer* early abortions are morally permissible than otherwise thought.

So, for example, one way of thinking of the early fetus is that it has a moral status because it has an actual future, a future the taking away of which by a parent who aborts it would be wrong. This seems to be a position that Harman is trying to exclude. But to include the decision to abort as one way that a fetus can lack a future one would have to argue that the decision is reasonable. Consider a fetus with a serious disease that will require risky fetal surgery, likely fatal to the mother. We might consider that such a fetus has no future not because it literally cannot survive but because its survival depends on a decision to abort that is a reasonable one; it is not required to give one's life to maintain a pregnancy. On the other hand, an early fetus that will die unless the parent takes some vitamins, something she ordinarily does, is one we would think of as having a future since the behavior is a reasonable one. What is needed is an argument that the decision to abort is more like the case of serious disease and not the vitamin. Harman's argument has not shown that the decision in the case of an ideal early fetus meets the standard of reasonableness.

A Metaphysical Response

Harman's position may attempt to avoid the circularity with its metaphysical peculiarities. Harman's view is not based on the decision that, for example, I may make or think I will make, but the decision that actually will be made, whether I know what it is or not. So, at any given point of time before t_n, some future decision will have been made at t_n, though it hasn't been made yet and we may not know what it is. So, Harman does not avoid the question of moral status, one might object; on the contrary, the moment an ideal early fetus comes into existence its moral status is determined (by the decision that will be made by t_n and its, thus, having or not having an actual future).

But this treats rational decisions as something that they are not: fixed circumstances that we can deal with but do not determine. It treats the decision to abort at t_n like an incurable abnormality that will cause the fetus to die— something the parent has no control over, and certainly not something that he or she will bring about by t_n. But while some past decisions can likely be treated this way, this doesn't seem to be the case for present or future decisions. To parallel the case of abnormalities, we can imagine an early fetus that will die unless an inexpensive treatment is undertaken by the parent. Treating the pending death as a fixed event would be an obvious error. Treating future or present decisions, and even some past decisions, in this manner involves the same sort of error.

One response is that the future decision is not like a pending death. The future decision is a decision, and as a decision it takes into account the full scope of what will have happened before it. To say that in the future, at t_n, the parent will have decided to abort will mean that the parent will have considered what has gone before and will have decided to abort nevertheless. In other words, though we talk about the future decision in a fixed manner, because it is a decision it has a dynamic aspect to it. To say that the parent will decide one way at t_n is to say that all things considered at that point, even things the parent is unaware of now, the parent will so decide.

But if this is the case, then the appeal to the future decision is useless. For Harman's view, the attractiveness of appealing to a future decision lies just in the fact that it, like an incurable abnormality, is fixed. And if fixed, then it can be taken to determine moral status—and so figure into a rational decision—the way a pending death from an abnormality can. But to say it is dynamic is just to say that the decision is open. It is essentially to recognize that the decision at t_n is like any decision at t_x and so does not help to make the decision at t_x.

At times Harman's view does not appear to require such a strictly metaphysical point of view in part because such a view seems to make decision making impossible (319).

Instead, we are to think of the decision that will be made at t_n as the decision the parent is *planning to have made* by t_n. This certainly seems like a reasonable way of looking at decisions. From this, Harman's reasoning seems to be as follows:

> (5) The parent believes she will still want to abort by the end of the early stage of the fetus, so her decision at t_n is to abort. Therefore,
>
> (6) at t_x, the fetus has no moral status.
>
> Therefore, (C3) she can rationally decide to abort at t_x.

I don't dispute that this is a reasonable account of decision making on the basis of future events. But even here the future decision is treated as a fixed event. We do not always have control over our circumstances, the outcomes of our actions, or even our own behavior. But if there is anything we have control over, it is our decisions. So, the decision in (5) cannot figure into a present decision in any sort of innocent way. A straightforward argument that the fetus lacks moral status before t_n, and not on the basis of one's decision, would be exactly what is needed to make the decision, but that is what Harman wishes to avoid.

Nonrational Decisions

Harman might deny the "rationality" of decision making in premise (1) and restrain it to mere decision making: the mere decision to abort determines moral status, and subsequent rational decisions can take this into account. It is certainly true that many of our decisions are not rational: they are made in haste, in fear, with uncertainty. Harman does state that "a pregnant woman who is genuinely unsure whether she will abort her pregnancy is in a unique position; it is importantly unlike other cases of difficult choice between two alternatives. Any good account of the moral features of the choice whether to abort a pregnancy should account for the unique uncertainty of such a woman's situation" (317). So perhaps the decision in the case of aborting an early fetus is *sui generis.*

One problem with this view is that it seems to go too far; only chronic nonrational decision makers could benefit from it. Consider a parent whose pregnancy induces a diminished mental capacity throughout the pregnancy such that she (nonrationally) decides to and takes measures to end the pregnancy. Here the circularity is avoided, and one can conclude that the fetus lacked moral status. Indeed, this is a case where the decision at t_n could be regarded as fixed. But such cases seem rare. Rational decision making is not something we decide whether to do; it is part of our natural interaction with the events and complexities of our lives. As reflective, decision-making, rational creatures who aim to get things right (who aim to do better rather than to do worse), events come to our attention, and, barring some diminished mental capacity, it is difficult to exclude rational reflection, including reflection on past decisions. Harman's position is that the decision made by t_n will determine the moral status, and barring a very short early stage, it is difficult to avoid some rational reflection in that period.

Decisions and Relevancy

At this point I've argued that if moral status is relevant and moral status depends on the decision that will have been made by t_n, then a decision at t_x (including t_n) cannot be rationally made. To say that moral status is relevant is not to say that the early fetus has moral status but only that the question has to be settled. As a final move, Harman might deny that moral status is even relevant in the first place, that it is not a question we need even ask, that the burden is on those who maintain such a status to show that it is relevant. I'll argue that this would not be a plausible move for her position.

Moral status may be relevant to a decision in two ways: relevant to making the decision and/or relevant to setting up the decision. When I decide between eating broccoli and eating cauliflower, for example, there are likely no moral issues that are relevant to *making* the decision. When I decide between selling my car to the person to whom I promised to sell it and selling it to the person who has offered me an additional amount of money, moral issues are relevant to *making* the decision.

It is because of what food is, the particular foods I'm selecting between, and the nature of morality that making the decision has no morally relevant features. If the broccoli was purchased by me and the cauliflower purchased by my roommate, then some moral issues would be some relevant to the decision (e.g., I should ask her before eating it). But this is to concede that morality is relevant at least to *setting up* the decision. Given the nature of morality, its relevancy to setting up decisions is ubiquitous. To argue that it is not is an argument about the nature of morality, not the nature of decision making. Thus, rational decision making that need not recognize moral issues depends on first correctly setting up the decision as not having relevant moral issues. For example, one might say of an abnormal fetus that will not survive the early stage andthat, due to its certain death, it has no moral status and there are no moral issues in *making* the decision to abort it. But to make such a claim is to concede that morality is relevant in setting up the decision. From these considerations we obtain the following result:

> (7) Correctly *setting up* the decision, *x*, to abort an ideal early fetus depends on whether the fetus has a moral status or not.
>
> (8) The moral status of the ideal early fetus is determined by the decision, *x*, that will be made.
>
> Therefore, (C4) correctly setting up the decision, *x*, to abort depends on the decision, *x*, that will be made.

Here, again, the circularity appears. Either the decision in (8) must be non-rational and so treated as a fixed event, or one must deny (7) and argue that moral considerations are not relevant to *setting up* the decision. But neither seems plausible: the first option has been discussed previously. The second option is ruled out by the very discussion—to discuss the very liberal view on abortion in a moral context is to concede that it is relevant to setting up the problem in the first place.

The relevancy problem could perhaps be offset by maintaining that early fetuses have a sort of primitive moral status. After all, there must be something special about a thing that gains moral status on the basis of whether or not it will live past a certain stage (in comparison to fruit flies, for example, that have no moral status at any stage of development). The ideal early fetus has enough moral status (primitive moral status) that we can ask relevancy questions, but not enough that we must attribute moral status. But if this is conceded, then Harman's view loses much of its attractiveness: moral considerations would thus be relevant prior to making the decision to abort.

Conclusion

The appeal of Harman's position is reminiscent of Thomson's famous arguments in "A Defense of Abortion." Thomson argues that we can make the decision to abort regardless of the moral status or personhood of the fetus; the morality of the decision, given the parent's right to her body, is in the control of the parent. Harman seems to take a similar approach: with the early fetus, moral status is entirely within the control of the parent. But while for Thomson this is due to some factor external to the decision itself, for Harman this is a result of the very decision to abort. Harman is likely correct that some early fetuses have moral status while others do not; whether a fetus will survive beyond the early stage is prima facie one of those factors. But if we allow such survival to be relevant to rational decisions, then survival cannot depend on such decisions in the first place.

Endnotes

1. One might argue, I note, that the question of moral status does not matter. Judith Thomson, for example, famously argues that even if the fetus is a person and has moral status, this matter may not figure as morally relevant to the decision to abort. See Thomson, Judith Jarvis. 1971. "A Defense of Abortion." *Philosophy and Public Affairs* 1, no. 1: 47-66. But for those who think the question of moral status and its relationship to the decision to abortion is more critical, however, determining the standard of moral status has been notoriously difficult. Such a conclusion about moral status does not settle the question of moral permissibility. Even if one believes, for example, that animals do not have moral status, one might think it wrong to harm them because of the desensitizing effects it has on the harmer. Or, though an automobile does not itself has moral status, the fact that a particular automobile belongs to someone else and not myself makes it wrong for me to take it without permission. Moral status, however, seems like an appropriate place to start given the relationship of a fetus to the paradigm of things with moral status— well-developed adult human beings.
2. Marquis, Don. 1989. "Why Abortion is Immoral." *The Journal of Philosophy* 86, no. 4: 183-202. Carson Strong, in contrast, believes that fetuses have no intrinsic properties but thinks they have moral standing though not on the basis of their future. See Strong, Carson. 1997. "The moral status of preembryos, embryos, fetuses, and infants." *The Journal of Medicine and Philosophy* 22: 457-78.
3. McInerney, Peter. 1990. "Does a Fetus Already Have a Future-like-ours?" *The Journal of Philosophy* 87, no. 5: 264-68.
4. Harman, Elizabeth. 1999. "Creation Ethics: the Moral Status of Early Fetuses and the Ethics of Abortion." *Philosophy and Public Affairs* 28: 310-24.
5. Tooley, for example, gives an argument that they do lack moral status. See Tooley, Michael. 1972. "Abortion and Infanticide." *Philosophy and Public Affairs* 2, no. 1: 37-65.

