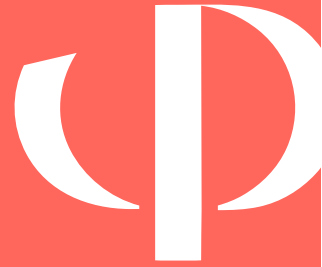


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APA NEWSLETTER ON

Philosophy and Medicine

MARY RORTY AND MARK SHELDON, CO-EDITORS

VOLUME 15 | NUMBER 2 | SPRING 2016

FROM THE EDITORS

Mary Rorty

STANFORD UNIVERSITY

Mark Sheldon

NORTHWESTERN UNIVERSITY

This issue of the *Newsletter on Philosophy and Medicine* opens with an excellent exchange from the recent Washington, DC, Eastern Division meeting on "Rationing in the ICU." Organized by Len Fleck, the panel treats from several perspectives the question of whether and under what circumstances new patients can displace present patients: What constitutes justice in the availability of intensive care? Four papers from a colloquium on "Healthcare Ethics" follow.

In an exchange on a paradox in reproductive ethics, Trevor Hedberg and Dana Howard puzzle the different evaluations of bringing into existence a child who will have a miserable life versus the optionality of bringing into existence a child who would have a happy existence. Kyle Fruh ponders the question of whether the claims of living donors that they benefit from the act of donation should count against the idea that such donation is an act of supererogatory virtue, and Lisa Fuller comments.

Our newsletter poet, Felicia Nimue Ackerman, turns her attention to reviewing a recent edition of a classic book on breast cancer, and, the chair of the Committee on Philosophy and Medicine, Nir Eyal, uses his column for a meditation on circumstances that might affect the question of when life is worth living.

FROM THE CHAIR

When Is It Best to Die?

Nir Eyal

HARVARD UNIVERSITY

If you greatly enjoy life, you should definitely continue living.*

What if your life is very bad, because of a grueling untreatable disease, solitary confinement for life, or other circumstances that may make life not worth living? Arguably, the badness of such circumstances can prevent

living more from being good for you. It can make living more bad for you. This does not mean that you would be wise to commit suicide, or that your friends or doctor should help you do that—these are more complicated decisions. What it means is, roughly, that if you died painlessly now, that event would be good for you.

Assuming that such degree of badness in a period of one's life can exist, the question arises what that degree is. How bad should your moment-to-moment existence be to make it better for you to die?

One answer to this question is that it's best to die before the average quality of life in your remaining time slices, and in your next time slice, makes them not worth living. If *worth living* is 0, then what makes a time slice worth it, on this view, would be a positive quality of life in that time slice. A time slice with so much misery or so few valuable experiences that its quality is negative would not be worth going through. If all you have ahead of you is a series of negative time slices, then you are better off dying neutrally now, before this series begins and persists.

A different view is that even a time slice that is slightly negative (in the sense above) is worth it, because longevity is good in itself. This view assumes that more life is always better, other things being equal, and argues that this makes even the addition of time slices that are borderline or slightly negative increases our life-long advantage. On an extreme strand of this view, longevity is very good for us, so adding time slices that are borderline or slightly negative improves life by a lot: on that extreme strand, sheer addition of life years already matters a lot.

I want to propose a third answer. When a life has been usually good, adding to it a time slice that is worth living but not much more than that is not always of benefit. To be good for most of us, a time slice usually must be much more than barely-worth living. Why? Because narrative matters. For a person who lived a very good life, a long series of far worse states at the end of it makes for a sad life story. It usually makes her life one of decline and failure, instead of one of ascent and success. It does so even if the long series at the end remains positive. By contrast, a sudden or a near-sudden death before the long series of compromised states begins avoids that decline.

Put differently, a plausible narrative about a person who dies after many successful early years followed by many miserable later years is one of failure. She started out well but ended up losing everything. A plausible narrative about a person who dies suddenly after many successful

early years is that she was successful. The latter narrative can remain plausible even if successful early years are followed by a very short and, hence, quite insignificant period of neutral or negative living (e.g., a few minutes of overwhelming chest pain).

A long-enough period of bad, neutral, or even slightly good living at the tail end of a much better existence does tend to hamper narratives a lot. Mohammad Ali's boxing career narrative would have been even more impressive had he retired at his peak, in the mid-seventies, and not after declining into a much plainer boxer in the early eighties. Life stories are similar. Sharp decline in life quality and success can vitiate an otherwise perfectly nice life story. And it can do so even when the quality of life in it remains positive. And the niceness of one's life story is a component of the overall goodness of one's life.

Again, this does not settle whether and when to commit suicide or to assist others in doing so. It does, however, affect that discussion, as well as discussions of resource allocation toward the end of life.

*Thanks to Gustaf Arrhenius for comments on an earlier draft

SUBMISSION GUIDELINES

The *APA Newsletter on Philosophy and Medicine* is published by the APA Committee on Philosophy and Medicine. We invite submissions of articles and book reviews on any topic related to philosophy and medicine, as well as responses to material that appears in this newsletter.

All papers should follow the APA guidelines for gender-neutral language and use endnotes rather than footnotes. The *APA Newsletters* use *The Chicago Manual of Style*.

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Submissions for spring issues are due by the preceding September 1. Submissions for fall issues are due by the preceding February 1.

ARTICLES

Skeptical Worries for ICU Rationing

Luke Gelinus
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1. COMPARATIVE BENEFIT/HARM PRINCIPLES IN ICU RATIONING

In what follows I will raise some skeptical concerns for ICU rationing. My basic claim is that deeply entrenched

features of ICUs and ICU care make it difficult to ascertain the ethically right rationing decision in a significant number of cases. I will begin from what I hope is a non-controversial assumption, which is that ICU rationing decisions often require us to make comparative judgments about the benefits that receiving ICU resources, or the harm of foregoing them, are likely to bestow on different patients.

Substantive rationing principles often assume that we have the ability to compare harms and benefits in this way. Consider, for example:

More Benefit: scarce ICU resources should be given to patients who will benefit most from them.

Imagine that there is one ICU bed and two candidates for it. The first candidate has stage IV lung cancer and is entering the dying process; while ICU resources may prolong his life a few days, allowing him to visit with family and imparting some genuine benefit, they will not restore him to a healthy baseline. The second candidate presents with suspected bacterial pneumonia and pleural effusions but is otherwise healthy. She is on the verge of requiring intubation and artificial ventilation. Nonetheless, there is a good chance the pneumonia will respond to antibiotics and the patient will regain her previous healthy and happy baseline. We should give the bed to the second patient. *More Benefit* explains why this is so: we should do this because we judge that ICU resources will be more beneficial for the pneumonia sufferer (who can be expected to recover a good quality of life) than for the cancer patient (who cannot).

More Benefit is not the only possible ICU rationing principle that assumes we can compare benefits or harms across patients. Another would be a principle that gave greater weight to avoiding the worst patient outcomes, even if this meant providing less benefit, on-balance. Here determining which outcome is worse than another requires us to compare the harms of foregoing ICU resources for different patients. While *More Benefit* is my main example in what follows, the argument does not require it. Those skeptical of *More Benefit* can replace it with the substantive rationing principle of their choice, so long as it requires an ability to compare benefits or burdens between patients. Any ethically acceptable approach to ICU rationing will, I think, employ some comparative principle of this sort, given that such comparison is an essential feature of all triage practices.¹

Two additional points about *More Benefit*: First, in some situations where *More Benefit* applies, it imposes *requirements* on ethical ICU rationing. Giving an ICU bed to one patient when there is a second who could benefit more from it is sometimes morally *wrong*. This is not to say that other ethical considerations do not apply in the context of ICU rationing, or that we will never need to balance the duty to provide more benefit against other rationing principles. It is rather to say that, in situations where there are no competing ethical considerations, or where *More Benefit* outweighs these other considerations, *More Benefit* gives rise to an all-things-considered ethical duty—the sort of duty that we must observe for our rationing practices to be ethically acceptable.

Second, I think More Benefit can apply even in situations where a patient is *already receiving* a scarce ICU resource that could benefit someone else. Imagine that the cancer sufferer in the above example has already been admitted to the ICU. My sense is that we would be justified to discharge the cancer patient if doing so is the only way we can provide adequate treatment to the pneumonia sufferer, and that More Benefit explains why this is the case. If so, More Benefit is stronger than any presumption created by an ICU-rationing principle of first-come-first-serve. I return to this point briefly at the end of the paper.

2. A SKEPTICAL ARGUMENT

In a range of important cases, it will be difficult to satisfy More Benefit. Why do we think this?

One factor worth noting is the inherent empirical uncertainty involved in much ICU care: it is difficult to predict the health outcomes of different ICU interventions with a high degree of reliability. Because of this it is tough to know whether one patient will *in fact* benefit, or benefit more, from a scarce ICU resource than another—in which case it is difficult to satisfy More Benefit. But I'll put this aside. Such empirical uncertainty characterizes all medical care and is not distinctive to ICU rationing. There is a deeper, I think deeper, ground for skepticism, which would exist even if we had knowledge of all empirical probabilities. This deeper ground for skepticism comes out in the following argument.

- Premise 1: What counts as a “benefit” or “burden” in the context of ICU care, as well as the degree to which something benefits or burdens a patient, is relative to the preferences and values of individual patients.
- Premise 2: There is wide variation in individual patient preferences concerning a range of health outcomes associated with interventions frequently administered in the ICU (e.g., dependence on a feeding tube).
- Premise 3: Because of this variation, we will not be justified to assume that the relevant health outcomes confer benefit rather than harm, and/or the degree to which they benefit or harm, without evidence of individual patient preferences.
- Premise 4: The ICU, by its nature, contains obstacles that frequently make it difficult to ascertain or hold justified beliefs about the relevant patient preferences.
- Conclusion: We will frequently not be justified in our beliefs about who will benefit more from a scarce ICU resource, in which case we will not know how to satisfy More Benefit.

This argument is, I claim, valid. If it is sound and the conclusion is true—if we do not know how to satisfy More Benefit—we will frequently not know how to engage in ethical ICU rationing.²

3. IN DEFENSE OF THE PREMISES

In this section I unpack and defend the premises, taking each in turn.

Defense of Premise 1: The first premise states that benefits and burdens are preference-sensitive in the context of ICU care. I grant that there is a narrow notion of “medical benefit/burden” on which Premise 1 might be challenged, one on which “benefit” and “burden” are limited to tracking physiological functioning and more objective measures of health. Indeed, some highly capable philosophers endorse a “separate spheres” approach, according to which a physiological notion of health, rather than a wider notion of quality of life or well-being, is the correct measure of “benefit” when rationing medical goods.³ There are different ways to defend this idea, but perhaps the most compelling is to point to cases where allocating on the basis of a wider notion of well-being leads to intuitively unacceptable results due to the presence of idiosyncratic preferences that influence the degree of subjective well-being bestowed by the item rationed. Consider, for example, a patient with a strong preference (expressed via advanced directive or living will) to be maintained in a persistent vegetative state (PVS) even when there is very little or no possibility of their regaining consciousness. Using a scarce ICU resource to keep this patient alive in a PVS may *guarantee* the patient a significant increase in well-being by satisfying this preference. However, many would be hesitant to use this guaranteed increase in well-being as a basis for favoring this patient over other patients for whom ICU services could yield more objective health benefits. For example, many would resist using the scarce ICU resource to maintain this person in a PVS rather than using it on a second patient when there is a chance—even a very small chance—to prevent the second patient’s death and restore them to a healthy baseline.

In response, note first that it is not clear whether such cases should be taken to support the idea that ICU rationing decisions should be made just on the basis of health benefits, as proponents of the separate spheres approach hold, or rather as forcing us to clarify the range of preferences relevant in this context. In particular, we should ask whether the preference here—to be sustained by aggressive ICU measures in a PVS, with no chance of regaining consciousness—is really the sort of preference whose satisfaction increases well-being. It is common for preference-satisfaction accounts of well-being to place constraints on the preferences that matter, for example, by limiting them to preferences not formed on the basis of mistakes about empirical facts (such as the empirical un/likelihood of regaining consciousness under certain conditions). Putting reasonable constraints on the preferences that matter for well-being will rule out many of the cases objectors might bring by showing that they do not involve genuine benefit, without eliminating the fact that well-informed people can reasonably disagree over the value of certain health states, as the argument below assumes.

