

Letter

Listening to the critics: a response to "Clinical ethics revisited"

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The signal value of Singer, Siegler, and Pellegrino's article, "Clinical ethics revisited," [1; [<http://www.biomedcentral.com/1472-6939/2/1>]] appears to lie in its recognition of the subdiscipline as the authors define it. Certainly, a series of critiques posted with the article [2] question the article's central thrust, that while clinical ethics remains a developing field of medicine that its general tenants are sound. Most damning, perhaps, is the original author's admission that, "if the goal of clinical ethics is to improve patient care and outcomes, there is scant evidence this has been achieved." If that is true - and it is a point upon which both critics and authors agree - then arguing as do Singer et al. for increased funding, more research, and a stronger educational posture is at best premature.

As Virginia Sharpe notes [2], the clinical ethic espoused by the authors is limited and perhaps incomplete from the start. Singer et al. insist that "clinical ethics is not founded in philosophy, law, or theology but, instead, is a sub-discipline of medicine, centering upon the doctor-patient relationship" [1, 2]. This assumes that *only* the doctor-patient relationship is important. The authors thus exclude - critically and I believe incorrectly - not only other professional "healing relationships" (with nurses, for example) but also those involving family caregivers and the institutional context in which care is provided for patients and through those caregivers.

And yet these often affect not only patient care and well-being, but also clinical decision making. The needs and

perspectives of patient surrogates effect, for example, questions of how patients with chronic progressive conditions should be treated (ALS, MS, etc.), and of course, the issues of continuance for those in a coma or a persistent vegetative state. A clinical ethics defined as involving only doctor-patient relationships is thus necessarily incomplete and limited from the start.

The assumption that clinical ethics is easily divorced from either philosophical or legal issues is similarly problematic. This "clinical-not philosophical, social, or legal" approach may explain the limits of the approach the original authors advance. The social perspectives argued in general bioethical approaches, the social restrictions presented in law and the general views of humanness and personhood advanced by theologians (and philosophically trained ethicists) all directly affect clinical medicine and the ethics of its practice. Procedures ranging from therapeutic or elective abortion, to palliative care or treat modalities for patients with chronic progressive conditions (MS, ALS, etc.) are at once clinical, philosophical, legal and theoretical problems requiring broader rather than narrower address.

Indeed, it is precisely because of the interplay between clinical decision making and social concerns that bioethics first was created. In the 1960s, for example, a purely clinical ethic was incapable of addressing the rationing of dialysis facilities among the many patients then undergoing dialysis in the USA. It was this debate that introduced moral philosophers as clinical commentators to the greater public [3]. Things haven't changed overmuch

in the intervening two decades. If appropriate outcomes are unclear socially or counter-indicated by law, then their clinical implementation will be problematic [4].

There is in the original article - but not in the critiques offered to date - a general refusal to acknowledge the importance of the social context in which medical decision making occurs. Here, Benatar's comments [5] are especially damning, and worth quoting: "The growth of bioethics has taken place in an era when medicine, particularly in the USA, has been transformed into a business, and health care has been commodified and bureaucratized." This may explain why, there has been a "loss of trust in health care professionals." Why trust those whose relation to the patient is in fact defined by commercial relations rather than historical associations of care and caring? And it may be that the commodification of health that has affected clinical outcomes by affecting treatment decisions. It almost certainly has affected patient-health professional relationships.

Contemporary medical ethics is redolent with cases in which the needs of the patient are opposed by the often commercially defined practice guidelines of hospitals and funding agencies. In his critique Daar cites the Gelsing case, "in which a teenager died while undergoing gene therapy in the hands of researchers who allegedly had conflicts of interest and failed to report to the authorities important previous research data that may have contributed to the fatal outcome [6]".

Another case in which the primacy of patient care seemed to have been suborned by commercial issues drives home the point. At the Hospital for Sick Children, in Toronto, Canada, the Olivieri case saw a physician ostracized and condemned for publicly announcing the dangers of a disease she was testing among juvenile patients with Thalassaemia Major [7]. Dr. Olivieri argued that as a physician her primary duty was to her patients, not the drug company that funded her work or the hospital that employed her [8]. For this she was suspended from her work by the hospital.

Singer et al. lament the failure of public engagement by clinical ethicists. But the truth is that too often those involved in clinical policy do not wish public dialog at all. This was underscored when the Cleveland Clinic Foundation's sought to implement a non-beating heart protocol - commonly known as the Pittsburgh Protocol - in the 1990s. It was done without public input, or apparently, legal review. The program was terminated after an investigation by the local prosecutor's office became a national issue. The use of specific drugs to facilitate organ extraction from respiring patients was seen as potentially actionable under state homicide statutes.

A CCF bioethicist, arguing the clinical efficacy of the plan, later described this as the imposition of unwanted and unnecessary public and legal attention to a fundamentally clinical issue. If clinically sound protocols were so treated, CCF ethicist George Aggich argued, "The future of bioethics may be not in the media spotlight, but in shadows where the quality of everyday patient care is enhanced [9]." What Aggich ignored was both the social and legal climate in which medical protocols exist. As Ankeny notes, public perception has a real effect on donation [10, for example. The problem was not, in the end, with public exposure but with the institution's failure to involve interested parties - local citizenry and their representatives - in a dialog over policy [11] with profound clinical and social implications.

It would seem from this and the other critiques offered by readers of the original paper that a methodologically based clinical ethics is a failure. It has served the needs of professionals but not the patients, or their carers. It thus in too many cases ignores the social context in which medicine is practiced and in which patients receive or are denied care. It ignores, in the original authors' formulation, the broad complex of healing relationships that contribute greatly to a patient's condition, and often his or her medical outcome. If clinical ethics is, in fact, a sub-discipline of medicine, it is one that necessarily must involve social, legal, and sometimes theological perceptions.

In the end, clinical ethics needs to be redefined in a manner that acknowledges that medicine is more than methodology, that patient outcomes result from a complex of factors extending beyond the "doctor-patient relationship." Before the subdiscipline can evolve into an effective perspective it therefore must engage the complex of economic and social factors influencing patient health and well-being.

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