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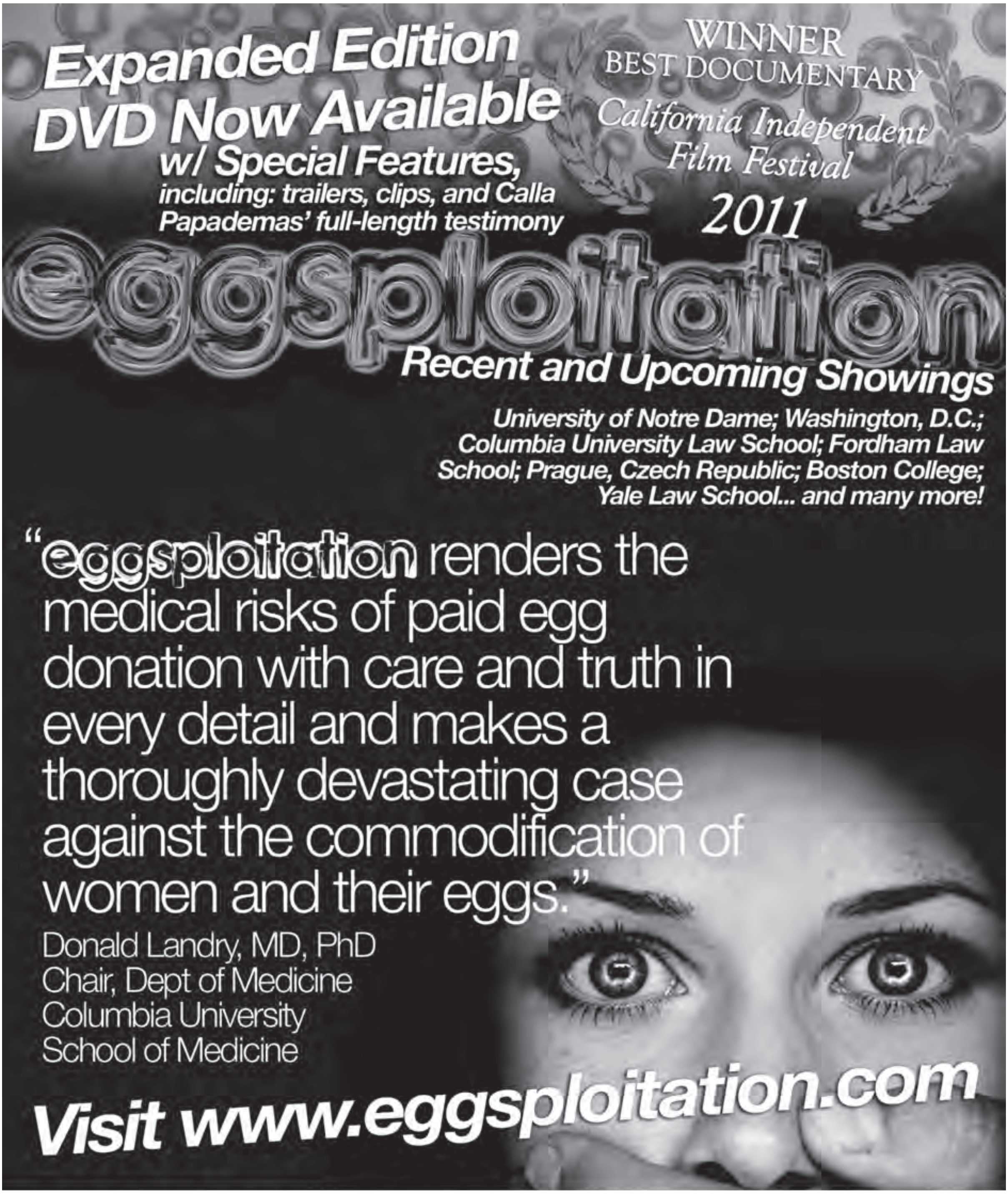

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THE AMERICAN ACADEMY OF PEDIATRICS AND FEMALE GENITAL CUTTING: WHEN NATIONAL ORGANIZATIONS ARE GUIDED BY PERSONAL AGENDAS

ROBERT S. VAN HOWE, MD, MS, FAAP

Abstract

The Committee on Bioethics of the American Academy of Pediatrics released a policy on female circumcision on April 26, 2010 proclaiming that some forms of genital cutting in minor females were permissible, particularly nicking the clitoris. The policy was quickly met with opposition and "retired" by the Academy on May 27, 2010. This paper explores the changes in policy from the Academy's 1998 position and the possible implications of the changes. It is argued that these changes were driven by the personal agendas of members of the Committee and of the author of the policy. The short-lived policy failed to recognize the basic human right to bodily integrity that applies to all humans, including infants and children, placing the Academy outside the mainstream of how ethicists currently view the rights of children.

Key words: American Academy of Pediatrics, female circumcision, human rights, bodily integrity, bioethics

The American Academy of Pediatrics (AAP) released a revised policy on female circumcision on April 26, 2010. (Committee on Bioethics 2010) The new policy was met with incredulity and opposition and was officially "retired" by the AAP on May 27, 2010. (American Academy of Pediatrics 2010) Consequently, for one month it was the policy of the AAP that some forms of genital cutting in minor females were permissible. By taking this position, the AAP, which had a reputation for working to protect the health and well being of children, had broken rank with the American Medical Association (1995) and other national and international medical organizations. This paper will explore the content of the AAP's revised April 2010 position on female circumcision, the flaws in its short-lived position, how the change in policy may have came about, and it will speculate why the AAP's Committee of Bioethics took the path they did.

The AAP's mission is "to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To accomplish this mission, the AAP shall support the professional needs of its members." (AAP Fact Sheet) Placing the needs of children first is laudable given a child's obvious vulnerabilities and lack of power. The revision in the policy on female circumcision appears to be incongruent with the AAP's focus on protecting the interests of children but rather emphasizes appeasing parents who, in some cases doubtlessly with the best of intentions, seek procedures that are harmful to their children. (Committee on Bioethics 2010)

The powerful movements of child advocacy over the past sixty-five years have resulted in the extension of basic human rights to all children. These rights have been secured in a variety of international agreements. (Convention on the Rights of the Child 1989, International Covenant on Civil and Political Rights 1976, Universal Declaration of Human Rights 1948, International Covenant on Civil and Political Rights 1966) One of the primary and most basic rights guaranteed by these agreements is the right to bodily integrity and security of person. This right prevents the cutting or amputating of body parts without an individual's consent or a compelling medical reason.

A Change in Policy

The April 2010 AAP policy on female circumcision made several changes relative to the policy published in 1998. (Committee on Bioethics 1998) While the 1998 policy opposed all forms of female circumcision, the April 2010 policy only opposed forms that pose risks of physical or psychological harm. The original policy recommended that physicians actively seek to dissuade families from carrying out all forms of female circumcision, whereas the April 2010 policy recommended only dissuading family from carrying out the "harmful" forms. The April 2010 policy recommended that, in addition to the compassionate education recommended in the original policy, providers remain culturally sensitive "to the cultural and religious reasons that motivates parents to seek this procedure for their daughters." (Committee on Bioethics 2010) The 1998 policy recommended "that its members decline to perform *any* medically unnecessary procedure that alters the genitalia of female infants, girls, and adolescents;"(emphasis mine)(Committee on Bioethics 1998) however, this recommendation did not appear in the April 2010 policy statement.

A large portion of the April 2010 policy statement was devoted to the ceremonial initiation of girls into their communities by "pricking or incising the clitoral skin." This "ritual nick" was described as "no more of an alteration than ear piercing," as "much less extensive than routine newborn male genital cutting," and as "not physically harmful."(Committee on Bioethics 2010)[1] The validity of each of these claims could be debated. The April 2010 policy put the AAP on record as considering cutting the clitoral skin as acceptable. Likewise, the April 2010 policy suggested that the AAP membership need not actively seek to dissuade families from pursuing a ritual nick. Finally, there was no longer a recommendation prohibiting practitioners from performing a ritual nick.

The April 2010 statement recognized that the "ritual nick" is precluded by US federal law but stated, "It might be more effective if federal and state laws enable pediatricians to reach out to families by offering a ritual nick as a possible compromise to avoid greater harm," (Committee on Bioethics 2010) making it appear as though the AAP would be lobbying for a change in the law.

Problems with the Change in Policy

There were several serious problems with these changes:

1. The April 2010 policy on female circumcision authorized physicians to incise the clitoral skin. While the seven members of the Committee on Bioethics were familiar with the scope of state and federal laws prohibiting such a practice, by taking this position, the AAP could be construed as encouraging its members to break these laws. In making such a statement, the Committee members should not have felt insulated by the current statutes. Legal experts, including the lead author of the statement, have indicated that laws

forbidding female circumcision are susceptible to First, Tenth, Fourteenth, and Fifteenth Amendment challenges. (Bond 1999, White 2001, Davis 2006) If these laws were ruled unconstitutional, physicians, following the recommendations of the April 2010 policy, would be free to implement this practice and possibly expand the "ritual nick" to more invasive forms of genital cutting to appease parents.