Second, there are real practical costs to adopting a separate-spheres approach to ICU rationing. Intensivists (and caregivers generally) do not, and should not, use

an objective notion of health to measure “benefit” in all cases. Indeed, in *most* situations they should base their recommendations and approach to treatment on how different interventions will bear on the patient’s wider well-being and quality of life as measured by the patient. The central role of well-being and quality of life (rather than health *per se*) is at least part of what explains why it is so important to give patients themselves the opportunity to make well-informed choices about whether to accept or reject the interventions available to them, even in situations where those interventions stand to promote objective measures of health. In asking caregivers to ration ICU resources just on the basis of potential health benefits, we would be asking them to use a method of evaluating “benefit” very different from—and indeed in some important cases in tension with—the concept of “benefit” they use, or should be using, in the regular course of clinical care. While it may be possible for intensivists to compartmentalize in this way, it is far from ideal. Those concerned to promote shared decision-making in ICU contexts, and the way in which objective measures of health-benefit stand in tension with and tend to subvert patient-centered care, have reason to resist a separate-spheres approach to ICU rationing.

Defense of Premise 2: The second premise says that there exists wide variation among patient preferences concerning health outcomes often associated with ICU care. The sort of interventions and health outcomes I have in mind here include things like having a new baseline where one is dependent on a feeding tube, or a tracheostomy for airway maintenance and/or artificial ventilation; having a new baseline where one is dependent on regular dialysis or renal replacement therapy, or regular blood transfusions, or powerful antibiotics, or a left ventricular assist device; living without a limb, or with an ostomy pouch; living with mid- or severe cognitive or motor impairment; and so on. Different patients experience the burdens of these health states very differently and, as a result, have varying degrees of aversion to them.

It is important to see that Premise 2 is an empirical claim and so might be challenged on empirical grounds. I accept it largely on the basis of personal experience providing ethics consultation in ICU contexts, where it is not at all uncommon to find wide variation in patient preferences concerning these types of outcomes. There is also empirical evidence for variation in patient preferences for different health outcomes, though much more work is needed to bring the literature on measuring patient preferences in economic approaches to health care (QALY, HUI, etc.) to bear on personalized medical decision-making.⁴

Defense of Premise 3: The third premise says that because of the variation in individual patient preferences, caregivers need evidence of patient preferences before being justified in concluding that one of the relevant outcomes (e.g., dependence on feeding tube) will benefit rather than burden, and/or the extent to which it will benefit or burden, the patient before them. For one patient a new baseline involving (say) a feeding tube, tracheostomy, and regular dialysis may permit a quality of life that is acceptable and such that these interventions confer significant benefit,

relative to foregoing them. A different patient may experience these things as extremely burdensome and intolerable and strongly prefer (say) supportive measures and palliation, even when the foreseeable outcome is death.

I want to emphasize that this dynamic is *routinely* in play in the ICU. People commonly experience ICU interventions, and the lasting physiological changes that result from these interventions, very differently from a quality-of-life perspective. Some people experience regular dialysis as extremely burdensome; others do not. Some people experience an ostomy bag as intolerable; others as no big deal. Some people are unwilling to go on living if they require tube feeds for nourishment, experiencing this as undignified and unnatural; others are willing to endure for the sake of other goods. Some ICU patients may prefer supportive measures to a long, arduous, and uncertain rehab; others may be willing to endure the rehab for a chance at more time; and so on. Because of this we cannot just assume that many routine ICU interventions will confer benefit, or how much they will benefit, in particular cases. We need evidence of *this* patient’s preferences and values before we can make such determinations.

To illustrate Premise 3, imagine two patients, Patient 1 and Patient 2. Before they fell ill, both patients enjoyed roughly the same (acceptable) quality of life. Without ICU resources both will likely die in a few days. But with the help of ICU resources, Patient 1 can likely be restored to a new baseline involving a feeding tube, tracheostomy for airway protection, and urinary catheter; and Patient 2 can likely be restored to a new baseline involving regular dialysis and an ostomy pouch. Premise 3 implies that without knowing the preferences of these patients regarding their likely new baseline, we cannot justifiably conclude that the ICU resource will benefit one more than the other. It seems to me that this is the right result.⁵

Defense of Premise 4: If the first three premises are true, we will need evidence of individual patient preferences when comparing the benefits/harms of ICU care across patients. The problem, however, is that the ICU, by its nature, contains epistemological obstacles that make it difficult for caregivers generally to ascertain the relevant patient preferences and values; this is the fourth premise. I will note five such obstacles.

Obstacle 1: Many patients in the ICU are incapacitated and unable to reflect on and/or communicate their preferences about the relevant choices. This significantly hinders the ability of caregivers to obtain current first-person testimony from patients themselves about their preferences, which would presumably be the best source of evidence in these situations.

Obstacle 2: Many of these incapacitated patients either do not have living wills or advanced directives that can be used as a source of evidence about their preferences, or they do have advanced directives, but they are not detailed enough to warrant conclusions about how much benefit would be conferred by different outcomes. Moreover, this is not necessarily due to negligence on the part of patients.

It is very difficult to express preferences about anything close to the full range of situations in which one might find one's self in an ICU.

Obstacle 3: Because of how often ICU patients are incapacitated and lack applicable advanced directives, caregivers frequently rely on surrogate decision-making in the context of ICU care. The problem is that surrogate decision-making is often unreliable and a poor guide to patient preferences. Often (though not always) surrogates are just as in the dark about the relevant patient preferences as caregivers. Indeed, some well-known empirical studies have concluded that approximately 50 percent of surrogate decision-making concerning life-support interventions (which will often be at stake in the ICU) result in choices the patient would not make.⁶

Obstacle 4: Even when patients are capacitated or their surrogates are reliable, time-constraints can undermine the ability of caregivers to obtain evidence of patient preferences. High-stakes decisions must often be made quickly in the ICU, leaving little or no time for shared decision-making between care staff and patients/surrogates.

Obstacle 5: Similarly, the modern ICU is (to vastly understate it) *stressful*. The hectic and emotionally taxing nature of the ICU makes it a prime place for cognitive bias and error, and is not particularly conducive to the type of shared decision-making that would help (which does not mean caregivers have no obligation to try; see below).

To sum up the argument, if whether, or the degree to which, ICU interventions benefit patients often depends on the patient's own values and preferences, and if caregivers are often not in a good position to ascertain those values and preferences, caregivers will often not be in a good position to determine whether ICU resources will provide more benefit to one person or another. And so they will not be in a good position to satisfy More Benefit. Thus, they will not be in a good position to implement ethical ICU rationing.

4. KEEPING THE SKEPTICISM IN BOUNDS

It is important to stress what I am *not* saying with this argument. I am not claiming that we should be skeptics about benefit across the board, or that we are never justified to conclude that a particular health outcome will confer benefit without special evidence of the patient's preferences. In many cases I think we are justified to conclude that certain health interventions and outcomes will be beneficial since for many interventions and outcomes there is general uniformity in patient preferences and agreement about the benefit they confer.

To go back to the earlier example, we can justifiably conclude that treating bacterial pneumonia with antibiotics will be beneficial, relative to doing nothing and allowing the infection to worsen, even if we do not have evidence of this patient's preferences and values. Similarly, I do not think we need independent evidence to conclude that an appendectomy will benefit an otherwise healthy person with a severely ruptured appendix. But this is precisely because there is likely to be much less variation

between individual preferences in these types of cases than in the ICU cases we've been discussing. *Almost everyone* of otherwise good health would prefer to have their bacterial pneumonia treated with antibiotics and their ruptured appendix removed. The same is not true, I submit, for extending one's life with a feeding tube, regular dialysis, artificial ventilation, or other bread-and-butter ICU interventions.

That said, I acknowledge that there are questions concerning how much uniformity in patient preferences is needed to ground confident judgments about benefit or, conversely, how much variation demands skepticism. If future empirical work were to demonstrate that patient preferences for the relevant ICU outcomes do not vary much at all—as little as, say, patient preferences for being cured of life-threatening pneumonia by antibiotics, or having a ruptured appendix removed—that would force us to re-evaluate the argument (Premise 3 in particular).

5. PRACTICAL IMPLICATIONS

Practically speaking, one correct and, indeed, obligatory response to the argument presented here is to work to overcome the obstacles that make ascertaining the individual preferences of ICU patients so difficult. Institutions should be incentivizing caregivers to engage in better shared decision-making. Clinical staff should be proactive and vigilant at looking for evidence of patient preferences and eliciting well-informed choices, making sure that patients and families know what the patient's new baseline is likely to look like, and painting a picture of its challenges and burdens as well as its benefits.

While I do not wish to downplay the importance of these measures, I worry that the obstacles discussed earlier are so endemic and deeply entrenched that removing them will be an uphill battle and probably not fully possible. Because of this I will end with some concrete implications of my argument. Interestingly, the skepticism I have defended does not always yield paralysis in the face of actual ICU rationing decisions. Indeed, it can be used to derive actionable advice in at least three situations.

The first situation occurs when we are faced with a choice of whether to discharge one ICU patient to make room for another. If a current ICU patient is clearly benefitting from ICU services (i.e., because this is a case where there is not wide variation in patient preferences or because we have good evidence of *this* patient's preferences), and the patient we could admit instead is one for whom skepticism is warranted (i.e., a patient facing health outcomes for which there is wide variation in patient preferences, and where we do not know their preferences), we should remain with the status quo and decline to discharge the first patient to make room for the second. For example, we should keep the otherwise healthy pneumonia sufferer in the ICU rather than discharge them to make room for someone we could restore to a new baseline involving a feeding tube, tracheostomy, ostomy pouch, etc., if we lack knowledge of the latter's preferences.

The second situation reverses the place of the patients in the first so that the patient for whom skepticism is warranted is

currently in the ICU while the person we could admit is one that would clearly stand to be benefited by ICU services. If, as I suggested earlier, More Benefit carries more ethical weight than a principle of first-come-first-serve, we would be ethically justified to discharge the current ICU patient to make room for the second patient. For example, we would be ethically justified to discharge a current ICU patient whose new best-case baseline will likely involve a feeding tube, tracheostomy, and regular dialysis to make room for a pneumonia sufferer who needs ICU resources to stay alive but can likely be restored to healthy baseline, when we lack evidence of the former's preferences.

Finally, if both patients in this same scenario—the one currently in the ICU and the one we could admit instead—are patients for whom skepticism about benefit is justified, there is (other things equal) no ethical reason to provide one rather than the other with ICU resources. In that case we should remain with the *status quo*, due to the costs of time and energy involved in discharging/admitting. For example, if a current ICU patient can be expected to regain a baseline involving a feeding tube and urinary catheter, and a candidate for ICU admission could be restored to a new baseline involving regular dialysis and an ostomy pouch, and we lack evidence of both these patients' preferences, we should (at least, other things equal) keep the first patient in the ICU rather than discharging them to make room for the second, given the costs in time, energy, and resources this will allow us avoid.

