Current Trends in Biomedical Ethics in the United States

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Enormous growth of medical activities and issues in the 1960s and 1970s stimulated birth of the field of contemporary biomedical ethics. Nevertheless, when one examines recent trends within the field in the United States, one is struck with how many significant transformations and developments have occurred since that time. This presentation examines recent developments in five areas—those of patient rights and autonomy, termination of life, manipulation of Nature, health care resource allocation, and decision-making by the general public. The author also notes that although bioethical issues have become politicized as major interest groups and the general public have become increasingly involved, the quest for consensus remains a central one for health care ethics in the United States.

Though there had been scattered interest earlier, the contemporary field of biomedical ethics in the United States really began to develop in the mid to late 1960s. During the 1960s a large number of advances occurred in basic research and clinical applications. That decade saw the advent of organ transplants, kidney dialysis, and prenatal diagnosis; widespread use of the respirator; the beginning of legal abortion; and development of some effective contraceptives. It also saw the establishment of two major health care programs that were partly or fully funded by the Federal Government: Medicare, providing health care for the elderly, and Medicaid, providing health care for the poor. The new technologic advances, it became clear, would generate difficult and historically unique moral problems. This circumstance, combined with the great explosion of activities and issues, stimulated birth of the field of contemporary biomedical ethics.

The first decade or so after those beginning years witnessed development of strong interest in the entire field. Courses began appearing in universities and medical schools; professional societies developed committees with special responsibility for ethical issues; medical journals began to carry articles on the topic regularly; and research on it also appeared in journals of philosophy, law, and social policy. In addition, a number of cases in biomedical ethics began to appear before the courts; various problems were also taken up by legislatures; and two important commissions were established by the U.S. Congress, one in 1974 and another in 1979.

The 1970s, in short, saw a great blossoming and unfolding of the interest that had been aroused for the first time in the 1960s. The net result was a decisive expansion and change in both the scope and nature of traditional medical ethics. At present, although the traditions of medical ethics certainly persist, they are now contained within the wider field of biomedical ethics—which is normally

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taken to include both traditional medical ethics and a wide range of ethical issues bearing on biological and social science research.

It could well take a page or more simply to list all the ethics topics that have come out of these developments in recent years. They include an array of matters dealing with the beginning of life (conception, abortion, prenatal diagnosis, genetic counseling and screening, fetal therapy, and so on) as well as a large number concerned with the end of life (care of the dying, termination of treatment, the distinction between ordinary and extraordinary care, the distinction between omission and commission in care of the dying, and so on). In between are topics dealing with all other stages of life—including organ transplants, artificial organs, research on human subjects, the AIDS crisis and the problems it raises for civil liberties and the public interest, issues of reproductive biology, surrogate motherhood, and so forth.

In sum, a simple list of all the topics dealt with in contemporary biomedical ethics would be long and rich. So it is perhaps not surprising that some years ago, when the Hastings Center took a comparative look at ethical problems in various fields and professions, it seemed as if there were more moral problems in medicine and biology than in all the other professional fields combined—including all of law, business, journalism, the armed forces, social work, public policy, and government.

When one tries to discern recent trends in the field of biomedical ethics in the United States, one is struck not only by how many of them have their historical roots back in the 1960s and 1970s, but also by how many have undergone significant transformation and development since that time. I would like in this presentation to talk about five major areas of great importance and comment on some recent trends within those areas.

**PATIENT RIGHTS AND AUTONOMY**

It was perhaps in this general area that the first and most significant developments took place in the late 1960s and 1970s. In 1967, for example, the Federal Government established the requirement for those receiving grant support that any research involving human subjects had to be screened by a special committee, not only to examine the potential hazards to patients, but also to make certain that informed consent had been given. That was the Federal Government's first important entry point into basic ethical questions relating to research.

Shortly thereafter, there emerged a great interest in the idea of "patient rights"—in the form of efforts to see that patients were accorded carefully prescribed rights and to ensure that those rights would place them in a position of parity vis-à-vis the rights of physicians. Various guidelines were developed along these lines, and a gradual agreement emerged to the effect that the relationship between doctor and patient should be that of moral equals, even though the doctor might possess considerably more technical knowledge.