2. The April 2010 policy stated that the AAP "Opposes all forms of FGC that pose risks of physical or psychological harm."(Committee on Bioethics 2010) This implied that female circumcisions that do not pose a risk of physical or psychological harm are permissible. The scope of what was permissible was not clear, as the Committee failed to provide a definition of what entails physical or psychological harm. Instead, the Committee placed the "ritual nick" within a hierarchy of culturally accepted practices without assessing the harm of these practices. The Committee stated that incising the clitoral skin is not harmful but failed to substantiate this claim on the basis of harm. The Committee left the meaning of "harm" to the interpretation of individual providers. This vagueness could be problematic. There are practitioners, especially in cultures where female circumcision is common, who fervently believe that more invasive forms of female circumcision do not "pose risks of physical or psychological harm." These practitioners could point to studies that link female circumcision to a lower risk of HIV infection (Stallings and Karugendo 2005) and to a significant decrease in the length of labor. (Essén et al. 2005)[2]Other studies suggest that female circumcision does not affect the ability of women to achieve orgasm (Catania et al. 2007) and that it does not have any long-term impact on mental health. (Applebaum et al. 2008) In one study of women who had reported being circumcised, no evidence of the cutting could be found in 63% of these women upon physical examination. (Grisaru et al. 1997) Many women who were circumcised as children do not perceive themselves as harmed. (Njambi 2004, Njambi 2009) When the many cultural benefits are factored in, (Boulware-Miller 1985) practitioners could easily convince themselves that any harm is more than offset by the many perceived benefits.

Before dismissing this possibility, two members of the 1999 AAP Task Force on Circumcision (American Academy of Pediatrics Task Force on Circumcision 1999) testified in court that cutting off the most sensitive portion of the penis (Sorrells et al. 2007) did not result in an injury. (*Flatt v Kantak*) This demonstrates how social norms can result in cultural blindness, even among the most educated. (Waldeck 2003) The AAP's use of imprecise language may have given a green light for more invasive forms of female circumcision in cultures in which they are not considered by that culture to be harmful.

3. The failure of the Committee to consider a female child's basic human right to bodily integrity and security of person in their discussion of female circumcision was somewhat baffling and ominous. One of the cornerstones for justifying the prohibition of female circumcision is the child's right to bodily integrity. (Boulware-Miller 1985) Can it be inferred that the AAP Committee on Bioethics does not believe that a child has the basic human right to bodily integrity, or was this an oversight? If the Committee believes that children do not have this right, then, in effect, they are inferring that children are not fully human, because if a child was fully human, she would have this basic human right. Without this basic right and without her moral worth being fully recognized, then she has become little more than chattel and would be considered and treated as a possession of her parents, thus giving her parents license to harm her at their whim[3] so long as they could find a cooperative physician. Women and children were once considered chattel and a

possession of the "head" of the family, and it appears that the Committee is pointed in the direction of this outdated paradigm.

The AAP's original 1998 position on female circumcision discouraged physician participation in these practices, (Committee on Bioethics 1998) but the April 2010 position removed this language. In addition to educating parents as to why their daughter should not be cut, the April 2010 policy emphasized a "respect for parental decision-making," which undermined the human rights of the child and allowed incising the clitoral skin.

The April 2010 statement advocated parental rights to the detriment of children's rights. Such a position was incompatible with other policies of the AAP. First, the mission of the AAP is to protect children. The April 2010 policy on female circumcision also contradicted its established policy on informed consent, parental permission, and assent, which states:

> [pediatric health care] providers have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses. Although impasses regarding the interests of minors and the expressed wishes of their parents or guardians are rare, the pediatrician's responsibilities to his or her patient exist independent of parental desires or proxy consent. (Committee on Bioethics 1995)

Second, parental rights are a legal myth. Instead of viewing parents as having a right to do as they wish with their child, it is more logical to view parents as having an obligation to secure and protect the rights of their child. Historically, parental rights are only invoked when a parent wants to do something that conflicts with the child's best interests. (Dwyer 1994) Health care providers have a similar obligation to secure and protect the rights of their child patients, not to act as cultural brokers. Unfortunately, with the revised policy, the members of the Committee on Bioethics appeared to have forgotten this obligation.

Why did the AAP Allow the Release of the April 2010 Policy Statement?

Given the backpedaling by the leadership of the AAP following the release of the new policy statement and its rapid retirement, it would appear that during the approval process the implications of the content of the statement were not fully appreciated.[4] Perhaps a look at the previous publications of members of the Committee that generated the statement would be illuminating.

Dena S. Davis, JD, PhD, a consultant to the Committee and the lead author of the statement, laid out her agenda, based on the "Seattle compromise" (Coleman 2000), for female circumcision in 2001. (Davis 2001) Davis's lengthy writings on genital cutting never acknowledge that a child has a right to bodily integrity and security of person, nor does she take seriously the position that male genital cutting in infants is a human rights violation. (Davis 2001, Davis 2003, Davis 2006) Such a view is inconsistent with the view taken by Davis in her 2000 *Genetic Dilemmas: Reproductive Technology, Parental Choices, and Children's Futures*, in which she advocates for protecting a child's right to an open future. She argued that parents were not morally entitled to make decisions for children that foreclosed their future options or which sought to force them into roles that were inconsistent with their natural inclinations and potential. (Davis 2000) The applicability of the right to an open future to male and female genital cutting is rather straightforward, yet Davis never makes an attempt at such an analysis.

When it comes to genital cutting of minors, parental control appears to be more important than the child's rights, future options, or autonomy for Professor Davis. In discussing male genital cutting she states, "Performing circumcision on a newborn at the parents' behest seems ethically acceptable, despite the fact that it deprives children of the freedom to make this important decision for themselves at a later time." (Davis 2009b) Oddly, in the same article she defends an older child's right to make the decision for himself. (Davis 2009b) Davis minimizes the impact of male genital cutting, but she is unwilling to engage in a discussion of the human rights issues associated with genital cutting. (Davis 2009a)

In her 1999 book *Children, Families, and Health Care Decision Making*, Lainie Friedman Ross, MD, PhD, argues that children are not Kantian persons and "do not deserve the same respect due to the mature rational adult," and "respect for persons do not apply to [children]." (Friedman Ross 1999a) Friedman Ross suggests that the best-interests standard be replaced by "constrained parental autonomy." For Friedman Ross, as long as parents provide for a child's basic needs (the details of which she never delineates), parents can do whatever they wish with their children. She believes more weight should be placed on serving the needs of family members in making decisions affecting children. She argues that even teenagers should not have the ability to dissent when the parents want to enter the child into research studies in which no benefit is expected from enrollment into the study, which would be a roll-back of the protections currently provided by federal regulations. (Code of Federal Regulations) Friedman Ross has also taken issue with the AAP's policy statement on informed consent, parental permission, and assent. (Committee on Bioethics 1995) In a 1999 opinion piece titled "Let the Parents Decide," she stated that children, regardless of age, have no final say in the medical care that is given to them, that the autonomy of children can be "impinged," and that children do not have the rights adults do. (Friedman Ross 1999b) Her views are at odds with the evolving international recognition and commitment to securing human rights for children. (Convention on the Rights of the Child 1989) In a 1997 letter to *JAMA* responding to a seminal study that found no association between male genital cutting and the risk for sexually transmitted infections in the United States, (Laumann et al. 1997) she provided a list of studies that she believed supported the practice of male genital cutting in infants. (Friedman Ross 1997)

Douglas S. Diekema, MD, chairman of the Committee on Bioethics, is also a member of the current task force addressing male genital cutting that has been meeting in secret over the past few years.[5] He has been interviewed regarding male genital cutting in several newspapers. He has been quick to laud the proposed benefits of male genital cutting while minimizing the extent of the risks. (Cornish 2010, Lyon 2010, Park 2010) He has never been quoted regarding a child's right to bodily integrity and security of person. In an article commenting on the case of divorced parents who disagreed as to whether their older child should have his genitals cut, Diekema states that it is essential that an older child agree to the cutting; however, he does not appear to believe that respect for persons or the opportunity to assent apply to male genital cutting in infants. He stated that family autonomy (complying with parental wishes) was more important than individual autonomy. (Diekema 2009) In situations in which parents refuse to treat their ill children, Diekema has argued for replacing the best-interests standard with the harm principle. The harm principle involves setting a threshold above which state intervention is justified. His analysis has two major flaws. He summarily dismisses using the substitute judgment standard (an evaluation of what a child would choose if competent) and the subjective and arbitrary nature of determining the threshold for state intervention. (Diekema 2004) The harm principle in effect removes the obligation placed on parents to do what is best for their children and replaces it with a paradigm of unfettered parental authority as long as a parent's neglect and abuse of their children remains below the threshold. This position of giving parents nearly unlimited latitude was reflected when Diekema recently appeared as a defense witness in a case in which a 16-year-old boy died because the parents failed to seek necessary medical care for him. He testified that the parents acted reasonably. The jury disagreed, finding the parents criminally negligent. (Mayes 2010)

Committee member Armand H. Matheny Antommaria, MD, PhD responded to an article on the ethics of male genital cutting (Benatar and Benatar 2003) by arguing that the discussion should be more focused on the non-medical benefits of male genital cutting and less focused on the individual. He takes the position that, at minimum, male genital cutting of infants should be at the discretion of the parents. There is no mention of the infant's human rights to bodily integrity and security of person. (Matheny Antommaria 2003)

With an agenda already clearly formulated, it is not hard to imagine that Davis had little trouble convincing Committee members — who, like her, failed to appreciate that human rights protections could apply to male genital cutting in infants — to relax the AAP's position on female circumcision in an effort to align it more closely with its position on male genital cutting. The Committee appeared to be more interested in protecting parental interests than in defending the rights of the children. The AAP and its membership have a long history of promoting a child's right to bodily integrity and security of person, and the AAP mission statement makes no mention of parents. If polled, I believe that most members of the AAP believe that a child has basic human rights and these rights are worth protecting; most members of the AAP believe that protecting human rights is more important than preserving cultural traditions; and most members of the AAP do not believe that any form of female circumcision is permissible. There was no evidence of dissatisfaction with the 1998 position following its release and no groundswell of support for altering the policy. The new policy on female circumcision developed by the Committee suggests that the Committee members were out of touch with the Academy's membership, the mission of the organization, and the worldwide movement towards the recognition and the securing of human rights for children. Ironically, on the same day as the April 2010 policy's retirement, the Royal Dutch Medical Association released its position on male genital cutting, determining that the non-therapeutic circumcision of males prior to majority violates the rights to autonomy and physical integrity and it urged a strong policy of deterrence.(Royal Dutch Medical Association 2010) In contrast, the AAP's April 2010 statement on female circumcision was a reflection of the personal and cultural biases of the Committee members who viewed genital cutting as permissible and children as little more than chattel. Not surprisingly, with the release of the April 2010 policy there were calls to rescind the new policy and replace the members of the Committee with AAP members who are representative of the Academy's membership. (Clow 2010, Makie 2010, Burke 2010, Strandjord, 2010)

Possible Explanations for the Alteration in Policy

Despite calls for an explanation,(Bewley 2010) the AAP has been silent regarding how the revised policy came about. There are only a limited number of possible explanations.