NOTES

1. See, for example, the 1994 statement by the Society of Critical Medicine Ethics Committee.
2. Those tempted to reject the extension of skepticism from More Benefit to ICU rationing more generally should keep in mind that the same argument can be run on other comparative benefit/harm principles.
3. See Dan Brock, "Priority to the Worse Off in Health-Care Resource Prioritization," in *Medicine and Social Justice: Essays on the Distribution of Health Care*, ed. Rosamond Rhodes et al. (New York: Oxford University Press, 2002); Frances M. Kamm, *Mortality, Mortality: Death and Whom to Save from It* (New York: Oxford University Press, 1993), 259; and (in this issue) Leonard M. Fleck, "Just Rationing in the ICU: What Benefits Count?" *APA Newsletter on Philosophy and Medicine* 15, no. 2 (2016): 6–10.
4. For empirical evidence of variation, see L. C. Baker M. K. Bundorf, and D. P. Kessler, "Patients' Preferences Explain a Small but Significant Share of Regional Variation in Medicare Spending," *Health Affairs* 33, no. 6 (2014): 957–63; A. E. Barnato, D. L. Anthony, J. Skinner, et al., "Racial and Ethnic Differences in Preferences for End-of-Life Treatment," *Journal of General Internal Medicine* 24, no. 6 (2009): 695–701; P. N. Post, A. M. Stigglebout, and P. P. Wakker, "The Utility of Health States after Stroke: A Systematic Review of the Literature," *Stroke* 32 (2001): 1425–29; R. F. Nease, T. Kneeland, G. T. O'Connor, et al., "Variation in Patient Utilities for Outcomes of the Management of Chronic Stable Angina: Implications for Clinical Practice Guidelines," *JAMA* 273, no. 15 (1995): 1185–90.
5. It is a further question what should be done if we can give ICU resources to one of these patients but not both. Other things equal (e.g., neither has a valid claim right to the resources), I think we should flip a coin.
6. J. Suhl, P. Simons, T. Reedy, and R. Garrick, "The Myth of Substituted Judgment: Surrogate Decision Making Regarding Life Support Is Unreliable," *Archives of Internal Medicine* 154 (1994): 90–96.

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Just Rationing in the ICU: What Benefits Count?

Leonard M. Fleck

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In this essay I address Luke Gelinás' "skeptical worries about ICU rationing."¹ In a policy statement in 1997, the American Thoracic Society took the position that when the ICU is full, and other patients at the proverbial door to the ICU need an ICU bed, the ethically appropriate rule to follow is "first come, first served." I criticized that rule in an earlier essay in this newsletter, essentially arguing that there were many circumstances in which a strict application of this rule would result in an outcome that was unreasonable and unjust.² For example, if a patient currently in the ICU is almost certain to die in the next few days no matter how aggressive the care that is provided to him, and a patient coming up from emergency surgery needs that ICU to maximize his likelihood of survival for many years, then that first patient should certainly be removed to a palliative care bed. I will not repeat the arguments that would justify more explicitly what seems a reasonable and obvious conclusion. In short, we could say that "benefit matters," both the size and likelihood of that benefit. This is not to say that benefit always matters, i.e., always trumps all other ethically relevant considerations. There will be many circumstances in which the "first come, first served" is the rule that ought to govern ICU bed allocation.

Gelinás is inclined to be supportive of the "benefit matters" perspective, although not necessarily as the dominant ethical consideration in all circumstances. But then he

has his skeptical worries. One of those worries, which experienced clinicians would certainly endorse, is that it can be very difficult to know with a reasonable degree of medical certainty which patient will, in fact, benefit the most from access to ICU care. There are so many clinical variables that can have a profound effect on outcome (for better or worse) that it will strike many as medically arrogant to make prognostic judgments about survival and quality of survival with great confidence, when fear and trembling would be more clinically (and epistemically) appropriate. Virtually every ICU clinician will have a story about a patient who miraculously survives an ICU stay, even though that clinician would have bet his life savings that that patient would not survive that stay. The ethical concern, of course, is that that patient would have been condemned to death if he had been transferred to palliative care to make room for some patient at the ICU door.

Gelinas quickly passes over these ethical concerns about prognostic uncertainty. His other worry, related to making benefit-related prognostic judgments, is that those patients (or surrogates speaking on behalf of patients) might have a very different conception of what counts as a benefit or harm for that patient. That is, those surrogates might judge benefit or harm from the preference/value perspective of that patient rather than from the pure physiological conception of benefit or harm with which that clinician might operate. Most physicians might say that if they were in the terminal stages of lung cancer in an ICU, semi-conscious, supported by dialysis and feeding tubes, they would happily allow themselves to be transferred to palliative care rather than endure more days in the ICU. On the other hand, many patients (or their surrogates) might desperately wish to cling to life in those same circumstances, perhaps judging that life of any quality was preferable to being dead.

The thought that Gelinas is asking us to consider is whether a clinician's judgment of what should *really* count as a benefit of ICU should be limited to the sort of physiological judgments clinicians are trained to make. After all, in many clinically complex circumstances, clinicians have been trained to respect patient autonomy, i.e., their personal judgment of what for them counts as a harm or benefit related to a proposed therapeutic option. Hence, if we are committed to a "benefit matters" perspective for purposes of determining how the allocation of ICU beds ought to be carried out, then we ought to give considerable weight to that patient's judgment of what counts as a benefit for him. However, as Gelinas notes, it is often difficult to ascertain the preferences of patients in the ICU, especially if they are terminally ill and their consciousness is impaired by a variety of medical factors. Surrogates are then supposed to speak for such patients. However, as much research has shown, surrogates are as likely as not to correctly express what that patient would judge for himself as being beneficial or non-beneficial. Gelinas' preliminary conclusion is

If whether or the degree to which ICU interventions benefit patients often depends on the patient's own values and preferences, and if caregivers are often not in a good position to ascertain those values and preferences, caregivers will often not

be in a good position to determine whether ICU resources will provide more benefit to one person or another. And so they will not be in a good position to satisfy Medical Benefit. Thus, they will not be in a good position to implement ethical ICU rationing.³

In fairness, Gelinas' position is not as stark as the quoted passage might suggest. Sometimes the objective evidence of benefit, or lack thereof, is evident to any reasonable person, and sometimes patient preferences are sufficiently clear as well, which means an ethically acceptable rationing decision can be made. But what should be done when clarity and reliability regarding patient preferences is lacking? This is one question we must consider in the remainder of this commentary. However, we must also ask whether patient preferences that are clearly and reliably known are necessarily determinative of the correct decision when a rationing decision must be made regarding admittance or removal from the ICU. This is the harder question.

Let me start by addressing this latter question. Let me also remind the reader of some key background assumptions. First, the ICU is a scarce resource. On any given day there are usually more patients who have some degree of need for that resource than there are beds available. This is why we have to address the rationing issue. Second, the ICU is a public resource. The ICU is what it is—exquisitely organized intensive care designed to save lives—because of substantial public investment in creating that resource, most especially through publicly subsidized medical research and similarly subsidized training of the health professionals that give value to that resource. Third, hospitals "own" those ICU beds, but they have neither the moral nor the legal right to award access to one of those needed beds to the highest bidder. Instead, the relevant norm for determining access to one of those beds will be justice-relevant considerations. Fourth, there are a number of justice-relevant considerations such as urgency of need, likelihood of benefit, equal access, or first-come first-served. But, fifth, the benefits that are justice-relevant cannot be merely subjective preferences, no matter how strong those preferences might be. Some might see this as a matter of respect for patient autonomy. But if we are faced with the need to make a rationing decision regarding an ICU, then justice-relevant considerations will trump autonomous demands for access to that ICU bed.

Imagine a patient, John W, with Stage IV lung cancer, who probably will survive for no more than two months. He was in an automobile accident two weeks ago that resulted in a traumatic brain injury that left him in a persistent vegetative state (PVS). He has a valid advance directive with very specific expectations for care, as well as a surrogate decision maker who will comply with those expectations. Specifically, he wants anything and everything that will prolong his life, even in a PVS state, because he believes that any state of being alive is better than being dead. That is, he sees that as a clear and profound benefit. He needs the ICU for his (demanded) aggressive cancer care, as well as ventilator support for the PVS. The ICU is full. Another patient, Jim X, was also involved in an accident and is coming up from the emergency room unable to

communicate any specific wishes. His survival is not assured with ICU care; best prognostic judgment is that his chances of full recovery might be 50/50.

I claim that Jim X clearly has a stronger just claim to that ICU bed than John W, even though it *might* be the case that he would end up surviving for a shorter period of time than John W. I also want to claim that it would be unjust to flip a coin to determine who had a just claim to that ICU bed. This would be especially true if that 50 percent chance of survival meant being restored to his former quality of life. I need to add that I would endorse this judgment even if Jim X had no advance directive, so the intensivists would have had no idea as to whether he was willing to endure the medical burdens that might be necessary to give him that 50 percent chance of survival. That is, the intensivists could not be certain that he would see that opportunity for survival as a net benefit. But, one might object, John W and his surrogate see his survival in PVS with a terminal cancer as an unequivocal benefit. Should that then trump the uncertainty associated with Jim X's circumstances? My unequivocal response is "no."

The key argument I want to make in support of my claim is that John W's strong preference for having his life sustained for as long as possible with maximal life-sustaining care has virtually no moral weight *so far as the just allocation of that ICU bed is concerned*. What *must* count, morally speaking, and what can *only* count when making a just rationing decision in these circumstances, is objective benefit (or objective probability of benefit), not a purely subjective conception by an individual. Being in a persistent vegetative state is experientially indistinguishable from being dead. Patients in such a state have no awareness of anything. Further, there is no hope for improvement (if correctly diagnosed). If we call to mind Daniels' claim that protecting fair equality of opportunity is at least one critical factor for determining the just allocation of health care resources, then John W has no remaining opportunities at all, whereas Jim X does.⁴ But the most critical point I want to call to mind is Dworkin's point regarding expensive tastes.⁵ If welfare (benefit) is going to be judged from a subjective perspective, then an individual who requires an extraordinarily expensive wine to achieve ten units of utility would have a just claim to that wine at social expense while everyone else who could achieve ten units of utility from a very inexpensive wine would have no just claim to that expensive wine (and overall social utility would be decreased because excessive resources would have to be used to satisfy those expensive tastes). Neither utilitarians, nor egalitarians of various stripes, nor sufficientarians, nor prioritarrians would endorse as just providing that expensive wine to our oenophile at social expense. And I believe the same is true for John W. From the perspective of objective benefit, John W receives no ethically significant benefit from being in the ICU.

We can vary our scenario with Jim X in a number of ways, and I believe my conclusion would still hold—that is, he would have a stronger just claim to that ICU bed than John W. We could imagine, for example, that Jim X's automobile accident was really an attempt to commit suicide. That would represent a strong preference to be dead rather than

alive. If subjectivity of preference were all that mattered, then John W would have the stronger just claim to that ICU bed. But the judgment made in all such cases in the ER is that this attempted suicide is assumed to be an irrational preference, relative to which the more objective judgment of ER physicians would take precedence. Jim X has a just claim to the opportunity to reconsider that judgment by having his life saved in the ICU.

Likewise, if we alter the scenario so that Jim X (not suicidal) has a 50/50 chance of survival, but survival would be as a vent-dependent quadriplegic, and we have no idea whether Jim X would regard such a life as a net benefit, Jim X would still have the stronger just claim to that bed over John W. This would give him the opportunity, assuming recovery, to decide for himself whether such a life represented a net benefit for him. I will affirm this same conclusion even if it were the case that Jim X were in these circumstances as a result of a cocaine drug overdose, as opposed to an automobile accident for which he was entirely blameless.

Having reached these conclusions, I want to propose what I take to be a more troubling case for the conclusion I see as being justified, namely, that subjective preferences are not relevant to the just allocation of ICU beds—objective benefit is what needs to count. This was a case that was brought to me by some ob-gyn residents. I wrote a commentary for the *Hastings Center Report* on this case.⁶ In brief, the patient was a 26-year-old woman with an ectopic pregnancy. She was a committed Jehovah's Witness. An ectopic pregnancy requires a surgical intervention, often with considerable bleeding that may require a transfusion. The surgeon informed the patient of this risk. She adamantly refused a blood transfusion, emphasizing that this was clearly contrary to her religious beliefs. She made it clear that she was willing to accept the risk of death. During the procedure itself, she started to bleed out and clearly needed a transfusion. But the surgeon was respectful of her belief. He used a drug to paralyze her, then administered a very expensive clotting drug used with hemophiliacs, Novo-Seven, along with Epogen. He did save her life without violating her religious beliefs, but she required ICU care for more than a week and racked up a total bill of more than \$100,000, which the hospital had to write off as charity care. The ob-gyn residents wanted to know whether she had a just claim to those resources for the sake of her religious belief. To their minds there were many very poor, uninsured individuals for whom that \$100,000 in charity care would have generated substantial health benefit.