In recent years, there have been few new theoretical or legal breakthroughs relating to this concept of patient rights and autonomy, but a lot of work has been done to establish the concept in the actual practice of medicine—a slow process. In general, repudiation of medical paternalism has given way to strong emphasis on patient autonomy.

At the same time, it is fair to say that some commentators believe the trend has gone much too far, not only reducing the legitimate authority of physicians but
also failing to recognize the actual complexity and psychological circumstances of patient decision-making. Hence, while much of the 1970s and 1980s saw growth of patient autonomy, there has been a tendency recently to call into question some of the excesses in that direction.

Overall, at present it appears that the relationship between doctors and patients should be seen as one of equals, with each attempting to educate the other and each sensitive to the other’s needs and rights. This implies a more balanced relationship than a heavy emphasis on patient autonomy might achieve.

THE SANCTITY VERSUS THE QUALITY OF LIFE

As a result of concern about termination of treatment, whether for elderly patients at one end of life or handicapped newborns at the other, there has been an ongoing debate about how we should understand the concepts “sanctity of life” and “quality of life.” The former concept, with deep historic roots, is usually taken to mean that life should be preserved whenever possible—and that all doubt about appropriate treatment should be resolved in favor of life’s preservation. The latter “quality of life” concept is of more recent vintage. While that phrase first emerged in the 1960s within the context of environmental issues, it soon migrated into the medical arena. There it has been used to help resolve the question of what is to be done when life might be preserved, but perhaps preserved at great psychological, moral, or spiritual cost to the patient. In that case, if the patient’s “quality of life” is going to be low, is it always the obligation of physicians to preserve life?

Although questions relating to the sanctity of life have arisen particularly in regard to care of the dying, they have also come up in matters involving painful and difficult treatment, where a patient’s life might be extended, say, by a cancer operation, but where his quality of life could be significantly compromised in the process.

It is sometimes thought that the sanctity of life concept requires that life be maintained under all circumstances, and it is sometimes also thought that the quality of life concept requires that the sanctity of life be always set aside in any conflict between the two principles. One problem is that neither concept has a very solid and fixed definition. This is particularly true of “quality of life,” which because of its nontechnical nature and relatively recent vintage admits of great variation in meaning.

Increasingly, however, many are coming to believe it impossible to distinguish sharply between the two concepts. For instance, in considering the sanctity of life, one can reasonably ask what it means to be alive in some meaningful fashion, and one way to answer that question is to invoke the quality of life concept. Similarly, in probing the quality of life, one can reasonably ask why life itself matters, and one needs the sanctity of life concept to effectively answer that. In short, it may well be that the two concepts must work hand in hand, each modifying and complementing the other.

Obviously, recent years have seen a lot of concern expressed in the United States about potential abuse of the quality of life concept—especially when that concept might be used to end a life that in the judgment of others is not worth living. The specter of Nazism is commonly invoked, and there is great worry that the quality of life idea would come to totally dominate the sanctity of life concept. The recent effort to try to find a way for the two concepts to work together in a com-
plementary way seems directed at countering that danger and making certain that neither is wholly able to dominate the other.

INTERVENTIONS INTO NATURE

Another subject of great importance, lacking an adequate title, might well be called "interventions into Nature." A longstanding theological and philosophical debate has revolved around the following question: How far, and in what ways, is it legitimate for human beings to intervene into Nature and manipulate Nature to their own ends?

Today the concern arises frequently in relation to genetic interventions into human beings' own nature, but it has been a question commonly posed throughout the entire history of medicine. One recalls that objections were raised to the use of ether and to many surgical procedures, and yet in time those interventions were accepted. By and large the inclination in the United States has been to allow such interventions unless one can decisively prove them likely to harm individuals or Nature.

Since that is rarely the case, the compromise solution has been to allow and facilitate such interventions, but to appoint supervisory or oversight bodies to make certain that appropriate guidelines are observed and that care is taken to do no damage. Overall, I believe, there was far more resistance to interventions into Nature in the 1970s than at the end of the 1980s. This may be largely because some of the potential harms invoked earlier (e.g., the dangers of recombinant DNA research) did not materialize. At present, while some groups regularly resist such interventions, there is little general resistance to them; and it seems that science can do almost anything it wants in our society so long as it complies with the extensive regulatory schemes set up to protect research subjects and the public.