1. *The previous policy on female circumcision needed to be changed because the previous policy failed to control the epidemic of female circumcisions within the United States.* While female circumcision was part of mainstream medical practice until the 1950s, (Dawson 1915, Rathmann 1959) currently there is no epidemic of female circumcision in the United States. This is an unlikely reason.

2. *The previous policy on female circumcision had failed to slow down the practice outside the United States.* This also is not true. The solidarity of developed nations and national and international organizations in rejecting all forms of female circumcision as a human rights abuse has sent a clear message to cultures that promote the practice. The AAP's previous statement contributed to this solidarity. The April 2010 policy on female circumcision would only be used to promote the practice in cultures in which it remains acceptable. The AAP recognized the importance of this solidarity when they retired the April 2010 policy. (American Academy of Pediatrics 2010)

3. *The previous policy on female circumcision was not culturally sensitive*. I would venture to guess that most AAP members would not have recognized this as a problem and most AAP members consider a child's right to bodily integrity and security of person to be much more important than cultural sensitivity. In recent decades, the consensus of international human rights declarations has taken the position that if a cultural tradition violates basic human rights, the cultural tradition is not worth preserving. There were no documented problems with the original policy, consequently the April 2010 policy addressed a problem that didn't exist with a solution that undermined the mission of the AAP and would have encouraged the practice in other cultures.

4. *The previous policy needs to be changed to prevent girls living in the United States who were going back to Africa to be circumcised*. There is no data on how often this occurs. In Sweden, immigrant women from circumcising cultures have little interest in perpetuating the practice. (Johnsdotter et al. 2009) In the new statement, the Committee referred to the success seen in Scandinavia, which is much closer to Africa than the United States, thus rendering a trip back "home" for a circumcision logistically easier, in preventing this practice. Why didn't the Committee recommend the implementation of the measures adopted in Scandinavia? Rather than inciting its membership to break the law or lobby to change the law to allow for a ritual nick, the AAP would better expend its influence to secure laws that punishes or deports those who allow female circumcision to occur. Once again, with the April 2010 policy the AAP was putting forth the wrong solution for a problem that didn't exist.

5. *The previous policy statement on female circumcision was inconsistent with the current AAP position on male genital cutting, which allows parents to direct physicians to cut the genitals of male infants based only on parental whim*. The previous policy on female circumcision did not allow *any* cutting of female genitals. The April 2010 female circumcision statement permitted forms of female circumcision that were less invasive and less harmful than the most common forms of male genital cutting. This concession on the part of the Committee has interesting repercussions. The Committee recommended the "nick," which clearly would be considered less harmful than the common forms of male

genital cutting but did not recommend forms of female circumcision, such as removal of the clitoral prepuce, that are analogous to the most common forms of male genital cutting. The logical explanation is that recommending clitoral prepuce removal would not be well-received because such an amputation would be perceived as too harmful to warrant such a recommendation. If removal of the clitoral prepuce exceeds the level of harm that is ethically acceptable, then the most common forms of male genital cutting also exceed the level of harm that is ethically acceptable.

By not providing an ethical analysis or human rights evaluation of female circumcision, the Committee may have been laying the groundwork for the task force evaluating male genital cutting to evade an evaluation of the human rights issues associated with male genital cutting. An ethical analysis of male genital cutting might not be welcomed since several members of the Committee are on record that the harm inflicted by the most common forms of male genital cutting is acceptable. The Committee recognized the inconsistency of allowing male genital cutting yet forbidding female circumcision. The Committee had two options:

a) *Allow the forms of female circumcision that are considered less invasive than the most common form of male genital cutting.* This would allow the practice of male genital cutting, which brings in more than $200,000,000 for physicians in the United States each year, to continue unabated. It would also set the stage for the AAP to justify a more positive position regarding male genital cutting than that published in 1999 and reaffirmed in 2005. (American Academy of Pediatrics Task Force on Circumcision 1999)

A problem with this option is that the basic human right to bodily integrity and security of person is ignored, the harm of male genital cutting is permitted, and cultural and moral relativism are used to justify denying children their basic human rights. (Zechenter 1997)

Also, to be consistent with a policy of tolerating male genital cutting, forms of female circumcision analogous to the most common forms of male genital cutting would merit the Committee's endorsement. Such an endorsement would not be generally accepted.

b) *Maintain a ban on all forms of female circumcision and recommend a ban on all forms of male genital cutting.* The AAP's current policy on male genital cutting and the April 2010 policy on female circumcision are both inconsistent with the AAP's policy on informed consent, parental permission, and assent in pediatric practice, which states that the inability to obtain the patient's assent "should also carry considerable weight when the proposed intervention is not essential to his or her welfare and/or can be deferred without substantial risk." (Committee on Bioethics 1995) Consistent with this policy, the best resolution to these inconsistencies is to delay the decision on genital cutting for both males and females until the child is competent to make a fully informed decision. By delaying the decision until the age of competency, the child's autonomy is respected, the child is no longer treated as chattel subject to parental whim, and cultural traditions, if the competent person is not coerced, can be preserved. If the competent individual chooses to undergo genital cutting to secure a cultural identity, the competent individual will have ownership of that decision, which may add further meaning to the experience.

The AAP, in taking the course it did, missed an opportunity to respect the basic human rights of children while preserving cultural options. But cultural and moral relativism is a very slippery slope. A relativist can justify nearly anything based on cultural pressures. (Zechenter 1997) In a modern society, it is imperative to recognize that there will be differences of opinion that need to be respected. We can have public debate on what rules a society will follow. But as John Rawls pointed out, the first priority of society is to guarantee that every citizen, regardless of age, has the most basic human rights. The most basic human rights, among which he includes the right to bodily integrity, can never be compromised for religious or cultural traditions. (Rawls 1971)

The AAP Committee on Bioethics changed its position on female circumcision when there was no empirical reason to change. The Committee moved away from the AAP's tradition of protecting the rights of children to a position of being culturally sensitive to the wishes of parents. The emphasis on parental authority, at the expense of children's rights, is seen in the writings of several members of the Committee and likely explains the resultant policy. If the Committee had performed a straightforward ethical analysis or a human rights evaluation, which should have been central to the process, they would not have reached the same conclusion. Cultural practices cannot justify the violation of basic human rights, and children should not be treated instrumentally to satisfy parental cultural expectations. Likewise, if the Committee had assessed the beliefs of the AAP membership, they would not have released a policy that placed physicians in the position of cultural brokers and the organization in the position of recommending illegal activities. The AAP was right to retire the April 2010 policy on female genital cutting. The AAP needs to learn from this mistake and populate their committees with individuals who can think objectively and rationally about genital cutting. Such an approach could easily result in the position similar to the one taken by the Royal Dutch Medical Association, which deters all forms of genital cutting. (Royal Dutch Medical Association 2010)

Endnotes

1. The anatomical equivalent to the clitoris is the glans (head) of the penis.
2. The title of the study by Essén et al. is misleading. Rather than finding no association between female circumcision and prolonged labor, their study found that circumcised women had labors that were statistically significantly shorter than uncircumcised women.
3. The term *whim* may be considered hyperbolic, a parents' intention to cut the genital of a child is often not based on a rational choice that considers the child's best interest. The range of parental consideration includes deeply held religious convictions and purely cosmetic preference. The term *preference* implies a rational choice, while the term *whim* reflects a lack of rationality. When the term *whim* is used it is to remind the reader that no attempt is made to judge the amount or the type of consideration that goes into the decision making process of an individual parent. Currently decisions based purely on whim are acceptable.
4. Although the language of the policy statement was clear, there was confusion within the AAP regarding the statement's content. On May 14, 2010, the president of the AAP responded to initial criticism of the new policy by asking critics to "read the policy statement" and then contradicted the policy statement by stating, "The AAP does not endorse the practice of offering a 'clitoral nick.'" (Palfrey 2010) Within weeks, following intense pressure from human rights groups and opponents of female genital cutting, the AAP "retired" the new policy. (American Academy of Pediatrics 2010)
5. Requests by members of the AAP to identify the members of the Task Force and the timing for their meetings have been ignored.

Editorial Note: For a full list of Dr. Van Howe's reference list please e-mail Hannah Wakefield, E&M Editorial Assistant, at hannah.e.wakefield@gmail.com

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Analysing Risk in Medicine and Surgery: a Traditional Jewish Perspective

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Abstract

No procedure in medicine or surgery is risk free. No matter how small or seemingly insignificant, there is an innate risk of further morbidity or mortality associated with every medication, treatment, or surgical procedure. The traditional Jewish perspective of life being sacred underlies a Jew's obligation to preserve life and health, as well the consequent prohibition from hastening death. As such, the intrinsic hazards present throughout medical practice result in Jewish patients experiencing an inherent conflict between protecting and forgoing life when entering into any medical procedure.