In my commentary I argued that this patient did not have a just claim to those resources, but it was not as if she herself had demanded those resources. But the obvious follow-up question was whether others in that religious community, who were facing surgery where there was a risk that they might bleed out, and who were without health insurance that would cover Novo-Seven and the relevant supportive care, could say they had a just claim to that same intervention to prevent their dying for their religious beliefs. My response to that had been that they would have to purchase an add-on rider to a health plan (if anyone were willing to offer such a rider); otherwise they would not have a just claim

to that care. For purposes of this commentary, however, I want to focus on the fact that this patient needed a week in the ICU for her recovery.

I ask the reader to put aside *this* patient with the ectopic pregnancy. Instead, imagine that a Jehovah's Witness patient, Julie Z, is in the ER as the result of an automobile accident. She has lost a lot of blood and needs surgery and a transfusion. She is refusing the transfusion for religious reasons, does not want to die, and demands instead Novo-Seven with the requirement of a weeklong stay in the ICU. The ICU is full. If she just had the surgery and a blood transfusion, she would not need the ICU. She would almost certainly make a full recovery in that case. But if she is admitted to the ICU, then a patient will have to be removed from the ICU. That patient, Joe Y, has the least favorable prognosis. He is 59 years old, has suffered several heart attacks, and is in late stage heart failure. There is a 40 percent chance he will not survive this ICU stay; if he is removed from the ICU to another unit, non-survival rises to 80 percent. If he does survive this hospitalization, he would have a predicted life expectancy of two years. But if our Jehovah's Witness patient were admitted to the ICU, she would almost certainly survive and have a predicted life expectancy of several decades.

If the ethically strongest consideration for determining who had a just claim to an ICU bed were "More Benefit," then Julie Z would clearly have a just claim to that bed. But the only reason why she *needs* that bed is because of her religious beliefs. Are those beliefs ethically analogous to Dworkin's "expensive tastes"? If that is a reasonable analogy, then clearly Julie Z would not have a just claim to that ICU bed, especially if it meant potentially denying Joe Y those two extra years of life. But it is easy to imagine objections to the analogy. Religious commitments seem radically different from acquired tastes for expensive wines. People do change their religious commitments, outgrow them on occasion, or have doubts. But very often they are more integral to who a person is than any acquired taste. This is why there are martyrs for their faith.

However, does this last point imply that Julie Z must accept martyrdom (no blood transfusion) for her faith rather than having Joe Y removed from the ICU and likely condemned to an earlier death *for her faith*? This is a not unreasonable conclusion. A liberal society ought to be respectful of many religious perspectives, but that respect is demonstrated by not interfering with those religious practices, as opposed to providing social resources that would facilitate specific religious practices. Especially problematic would be providing such social resources at the expense of the just claims of others in that society to those resources. This is what would seem to be the case with Joe Y and Julie Z. To further illustrate this point, we can again modify our scenario with John W. We can add that both he and his surrogate are conservative, fervent Roman Catholics committed to a strong Right to Life perspective. This is the ultimate source of their demand for unlimited ICU care. Adding this feature, I argue, alters none of my earlier conclusions regarding John W. If anything, it would undermine further his claim to ongoing access to that ICU bed.

Here is another objection that might be raised in defense of the More Benefit rule. What matters, and what matters alone, for purposes of making a just rationing decision with regard to an ICU bed, are reasonably expected benefits. The clinical history behind how that patient came to need that ICU bed should be ethically irrelevant to making an allocation decision. Thus, the cocaine addict and the drunk driver who now need access to an ICU bed as a result of irresponsible choices that they made should have stronger just claims to an ICU bed if such access promises likely extra decades of life, say, relative to Joe Y (whose heart disease might have been a product of either bad genes or bad eating habits). I would be inclined to endorse this very specific conclusion, with these specific examples. But I am less confident that this analysis can be readily or correctly applied to Julie Z, if the implication is that this would justify removing Joe Y from the ICU.

As noted already, in my earlier essay in this newsletter I criticized the "first come, first served" rule, if it is construed as the dominant rule that should govern ICU rationing decisions. But I also noted that it does have some moral legitimacy in some circumstances. Patients in various stages of anticipated (but not certain) recovery in the ICU are not always at risk of premature removal if someone appears at the door of the ICU with a somewhat better likelihood of more benefit and longer benefit. Joe Y will likely not survive more than two years, but Al (at the door of the ICU) will likely survive four years with ICU care. The "first come, first served" rule would not allow Al to displace Joe, and I think that is the ethically correct conclusion *even though Al would get more benefit*. There is not enough of a difference between the prospects of Al and Joe to generate an ethically justified judgment to remove Joe in favor of Al. But Al would have the right to displace John W because the difference in prospective benefit is very large, and hence, ethically significant. The Thoracic Society (1997) would clearly agree with this judgment. Their view is that an ongoing right to an ICU bed depends upon more than marginal ongoing benefit from occupying that bed. John W is getting no more than the most minimal of objective benefit from continuing to occupy that ICU bed, so Al would have a right to displace him. A case could be made for saying that Julie Z could displace him as well, but Julie Z does not have the right to displace Joe Y because he is continuing to benefit—and it is more than a very marginal benefit—and he was there first. Julie's religious commitments do not add any moral weight to her claim to that bed. We can concede that her religious commitments are not correctly thought of as being analogous to Dworkin's expensive tastes. The more correct conceptualization would be to characterize them as "illiberal demands." As such, those illiberal demands are an integral part of the history that generated her need for that ICU bed. Consequently, they negate her having a just claim to an ICU bed now occupied by someone who is benefitting from having access to that ICU bed.

In concluding, let me reiterate my key point from my earlier (2015) *Philosophy and Medicine* newsletter essay. There are a number of justice-relevant considerations that may legitimately be used to yield just rationing decisions regarding the ICU when full. Likelihood and size of

objective benefit would be one such consideration; first-come, first-served would be another. How to balance these sometimes competing considerations in a range of clinical circumstances should be a product of rational democratic deliberation, because moral argument alone will often not be determinative of the ethically correct decision.⁷ Assertions of subjective benefit related to personal values and preferences might have ethical legitimacy when there are multiple ICU beds available (hence, no problem of justice). But when the ICU is full, justice is the relevant norm for the allocation of those ICU beds. Under those circumstances, subjective assertions of benefit by patients or their representatives should have no ethical relevance.

NOTES

1. Luke Gelinus, "Skeptical Worries for ICU Rationing," *APA Newsletter on Philosophy and Medicine* 15, no. 2 (2016): 2–6.
2. Leonard Fleck, "Rationing in the ICU: First Come, First Served," *APA Newsletter on Philosophy and Medicine* 14, no. 2 (2015): 31–35.
3. Gelinus, "Skeptical Worries for ICU Rationing," 5.
4. Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985).
5. Ronald Dworkin, *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge, MA: Harvard University Press, 2000), 48–59.
6. Leonard Fleck, "Case Study: My Conscience, Your Money," *Hastings Center Report* 25 (Sept./Oct. 1995): 28–29.
7. Leonard Fleck, *Just Caring: Health Care Rationing and Democratic Deliberation* (New York: Oxford University Press, 2009).

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What Does Admission to the Intensive Care Unit Mean, Morally Speaking?

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In the United States, the number of critical care beds—intensive care, premature/neonatal, coronary care unit beds, and psychiatric intensive care—is on the rise, even in an era of hospital consolidation.¹ Even so, demand can still outstrip availability, as can happen in the wake of mass trauma, for example. Advances in every domain of critical care increase the value of that care, increasing the

demand for it. The most costly means for bringing demand and supply into equilibrium is to build intensive care (IC) services equal to the demand.² In the absence of either the political will or a moral consensus to build ICUs on this scale, some measure of rationing must occur.³ As a clinical matter, that kind of rationing can occur at the point of admission to IC or afterward.⁴ Removing patients from the ICU strictly for reasons of rationing is politically and morally fraught, involving as it would exposure to meaningful risks of death. In this analysis I will explore whether it can be morally defensible as a matter of principle to decline to admit certain patients to the ICU or to remove patients from the ICU for reasons other than their falling below the thresholds of expected benefit that make them eligible for that level of care in the first place. One way to move toward an answer to this two-part question is to consider what admission to the critical care unit means in the first place. Depending on what we understand admission to mean in a moral sense, we may or not be able to fail to admit or withdraw patients from the ICU for reasons other than their medical prospects.

WHAT IS THE MEANING OF ADMISSION TO A CRITICAL CARE UNIT?

How are we to understand admission to a critical care unit? Some possible meanings are that admission is a gift, a promise, a covenant, a contract, or the observance of a duty. I will discuss these options in turn for their significance in withholding or withdrawing IC.

A. A gift? A gift is "something, the possession of which is transferred to another without the expectation or receipt of an equivalent; a donation, present."⁵ In the language of the law, a gift is "the transference of property in a thing by one person to another, voluntarily and without any valuable consideration." Would it make sense to extend these notions to admission to the ICU? Is admission a gift this way, something given without any expectation in return? As something given without "any valuable consideration"?

This interpretation of admission to the ICU does not seem right for a variety of reasons, especially since ICUs for the most part always involved "charged costs," namely, costs assigned to the treatments, interventions, and services involved. The patient receiving IC is treated as the presumptive payer for that care, and treatment costs are assigned to the care even if patients themselves cannot ultimately pay. If the patient cannot pay, the costs of care are met in other ways—through government subsidy, philanthropic contributions, or by building the expenses into the costs charged to patients receiving other kinds of care. By contrast and by definition, gifts do not come with invoices.

For the sake of the argument, however, let's assume that admission to the ICU is a kind of gift, a gift of immediate, life-saving services, ultimately given independent of ability to pay. As gifts are ordinarily voluntary acts, at least with respect to giving to a particular recipient, treating IC admission as a gift might weaken any given patient's claim on it. At their discretion, clinicians could offer IC or they might not, which indeterminacy seems a dangerous

way to confer life-saving resources. But still for the sake of the discussion, let's assume that admission to the ICU is a kind of gift. It does not follow from interpreting IC admission this way, however, that patients are entitled by the initial admission to indefinite ICU care at indefinite cost. The nature of gifts as discretionary means that the initial admission does not necessarily entail "future gifts" of continuing care, either from the specific institution that admits the patient or from the society standing behind those institutions. Unless we interpret it as also entailing the expectation of an indefinite series of gifts afterward, we do not have in the idea of gift an absolute shield against withdrawing IC from some patients.

B. A promise? Might we understand admission to the ICU as a kind of promise? To promise means "to give verbal assurance of; to undertake or engage, by word or writing addressed to another person, to do or refrain from (some specified act), or to give or bestow (some specified thing)," usually to the benefit or advantage of the person concerned. That which is promised "is undertaken to be done or given."⁶ In a sense, admission to the ICU does function as a promise. Admission implies that clinicians will offer patients a level of care that is valuable to them in their circumstances and without regard to their ability to pay the incurred costs. As in the case of "gifts," however, promises are subject to constraints that may not be foreseeable at the time of the original pledge. Moreover, it does not follow that an initial promise of that kind entails a promise of indefinite care at indefinite cost. Any promise that inheres in the initial admission to IC is, in a sense, met by that admission. To be sure, patients and their families may interpret admission as implying an indefinite stay at indefinite costs, but even promises have limits. For example, even if a standard of care is in place to guide clinical decisions, it does not follow that a patient is *always* entitled to receive that standard of care, if circumstances change. As in the case of "gifts," promises are subject to constraints that may not be foreseeable at the time of the original pledge.

C. A covenant? Might we understand admission to the ICU as expressing a covenant, with the kind of obligations entailed in that kind of relationship? The term covenant means "a mutual agreement between two or more persons to do or refrain from doing certain acts; a compact, contract, bargain; sometimes, the undertaking pledge or promise of one of the parties."⁷ In certain contexts, the idea of a covenant can involve arrangements between parties unequal to one another, such as God and humanity or a king and vassals. In these arrangements, one side may be bound to accept the terms of the arrangement, rather than to contribute to them, an acceptance that is condition of a continuing relationship. In this sense, a covenant usually expresses some measure of beneficence exhibited by one party toward the other, but also some standards of expected behavior from the recipients as well.