RESOURCE ALLOCATION

During the 1960s and much of the 1970s, the topic of resource allocation was simply not important. By the end of the 1970s, however, medical care costs had mushroomed, and a major search was underway for ways to contain them. At the same time, it was increasingly being recognized that medical technology had the potential to produce an infinity of cures for an infinity of illnesses at an infinite price—but that in both theory and practice some limits would have to be set on health care resource allocation.

During much of the 1970s, considerable effort went into developing principles and procedures that would help achieve equity of access to care in the face of potential shortages. In general, those efforts were not very successful, largely because it was hard to get agreement on what would constitute just access to health care and what might comprise a minimally adequate level of care.

During the 1980s, as the cost pressures increased, the discussion shifted. Among other things, proposals were made to limit health care entitlements to the elderly on the basis of age, to force patients to spend more out of their own pockets, to set limits on various states' entitlement programs, and to limit the kind and extent of health care coverage provided by private enterprise.

At this point there is very little agreement on just how much should be spent for health care relative to other things, or on how best to limit costs. Although cost containment efforts have continued apace, the results have tended to be unimpressive. At present, it appears that there will be even more pressure to control costs in the future, together with a
much more direct and open discussion of rationing. One state, Oregon, has in fact limited organ transplants significantly, and has established a state system of priorities to be used in providing health care. Other states seem likely to follow this lead.

PUBLIC DECISION-MAKING

One of the great changes that came out of the 1960s and 1970s was the far larger role assigned to the general public in making health care decisions and allocating health care resources. The earlier Hippocratic ethic really gave the patient no decision-making role at all, leaving everything to the physician. In contrast, today the U.S. public plays an increasingly active role in various ways—from individual patients taking part in decision-making about their own health care to legislators and administrators making broad decisions about health care policy and resource allocation.

The question remains, however, as to how much the medical profession should manage and regulate itself, and the extent to which it should be externally regulated by the Government. On the whole, physicians remain strongly opposed to government intervention, but that resistance seems considerably weaker now than it was 20 or 30 years ago. Among other things, many physicians now recognize that substantial public involvement can be expected so long as the public is paying a large share of health care costs.

One recent development of great importance in this area has been the emergence of hospital ethics committees. The purpose of these committees is to provide advice and counsel—not make decisions—about difficult moral problems that arise in the daily practice of medicine within the hospitals they serve. Some 60% or more of all American hospitals now have an ethics committee, the membership of which typically includes physicians, nurses, social workers, lawyers, and some outside lay people.

In general, these committees carefully scrutinize ethical issues, make themselves available as a resource, and render opinions on particularly difficult ethical subjects upon request. Beyond that, they help to organize educational programs and in some institutions help to write policy on relevant matters such as issuance of “do not resuscitate” orders.

What is striking about this overall trend is that the U.S. public now has a very significant and pervasive role in a great deal of health care delivery. This means that lay people are becoming increasingly familiar with the way medicine operates in this country, with its internal problems, and with difficulties inherent in the relations between doctors and patients, doctors and administrators, and hospitals and the broader political order. It is now generally accepted that the public will have a significant role in decision-making, and while physicians continue to mutter about the situation, they understand that it is probably a fact of life. An important question that has emerged of late, therefore, is how one can ensure that physicians maintain their own integrity and sense of responsibility while at the same time sharing considerable power and authority with nonmedical people.

These are five major areas of concern and some recent trends within them. There is one other trend that I would note, one that may be of great importance in the future. That is the increasing tendency to politicize health issues, a development that has drawn up strong factions against each other and has produced some very acrid and unpleasant
public debate. While this has long been the case regarding abortion, it has recently become the case increasingly with regard to termination of treatment, some genetic issues, and allocation of health care resources.

With specific regard to biomedical ethics, in its early days this was a relatively small and quiet field. Most of the people involved worked closely with one another and most were on relatively friendly terms. As the field grew, however, the issues expanded beyond the sole domain of medical ethicists to include many religious and cultural interest groups and the general public. Hence, on occasion debates began to involve ordinary tactics of the political marketplace and some of the unpleasant rhetoric that goes with them. In general, one has seen much more of a tendency to choose up political sides, a greater polarization of the issues, and fewer efforts to develop compromise solutions. Nevertheless, despite the threat posed in this manner by political issues, the quest for consensus remains a central one for health care ethics in the United States.