How does one weigh the potential risk that accompanies a certain treatment against the possibility of cure or prolonged survival? By grading risk as low, moderate or high this paper discusses the various considerations applicable to Jewish law in analysing risk in a variety of medical and surgical scenarios, including palliative care, living organ donation and cosmetic surgery.

In Judaism, a low risk scenario is defined as being of trivial risk and broadly accepted in society and, as such, can always be entered into. Moderate risk scenarios can be entered into only with good reason, for instance to enable earning a living. Scenarios in which there is a 50% or greater chance of experiencing harm are graded as high risk and can only be entered into in the most stringent circumstances, such as saving one's own life. This classification endeavours to promote normal life, permitting those activities in which risk is both trivial and accepted while consenting to hazardous behaviour in the context of adequate reasoning.

Introduction

The term "Jewish medical ethics" is somewhat of a misnomer. It implies that, like secular medical ethics, there is a distinction between legality and morality. In contrast, Jewish medical ethics views Jewish law (halacha) and ethics as synonymous. Halacha is the code by which an observant Jew lives his or her life, as derived from Biblical, Talmudic, and rabbinic teachings. Jewish medical ethics is the application of Jewish law to medicine—the amalgamation of an ancient and rigid tradition of ritual and belief with the modern and constantly evolving realm of medical practice.

The association between Judaism and medicine is more significant than the need for a mere application of halacha to certain aspects of the modern world. Rather, it is the manifestation of one of the most fundamental concepts in Jewish tradition, namely the sanctity of human life and one's subsequent duty to preserve life and health, that has resulted in such a clear association through the ages. The concept of sanctity of life is derived from the belief that man is created in the image of God[1]. As such, certain qualities are attributed to life on account of the divine nature of its creator. God is infinite, so, too, human life is deemed of infinite value and by definition can neither be quantified nor qualified. A single life has the same value as that of a million people. So too the life of an older or unhealthy person or a person with a mental disability is worth no less than that of a young or healthy individual. Furthermore, the importance ascribed to life confers an active duty to protect life and health. The Talmudic maxim "to save one life is tantamount to saving a whole world[2]" expresses the significance of both the sanctity of life and its preservation. In fact, preservation of one's life takes precedence over all other commandments, with the exception of three cardinal sins: murder, idolatry, and forbidden sexual relations[3]. Consequently, one is prohibited from shortening a life, if even for a mere instant. The Talmud rules that if a person killed someone falling from a high roof whose death was considered assured, he would nevertheless be considered guilty of murder, even though he hastened his victim's death by a few moments[4].

No procedure in medicine or surgery is risk free. No matter how small or seemingly insignificant, there is an innate risk of further morbidity or mortality associated with every medication, treatment, or surgical procedure. In view of both the supreme value that Judaism places on life and the subsequent prohibition of hastening death, how does one weigh the potential risk that accompanies a certain treatment against the possibility of cure or prolonged survival if treatment were successful? In the case of a terminally ill patient, does one potentially sacrifice the definite short period of life of that patient for the chance of extended survival by administering a hazardous procedure? Is such risk permissible if treatment is purely palliative? This paper discusses the various considerations applicable to Jewish law in analysing risk in a variety of medical and surgical scenarios, including preventative health care, living organ donation, and cosmetic surgery, in addition to those questions already raised.

Low Risk

In general terms, Judaism quantifies risk into three categories: low, moderate, and high[5]. The broad and sweeping category of moderate risk remains best approached via elimination of both low and high risk definitions. A low risk activity can be done in all circumstances, without concern for potential of harm. Although the definition of harm is somewhat subjective, for the purpose of this paper harm may be defined as physical injury or damage. It is important to note that, in contrast to the scientific or medical world, Judaism does not define low risk merely as a statistically low chance of experiencing harm, but as something that is considered of trivial risk and hence is generally practised or accepted in society. For example, driving a car or airline travel can be done without an assessment of harm and benefit, despite the inherent risks involved, as both the risk is low and such behaviour is commonplace in society. This is based on the halachic principle that "G-d protects the simple[6]," and hence one is not reprimanded for doing what is broadly accepted across society.

It should be noted, however, that with respect to assessing risk, factual information is required to permit a potentially risky activity. It is not sufficient to rely on the actions of the many if they act with disregard of a widely acknowledged significant risk. For example, whilst cigarette smoking may be practised by over 28% of the adult European population[7], the almost total acceptance of the significant dangers of smoking in causing morbidity and mortality results in the prohibition of cigarette smoking according to Jewish law, regardless of the huge population of smokers worldwide. In short, the concept ensuring heavenly protection when carrying out the normal activities of daily living is only applicable when the risks involved are trivial *and* the action is broadly accepted in society.

Routine Vaccination

This halachic principle can be applied to permit the routine vaccination of children against infectious diseases. The risk of anaphylaxis after vaccination of children and adolescents for a variety of vaccines including measles-mumps-rubella, hepatitis B, diphtheria-tetanus-pertussis, and Haemophilus influenza type b has been identified as a risk of 0.65 cases/million doses[8]. As the risk of anaphylaxis and other associated side effects of vaccination are sufficiently low and routine vaccination of children is generally accepted and practised in society, Jewish law deems the innate risk of vaccination to be negligible and hence routine vaccination is permissible. In fact, such preventative health measures are considered obligatory according to significant halachic authorities[9].

High Risk

According to halacha, a high risk scenario is defined as one in which there is a 50% or greater chance of experiencing harm[10] and can generally not be entered into unless in very specific circumstances. In fact, one is forbidden to expose oneself to such probabilities of harm even to save another's life[11]. Such failure to act would not condemn the potential rescuer regarding transgression of the commandment "do not stand over your neighbour's blood[12]," which obligates one to save a life in lesser risk scenarios. However, one is permitted to enter even very high risk scenarios in order to save one's own life. This ruling is derived from a story in the book of Kings in which the Assyrian army had besieged the city of Jerusalem, resulting in widespread famine:

> *There were four leprous men at the entrance of the gate; and they said one to another:'Why sit here until we die? If we say: We will enter into the city, then the famine is in the city, and we shall die there; and if we sit still here, we die also. Now therefore come and let us surrender into the hands of the Arameans; if they save us alive, we shall live and if they kill us, we shall die.'* [13]

In light of certain death through starvation, the lepers decided to surrender to the invading Aramean army in the hope that they would permit them to live, thereby forgoing their certain, although limited, life for the possibility of prolonged survival. This story is used by the Talmud[14] to permit a patient with a terminal illness to undergo hazardous or risky treatment, despite the chance that such treatment may result in the immediate loss of life. It should be noted that this apparent disregard for the patient's limited, yet guaranteed, temporary life does not devalue life or permit euthanasia. In fact, one is permitted to desecrate the Sabbath to retrieve a trapped, mortally wounded patient with no hope of long term survival[15]. Rather, the permission granted by the Talmud to potentially sacrifice short term survival in favour of the chance of a full restoration of health demonstrates the default position taken by Judaism to promote life in whatever context.

It should also be noted that in such a scenario, in which the risk of mortality is equal to or greater than the chance of long term survival, although the patient is permitted to undergo the hazardous treatment, he or she is entitled to choose whether to undertake or refuse treatment[16]. This detail is of great significance in the world of Jewish medical ethics where, in contrast to secular medical ethics, the principle of autonomy does not dominate. The sanctity of life and subsequent duty to preserve life and health indicate that, while no patient may be coerced to undergo a procedure against their will, one is prohibited from refusing treatment that would be beneficial to life. Therefore, in such a scenario in which the risk of mortality associated with a procedure is so significant, the fact that the prohibition of refusing potentially beneficial treatment does not apply emphasises the difficulty posed by such a scenario.

As noted, the above ruling applies in a case in which the patient is terminally ill. In Judaism, a terminal illness is defined as one in which life expectancy is less than 12 months[17]. Therefore, if the aforementioned hazardous treatments could extend survival to a minimum of 12 months, this would be considered sufficient long term survival to permit such treatment to be undertaken. The question arises as to whether a hazardous treatment that could only extend life expectancy to less than 12 months would be considered permissible. It may be that a patient would be permitted to undergo such treatment due to the general prohibition of withholding therapy. According to halacha, therapy can only be withheld when certain mandatory criteria are fulfilled. One criterion is the patient's own desire for treatment to be withheld[18]. Therefore if the patient requested the treatment, hazardous or otherwise, they would be entitled to it, as failure to administer therapy would equate to the practitioner incorrectly withholding therapy against the patient's wishes.

Palliative Treatment

Another related question is whether one may undergo hazardous treatments for a condition that is not life threatening, yet causes extreme pain. There is debate amongst experts in halacha as to whether treatment for purely palliative purposes would be permissible, with some opinions holding that one should not undertake high risk procedures in non-life-threatening conditions[19] while others hold that while such treatment is not encouraged, neither is it forbidden[20]. Leniencies may exist, however, regarding palliation of pain during end of life care, with some authorities permitting aggressive pain control, despite the risks associated with respiratory depression and other significant side effects[21].

Moderate Risk

A moderate risk can be defined in Judaism as one that is not undertaken trivially by society, regardless of the percentage chance of harm involved; however, nor it is one where the potential of experiencing harm poses a significant danger to merit prohibition in all but the most ominous circumstances. According to halacha, such moderate risk could be entered into with good reason, for instance to enable earning a living. In discussing the necessity for due haste regarding payment of workers, the Talmud asks, "Why does he climb a ladder or hang from a tree or risk death? Is it not for his wages?" [22] Intrinsic to this argument of the Talmud is the assumption than one may partake in otherwise prohibited risky behaviour to earn a living.