It is unclear that we should interpret admissions to the ICU in this latter sense of covenant, that is, in ways that involve some kind of status difference between the parties involved. It is true, of course, that on one side of the ICU admission stand people healthy enough and

knowledgeable enough to offer healthcare services while on the other side stand people whose diseases, disorders, and injuries put their very lives at risk. It is this status difference that makes admission to the ICU desirable, but it is unclear that this difference amounts to the kind of status difference presupposed in covenants. Healthcare providers are not gods, and they are not kings either; patients are not creations, and neither are they vassals. It is not clear, therefore, that we ought to theorize the relationship between clinicians and patients as people *morally unequal* to one another, with patients somehow morally beholden to clinicians. For purposes of this discussion, then, not much is to be gained by interpreting admission to the ICU as a covenant, except in the meaning of that term as an agreement or contract, to which term I turn next.

D. A contract? A contract is "a mutual agreement between two or more parties that something shall be done or forborne by one or both."⁸ On this meaning, admission to the ICU might be understood as a contract that healthcare providers will provide IC to patients in exchange for payment; the patient may pay him- or herself, or the payment may come from a third party, such as a private insurer or government. By reason of certain background financial commitments to cover the costs of healthcare, we might even say that some people are entitled by those contractual understandings to IC services, so long as the terms of the initial arrangements spell out that entitlement. Should governments and/or insurers fail to provide treatment in accord with medical standards of care, they might be understood as breaching the terms of the contract. In these senses, IC decisions are not apparently different than other kinds of contracts between one party expecting services from another party, and in many instances it makes sense to analyze IC decisions along these lines.

In one important sense, however, it does not follow that this understanding of ICU admissions—as contracts—offers no room for modification of the terms of the contract, especially in regard to indefinite care at indefinite cost. Hoped-for outcomes in IC may fail to materialize as quickly as expected, they may fail to materialize at all, or the expected cost of realizing those outcomes may soar. When it comes to contracts in general, people are free, of course, to choose to make arrangements that have little or no value to them, that drain their financial resources, or that have remote possibilities of success. If this is all there were to ICU decisions, there would be no difficulty at all in treating IC decisions solely as contracts involving only the parties concerned. But ICUs operate under conditions of scarcity, meaning that a contract with one patient can exclude other patients from access to life-saving treatment.

Given that ICUs constitute an important social good, it is not clear that one party has the right to contract those services in a way that excludes other parties from access—to have a certain kind of monopoly on services, to put the matter that way. There are at least reasons in principle, then, to limit the way in which ICU decisions function to choke off access to all people who might benefit from them. It does not follow, therefore, that admission to the ICU means that clinicians have executed a contract to provide an indefinite amount of care at indefinite cost to patients it admits. Neither does it

follow from interpreting admission to the ICU as a contract that healthcare institutions—as gatekeepers to IC—have no duty to other people who can benefit from that level of care. In other words, social interests can intervene against private contracts for the public good if those contracts restrict access to an important social good. A government might, then, work to establish formal rationing standards for IC in order to preserve that access in the same way that governments intervene in policies governing transplantable tissues and organs. In principle, those standards could apply at the point of admission or afterward, depending on what was necessary to ensure meaningful access to IC across the range of people whose lives depend on it.

It is, of course, ordinarily important to respect contracts according to the terms of their agreements, but even contracts can be modified after the fact for good reasons. It can be noted, for example, that the law rejects certain kinds of trusts in perpetuity, insofar as they seek to direct the behavior of parties far in the future. Trusts, like contracts, sometimes overreach in their expectations of what is desirable and possible, and both ethics and the law permit the modification or even outright dissolution of trusts—and contracts too—in the light of an overreach of expectations, failure to come to a meeting of the minds about the meaning of agreements, or circumstances that change expectations on either side of the agreement. In 1992, for example, the U.S. Supreme Court gave self-insuring businesses the right to limit insurance coverage for diagnoses of AIDS and other diseases after the fact.⁹ Even if we give considerable credence to the idea that admission to the ICU amounts to a contract between the parties, payers and patients, or patients and providers, it does not follow that the agreement can never be changed with regard to standards of admission or standards of continuing care. The interpretation of admission to an ICU as a contract, then, does not in itself mean that any and all patients must necessarily be admitted to that level of care. Neither does it mean that patients have the right to an indefinite amount of care for an indefinite amount of time and at an indefinite cost. Any agreement involved in the provision of IC must be responsive to supervening social interests in maintaining access and equity in regard to that level of care. To be sure, once admitted to an ICU, a patient has a *prima facie* right not to be withdrawn from the ICU for anything less than a compelling reason of equivalent moral weight; but nothing in the idea of IC admission as a contract necessarily protects them from that action.

E. The observance of a duty for which there is a correlative right? As against the other meanings considered so far, would it be a conceptual improvement to treat admission to the ICU as the observance of a duty, in at least a *prima facie* sense?

In one sense, ICU admission is a duty insofar as the law is concerned, if—all things considered—that admission represents the standard of care for a given patient. Certainly, a patient or the patient’s surrogate decision-maker might decline the admission, if they judge the treatment less valuable than some other option. Some patients might wish to decline IC because they wish to avoid prolonged treatment; the patient might have had several IC admissions

before and is now willing to accept the prospect of death rather than the foreseeable cost of IC. Even so, clinicians have a presumptive duty under the law to observe the standard of care for all patients, and if IC is the level of care that reasonable physicians ought to offer patients relative to their circumstances, then that is what they should do. On the other side, on this interpretation, it follows that patients would ordinarily have a right to expect ICU care as a matter of course, should their treatment require it.

That clinicians have a presumptive duty to offer IC, and that patients have a presumptive right to that level of care, does not mean, even so, that all patients must be admitted to the ICU under all circumstances, or that institutions have a limitless obligation to provide that level of care at indefinite cost. Presumptive duties are *prima facie* duties, and presumptive rights are *prima facie* rights, in the sense that they might be overridden should there be supervening duties and rights. For example, if a patient expects to be admitted to an ICU on a particular day, but a natural disaster destroys the hospital, it would be hard to conclude that clinicians failed to exercise their duty toward the patient. Neither is it clear that the patient could claim that his rights to admission were violated. That the duty to admit to an ICU is a *prima facie* duty as against an absolute duty opens the door to—among other things—the prospect of a selection process for deciding who should be admitted when not all can be admitted.

One selection process for these decisions is to admit is on a “first-come, first-served” basis, but other approaches can be defended as well, since there may be good reason to apportion the benefits of the IC in other ways. It is not irrational, for example, to think that estimated benefit of IC measured in total years of life saved might enter into admissions decisions, under conditions of IC scarcity. If two parties are seriously injured by lightning, one of them being 5 years old and the other being 85, and only one ICU bed is available, might it not make sense to tip the admission decision in favor of the child, no matter that the 85-year-old arrived at the hospital five minutes before the child?¹⁰ What is true of admission seems true of removal from IC as well. Ordinarily, patients are entitled to the standard of care appropriate to their condition, but under conditions of scarcity, a mechanism for removing certain patients from IC seems justified in principle. A task force of the American Thoracic Society seems to admit as much when—even in the course of defending a first-come, first-served rule to IC—it acknowledges that the duty of physicians to benefit their patients “has limits when doing so unfairly compromises the availability of resources needed by others.”¹¹ Framing the ICU in terms of contractual expectations and obligations does not, therefore, by itself always require decisions to admit or to make admissions decisions irrevocable. As the legitimacy of setting aside trusts shows, it is unwise to treat admissions decisions as somehow entirely isolated from subsequent and changing circumstances.

CONCLUSIONS

Admission to an ICU can be construed in a variety of ways, but none of its meanings are inconsistent with the idea that—under certain conditions—some people may be denied that level of care against their wishes; neither

are those meanings inconsistent with the idea that some people may be removed from IC under certain conditions.

Treating admission to an ICU as a *gift* might capture some of the beneficence at the moral root of medicine. There is surely merit in trying to sustain the lives of people so far as they themselves value those lives, and medical interventions can look like gifts, all the more so when they confer enormous advantage. The provision of some medical care without cost to certain individuals may reinforce the idea that the ICU is indeed a gift. Even so, interpreting admission to the ICU as a gift does not mean that “gift-givers” are obliged to offer that gift to anyone in particular, and neither does that interpretation mean that gift-givers must continue to give in the wake of an initial gift and offer indefinite care at indefinite cost. There is nothing in the idea of “gift” that makes it impossible as a matter of principle to decline to offer IC to certain individuals and—in light of changed circumstances—withdraw IC from some parties, whether those changed circumstances involve changes in the patients’ health or others’ need for IC.

Treating admission to the ICU as a *promise* also captures some of the beneficence that underlies medicine, and that beneficence is typically expressed in the fiduciary responsibilities medicine imposes on itself. For example, the American Medical Association asserts in its principles of medical ethics that “a physician shall, while caring for a patient, regard responsibility to the patient as paramount.”¹² Admitting patients to IC might be seen in the light of this moral commitment to set the patient’s interests above one’s own. Even so, treating admission to the ICU as a promise does not mean that clinicians and policy-makers must promise that level of care to all patients who might benefit from it without regard to the costs involved, without regard to the expected benefits of IC, and without regard to the obstacles that care for some puts in the way of care for others. Not all promises can survive life’s vagaries intact, no more in medicine than in other areas of life.

Not even an interpretation of admission to the ICU as a kind of *covenant* secures people admission to the ICU under all circumstances or continuing IC under all circumstances. Certain interpretations of the term covenant presuppose the exercise of beneficence by one party toward another, but this meaning usually presupposes some measure of status inequality between the parties involved. It does not appear wise to conceptualize the relationship between healthcare providers and ICU patients in this way, that is, in a way that involves higher status parties conferring benefits on lower status parties, as against parties in relationships of presumptive equality. To protect presumptive equality in healthcare relationships, it is better, morally speaking, to analyze ICU decisions according to the meaning of covenant that is more or less synonymous with contract.

Treating ICU decisions as a *contract* makes a certain amount of sense. In some ways, IC is just another kind of medical service, and people should generally be free to pursue it, and clinicians should generally be free to offer it, on terms acceptable to both sides. But insofar as ICUs are an important social good, they should be protected from contracts that limit access to all other patients who might

need that level of care. At the very least, some patients should not be able to “buy up” all available IC services, to the exclusion of all other parties. In order to protect against some patients monopolizing IC to the life-threatening disadvantage of others, society is entitled, in principle, to intervene in the market of IC contracts, in order to preserve access to that level of care. As it does in other ways, too, the law might also intervene in contracts after the fact because of changed circumstances, though it would be bound to do so only in the face of compelling reasons.

Admission to the ICU can also be meaningfully interpreted as the *observance of a duty* in relation to a correlative right. The duties and rights here are, however, *prima facie* in the sense that they are open to exceptions as matters of ethics and the law. It does not follow as a matter of ethics that a presumptive duty to provide IC must always be observed, if there are morally or legally significant reasons to do otherwise. A duty implicit in admission to IC may be undone in the face of unforeseeable circumstances, for example. This is certainly not to say that IC decisions should be subject to revision at will. The observance of duties toward patients is fundamental to securing trust in healthcare relationships, but as with contracts, the explicit and implicit terms of duties in regard to IC are not immune to modification.

Taken together, these considerations of what ICU admission might mean in a moral sense support the conclusion that people are not entitled to IC in any absolute way, neither at point of admission nor once admitted. Changing circumstances open the door to limiting IC according to rationing standards, as do considerations of justice, no matter how we understand the meaning of admission to the ICU. In a sense, this conceptual work is the easier part of the work involved in any theory of rationing. If we concede that in some circumstances some people may be turned away from IC and that some may be withdrawn from IC, then we need a principled way to make these decisions. For example, it will be important to ask how those standards can be crafted and implemented in ways that respect the fiduciary and legal responsibilities physicians have toward their patients. It will be no less important to ask how those standards should be implemented on the practical level. I have not offered any moral counsel here about these matters, but I have tried to say why certain understandings of admission to the ICU do not preclude the need for such standards.

