
BIOETHICS OUTLOOK

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**“ In my prayers I asked outright for
wisdom.”**

Brian Dwyer

In this issue

Brian Dwyer's memorable address to an Intensive Bioethics Course is reprinted in this issue. And an 'in memoriam note' is found on page two.

Helen McCabe reviews a recent addition to the bioethics literature which addresses the prospects for people working in 'managed care' institutions to respond to people whose lives are marked by psychiatric illness. In so doing she clarifies much of what is ethically at stake in 'managed care'.

As an aged medical retiree I feel somewhat like a fish out of water addressing such an audience which is devoted to improving its collective understanding of bioethics! I have no profound knowledge of the subject. Fortunately for me, after dinner speeches should be more for entertainment than education¹. But even in this situation I am uncomfortable. I feel rather the way Mr Graham Gooch, a retired English Cricket Captain, must have felt when he was resurrected, dusted down and sent to Australia to defend his country's honour in the recent "Ashes" series. Even as entertainment value most thought he was "over the hill" - and, mind you, he was only forty-one!

Tonight, with your indulgence, I thought it best if I simply reviewed some experiences of my medical career which, for me, had a major bearing on ethics at the time and not surprisingly continue to be important issues of debate and discussion.

As my story is a personal view through a very small window of medical practice over the past fifty years, I should define for you now the limits of my experience. Essentially

Vale Brian Dwyer 1925-2006

'When things go wrong, you have to resist the temptation to disappear. You have to go straight back out and talk to the family'. Of all things that Brian Dwyer said to me in the years that he was a member of the Management Committee of the Plunkett Centre, that remark best captures his sense of what constitutes good medical ethics.

Things go wrong in the professional lives of the very best, be they doctors, lawyers, architects, teachers. When that happens, even the most experienced and courageous professional is likely to be tempted to do the wrong thing: to duck for cover, to blame someone else, to brazen it out, etc. Brian knew that, and no doubt felt the pull of those temptations.

But he also knew what any truly good doctor knows. Sick people, and their families, are vulnerable, dependent, anxious. (This continues to be true today, as the culture fosters the idea that sick people are mere consumers and doctors mere service providers.) Sick people, old people, frail people need to be able to trust their doctors not only to have the knowledge and skill to diagnose what is wrong with them and to do whatever is possible to heal them. They also need to be able to trust in the doctor's professionalism (in the true sense of that much-corrupted idea): the doctor's readiness to suppress his own self-interest, to be intellectually honest and truthful, to be humble as well as courageous, to be genuinely committed to serving the needs of the person caught in the predicament of illness. Brian knew all this, and his professional life was characterized by those qualities of character.

Brian's career was marked by a series of firsts. He established the first intensive care ward in an Australian hospital, the first multi-disciplinary pain clinic and the first palliative care service. He was a great medical educator, dean of what is now the Australian and New Zealand College of Anaesthetists. The anaesthetics department at St. Vincent's Hospital in Sydney is rightly named in his honour: he was an outstanding example of all that is best in Australian medicine.

Lest this sound too earnest, let me say also that Brian had a terrific sense of humour: he certainly never allowed me to forget what an incurable disability it was to have come from Melbourne! And he was a great athlete: they say he supervised an operating room in the same quiet but authoritative way that he supervised the field when he captained the New South Wales cricket team. He will be greatly missed, not only by his beloved wife Jacqueline and their children, but also by the rest of us.

Edmund Pellegrino once said: 'As soon as we step outside the narrow perimeter of our own expertise we are vulnerable to the ethical standards and character of those whom we consult.' Anyone who consulted Brian Dwyer could have complete confidence in his wonderful knowledge and skill and in what he truly professed: an undiluted commitment to the good of each individual patient. *Vale Brian!*

Bernadette Tobin

I was a specialist anaesthetist, seemingly directed by fate to establish over a thirty year period, successively, an Intensive Care Unit, Pain Clinic and finally, a Palliative Care Service at St. Vincent's. Perhaps you will now appreciate the relevance of the theme for this talk which, at all times, reflected my greatest need. With Ben Sira I would say that:

"In my prayers I asked outright for wisdom."