Arguably, the most commonplace medical procedure that can be deemed of moderate risk is general anaesthesia. The current risk of anaesthetic mortality is between 0.5 to 10 per 10,000 administered anaesthetics[23], and, despite advances in the safety of anaesthesia over the last three decades, the many contraindications for anaesthetising patients coupled with the fact that no practitioner would allow their patient to undergo anaesthesia frivolously, leads to the conclusion that general anaesthesia is not yet a low risk procedure. It therefore holds the halachic grade of a procedure that can be undertaken with good reason, which, of course, qualifies preservation of life and health.

Cosmetic Surgery

The topic of cosmetic surgery poses an interesting question regarding the permissibility of undertaking the associated risks of both surgery itself and anaesthesia. Does the voluntary and purely aesthetic nature of cosmetic surgery lend itself to the conclusion that the hazards associated correlate to a reckless, and, hence, prohibited undertaking of risk? Judaism is sensitive to and sympathetic to all genuine accounts of human suffering, including the subjective issues of self-perception and self-esteem. Despite this, the late Lord Jakobovits, former Chief Rabbi of Great Britain, identified four potential theological and legal difficulties regarding cosmetic surgery[24]. In addition to the potential risks to life associated with surgery, Lord Jakobovits cited the theological and philosophical concern for changing God's work or "flying in the face of providence." Is the manipulation and remodelling of one's appearance equivalent to an affront to divine judgement, or is cosmetic surgery merely a fulfilment of the Biblical obligation to preserve life and health? The theological conflict between the divine nature of disease and man's efforts to control and eradicate ill health pertains to medical practice in its entirety. However, the debate surrounding the permissibility to manipulate physical appearance may be resolved by the Biblical verse instructing mankind to subdue and have dominion over the earth[25].

An additional difficulty posed by cosmetic surgery is the Biblical prohibition against wounding the body[26]. However, as already mentioned, preservation of life takes precedence over all other commandments, with few exceptions. Therefore the prohibition against wounding or cutting the body would also be removed if necessary to save a life. The problem arises, however, with the fact that, although cosmetic surgery may remove a social stigma or relieve the difficulties caused by one's appearance, it is not life-saving, and, hence, the prohibition against wounding the body remains. Contemporary halachic authorities[27] rule that this prohibition is only applicable when such action is malicious or with intention to harm. Consequently, cutting the body as part of cosmetic surgery would be permissible according to halacha.

The Biblical prohibition "a woman shall not wear that which pertains unto a man, neither shall a man put on a woman's garment"[28] has been extended to include any action involving a man's excessive attention to beauty. This poses an additional concern regarding the acceptability of cosmetic surgery for males. Does a surgical procedure that is sufficient to alter a man's self-perception constitute an excessive consideration of appearance, thereby meriting prohibition due to the aforementioned verse? The response to this concern, however, also resolves the query as to the permissibility of subjecting oneself to the hazards associated with the moderately risky domain of surgery for aesthetic purposes. In Judaism, genuine psychological suffering caused by a disfigurement or blemish, or even an entirely subjective and self-perceived flaw, which is sufficient to prevent the individual from taking part in society, finding employment or marital possibilities, is considered a legitimate and indisputable medical disorder[29]. Therefore, if there were such reason to believe that cosmetic surgery would permit a normal life to be led, then both the Biblical prohibition cited and the concern for undertaking the risks associated with both the surgery itself and anaesthesia would be negated.

Organ Donation

Living organ donation also poses an interesting question regarding the balance of benefit and risk. Taking into account the dangers of transplant surgery itself, in addition to the risk of infection and anaesthesia, the risk of surgical mortality from live kidney donation is 3.1 per 10,000 donors[30]. Whilst this is by no means a trivial risk, taking into account available data one would classify organ donation as of moderate risk. Does the benevolence of this action merit permissibility despite the significant risks imposed upon a benefactor who experiences no medical problems themselves? The Biblical verse, “do not stand over your neighbour’s blood[12]” is used by the Talmud[31] to obligate the saving of one’s fellow from a dangerous scenario. As previously mentioned, this obligation is applicable in scenarios where the risk of harm for the saviour is less than 50%; however, this obligation does not extend to scenarios in which the saviour would have to undergo suffering or donate any organ or tissue[32]. Such donation, whilst not obligatory, is a *middat chasidut*, a noble deed worthy of praise. There is discussion amongst the halachic authorities as to whether donation of a regenerating tissue, namely blood or bone marrow, to save another’s life would be obligatory. The potential classification of the risk of blood donation as trivial may represent a sufficient low risk to obligate blood donation in the context of saving life.

Conclusion

The absolute and infinite value that Judaism places on life underlies the obligation to preserve life and health and the consequent prohibition from hastening death. However, the intrinsic hazards evident throughout medical practice result in an inherent conflict between protecting and forgoing life. The stratification of risk into three major categories instructs the observant Jew as to the permissibility of entering into scenarios in which the risk of mortality ranges from trivial to sizeable. This classification endeavours to promote normal life, permitting those activities in which risk is both trivial and accepted in addition to consenting to hazardous behaviour in the context of adequate reasoning. Despite the aforementioned obligation to preserve life, Judaism recognises both the balance of probability and the patient’s uneasiness when an exceedingly hazardous treatment is indicated for a terminal illness, assigning the patient a previously unattained degree of autonomy.

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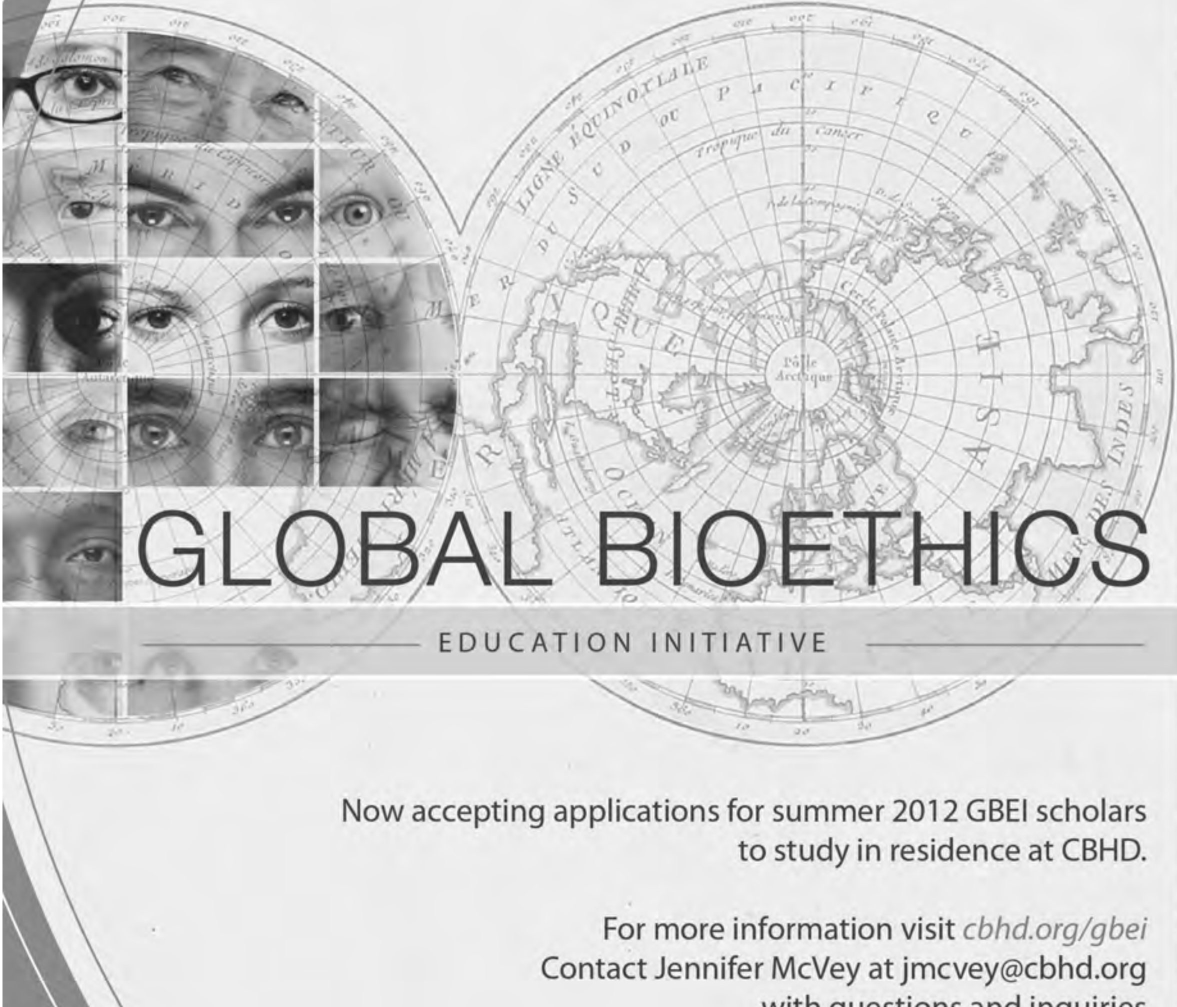

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The Position of the Family of Palliative Care Patients Within the Decision-Making Process at the End of Life in Singapore

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Abstract

The position of the family unit within the decision making process at the end of life in the context of Singapore is frequently underplayed and poorly understood due in part to its complex interplay with almost every element of patient care. Yet clearly its elucidation is of utmost importance to health professionals involved in caring for the terminally-ill in Singapore. Not only is Singapore a melting pot of various cultures but also significant inter-ethnic variances arise as a result of coadunations of specific social, educational, cultural, religious, and financial factors. In general, the family plays a role of a surrogate in decision-making, a provider in financial matters, a psychologist, a care-giver, a minister to spiritual needs, and an executor of post-mortem wishes. Whilst these roles seem to translate across all ethnic groups and cultures in Singapore, some distinct differences are apparent which prevent simple generalisations being drawn. This is particularly the case given that significant variations occur even within each family irrespective of ethic group. This paper focuses on the decision making preferences of the dominant Chinese populous.