NOTES

1. Neil A. Halpern and Stephen M. Pastores, “Critical Care Medicine in the United States 2000–2005: An Analysis of Bed Numbers, Occupancy Rates, Payer Mix, and Costs,” *Critical Care Medicine* 2010 (38): 65–71.
2. Leonard M. Fleck has speculated that an increased supply of ICU beds would, in fact, only increase demand, as the perceived value of that level of care would motivate clinicians to offer it to more patients. See “Rationing in the ICU: First-Come, First-Served?,” *APA Newsletter on Philosophy and Medicine* 14, no. 2 (2015): 2. http://www.apaonline.org/?medicine_newsletter.
3. American Thoracic Society Bioethics Task Force, “Fair Allocation of Intensive Care Resources,” *American Journal of Respiratory and Critical Care Medicine* 156 (1997): 1282–1301.
4. Prior to decisions at the clinical level, political rationing occurs in jurisdictions that limit ICU beds according to a legal process involving proof of demonstrated need.

5. "Gift," in J. A. Simpson, E.S.C. Weiner, preparers, *Oxford English Dictionary*, 2nd ed., vol. VI. (Oxford: Clarendon Press, 1998), 502-503.
6. "Promise," *Oxford English Dictionary*, vol. XII, p. 614.
7. "Covenant," *Oxford English Dictionary*, vol. III, p. 1069.
8. "Contract," *Oxford English Dictionary*, vol. III, p. 835.
9. David G. Savage, "Court Lets Firms Cut Healthcare: Benefits: Supreme Court Gives Leeway to Self-insured Companies. Case Involves AIDS Patient Whose Coverage Fell from \$1 million to \$5,000 after Illness was Revealed." *Los Angeles Times*, Nov. 10, 1992.
10. See Leonard M. Fleck and Timothy F. Murphy, "First Come, First Served in the Intensive Care Unit: Always?" *Cambridge Quarterly of Healthcare Ethics* (submitted).
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The Moral Permissibility of Removing Patients from Intensive Care

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I claim that under certain conditions, it is morally permissible to remove patients from an intensive care unit (ICU), even when patients or families disagree with doing so.

An ICU is a hospital facility for providing intensive nursing and medical care and for administration of sophisticated monitoring and resuscitative equipment to patients who have unstable and life-threatening medical conditions. The purpose of an ICU is to improve outcomes, that is, to improve the condition and chance of survival of patients.

In 2011, 26.9 percent of hospital stays in the United States involved ICU charges, accounting for 47.5 percent of aggregate total hospital charges. These figures indicate that over a quarter of all hospital stays involve use of intensive care, and that this use of intensive care accounts for a disproportionate fraction of hospital costs.¹ Furthermore, one in five deaths in the United States occurs in a critical care bed.²

As for any patients, treatment decisions for patients with life-threatening and terminal illnesses should be based on shared decision-making that takes into account both scientific evidence and patient preferences. Because critically ill patients are often unable to make decisions, decision-making often involves clinicians and families. The concept of shared decision-making is well developed, and experts in critical care have put forth recommendations to facilitate shared decision-making for critically ill patients.³

Because diagnosis, monitoring, and treatment of critical illness requires extraordinarily intense resources, others, aside from patients, families, and their immediate

healthcare providers, have a stake and may legitimately have a claim regarding the stewardship of these resources.

Under the circumstances, guidelines about the fair use of these resources should be developed and followed. Concern for fiscal sustainability requires that intensive care should be allocated efficiently. At the same time, concern for justice requires a fair process for distribution of this resource. In fact, such a fair process with the necessary features does exist. The elements of a fair process for ICU management include (1) guidelines with explicit criteria for ICU admission, discharge, and triage that have been established by a legitimate body; and (2) procedures for minimizing and resolving disagreements.

The first element is available in the form of the Guideline for ICU Admission, Discharge, and Triage of the American College of Critical Care Medicine of the Society of Critical Care Medicine.⁴ Notably, these guidelines state, "Because of the utilization of expensive resources, ICUs should, in general, be reserved for those patients with reversible medical conditions who have a reasonable prospect of substantial recovery." The discharge criteria in the guidelines are of particular relevance here. In particular, the guidelines recommend that that patients be discharged (1) when a patient's physiologic status has stabilized and the need for ICU monitoring and care is no longer necessary, or (2) when a patient's physiological status has deteriorated and active interventions are no longer planned. Under either of those circumstances, discharge to a lower level of care is appropriate.

While not stated in the guidelines, because it was not a criterion that was in dispute at the time the guidelines were written, an additional defensible discharge criterion is that the patient has died. Certainly, more recently, this criterion has become more contentious as disagreements about the definition of death have arisen.

The second element, procedures for minimizing and resolving disagreements, also exists. A number of professional societies have joined to endorse a policy for responding to contentious treatment requests. This is the Official Policy Statement on Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units, which is a joint statement of the American Thoracic Society, the American Association of Critical Care Nurses, the American College of Critical Care Medicine, the European Society of Intensive Care Medicine, and the Society of Critical Care Medicine. The policy recommends a process for addressing disagreements that has several features: (1) institutional implementation of strategies, particularly proactive communication and early involvement of experts to prevent intractable treatments conflicts; and (2) management of intractable disputes through conflict resolution. The latter should include hospital review, attempts to find an alternate willing provider, and opportunity for external review of decisions. There is also a recognition that disputes sometimes arise in very dire circumstances in which time is of the essence, so that abbreviation of process may be needed. A final recommendation of the policy statement is that the medical profession should lead public engagement efforts

and advocate for policies and legislation about when life-prolonging technologies should be used.

While one might choose to disagree with some of the details of the policies or procedures that have been developed, or one might find that some institutions and clinicians fail to act on the recommendations, I do believe that, on the whole, the conditions can be met for justifiably having patients leave the ICU, even when they or their families might disagree with the decision to do so.

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DISCLAIMER

The views expressed here are mine and not necessarily a reflection of the policies of the National Institutes of Health or the U.S. Department of Health and Human Services.

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1. Barrett et al., "Statistical Brief #185: Utilization of Intensive Care Services, 2011."
2. Cook and Rocker, "Dying with Dignity in the Intensive Care Unit."
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Removing Patients from the ICU: Is It Ever Morally Justifiable?

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Critical care teams have broad authority over ICU admission decisions, and medical triage is the widely accepted standard for making those admission decisions. Triage is the broadly endorsed approach for responding to medical

emergencies. It is the approach that was immediately adopted by healthcare workers on September 11, 2001, for dealing with the medical needs that were expected once the Twin Towers of the World Trade Center collapsed, and its appropriateness has not been challenged in any of the subsequent literature. Triage is the public health model for responding to domestic medical emergencies that requires healthcare professionals to make judgments about the likely survival of patients who need medical treatment. Recognizing that some people have urgent needs—they will die or suffer significant harm if not treated very soon, and that the resources available—supplies, facilities, trained personnel—are scarce, patients are sorted into three groups. They are either treated, put aside, or asked to wait, according to their group classification. Those who are not likely to survive and whose treatment would, nevertheless, require a tremendous amount of resources are deprived of treatment so that the available resources can be used to save the lives of those who are more likely to live. Those who are likely to die without treatment but who are likely to live if treated promptly are treated first. Those who are in need of treatment but who can wait longer without dying are treated after those who are urgently ill.

On the morning of September 11, 2001, the disaster plan which had previously been developed and practiced was implemented at hospitals throughout the New York City area. Beds in intensive care units (ICUs) were emptied. Elective surgery was canceled. Patients who could have been sent home were discharged, including patients who had already been anesthetized for elective surgery. Collection activities in bloodbanks went into high gear, but the bloodbanks were only accepting type O donors.

In medical emergencies, healthcare professionals deliberately disregard the concept of giving everyone a fair, equal opportunity to receive medical treatment, and they also pointedly ignore relative differences in economic and social standing. Instead, they focus exclusively on the medical factors of the likelihood of survival and the urgency of need. No one presumes to measure whether or not each patient has previously received a fair or equal share of available resources, and no one stops to assess who has been more or less advantaged. No one sorts out the small differences between individuals that would provide somewhat greater utility from one allocation rather than another. And no one criticizes medicine for not attending to those differences.¹ In fact, the long tradition of medical ethics, dating back at least to the Hippocratic tradition, requires physicians to provide treatment based on need. Hence the ethics of medicine appears to require physicians to commit themselves to unequal treatment, since need is unequal, and also to the non-judgmental regard of each patient's worthiness.

Because the supply of ICU beds is limited, because the demand for the special services that they provide often outstrips the supply, and because life and death are at stake, a just system for allocating beds is in order. Medical triage is the obvious policy choice for making those difficult decisions. Yet, although it is reasonable to endorse a medical triage approach for admitting patients to the ICU, discharge decisions are far more complex, and the

complexities may make medical triage an unacceptable standard for making discharge decisions.

Allow me to explain the obvious inconsistency that I am suggesting.

Once admitted to the ICU, at a certain point in some ICU patients' course, it may become clear that they will not recover from their serious medical condition(s). The best that a continued stay in the ICU can accomplish is to prolong life, often without any meaningful consciousness or interactive ability. Often enough, with continued ICU treatment, death is not imminent: with continued ICU care, the lives of these patients can be prolonged for a significant period.

Although the triage arguments that I presented above can incline people to conclude that a just allocation of scarce medical resources would justify withdrawing the continued use of the ICU bed from such patients, today's legal and regulatory realities make it impractical and unjust to do so. That is because achieving justice is often complicated. Yet we have a tendency to simplify situations and focus on a narrow range of considerations. Instead of considering how a policy will impact everyone who will be affected by its implementation, some prefer to look at only a subset of those who will benefit or suffer as a result. For example, some may be inclined to think of the matter in terms of which of these two patients should get the bed in the ICU. Or, for example, the decision makers in Michigan State concluded that the water supply for Flint, Michigan, should be drawn from the Flint River instead of Detroit because that would save money. I offer the second example because what we know today makes it clear that the short-range advantage of saving money was not at all justified and that many more factors should have been factored into the decision.

Similarly, even though I find the result disturbing, when I look at the broad range of consequences that have to be taken into account in ICU decisions, I conclude that patients with likely poor outcomes cannot be discharged from the ICU when they or their surrogate decision makers oppose the discharge because doing so would involve treating others unjustly. The impact on others to do so (as, for instance, to other patients on a standard care floor) and the current regulatory environment make it untenable.

JUSTICE

In reaching this conclusion I draw on what I have learned about justice from Aristotle. In the *Nicomachean Ethics* he makes several important points. He explains that "Justice, alone of the virtues, is thought to be 'another's good', because it is related to our neighbour"² and "Justice . . . is not part of virtue but virtue entire . . . as a relation to one's neighbour."³ These statements suggest that a just distribution of resources should consider the impact on everyone involved because everyone affected by a decision is my neighbor.

Aristotle then goes on to explain that distributive justice "is a species of the proportionate."⁴ He then elaborates, writing that, "but **how** actions must be done and distributions effected in order to be just, to know *this* is a greater achievement than knowing what is good for health;

though even there, while it is easy to know that honey, wine, hellebore, cautery, and the use of the knife are so, **to know how, to whom, and when** these should be applied with a view to producing health, is no less an achievement than that of being a physician."⁵ Sorting through the how and whom and when is complicated, difficult, and requires discernment.

In part, it is difficult to discern what justice requires because there are many principles of justice. Although there are philosophers who argue over which principle expresses the essence of justice, I have argued elsewhere that the diverse principles of justice are salient in different situations, and there is no single, simple principle of justice. Aligning myself with Aristotle, I maintain that in various contexts, fulfilling the requirements of justice can involve following one or more of several distinct principles. Some of the principles of distributive justice include equality, maximize benefits, maximin, difference principle, first-come-first-serve, and avoid the worst outcome. Whereas, "avoid the worst outcome" is the principle that leads us to accept medical triage for admission to the ICU because the context is different when we consider making ICU discharge decisions, "avoid the worst outcome" may not be the appropriate principle.