As an undergraduate in medicine at Sydney University from 1943 to 1948, like all other undergraduates I had virtually no exposure to medical ethics except for two or three afternoon lectures in 1945. The Hippocratic Oath, the rules of medical practice and the permissible extent of advertising were explained. For some understanding of how to manage the life and death issues which were to surface with the first patient contacts as a new intern in a hospital, one had to fall back on one's moral upbringing through parents, school and the Church, all of which was underpinned by some immanent sense of good and evil, right or wrong. In my own case the path to follow seemed to be:

- Fear God and his punishment.
- Fear Women for their potential to induce questionable thoughts or actions.
- Respect all human life and personal property.
- Love one's parents and neighbours, and
- Avoid the law and be polite to policemen!

Valuable as this background may have been, it failed to fill the ethical vacuum you felt when the awesome problems encountered in day-to-day hospital practice had to be resolved.

Fortunately, practical guidance soon came - mainly from the senior nursing sisters and older colleagues. In a haphazard way it was designed to prevent you causing patients some irreparable harm. You soon learned that miraculous cures were out of your reach. "*Primum non nocere*" was the first commandment of medical ethics.

While senior nurses exerted a necessary authority and demanded obedience, it is pleasing to recall that the junior nurses who

were more of one's own age had ideas which were more compatible with one's own, and, indeed, more conducive to happier interpersonal relations.

As an intern one saw for the first time death and dying, cancer in all its manifestations, drug and alcohol abuse, senility, strokes (and their aftermath, unconsciousness), the effects of massive trauma, malformed children, Down's syndrome - the list goes on and on!

While all this was sad, at the same time it seemed to be inevitable. All you could do was to relieve some pain and discomfort and offer support to patient and family. Pneumonia was welcomed as "the old man's friend" when it occurred in an elderly patient perhaps dying from cancer or unconscious from a stroke. Anaesthesia was risky. Radical surgery was rarely performed, and intravenous or tube feeding was never used for the dying. Patients received essential nursing and symptomatic relief while the priest or minister was always involved whenever death seemed imminent.

In this way, the process of dying was not drawn out by any treatment given in some forlorn hope of prolonging life. Nor were patients knowingly killed by direct active intervention. The disease process itself killed the patient, while doctor and nurse offered relief and comfort.

My life then took me in 1951 to Oxford where I became involved in a technological and pharmacological revolution which was to change the face of patient resuscitation and introduce major ethical issues which remain with us to this day. It happened in this way.

The Copenhagen Epidemic

In 1952, a massive epidemic of bulbo-spinal poliomyelitis broke out in Copenhagen, producing respiratory paralysis within a few weeks in over 700 people. They occupied all the urgent beds of the city's hospitals and, due

to the inadequacy of the "iron lung", the only mechanical respirator then known, the early mortality was approximately 100%. Patients were suffocating, literally drowning in their own saliva which, in turn, produced fatal pneumonia. At first, nothing seemed to help and people were despairing as their loved one died in front of their eyes. Then, a possible answer was discovered. This required the creation of an artificial airway through the trachea and then the manual ventilation of the lungs through a breathing tube placed in the trachea. A rubber anaesthetic breathing bag filled with air was squeezed ten to fifteen times per minute continuously day in and day out for weeks to simulate normal breathing.

All this was carried out by volunteers who were drawn from the ranks of medical students, families, nurses, friends, doctors - anyone who could be trained. The medical and many other services of the city were virtually brought to a standstill by this mass effort in resuscitation. In time the mortality rate progressively dropped to about 25% - truly, a remarkable achievement at least for the immediate acute phase of the illness. But a major problem continued which involved all the complications of the long term survival of patients who remained permanently paralysed and grossly disabled.

In time, technicians and anaesthetists designed and built new mechanical respirators which replaced the primitive manual methods, thus preparing the ground for long term respiratory support in patients with all types of respiratory failure.

The Dawning of a New Era in Resuscitation

The next phase was a pharmaceutical revolution through the development of new drugs which could artificially maintain blood pressure, heart function, control convulsions and cure previously fatal infections. At the same time patients (both conscious and unconscious) could be sustained indefinitely by artificial feeding methods either via tube feeding or intravenous infusions of protein,

fat or glucose or through direct intubation of the stomach or intestine.

Next, where thought to be indicated, a state of artificial hibernation or suspended animation could be induced at will to lower body and brain metabolism by using drugs and the surface cooling of the body. Should the kidneys fail, their function could be taken over by dialysis. The body's skin covering, muscles and joints could all be protected by specialised physiotherapy and nursing.