A particularity of the Chinese population in Singapore is the significant interplay of elements of Christian, Confucian, Buddhist, Taoist, and Mohist beliefs in varying proportions. Of particular interest within this blending is the combination of Confucian ideals of familialism with western ideals of individualism, a combination which is relevant to palliative care teams involved in the patient's care as they endeavour to provide holistic care to both the patient and his family. Ascertaining the patients' and their families' position, beliefs, hopes, and goals of care is imperative to the provision of good, patient-centred care and the cornerstone of palliative care interventions. This paper will aid in positioning the role of the family within this concept and will provide ethical rationale for this assertion.

The Position of the Family Within the Palliative Care Concept

Given the definition of palliative care forwarded by the World Health Organisation (WHO), the position of the family unit is afforded prime importance.[1] According to this definition, palliative care is

> an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:
>
> - provides relief from pain and other distressing symptoms;

- affirms life and regards dying as a normal process;
- intends neither to hasten nor to postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.[1]

Divining the position accorded to the family by such a definition unearths a number of significant requirements of which health professionals should be cognisant. These include the need to

1. consider the family on equal footing with the patient
2. enhance the family's quality of life
3. relieve and prevent suffering of the family in addition to that of the patient
4. treat any physical, psychosocial, and spiritual problems of the family in addition to those of the patient
5. support the family throughout the patient's illness
6. support the family through the bereavement process

Furthermore, health professions need to involve the family in the following

1. assessing the patient for psychosocial, psychological, and spiritual aspects as part of a holistic assessment
2. providing a support system to help the patient live as active a life as possible

Given these factors, there are ample reasons that the family be involved within the care of the patient, and this has not been in question particularly within a nation where it is postulated that many within the Chinese community still hold to the belief that the nucleus of any consideration remains the family rather than the individual. Here what is of concern is the place family occupy in the decision making process particularly at the end of life. When we infuse this consideration with local factors we see the unique position that families occupy within Singaporean thinking.

The Confucian Effect

There is no denying that the Singaporean Chinese community still holds to a number of sentinel elements of Confucianism, though in varying degrees. A significant element is the "horizontal" aspect of Confucian thinking in relation to the individual. Central to this concept is the importance placed on the delicate and complex interweaving of relationships within an individual's family and within his or her larger community.[2-4] Here the intimate interconnections between individuals and their effects upon the family are of concern. This communitarianism, like ideals that consider the greater good of the family unit as prime, rather unsurprisingly places the family unit rather than the individual at the centre of any decision making process. After all, given these delicate interlocking connections within families, any decision taken will have ripple effects on all those within the family unit. Thus, it is unsurprising that many hold that the family unit as a whole ought to be involved in any decision making process.

Such a stance puts this ancient Chinese concept at odds with the western ideals of informed consent for three reasons. Primarily, the idea of decision making within the western model requires that the decision to be made by the patient; yet, the family unit acting upon a consensus decision or through a senior member of the family appears, on the surface, to usurp the idea of individual choice and self determination.[3, 5-6] Secondly, it follows that the decision cannot possibly be free of external influences given that Confucianism requires "engaging and interactions in a network of relations with others," hence the involvement of the larger family unit in arriving at a decision.[7] Some concern then arises regarding the presence of coercive factors within the decision making process and whether the patient's best interests are in fact being protected. Yet, within this scenario some reassurance can be gleaned from the presence of another Chinese concept of filial piety, which will be explained later. This facet, along with the presence of a palliative care team, can be seen to act to ensure that these rights are protected. Finally, occasions frequently occur in which the decision is not made by the patient at all but by the family. In fact, the patient may not even be in receipt of the full facts of his or her condition. Such a situation stems from the belief that the family as a whole or its senior members are better equipped to deal with the situation and more adept at adjudging the potential response and effects of the news on the patient. After all, it is they, as some family members have argued, who as a unit will bear this burden and its consequences. Furthermore, the maintenance of hope is considered integral to care and recovery, and, in the pursuit of this hope, nondisclosure and even sometimes misleading of the patient are adjudged to be acceptable. Additionally, such discussion amongst some Buddhists and Taoists is considered inauspicious and even considered taboo.[5]

Veritably a significant argument to explicate this position of so conspicuous an involvement of the family in the decision making process lies in part in the fact that any illness, and particularly a life-threatening one, affects not just the patient but the entire family. It also prevents the wishes, rights and hopes of the family being simply overruled or relegated situation in all this concern for the patient. This is particularly apt given that Singaporean families play very active roles in the care of their family members.[8-9]

One manifestation of this is the matter of the costs incurred in caring for the patient, be it in the home, the hospice, or an acute setting. This is because all Singaporeans contribute into an individual pot of money that is designated for his or her medical costs, called Medisave.[11] When this fund is exhausted, family members can elect to draw on their own Medisave accounts to pay for the care of their loved ones. However, Medisave itself doesn't cover all the costs, and the required top ups are sometimes passed on to the family. The incurring of such costs may lead to significantly differing decisions being made from situation to situation, even within the same family unit. A recent case that highlights this is that of a young lady with a haematological malignancy who opted not to have treatment despite a reasonable chance of remission offered by western care. Having exhausted her own Medisave and after consulting with her family, she opted to protect the future of her younger siblings by conserving the family's meagre financial resources for the siblings' education. Instead, she chose the cheaper traditional medicine option in neighbouring Malaysia. She passed away not long after.

Such family involvement also provides rationale for the relatively low use of Advanced Medical Directives. Patients feel that their wishes, hopes, and aspirations are protected and respected within this set-up. It is easy, then, to see why so many patients simply waive their rights to autonomous and direct decision making and intentionally opt to allow their family members to protect their interests.[12-15] This is particularly true of the elderly non-English-speaking patients who are more likely to hold traditional beliefs.[16]

Filial Piety

A significant factor that also needs to be considered in the reckoning of the position of the family within the decision making process, particularly in Singapore, is the effect of local cultural factors, particularly the concept of filial piety. This concept, which prevails in the psyche of a significant segment of the Chinese community, expects the younger generation to care for its elders.[6, 12] This expectation is policed by the larger family and community through the invocation of an underlying aversion of familial disapproval and the need for the preservation of "face" or personal honour and dignity of the carers within the community.[6] Here a failure to care for the family elders would be reason enough for a family to lose "face" in a community which revels in strong family ties. It is therefore unsurprising that such a precept often translates to a strong desire to preserve the life of a family member even in dire situations.[17-18]

No consideration of the effects of culture on the decision making process particularly in a modern metropolis such as Singapore, would be complete without acknowledging the growing influence of western culture on values and thinking. Indeed such a blending of these two influences has already been found amongst immigrant families in the west and can be shown to impact the ideals of consent.[19-20] Such "transition" has also been shown amongst the Singaporean Chinese community, negating a simplistic idea of a universality of practice amongst this group.[21]

There is no ignoring the fact that these various facets of societal level values have a role to play in the decision making process.[25] Yet it has been shown that differences even exist between what people of a certain cultural belief say they aspire to and what they actually practice, pointing the need to consider each case with its specific conditions.[22]

Ethics

The argument for more family involvement in the decision making process becomes more clear within the Singapore context upon consideration of the involvement, ranging from financial to social and spiritual support of the patient, that is offered by and required of families. Given that decisions being made have a significant impact on many in the extended family it would be only logical that these members have some input. However, though familial input is not really in question, the concern is that familial input should have a certain place and a certain weight in decision making.

Opposition to such "enmeshed" involvement usually begins with the defence of individual choice. However, given the evidence that has been presented, a number of ethical considerations need to be reconsidered. Certainly all effort should be made to maintain an individual's identity and choices, but certain other compelling factors ought to be given a hearing. Prior to proceeding with this, a number of factors need to be clarified.

Firstly, this paper does not suggest that the autonomous choice of a patient be usurped in favour of the families, but it does suggest that their input be taken into account early on given the 'domino effect' of decisions on each involved family member and the expectations that are consequently heaped upon them. Certainly there is no point of arranging for a patient to go home if the family decline this option. Nor is it viable to offer the patient treatment that the family will not financially agree to, especially when the family will bear the costs. Certainly treatment options being offered ought to also take into account the family's willingness to support such an intervention from a care, spiritual, and cultural perspective. A recent case in which cultural belief was at the centre of the patient's concern is a situation in which a patient notified his doctors that he wished to admit himself to the hospital for fear that his dying at home would be a psychological and psychical burden to his family. Yet the family disagreed though they clearly were struggling at home and would have welcomed the offer of respite. The decision came down to the fact that the patient was liable to pass away in hospital, and, though they had been prepared for his demise and for the possibility that he may indeed require a hospital admission when close to death as he clearly was now, they were concerned that his death would take place during the "hungry ghost month." According to belief, during this month the gates of hell are opened, and lost souls, or "hungry ghosts," leave the lower realms to visit the living. It is believed that in the midst of this "chaos," the patient's soul would become lost and unable to find its way home, leaving his soul a "hungry ghost." In this situation the family were clearly against a move that might leave the patient susceptible to such an abhorrent possibility and were able to convince him otherwise. Part of the issue arising here lies in the Mohist belief about not being a burden to the family.[23-24] Only in fully understanding the interplay of factors and the dynamics of the family can a better picture be drawn of the true goals of the family. Indeed, upon conversation between the patient and the family, and after being reassured, the patient happily declared that it remained his wish to die at home.

Similarly, cultural factors need to be considered when the family elder or spokesperson is the decision maker.[23-24] Such cultural consideration cannot be sidelined despite the difficulty of meshing it with western ideals such as autonomy. Yet this concept is not entirely alien to western culture. Indeed the idea can be considered a "waiver" where instead of it being made in favour of the physician it is instead in benefit of the family member.[27] Such a waiver oughtn't simply be taken at face value nor be based purely on the fact that the patient is of a culture that may subscribe to such ideals. Rather, each case should be taken on its own merits, and validity ought to be established. Once this is done and the waiver deemed valid, the choice should be respected as a conscious choice of the patient. According to this concept, there is valid ethical rationale for supplanting the individual's voice in favour of the family.