T. M. Scanlon alerts us to the variety of human values that contribute to "a shared sense that certain things are worthwhile" and make up the relevant framework for agreement on the principles to employ in making various kinds of allocation decisions. Scanlon suggests that people who are "moved by the aim of finding principles that others, similarly motivated, could not reasonably reject" will be able to identify the principles that are salient for different allocation decisions. In setting ICU admission policy, there is wide agreement, an overlapping consensus, in fact, that the "vital importance for well-being" and the "best chance of surviving" are the most relevant considerations. By settling on these principles we are, in fact, rejecting other principles as irrelevant to the decision at hand. As a principle for making the allocation decisions, "equality" is ruled out when we consider that giving everyone in the community an equal amount of time in an ICU bed would be patently ridiculous. "Maximize benefits" is ruled out when we do not prioritize those who are likely to live the longest and provide ICU beds even for people who may be elderly. The "difference principle" is ruled out when we don't consider how well off a patient's previous life has gone. And "first-come-first-serve" is also rejected because need is considered more important than the chance of who reached the hospital threshold before whom. So, which factors and which principles come into play in ICU discharge decisions?

CONSIDERATIONS IN ICU DISCHARGE DECISIONS

In the Newborn Intensive Care Unit (NICU), the problem of scarcity is overcome by stretching resources a bit. When all of the beds that the state allows the unit to have are filled, and another needy newborn arrives in need of NICU care, the team just moves in another bed. NICU beds are very small, and NICU teams are experienced in stretching

their resources and dividing their energy among their tiny patients. In other words, they avoid setting any newborn aside in both admission and discharge decisions by giving each infant a wee bit less attention in order to squeeze another patient into the unit.

Allocating beds justly in adult ICUs is very different from making those decisions in the NICU. Adult beds are large, and adult patients require a tremendous amount of nursing care. There is no space for wheeling in one more bed to the ICU, and there is no supply of extra equipment that can be allotted to an additional patient. Also, in adult ICUs, one nurse is typically assigned to treat only two patients because the level of care requires that much attention.

Whereas the factors that require attention in ICU admissions decisions are clear and relatively obvious, the numerous additional considerations that require attention in ICU discharge decisions require an examination of less obvious issues. Their relevance needs to be demonstrated. Below are some reasons that should make people reluctant to impose policies for ICU discharge over the objections of patients and their families.

Respecting the values of others has become a central element in medical ethics. It is acknowledged as the mark of respect for patient autonomy, and it has been codified in the 1990 Federal Patient Self-Determination Act. This act gives patients the right to make decisions about their own medical care. More recent state surrogacy bills give family members of patients similar rights to make choices about accepting or refusing medical interventions on behalf of a patient. To the extent that these laws leave the authority for decisions about continuing and discontinuing critical care in the hands of patients and family members, imposing an ICU discharge decision over the objections of a patient or a surrogate contravenes the ethically required respect for their values.

Medical malpractice legislation and legal liability for good clinical practice makes clinicians and institutions responsible for upholding the standard of care. To the extent that continued ICU care is consistent with the standard of care and required for prolonging the patient's life, clinicians and institutions would be liable for any harm (e.g., death) that results for removing a patient from ICU care in opposition to the wishes of the family or the patient. Because we want clinicians and institutions to uphold the standard of care and because we want them to be reluctant to deviate from the standard of care out of fear of burdensome and costly lawsuits and a desire to avoid reputational risks, policies that would reverse these incentives should be avoided.

Moving a patient from an ICU with a staffing level of two patients per nurse to a regular medical floor with eight patients per nurse exposes other patients to significant burdens. To the extent that the required nursing care for the discharged ICU patient is provided, the remaining seven patients on the floor suffer a severe deterioration in their level of care. Given that they are deprived of the level of care that they otherwise would be entitled to have, they are all treated unjustly.

Nursing burdens and the moral distress that nurses would experience provide yet another reason for not imposing unwanted ICU discharge decisions. Provision 4 of the American Nursing Association Code of Ethics for Nurses provides that "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care." This provision makes it clear that nurses should refuse to accept both the discharge of patients who still need the "optimal care" of the ICU and the risk imposed to patients on a regular hospital floor of having an ICU patient who requires a tremendous amount of nursing attention transferred to standard care unit. Furthermore, empathy for the moral distress of a nurse who is asked to perform the impossible job of providing optimal care for the discharged ICU patient and all of the other seven patients in her charge during the same shift should make reformers hesitate. The nurse is left in the ethically untenable position of having to fail in fulfilling a duty to some patients. Deliberately imposing such impossible choices on anyone should not be an ethical option.

Considering this convergence of factors that argue against imposing ICU discharge on a refusing patient makes it clear that it shouldn't happen, and it's not going to happen. In case that conclusion makes you uncomfortable, recall that John Rawls taught us to think about ethics in terms of ideal and non-ideal theory. Perhaps in an ideal world, avoid the worst outcome/medical triage should be the principle for ICU discharge. Nevertheless, in our complicated, non-ideal world, triage discharge decisions are not acceptable. Many social changes would be needed or decisions to abandon numerous core ethical values would have to be made in order to implement a policy of medical triage for ICU discharge.

- (1) Respecting the values of others (patients, families) would have to be sacrificed.
- (2) The scope of surrogate authority would have to be severely limited.
- (3) Liability and responsibility for good clinical practice would have to be diminished.
- (4) The imposition of significant burdens on other patients would have to be accepted.
- (5) Nursing obligations, burdens, and moral distress would have to be ignored.
- (6) The authority of nursing administration to stand up for good patient care and good nursing practice would have to be dissolved.

It's not obvious that making such changes would be good for society and worth whatever benefits that might result from discharging patients from ICUs over the objections of patients and surrogates.

NOTES

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3. *Ibid.*, v2,1130a.
4. *Ibid.*, v3,1131a.
5. *Ibid.*, v9,1137a. Emphasis added.

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Unraveling the Asymmetry in Procreative Ethics

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1. INTRODUCTION

Asymmetry in the ethics of procreation consists of two distinct ethical claims. The first is that it is morally *wrong* to bring into existence a child who will have an abjectly miserable life; the second is that it is *permissible* not to bring into existence a child who will enjoy a very happy life.¹ Both claims of the Asymmetry are supported by strong moral intuitions, but finding a plausible moral theory which can accommodate both claims has proven a difficult task. In fact, the inability to provide coherent theoretical support for the Asymmetry has led some authors to reject it.² Other philosophers have posed creative, though controversial, ways of vindicating this view.³

In this paper, I distinguish between two variations of the Asymmetry. The first is Abstract Asymmetry, the idealized variation of the Asymmetry that many philosophers have been trying to solve. The second is Real-World Asymmetry, a non-idealized variation that applies explicitly to cases of ordinary human reproduction. I argue that the Real-World Asymmetry can be defended by properly acknowledging the general wrongness of causing someone else to suffer, the limits of what morality can reasonably demand of us, and the significance of respecting women’s autonomy. I then argue that Abstract Asymmetry, which is idealized in ways that eliminate the import of morality’s demands and respect for women’s

autonomy, is indefensible. We lack good reason to think our intuitions’ underlying Abstract Asymmetry are reliable, and Abstract Asymmetry also conflicts with a plausible moral principle.

2. DISTINGUISHING TWO ASYMMETRIES

I have already described the Asymmetry in broad terms, but it is actually ambiguous between two different sets of claims. Here is the first set of claims, as described by Melinda Roberts:⁴

- Claim 1: It would be wrong to bring a miserable child—a child whose life is less than worth living—into existence.
- Claim 2: It would be permissible not to bring a happy child—a child whose life is worth living or even well worth living—into existence.

These claims are illuminated more explicitly in Figure 1.

In Figure 1, we have two procreative choices to make. We are choosing whether or not to bring Meg into existence (shown in worlds w1 and w2), and we are choosing whether or not to bring Hans into existence. In the graph, Meg and Hans only exist in the worlds where their names are bolded, and the choices of whether to bring them into existence are independent from one another (i.e., Meg’s existence or nonexistence has no impact on Hans and vice versa). If Meg were to come into existence, she would have a dreadful life characterized by great and persistent suffering. In contrast, if Hans were to come into existence, he would have one of the best lives possible. It would be wrong to perform act a1: we ought not to bring Meg into existence. In contrast, it would be permissible to perform act a3: we may permissibly choose not to bring Hans into existence. The central puzzle of the Asymmetry is how we can explain why act a1 is obligatory while act a3 is not.

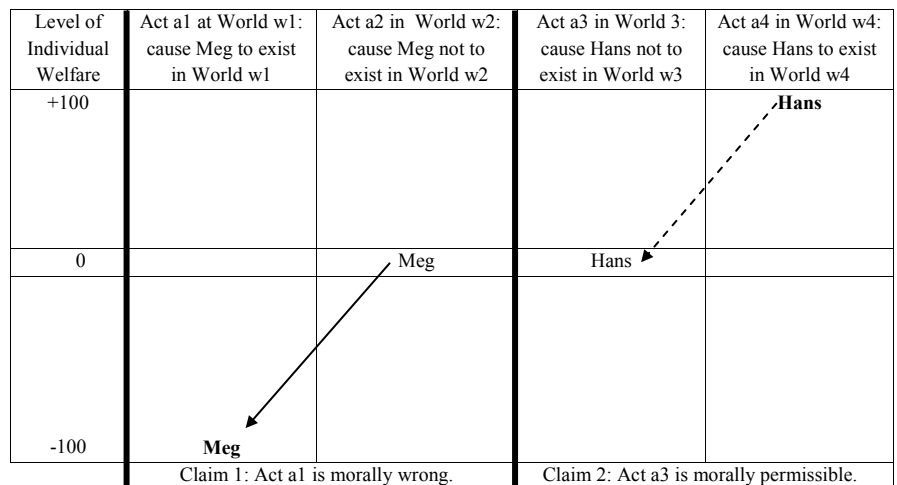


Figure 1. The Asymmetry⁵

But there is something peculiar about this presentation of the Asymmetry. Meg and Hans are the only individuals affected by their coming into existence; no one else’s welfare is altered. It is as if we are to imagine pushing

buttons regarding which world we bring about: the corresponding person simply pops into existence with a home, an education, and a suitable job.⁶ Obviously, this thought experiment is much different than the actual process of conceiving and raising a child, which requires substantial long-term investments of physical and emotional energy, especially for women, since they are the ones who gestate children.

Let us call the Asymmetry portrayed by the union of Claims 1 and 2 (and depicted in Roberts' graph) *Abstract Asymmetry*. Given its idealized nature, the Abstract Asymmetry can be contrasted with another Asymmetry, which I represent as the union of Claims 3 and 4:

Claim 3: Under ordinary conditions of human reproduction, people are not morally permitted to bring into existence a child who would have an abjectly miserable life.

Claim 4: Under ordinary conditions of human reproduction, people are not morally obligated to bring into existence a child who would have a very happy life.

Since Claims 3 and 4 are explicitly grounded in the conditions of typical human reproduction, call their union *Real-World Asymmetry*. Also, notice that both claims in the Real-World Asymmetry leave open the possibility that there can be extreme circumstances where we are obligated to perform these actions, such as if the only way to save the world were to bring a child into existence who would live a miserable life, or if procreation were required for the continuation of the human species.⁷ If we wish to defend the view that presently living human couples should refrain from bringing into existence children that would live miserable lives but are not similarly obligated to conceive and raise children who would live happy lives, then affirming Claims 3 and 4 are sufficient: we do not need to defend the Abstract Asymmetry to secure this result.

Now the pivotal question emerges: Can we secure Real-World Asymmetry? Moreover, can we secure it more easily than Abstract Asymmetry? We can start by trying to get the Real-World Asymmetry in hand.

3. SECURING THE REAL-WORLD ASYMMETRY

To secure Real-World Asymmetry, we can appeal to three fairly basic ethical principles. We will begin with Claim 3. This principle is well supported by the general moral duty to avoid causing suffering. It is morally bad that people suffer, and *prima facie*, we ought not to cause other people to suffer if we can avoid doing so. Moreover, in the circumstances specified by Claim 3, the suffering of the child would be *extremely* bad. Thus, a child should only be forced to endure this kind of life in desperate and outlandish circumstances.