The poor suffering body was then attached to an ever-increasingly complex and invasive monitoring system which recorded for posterity its physiological status at any moment.

What was usually not known during the days or weeks of this "State of the Art" resuscitation was how patients felt. Why? Because either they could not speak or they had been rendered semi-conscious by sedation. You can draw your own conclusions as to the effect all this might have had on confused and anxious relatives.

The enormous financial cost to the community and, often, to the patients was justified by the thought that some patients were now living who would otherwise have died. But, on the other hand, while some regained full health, others remained permanently incapacitated. One simply could not predict the final outcome at the beginning of the resuscitation programme with absolute certainty for any individual.

Now the questions that had to be asked came thick and fast as Copenhagen's resuscitation revolution had become global. A new medical discipline had appeared which was to require separate hospital wards, specially trained medical nursing staff and a mountain of sophisticated technical equipment to be purchased and installed.

Were we now exceeding the reasonable bounds of human endeavour? Were we unconsciously seeking to become God-like in our new-found power and authority over life? Or, were we simply acting as God's agents in applying our human response to a newly identified threat to life?

Today we ask: Should anyone die, or (perhaps more correctly) be allowed to die, without the full application of our modern

medical and technical wizardry? May we ethically ever withhold treatment? If this is permissible, when may we, and under what conditions? May we suspend active treatment once it had been commenced?

Should everyone be given the chance of survival under these extreme circumstances or should our efforts be confined to the young, potentially productive and previously fit members of our community? Or should this extraordinarily expensive treatment be given only to those who can afford it? Who, then, would be best qualified to make the necessary decisions - the attending doctor and his colleagues, the ethicist, the hospital management with its accountant and Board of Directors, the lawyers, especially those involved in litigation, or finally the Government? In each specific instance, those at the centre of all this profound confusion are a patient and the relatives (whose opinions may not be sought for various reasons or who may feel incompetent to interfere). Since all involved must have some influence on the steps to be taken, it is not surprising that such disparate groups may produce in the end a camel when they are seeking to create a horse!

When, in 1960, I established an Intensive Care Unit at St. Vincent's and the onus of responsibility for these decisions was mine, I was fortunate to have had a flash of heavenly insight to which I have not publicly admitted before. I was given permission to name the new ward. I chose to name it after St Camillus de Lellis who was known as the patron saint of gamblers! What better guidance could one hope for when the chips were down and you had run out of ideas?

For me, Pius XII in February and November 1957 provided the first ethical guidelines so desperately needed by anaesthetists and intensivists. He said:

"... if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply. There is not involved here a case of direct disposal of life of the patient, nor of

*euthanasia in any way. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life."*³

Now I wish to refer briefly to another ethical dilemma of which we are all aware - that is, the treatment of patients with advanced cancer and other terminal illnesses which have similar physical, emotional, psychological and spiritual problems, including AIDS and multiple sclerosis.

To me, the issues involved here largely revolve around a profound ignorance of the potential of proper medical care, the lack of a basic understanding of the individual's needs and a total inability to interpret the deeper meaning of the patient's general cry for help. Sadly, those closest to these patients who are responsible for their total care - most commonly doctors - often seem unable to cope with death or the dying process in a positive and sensitive way. Their medical training has been inadequate and wrongly focussed in these matters. On the other hand, the protagonists of euthanasia, be they ethicists, philosophers, theologians or doctors, base their arguments on theoretical concepts of death, dying and suffering which have an anecdotal basis and, in general, lack personal experience of caring for numbers of such patients over a significant period.

Hans Kung, reflecting on euthanasia, supported the practice provided that the patients were old rather than young and that only a doctor could perform the act after seeking the agreement in consultation with other colleagues. On this basis one could imagine an ever-widening circle of doctors involved in this process, eliminating any future need for their education in palliative medicine and a rapid decrease in the community's confidence in the ethical standards of their doctors. There would be significant role changes in our community - disease would no longer kill people naturally, doctors would kill people unnaturally and God's role in the final decision would be redundant. Hippocrates, our icon of medical ethics, would now be dismissed as a silly old Greek.

Alternatively, one could follow the advice of a now-deceased orthopaedic surgeon who said to a particularly troublesome patient who had been hospitalised for some weeks with complicated leg fractures: "You know, Mr. Smith, if you were a horse we would shoot you." Another easy way out for the harassed doctor, but hardly ethical!

