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Ethical Issues in Community and Research Medicine

The following guest editorial by Saltonstall Professor of Population Ethics, Arthur J. Dyck, is reprinted from the *New England Journal of Medicine*. In it reference is made to an article, "Ethics of a Cottage Industry in an Age of Community and Research Medicine," by Paul Ramsey, professor of Christian Ethics at Princeton. Professor Ramsey's article appeared in the same issue, April 1, 1971, of the *New England Journal of Medicine*, pages 700-706.

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by
Arthur J. Dyck

Ramsey's essay in this issue of the *Journal* identifies two broad areas in which serious ethical issues arise for the practice of medicine — namely, community medicine and medical research. His excellent discussion of these issues suggests that when medicine attempts to make judgments about social well-being and when its practitioners become increasingly dedicated to the advancement of science, important questions must be raised regarding the role, warrant and principles of medical practice. What tasks and what judgments accrue to physicians as physicians? What are they trained to do and what ought they to be trained to do? By what primary principles and modes of ethical reasoning is and ought their practice to be governed? Let us briefly examine a specific instance in which current medical practice is involved sometimes implicitly, sometimes explicitly, in conflicting ways of answering these questions.

In a recent series of articles in the *Journal*, Milunsky et al.¹ review the current state of prenatal genetic diagnosis and argue for the widespread use of amniocentesis. As they use the term, amniocentesis refers to the aspiration of fluid from the amniotic sac for the purpose of making cytogenetic

studies. The immediate rationale for this use of amniocentesis is to advance the practice of genetic counseling by basing predictions of an increasing number of diseases upon actual diagnoses in utero instead of calculated probability risks. The advantages that they cite for this more accurate counsel is that it reassures couples regarding the normality of the fetus, it permits the decision to intervene through abortion where abnormalities are detected, and it provides a way of preventing the births of infants with irreparable genetic defects and fatal genetic diseases. Milunsky and his co-workers recognize that this last use of amniocentesis changes the traditional role of the physician so far as he can now predict diseases accurately before birth and provide the means of preventing the birth of a child with mental defects or fatal diseases. Hence, we enter a new era of social and preventive medicine.

Throughout the discussion of the diagnostic use of amniocentesis as advocated by Milunsky et al., there is no explicit recognition of the fetus as a patient. Apparently, genetic counseling does not include the task of preparing a family to accept and care for a defective child. "Therapy" at the present time is aimed at the family and not the fetus. In an earlier essay, John W. Littlefield spoke specifically to this issue:

Prenatal genetic diagnosis will constitute a major medical advance only if therapy can be given once a diagnosis is made. Eventually and occasionally, this may be prenatal therapy for the fetus. . . . But society and the professions must appreciate and accept that the proper therapy now is for the family, and at times that means abortion.²

Clearly, neither reassurance for the family nor abortion provides therapy for the fetus. The hope is held out for eventual and occasional therapy for

the fetus, with no explicit reference to the kinds of postnatal therapy presently available. For now, the treatment of the diseases of this "sometime patient" is, in this view, achieved by its elimination as a patient and as a living entity.

Suppose a physician argues that deciding whether to treat the fetus as a patient is a judgment that a physician as physician is not in a position to make. In effect, this is the view taken by Milunsky et al. when they suggest that physicians and society are, and should remain, impartial or neutral regarding decisions by families about whether to use amniocentesis and whether to abort the fetus where deformities are detected. This point of view is strange considering both the traditional role of physicians and current medical practice.

As the physicians' role was traditionally depicted in the Hippocratic Oath and many subsequent codes, he was expected to be the physician advocate of both the pregnant woman and developing life within the womb. If, as Milunsky et al. suggest, both physician and society should be impartial regarding the use of amniocentesis to prevent diseases by eliminating the diseased, what advocate is left for defenseless life? Are physicians about to abandon also their time-honored role as advocates on behalf of the hopelessly ill, the unconscious and the experimental subject who is uninformed? And even if one wishes to leave the exact status of the fetus as a human life an open question, should it not be part of the special responsibility of the physician, as it certainly has been traditionally, to err on the side of saving and fostering human life rather than to develop or encourage programs that selectively prevent such life?

To drop the fetus as a patient at this time in history is also incongruous with the aims and increasing accomplishments of contemporary fetology. Furthermore, why should physicians claim increasing responsibility for defining and specifying the end of human life, and decreasing responsibility for defining and specifying the beginning of human life? Why, for example, should the absence of signs of brain activity spell death while signs of brain activity in the eight-week-old fetus are largely unheralded as signs of human life? If physicians nevertheless insist that specifying when human life begins is not a medical decision, by what warrant do they decide that the fetus is not a patient and that his life is dispensable? As Ramsey has indicated, the medical warrant for recommending abortion occurs only when a fetus threatens the life or the health of a pregnant woman.

To decide that a given set of diseases is to be eliminated by elimination of the diseased is one of the principles on which programs of eugenics and euthanasia rest. Decisions of this kind are surely not morally neutral. What special competence does a physician have to decide that a society ought to prefer death to giving custodial or remedial care for those who require it? Milunsky et al. cite the costs of care for the mentally retarded in Massachusetts. What a meager sum this is as compared to the amount of money being spent for destroying lives in Vietnam! If saving money is important, why not save much more money and save lives as well by thinking of other costs that could be cut? One of the problems here is that, as the physicians strive to contribute to social well-being, they find that only certain kinds of actions are predictably within their power as physi-

cians. Hence, they look to the surest way in which they can affect social policy. Their warrant for doing so is very unclear, and, whereas we can vote out those who might suggest legislation that permits or encourages selective killing, including capital punishment and the like, our recourse in forming the conscience of physicians is less certain. Heretofore, in the area of abortion, we have generally put constraints upon physicians and others on behalf of the fetus. The assumption that the use and application of amniocentesis is a neutral sphere for physicians and society presupposes that, for physicians and society, abortion is not a moral issue, and that existing or future laws do or will assure that abortions are decided solely by families and physicians. To go that way is not morally neutral, and it is not life affirming.

Like so many technical innovations, amniocentesis is a powerful tool in search of a noble purpose. On the whole, medicine has exhibited a remarkable degree of compassion for the ill whatever their condition, aggressive zest in affirming, extending and enhancing life, and loyalty to the welfare of individual patients whatever their presumable social utility. The use of amniocentesis is surely to be judged by these principles, for if it is not, it threatens to erode them.

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