Decision making can be distressing for any patient, and a more detached, informed family member may be better positioned to assess the pros and cons of the treatment options being faced. The informed family member may be simply the person who is best versed in the patient's and the family's choices and goals and someone who is able to assess the reality of each option given the family's resources, the cultural, spiritual, and financial repercussions as well as the family's ability and desire to support these options.

This would be analogous to considering such a spokesperson as a surrogate or even the possessor of enduring power of attorney. Certainly questions such as the validity of the spokesperson position are bound to arise; however, this can be established to a large extent by a family consensus at a family meeting with a palliative care team.

Thus far considerations have viewed family involvement as limiting the choices of patients. However, the opposite is also true. Decisions taken by the family could be deemed too aggressive and unrealistic. In contrast to the examples of decisions that curb the patient's choices, it is equally possible that decisions could be made by family members to pursue certain options that would be considered aggressive and sometimes unrealistic in the hope of preserving the life of their loved ones. Because of the fear of "loss of face" or of failing in their filial duty, these families push for treatment avenues that may be considered futile or may place what may be considered by most physicians to be an unreasonable burden on the patient to meet unrealistic hopes. Once again, there may be a perfectly rational reason for this, but, once more, palliative care teams are adept at "readjusting expectations." Similarly, any decisions that may be called into question by the palliative care team can be put to the family as a whole, as should any decision that conflicts with the patient's previously stated wishes. Certainly, consensus may not always be possible, and an ethics consult may be called for if all other attempts to arbitrate differences fail. It would seem "moral decisions must be made in the real world of scientific and economic facts" only paints half the picture. Increasingly there needs to be a purposeful heeding of cultural and social facets in engendering effective and sensitive care for patients and families.[26]

Additionally, and rather tenuously, the position of the family can also be argued from the collective impact of ill effects decisions may have given the strain upon the family as a whole that may be provoked by the patient's choices upon the family as a whole be it from a physical, social, spiritual, or financial view. There is a possibility, then, that there is a place for curbing the autonomy of the person if it produces a ripple effect of bad outcomes for the larger group. A compromise may lie, then, in the involvement of the family early in the decision making process as is practiced in some quarters in Singapore. Yet in line with local practice, this argument neither explains nor justifies usurping the rights of the patient completely or placing the goals of the family above that those of the patient.

Conclusion

Within the complex psychosocial and cultural milieu of the local Singaporean context, there is a growing acceptance that the present clinical practice of involving the family early in the decision making process, particularly if the patient has no objections is warranted.

However, as is also local practice, it is imperative that the wishes of the patient at the initiation of such involvement be attained. Only when it is not possible to attain the wishes of the patient should the palliative care team act to the patient's best interest through a thorough holistic assessment.

Further research is being undertaken to clarify the position of patients at the end of life and their choices regarding decision makers in decision making at the end of life. This data will be invaluable to health professionals working in increasingly acculturate environments. It is hoped that, given the circumstances and contexts, differences in cultural, social, and religious beliefs will be taken into account when determining the position of the family in the decision making process

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BOOK REVIEWS

Christian Bioethics: A Guide for the Perplexed

Agneta Sutton. London, UK: T&T Clark/Continuum Books, 2008.

ISBN 0-567-03196-9; 180 PAGES, PAPER, $24.95.

Written by Agneta Sutton (Department of Pastoral Theology at Heythrop College in the University of London, UK), this introductory volume's eleven chapters categorize the contemporary bioethical landscape effectively and intuitively. Starting with beginning- and end-of-life issues, she raises difficulties about the definition of life and personhood. Then reviewed are technological advances that pepper the modern landscape: reproductive medicine, genetic testing and gene therapy, organ transplantation, human-animal hybrids/chimeras, and medical research. The author closes with reflections on the treatment of animals and environmental ethics.

Sutton distinguishes between sanctity and quality of life, and importantly grounds a Christian bioethic on sanctity—the intrinsic value of humans—based on what sort of substances we are: bearers of the *imago Dei*. In sharp contrast, the "new" outlook represented by utilitarian bioethicists (cf., Peter Singer) prioritizes quality of life, focusing not on the nature of living beings, but on how things go for them. Because of its clear application to so many issues, this distinction is the most praiseworthy and useful tool Sutton provides.

Sutton has a distinctly British perspective, and so UK/European practice and legislation form the larger part of her case studies. This is helpful for American readers, who may not be familiar with the history of important precedents being set in Europe, especially those pertaining to issues in human-animal hybrids, cybrids, transgenic organisms and chimeras.

Unfortunately, this volume does not address the problem of human egg donation despite an otherwise comprehensive section on assisted reproductive technology. Sutton offers only brief comment on egg *extraction*, required for IVF treatments using the gestational mother's own genetic material. Acknowledging the risks of hormonal ovary stimulation, she fails to address the widespread use of *donor* eggs, which requires additional hormones to stop, then sync, donor ovarian function with the recipient's. The laparoscopic surgical extraction procedure adds to the list of severe potential complications, which already includes reproductive cancers and infertility. The highly suspect and coercive practices of fertility clinics (e.g., discarding donor information post-procedure; advertising exorbitant compensation for 'donated' eggs); the absence peer-reviewed medical research on egg donors (making a joke of 'informed' consent); and the troubling fact of disembodied conception, and we've got an issue worthy of more attention.

While her concluding discussion of environmental ethics is a welcome expansion of bioethics, Sutton entertains a metaphysic of the natural world that is inconsistent with her otherwise orthodox view of creation (including human life) as the handiwork and image of God. She attempts to show that Gaia theory is compatible with a Christian view of creation, which, in my opinion, is untenable. Earth's supposed self-regulation as a living organism (157–159) is manifestly *in*compatible with scriptural accounts of the divine *Logos*' maintenance of the world (John 1:1–4, Col 1:15–18). And postulating Gaia theory is extraneous—God's appraisal of creation as "good" and "very good" (Gen 1) and his commission of human stewardship is sufficient to ground Christian bioethical reflection on ecology and the environment.

These reservations aside, *Christian Bioethics* succeeds as an introduction to bioethics, clearly depicting the core issues and questions while offering a Christian voice that supports the dignity and sanctity of human life.

Reviewed by Evan C. Rosa, BA, who lives with his wife in Fullerton, CA USA while he is pursuing a MA in religion and ethics at Talbot School of Theology at Biola University. He also is the Communications Director for The Center for Bioethics and Culture in San Ramon, CA, USA.

Genetic Dilemmas: Reproductive Technology, Parental Choices and Children's Futures, 2nd edition.

Dena S. Davis. Oxford: Oxford University Press, 2010.

ISBN 978-0-19-537438-4; 211 PAGES, PAPER, $24.95

Choice is one of our most basic liberties; we live in a choice-filled, pro-choice world. The objects of our choices are no longer limited to clothing or cars, but, with the explosion of reproductive technologies, the objects of our choices include the "kinds of children" we procreate. It is to these choices that the book *Genetic Dilemmas: Reproductive Technology, Parental Choices, and Children's Futures* by Dena S. Davis is addressed. Davis focuses on specific technologies through a novel secular lens that examines the ethics of reproductive technologies from the unique perspective of the potential child's right to an open future. In so doing, she provides genetic counselors with an ethical basis for limiting parental autonomy in their utilization of genetic technology.

Davis' approach is practical and principled. She is not interested in the metaphysical questions that swirl about these issues (for instance, the concept of the child as gift) or in the morality of the given technologies themselves—thereby artfully dodging the abortion dilemma. Her concern is that these technologies are often used to further parental agendas, consequently compromising the child's future choices. Davis is firmly committed to autonomy, but she is most concerned with the autonomy of the child. From her perspective, parental autonomy is bounded by the future autonomy of the prospective child, which counselors have a responsibility to protect.

Davis limits her discussion to technologies by which parents make choices for their child or for the "kind" of child they will have: PGD that selects *for* a disability, childhood testing for late-onset genetic traits, sex selection, cloning, and enhancement. Early on, she discusses the "harm conundrum" (Is it better to have a less than optimal life than no life at all?) and concludes that parents are obligated to protect their child's "rights-in-trust," providing the best possible life for their child. The deliberate choice of a defective embryo over a normal one is therefore morally wrong. She further argues that directed procreation turns hope into entitlement and a child into a means to the parents' ends; testing a child for adult-onset traits eliminates hope which is grounded in uncertainty and violates a child's later right to decide what personal information to disclose to their parents; sex selection forces a child to conform to parental gender stereotyping beginning even before birth. Concerning cloning, Davis distinguishes between logistical and duplicative cloning, finding the latter immoral. While she acknowledges that expectations are found in all normal parent-child relationships, the investment involved in utilization of enhancement technology elevates these expectations to unprecedented levels and limits the right of each individual to be a surprise to herself (164).

In our approach to childbearing, we have shifted our conceptualization from procreation to reproduction and back to procreation—but with a new twist. We have replaced chance with technological choice, exploiting it to fine-tune our families and instantiate our preconceived notions of what kind of children we wish to have. Rather than using reproductive technologies to offer our children more open futures, we constrain our children by means of it.

In her attempt to dodge the abortion dilemma, Davis applies her argument only to chosen children: only the "chosen" have "rights-in-trust" that warrant protection. Therefore a child's rights ultimately remain contingent upon parental choice. Alternatively, an argument that emphasizes parental responsibility rather than a child's rights obviates the potential conflict inherent in any rights talk. Despite this shortcoming, Davis' argument is an intriguing and thought-provoking addition to the conversation concerning the utilization of genetic technologies, opening our eyes to the many ways in which we constrain our children by the choices made on their behalf.

Reviewed by Susan M. Haack, MD, MA (Bioethics), FACOG, who is a consultative gynecologist at Hess Memorial Hospital and Mile Bluff Medical Center in Mauston, Wisconsin, USA.

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