Still I would assert that to deliberately give a fatal dose of some drug to a distressed dying patient is also an easy way out. It is also unethical. It is murder. And it is unnecessary. There are alternative means available to relieve pain and suffering, which are admittedly not easy, since they require a presence, time, knowledge and sympathetic understanding of the whole patient's and relatives' needs. This is effective at the time and leaves none of the lingering doubts and guilt of "the quick fix" lethal injection.

The answer to the community's fears about death from cancer or related illnesses, and to those who seek to destroy another's life to ease the patient's burdens lies in the knowledge and continuing refinement of palliative care medicine. This discipline must be taught at medical school and teaching hospital levels, to both nursing and medical graduates and to undergraduates through the medium of palliative care units attached to teaching hospitals.

In conclusion, I must say that my medical life has been clouded by my ignorance of philosophy, bioethics and moral theology. For the future it is my deepest hope that all involved in the professional care of the sick should be taught, according to their capacity, the essential truths of these subjects. Ethics departments should be active in every teaching hospital and be responsible for consultative advice for all hospital units. The John Plunkett Centre for Ethics in Health Care is an ideal model to follow.

Pat Walsh, lecturer in ethics at Kings College, London wrote recently in the *The Tablet*⁴ as follows:

"The frequent criticism of doctors pressed to make ethical decisions for which their clinical training did not prepare them is, of course, largely unfair. I am well aware of the resentment doctors and nurses feel when they are blamed both because they

are thought to have over-reached themselves in deciding who shall live and who shall die and because they sometimes take refuge in appeals to purely clinical judgement. Nevertheless, the truth is that doctors are increasingly taking decisions which are more moral than clinical and that they are no better equipped to take such decisions than the man or woman on the Clapham omnibus."

And finally for inspiration I offer Ben Sira's words in our own quest for wisdom:

"When I was still a youth before I went travelling, in my prayers I asked outright for wisdom.

Outside the sanctuary I would pray for her, and to the last I shall continue to seek her.

From her blossoming to the ripening of her grape, my heart has taken its delight in her.

My foot has pursued a straight path, I have sought her ever since my youth.

By bowing my ear a little, I have received her, and have found much instruction.

Thanks to her I have advanced;

Glory be to him who has given me wisdom,

For I was determined to put her into practice, have earnestly pursued the good, and shall not be put to shame."

Footnotes:

1. After dinner speech, John Plunkett Centre Second Annual Intensive Bioethics Course, Manly, July, 1995.

2. Ben Sira, *Ecclesiasticus*, Appendices 51, extract from "Poem on the quest for wisdom".

3. Pope Pius XII, "The prolongation of life" (Nov. 24, 1957), *The Pope Speaks*, 4: no.4, p.320 (1958).

4. Pat Walsh, "Doctors in a minefield", *The Tablet*, 29 April, p.529 (1995)

Rationing Sanity

A book review by Helen McCabe

The advent of managed care in the United States has generated an abundance of ethical comment; *Rationing Sanity: ethical issues in managed mental health care*¹ is yet another attempt to grapple with the complexities of this concept and the implications it has for the ethical terms of health care resource distribution. Throughout this collection, the plight of those who suffer mental illness provides a focus for thinking about managed care; for this reason, the book distinguishes itself, to some degree, from earlier commentaries on managed care. Nonetheless, for the most part, contributors to this collection address the more common themes in the managed care literature and, with the exception of the first chapter, employ the more familiar philosophical theories in which to think about them. Hence, we find a rehearsal of the familiar utilitarian and principle-based (usually egalitarian) approaches to determining the ethical merits, or otherwise, of managed care arrangements.

For this reason, the book could be criticised for its lack of novelty if it were not for the contribution by Gary Belkin who offers an important discussion on the changed epistemology of medical knowledge underlying managed care. Belkin urges bioethicists to look beyond the philosophical approaches they employ so as to return to the earlier stated aspirations of bioethics: to prevent the suffering individual from being reduced to a scientific (either physiologic or economic) construction. However, his counsel goes largely unheeded throughout the book which, notwithstanding at least some meritorious contribution, renders the problems of subsequent chapters all the more substantial. For this reason, the placing of Belkin's argument to the forefront of the discussion is a curious editorial choice.

Notably, the contributors are concerned to address a problem within the American health care system the distinctiveness of which sets it apart from the systems of other nations. Nonetheless, given the influence of American culture generally, together with an already evident inclination to inculcate at least some aspects of managed care into a wide range of health care contexts, it would be prudent to explore the ethical merits of this concept in advance of that trend.

Generally, *Rationing Sanity* provides an overview of the state of the debate on managed care among contemporary liberal and utilitarian analysts; a perusal of its contents would bring a novice to the subject up-to-date with the general tenor of that debate. For those employed within the health care domain, particularly those holding administrative and policy-making positions, it may hold at least some interest. In representing the dominant philosophical approaches employed in contemporary bioethical debate, it may prove a useful text for teaching purposes. However, with the exception of Belkin's contribution, it does not add anything novel to the vast ethical literature on the problem of managed care; anyone who has been studying the topic more conscientiously would be disappointed. Moreover, in neglecting to include a discussion of those approaches derived from other philosophical traditions, the debate is narrowed considerably. Nonetheless, it attempts to address the much neglected plight of those who suffer mental illness and, for this reason, earns considerable merit in highlighting the need for a more deepened debate on managed care than what has been the case to date.

Rationing Sanity could, then, provide a starting point from which to conduct that debate; an overview of the various contributions will serve to highlight the more obvious points to be addressed.

Managed Care - a changed epistemology of medical knowledge

Following the editor's instruction, Belkin considers the re-conception of medical knowledge intrinsic to the managed care approach. While attention to this particular matter is not entirely without precedent,² Belkin probes the epistemological basis of managed care more expansively, pointing out that its neat coherence with the aspirations of contemporary political aspirations and economic ideology render it suspect. For this reason, he urges the bioethical community to look beyond the standard philosophical approaches and the assumptions they harbour (such as that the problem of resource distribution is institutionally remediable) and turn, instead, to a consideration of the way in which the rational, technical conception of medical knowledge underlying the managed care concept differs from the epistemology of *professional* medicine.

Belkin makes a start on this project, rightly pointing out that managed care medicine, in distinction from professional medicine, is preoccupied with problems of measurement; for this reason, it is employed readily (albeit, improperly) within the dominant worldview of a modern industrial society. The Diagnostic and Statistical Manual (DSM) system of mental health diagnoses represents one instance of the technical formula conception of medical knowledge of which Belkin is critical: he argues, for instance, that the DSM presents a very selective picture of what constitutes mental illness and that its authority lies, moreover, in its propensity to meet other social interests, such as containing health care expenditure. That is, the DSM, like other expressions of what has come to be called 'evidence-based medicine', has been, for the most part, accepted uncritically because it so readily supports social (particularly economic) goals, as distinct from the health care well-being of the mentally ill.

Belkin urges ethicists to be mindful of the 'historical moment' in which they operate, as well as to broaden the 'intellectual touchstones and traditions' of their inquiries so as to address a significant problem inherent

in managed care: the fragmentation of the 'medical subject' and its re-conception as an *economic* agent or 'average probability'. In this sense, Belkin is concerned as much with remedying contemporary bioethics as he is with remedying resource allocation arrangements.

Whether Belkin is right to argue so or not (and there are grounds for thinking that he is), his counsel goes largely unheeded throughout the remainder of the book, thereby depriving the reader of a nuanced and, therefore, more interesting approach to the managed care debate. Nonetheless, what *is* offered will help the reader in understanding, at least, the current terms of that debate; for this reason, a brief overview of the remaining contributions to *Rationing Sanity* will be conducted under the heading of the two dominant philosophical approaches employed in this debate: utilitarianism and principle-based approaches.

Utilitarian contributions

In chapter 2, Buchanan argues for the merits of managed care. This he does by attempting to combine the ethical purpose which properly guides medical professional activity with that which (Buchanan proposes) guides managerial 'professional' activity, *that* being (a poorly-articulated notion of) 'excellence'. In other words, Buchanan attempts to combine the morally distinct roles of business manager and medical professional. In doing so, he is able to argue that the practice of medicine is, morally, the same as running a business and, for this reason, the ethical requirements of medical practice are protected better in a managed care context than within the traditional professional ethos.

To illustrate his point, Buchanan argues that, under fee-for-service (FFS) arrangements, claims to altruism on the part of the medical profession are dubious given that the financial incentives within this arrangement render it impossible to determine whether medical practitioners act, primarily, to uphold their patients' best interests or whether they act to advance their pecuniary fortunes. That is, Buchanan holds that because it is not possible to measure,

in some calculative way, the motive behind treatment decisions in a FFS environment, it must, therefore, be deduced that we cannot trust that medical practitioners are, as they claim to be, altruistic. What we need to do in order to detect medical altruism, says Buchanan, is to measure the number of times medical practitioners act as advocates for their patients in seeking the desired health care resources from MCOs.

Buchanan's chapter is an elaboration of an earlier paper published in 2000;³ here, as in that paper, he argues that MCOs offer a sanctuary in which the (unspecified) ethical obligations that medical practitioners bear will be protected. Indeed, he goes so far as to insist that, given the self-interested nature of human agents, only those practitioners who work for a reputable MCO can be trusted to place their patients' interests ahead of their own.

However, Buchanan fails to see that measuring motivation (among other things) is not possible in any such simple sense. He also fails to address a range of powerful objections to one of his underlying assumptions: the conception of health care as a commodity. And, significantly, he fails to identify the way in which utilitarian approaches act to intensify the vulnerability of those who are least able to protect their own interests, such as the severely mentally ill. This follows from one of the major premises of the utilitarian worldview which, in requiring that we act to 'maximise' either individual preferences or, similarly, overall 'happiness', places at a disadvantage the minority groups within any given population. Overall, in simply assuming, without considered argument, the moral superiority of the market context over the professional ethos, Buchanan's argument is left, suspended, in considerable doubt.

We find a second utilitarian argument in Chapter 3, where Kamm considers the problem of determining access to a research trial of the costly antipsychotic drug: Clozapine. Her overall aim is to uphold the utilitarian requirement of maximising the greatest (what is in this case) benefit to the greatest number of individuals which she attempts to do by taking the reader through the arduous utilitarian journey of weighing, calculating, measuring and balancing. In the

end, Kamm concludes, as she must, that it is ethically justifiable to withdraw an individual research participant from the Clozapine trial if, by doing so, larger numbers of individuals benefit. Moreover, those who do not benefit sufficiently from Clozapine incur an actual *obligation* to withdraw from the trial. In this respect, Kamm is loyal to the utilitarian basis on which she constructs her argument inasmuch as she holds that some individuals may be excluded from the trial *in order* to benefit others. Similarly, others are *included* in the trial (those who are restored to better mental health) *not* because they regain the moral good of health but, rather, *because* they are, thereby, able to return to work and, in turn, provide the additional financial means (presumably through their taxes) for extending the benefit to even more individuals. In doing so, they 'maximise happiness' further. That is, individuals are admitted to the Clozapine trial on the grounds that they are able to contribute to the maximisation of some unspecified notion of 'happiness' and not for the sake of their health, as such. In this way Kamm's argument highlights a major ethical flaw within utilitarianism: its propensity to violate the right that each of us bears to be treated, as Kant insisted, as ends in ourselves, and never merely as a means to the desires or ends of others.

Ultimately, Kamm's detailed and laborious struggle is a utilitarian attempt to resolve the problem of discontinuing non-futile medical treatment. To the extent that she succeeds, a case can be made for granting to MCOs what they already (illegitimately) assume: a role in rationing health care resources, such as Clozapine. However, taken to its full utilitarian conclusion, Kamm's argument, like Buchanan's, is unable to counter a range of objections raised to its underlying philosophical approach: for this reason, Kamm's argument, like Buchanan's is unconvincing.

Egalitarianism and the principle-based approaches

Most other chapters in the collection offer principle-based approaches to considering the problem of managed (mental health) care: in chapter 4, for instance, Rakowski attempts to

meet both the needs of the most seriously mentally ill while, at the same time, avoiding (what he considers) a 'paternalistic' compulsory, universal health insurance scheme. That is, Rakowski attempts to balance the requirements of two (oftentimes) conflicting principles: the demands of a principle of justice and those of the principle of respect for a particular conception of patient autonomy.

To overcome the apparent conflict here, Rakowski maintains that, in view of a particular conception of autonomy, individuals ought, through their spending and insurance decisions, determine for themselves what they will access in the way of health care resources. However, he also harbours concerns about the well-being of those who lack the capacity to exercise this degree of autonomy: the seriously mentally ill. In the interests of fairness, Rakowski argues for the introduction of a safety net, the justification for which he attributes to an obligation that each of us already bears to those in dire need.

Rakowski's 'equality of fortune' approach is influenced by the egalitarian views of John Rawls inasmuch as it is concerned to restore to the seriously mentally ill equal opportunities or life chances or, that is, the 'fair footing' they had prior to the onset of their illness. Having been restored to that fair-footed state, then, it would be expected that previously mentally ill individuals would be able to assume, independently, responsibility for meeting the costs of their own mental health care. In other words Rakowski is intent upon providing the opportunity to those in dire need for regaining their autonomy. In this way, he attempts to temper the conflict between the two principles.

However, there are several problems with this approach which go to the heart of modern, liberal, principle-based approaches. Firstly, he attempts to direct health care activity towards the goal of autonomy instead of health so that the moral tenor of health care activity becomes distorted. For instance, if autonomy is to guide distributive decision-making, then he necessarily excludes from consideration those who are unlikely ever to

achieve the requisite degree of autonomy he so much values. That is, in attempting to assist the seriously mentally ill to regain their autonomy, Rakowski overlooks the fact that some of those who suffer *serious* mental illness may never, no matter how much is provided in the way of health care resources, regain (or, in some cases, even obtain for the first time) the level of autonomy necessary for making independent decisions. Hence, in ordering distributive deliberation so as to restore a particular notion of autonomy, he excludes from consideration those who would be included within a professional ethos where care would be the determinate guide. Secondly, it is unclear where in Rakowski's approach we would find the necessary philosophical resources for supporting much in the way of obligations to others; while he asserts that each of us bears an obligation to those in dire need, it is not clear from within the abstract theory he adopts *why* we would.

Thirdly, in elevating the principles of respect for patient autonomy to a place of such importance, Rakowski (among others) overlooks the social nature of human beings and our propensity for flourishing in relationships of interdependency rather than in isolation. For instance, if we look to the realm of health care we find that it is only in those Western nations which support universal health insurance schemes that those in actual health care need are likely to gain reliable access to the necessary resources. In the highly individualistic context of the United States, we find more than 44 million people (the poor) excluded from access to these resources. Proponents of the latter kind of arrangement, however, are not prepared to concede that universal health insurance schemes are justified; rather, they want to honour the principle of respect for individual autonomy notwithstanding the consequences. However, what they overlook is that those who are unable to afford the cost of health care will, should they become ill, also lose (along with their health) a certain level of autonomy. In other words, as McFarland points out in the following chapter, this kind of principle-based argument inevitably brings us, full circle, back to the original problem. So, if we were to adopt Rakowski's view, then the conflict between the two principles would lie

unresolved and the purpose for which we engage in health care activity would become self-defeating. What we need, then, is a richer conception of both community and autonomy, together with a sturdier moral objective, such as health itself, towards which to guide distributive decision-making.

In chapter 7, Brock provides another principle-based approach in an effort to counter the problems associated with utilitarianism. To do so, he elects to give up the idea that any effort to solve the problem of resource allocation can be achieved in ways that ensure a *perfect* outcome. In particular, Brock wants to side-step the utilitarian-based 'tyranny of the majority' problem whereby, in the process of democratic decision-making, the interests of the majority inevitably take precedence over those of the minority. He does this by arguing for the development of a *procedure* for determining distributive decisions rather than focus upon any particular outcome. Similarly, in chapter 9, Nelson employs a procedural approach in proposing a distributive principle to which he believes, in the interests of prudence, everyone would agree to: 'saving the worst off (principle)'.

At the same time, however, Nelson is keen to avoid imposing his principle of 'saving the worst off' in such a way as to exclude from consideration other morally salient constraints and goals. For instance, in the interests of cost-containment, he limits the scope of his principle to particular medical conditions. Nonetheless, Nelson concedes that adopting such a principle does not provide a clear and powerful solution to the problem of health care resource distribution; what it does offer, he suggests, when considered against a range of other determinative constraints, is a 'morally more defensible' approach than what is offered by utilitarianism.

This might be true. Nonetheless, while Nelson attempts to protect the 'worst off' in ways that utilitarians do not, the protective effect of his 'saving the worst off (principle)' is probably too thin to be of much help to those he has in mind. This is particularly the case when it is considered in the light of two other features of his approach: a strong emphasis on

respecting the principle of patient autonomy together with an absence of a richer moral goal for guiding health care activity, such as the good of health. So, notwithstanding the efforts to protect the most vulnerable members of society (the seriously mentally ill being among them), Nelson's principle-based approach is likely, also, to founder.

Finally, in chapter 10, Powell imitates the views of many other contemporary bioethicists in arguing that the rational, scientific basis of managed care's treatment guidelines serves to protect the integrity of treatment approaches from the distorting effects of financial, political and other influences. Powell also claims that the employment of these guidelines can serve to settle factional disagreements over various clinical phenomena, as occurs among mental health professionals. For these reasons, she insists that the distributive role of MCOs is justified and, moreover, that any distributive decisions made by MCOs ought to be respected by clinicians. At the same time, Powell is mindful of the claims of the particular notion of autonomy upheld by contemporary, liberal bioethicists; for this reason, she attempts to ameliorate the effects of any breaches upon an individual's autonomous decision-making by imposing upon clinicians the duty to both disclose to patients the nature of all medical options for treating their medical conditions, as well as to advocate on behalf of those patients who are excluded from access to particular resources by MCO's. In this way, Powell prescribes in the last chapter of the collection what Belkin questions in the first: an uncritical acceptance of the changed epistemology underlying the concept of managed care. That is, Powell (among others) fails to see what Belkin points out: that the authority of these guidelines rests more obviously upon their coherence with broader social and political objectives (such as to curb public spending) than with their coherence with sound clinical practice. While calls for restraint with regard to expenditure on health care resources might be justified, it does not follow, necessarily, that the managed care

approach, in attempting to do just that, can be adopted uncritically. More work would need to be done to ensure that the rationing decisions of MCOs reflected (among other salient considerations) an unbiased approach to collecting and employing the 'evidence' upon which they rely and, moreover, that such 'evidence' was consistently correct at all times in all places and with regard to all patients. For this is the very tall claim that proponents of managed care make, a claim which Belkin is wise to question.

Powell's solution to overcoming the problem of conflicting principles (fairness and autonomy) is well-rehearsed in contemporary debate whereby it is assumed that any limits placed on access to health care resources (and therefore on autonomous choice) can be justified by an act of disclosure. However, in deciding as much, they overlook what Pellegrino⁴ describes as 'the fact of illness', as well as the vulnerability of the patient (particularly that of the mentally ill patient). They also fail to recognise (among other things) the obstacles to maintaining professional medical integrity inherent in managed care contexts.

Ultimately, in the precarious effort to uphold the requirements of two or more 'thin', vulnerable and, moreover, conflicting principles, Powell and her philosophical colleagues fail altogether to notice that the safety net of an epistemologically defensible construct is lacking. And, along with a range of additional shortcomings, utilitarians also find themselves equally at sea.

Conclusion

Overall, this collection reflects modern utilitarian and liberal approaches to the problem of health care resource distribution. With the exception of Belkin's contribution, the unanimous support of managed care arrangements throughout this collection is, at best, question-begging if not a little naive. Or, at least, in the absence of a richer philosophical basis from which to consider the concept of managed care, together with a largely uncritical acceptance of its epistemological basis, *Rationing Sanity* has little to offer that is new to a debate. What it inadvertently does, however, is to highlight the extent to which the mentally ill are, under managed care, vulnerable to being reduced to what Belkin calls "economic constructions". Nonetheless, the contributions recorded in *Rationing Sanity* offer, for the most part, some sophisticated elaborations of the usual approaches taken in the debate on managed care. A perusal of the book would be useful, then, for anyone studying contemporary bioethics and, for this reason, could be recommended.

Footnotes

1 J. Lindemann Nelson (ed.), *Rationing Sanity: ethical issues in managed mental health care*, 2003, *Georgetown Uni Press, Washington*.

2 See, especially, R. Upshur, "If not evidence, then what? Or does medicine really need a base?", *Journal of Evaluation in Clinical Practice*, Vol.8, No.2, 2002, pp. 113-9. See also, M. Rodwin, 'The politics of evidence-based medicine', *Journal of Health Politics, Policy and Law*, Vol.26, No.2, 2001, pp.439-46.

3 A. Buchanan, 'Trust in Managed Care Organisations', *Kennedy Institute of Ethics Journal*, Vol.10, No.3, 2000, pp.189-212.

4 E. Pellegrino, 'The Commodification of Medical and Health Care: The moral consequences of a paradigm shift from a professional to a market ethic', *The Journal of Medicine and Philosophy*, Vol. 26, No.6, 2001. pp.559-79.

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