Securing Claim 3 is straightforward, but securing Claim 4 is more challenging. If a person's suffering is a strong moral reason not to bring a person into existence, then why would a person's happiness not be a strong moral reason in favor of bringing a person into existence? It seems very difficult

to deny that the creation of person with a happy life is a morally good thing. This fact alone—the fact that an action makes the world a better place in some way—appears to provide a moral reason to perform that action. But if that is correct, then one fears that people will frequently have a moral obligation to have children. So how can Claim 4 be supported?

There are two promising routes to securing Claim 4. The first stems from the recognition that morality does not demand that we always perform the action that maximizes the good. After all, there are some actions, even in the realm of procreation, that are supererogatory—morally good to do, but not morally required. Judith Thompson provided a famous example of such a case more than forty years ago.⁸ Suppose you wake up to discover that you are strapped to a famous violinist who has a fatal kidney ailment. You were kidnapped during the night by the Society of Music Lovers, and because you are the only one who matches the violinist's blood type, the violinist's circulatory system is now connected to yours so that the violinist may make use of your kidneys. The violinist must remain connected for nine months to recover; then he can be safely disconnected. In critically reflecting on this case, almost everyone agrees that it would be permissible for you to disconnect yourself from the violinist even though the benefit to him and the Society of Music Lovers would vastly outweigh the burdens you must endure for nine months. One of the central reasons for thinking that it is permissible to disconnect from the violinist is that there are limits to what morality can demand of us: there are certain situations where we can sensibly say that an action would be a morally good thing to do but that we cannot be required to do it.

Bringing the happy child into existence might be a good thing to do, but it cannot be required of anyone. The responsibilities and burdens associated with childbirth and parenting are among the greatest and most demanding that a person can experience in her lifetime. Pregnancy can be the most physically and emotionally challenging experience of a woman's life and frequently affects her physical appearance for the remainder of her life. Caring for children is no easy task either. The investments of time, emotion, and financial resources required to be a good parent are extraordinary. They are also enduring: children do not typically leave their parents' care until they are close to twenty years old. Burdens this significant and this long-lasting cannot be required of anyone. While many happily embrace these duties and find the rewards of parenting far greater than the burdens, we must not force people to bear such burdens when they do not want to endure them.

Some philosophers resist this burden-based defense of Claim 4. David Benatar, for example, argues that this defense is unsatisfactory because "it implies in the absence of this sacrifice we *would* have a duty to bring happy people into existence. In other words, it would be wrong not to create such people if we could create them without great cost to ourselves."⁹ Benatar is right about this implication but wrong to think it problematic. If the ways in which we were born and developed into adults were radically different (such that they did not impose these costs on us), then it's

quite reasonable to suppose that our duties with regard to reproduction and parenting would be very different. Drastically changing a morally salient factor in a particular case will often affect our evaluation of that case. This result should not bother us because all instances of procreation in fact do involve substantial costs that someone must bear.

A further response to Benatar's objection stems from an important observation related to these costs: women typically bear more of the reproductive costs than men. Some of these costs are physical—the result of differences in male and female biology. Others are culturally enforced: women are still generally expected to bear more of the responsibilities of childcare than men in most of the world. Thus, proper concern for gender equity and respect for women's autonomy also generates strong support for Claim 4. An obligation to produce as many happy children as possible would force many women to live lives devoted almost entirely to reproduction; they would lack the freedom to pursue any other ambitions or goals.¹⁰ Such an outcome is morally unacceptable even if the happiness of the children outweighed the suffering and inconvenience of the women who gestated (and likely raised) all these children.

We now see how the Real-World Asymmetry can be vindicated. Claim 3 can be supported by a general duty to avoid causing suffering. Claim 4 can be supported by acknowledging that even though increasing overall happiness is a moral reason to perform an action, other factors—namely, the burdens associated with gestating and raising children and the importance of respecting women's autonomy—outweigh this consideration in the case of reproduction.

However, we should reflect a bit more on the sentiment underlying Benatar's objection. Perhaps the true worry is that intuitively, Real-World Asymmetry is not strong enough to capture our deepest convictions about the ethics of reproduction. Other philosophers have expressed a similar concern. Roberts suggests not only that the Abstract Asymmetry is highly intuitive but also that Claims 1 and 2 might be "important constraints on any adequate moral theory."¹¹ Similarly, McMahan claims that the Abstract Asymmetry is "deeply intuitive and probably impossible to dislodge."¹² Despite these protests, I argue in the next section that the Abstract Asymmetry must be rejected.

6. ABANDONING THE ABSTRACT ASYMMETRY

The primary support for the Abstract Asymmetry is an intuition that some philosophers claim to hold quite deeply. When we consider the details of the Abstract Asymmetry, however, it is difficult to understand why these intuitions are so deeply held. The Abstract Asymmetry is, as I mentioned earlier, a case of procreation in a vacuum. Referring back to Figure 1, worlds w1 and w2 are identical except that Meg exists with -100 welfare in w1 and does not exist in w2, and worlds w3 and w4 are identical except that Hans exists in w4 with +100 welfare and does not exist in w3. Everything else in these worlds remains unaffected by Meg and Hans' existence or nonexistence. Given these idealized circumstances, how could anyone have a clear intuition about what our reproductive obligations are? No

human being has ever witnessed or experienced a case of genuinely costless procreation, so it is neither realistic nor sensible to think that we could have fine-tuned, reliable intuitions about this kind of reproduction. As a result, we should be suspicious of our intuitions about the Abstract Asymmetry and not hesitate to revise them in the presence of a good reason to reject it. Moreover, I believe there is at least one good reason to reject the Abstract Asymmetry.

Claim 2 of the Abstract Asymmetry, which states that there is no obligation to bring Hans into existence, is false because it violates this moral principle:

Goodness for Free: If we can perform an action that causes something good to happen without sacrificing anything at all, we are morally obligated to perform that action.

Since virtually every moral decision we make involves some moral or non-moral costs, this principle is almost never applicable to ordinary moral decisions. However, it is applicable to Claim 2. We can bring Hans into existence at no costs, moral or otherwise, to ourselves or anyone else. Given that Hans would have an extremely happy life, bringing him into existence would be a morally good thing to do. That an action causes something good to happen surely counts as a morally salient reason to perform that action. That reason can be overridden by other considerations (such as the two I mentioned in discussion of Claim 4), but the Abstract Asymmetry is deliberately constructed so as to eliminate all other morally relevant considerations. Thus, defenders of Claim 2 do not have a countervailing reason that they can offer for not bringing Hans into existence. We are left with a morally salient reason to bring Hans into existence and *no reasons at all* not to bring him into existence. Thus, consistent with *Goodness for Free*, we are obligated to bring Hans into existence under the conditions specified by the Abstract Asymmetry.

By abstracting away from the real-world conditions of reproduction, defenders of the Abstract Asymmetry have inadvertently made Claim 2 indefensible. The only apparent support that can be offered for it is an appeal to intuitions, and these intuitions concern a case utterly unfamiliar to us—one far different from ordinary human reproduction. Even assuming that moral intuitions are useful as starting points for ethical inquiry and that they might sometimes serve as appropriate checks on whether a theory generates plausible cases, we cannot rely on moral intuitions alone when we encounter realms of ethical thought that are unfamiliar to us. Our intuitions are clearest and most reliable regarding situations that manifest frequently in the world around us and invite our introspection. But a case of procreation that does not have any impact on anyone else in the world is in no way this kind of scenario. Thus, it is unsurprising that our intuitions about it go awry.

CONCLUSION

I have argued that the Abstract Asymmetry, which has been the subject of much philosophical discussion, should be rejected. Fortunately, there is a less idealized set of claims, which constitute the Real-World Asymmetry, that can be secured rather easily. These claims are sufficient to establish

that, in nearly all cases of ordinary human reproduction, it is wrong to bring a child into existence who would have a miserable life but not obligatory to bring a child into existence who would have a happy life. This Asymmetry is not the one that every philosopher intuitively desires, but it must suffice: its abstract counterpart is indefensible.

NOTES

1. J. McMahan was the first to give this union of claims this title, and most other philosophers have followed his lead when referring to this issue. McMahan, "Problems of Population Choice," *Ethics* 92, no. 1 (1981): 100
2. J. McMahan, "Asymmetries in the Morality of Causing People to Exist," in *Harming Future Persons*, eds. M. Roberts and D. Wasserman (Dordrecht: Springer, 2009): 49–68; I. Persson, "Rights and Asymmetry Between Creating Good and Bad Lives," in *Harming Future Persons*, 29–47; P. Singer, *Practical Ethics*, second edition (Cambridge: Cambridge University Press, 1993).
3. D. Benatar, *Better Never to Have Been* (Oxford: Clarendon, 2006), esp. pp. 32–34; Roberts 2011b; M. A. Roberts, "The Asymmetry: A Solution," *Theoria* 77, no. 4 (2011b): 333–67.
4. Melinda Roberts, "An Asymmetry in the Ethics of Procreation," *Philosophy Compass* 6, no. 11 (2011a): 765.
5. This graph is adapted from Roberts, "An Asymmetry in the Ethics of Procreation," 766; Roberts, "The Asymmetry: A Solution," 345. She assumes that we can compare the welfare of those who exist with those who do not exist and represents nonexistence with a welfare level of 0. This claim is controversial (Feldman 1991, Holtug 2001, Roberts 2003), but for the purposes of graphing the asymmetry, I consider it an acceptable assumption.
6. Melinda Roberts presented the choice to bring Hans into existence in this manner when she discussed the Asymmetry during an invited lecture at the University of Tennessee.
7. A duty to procreate might not be limited to such extreme scenarios. Saul Smilansky ("Is There a Moral Obligation to Have Children?" *Journal of Applied Philosophy* 12, no. 1 [1995]: 46–48) offers eight distinct reasons that might give rise to an obligation to procreate.
8. Judith Thompson, "A Defense of Abortion," *Philosophy and Public Affairs* 1, no. 1 (1971): 48–49.
9. Benatar, *Better Never to Have Been*, 33.
10. C. Overall, *Why Have Children?* (Cambridge, MA: MIT Press, 2012), 73–75.
11. Roberts, "The Asymmetry: A Solution," 2.
12. J. McMahan *The Ethics of Killing: Problems at the Margins of Life* (New York: Oxford University Press, 2002), 300.

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Response to Hedberg

Dana Howard

THE NATIONAL INSTITUTES OF HEALTH

In "Unraveling the Asymmetry in Procreative Ethics," Mr. Hedberg asks us to check our intuitions. Trevor argues that

By abstracting away from the real-world conditions of reproduction, defenders of the Abstract Asymmetry have inadvertently made Claim 2 indefensible. The only apparent support that can be offered for it is an appeal to intuitions, and these intuitions concern a case utterly unfamiliar to us—one far different from ordinary human reproduction. Even assuming that moral intuitions are useful as starting points for ethical inquiry and that they might sometimes serve as appropriate checks on whether a theory generates plausible cases, we cannot rely on moral intuitions alone when we encounter realms of ethical thought that are unfamiliar to us.

I find this claim to be deeply compelling but also provocative. If this claim were true, I worry for the possibility of philosophy. And yet I find myself often dismissing some of these more outlandish cases precisely because I implicitly share Mr. Hedberg's skepticism about the relevance of our philosophical intuitions on the matter. So in this response, I am going to present some ways to put pressure on this idea that we can't trust our intuitions about some of these more outlandish cases.

First, I should note that *Goodness for Free*—the principle that undermines Claim 2—seems to rely on our intuitions in the very same sort of way that the Abstract Asymmetry did. According to *Goodness for Free*:

Goodness for Free: If we can perform an action that causes something good to happen without sacrificing anything at all, we are morally obligated to perform that action.

But as Mr. Hedberg notes, "this principle is almost never applicable to ordinary moral decisions." This seems right. So we should ask, according to Trevor's logic, whether we should be suspicious about our intuitions about such a principle that really only applies in the realms of ethical thought that are unfamiliar to us. After all, if *Goodness for Free* were to actually be relevant for Claim 2, it must imply the following principle:

Non-Person Affecting Goodness for Free: If we can perform an action that causes something good to happen—but not good for anyone who would otherwise exist—without sacrificing anything at all, we are morally obligated to perform that action.

I think that our intuitions about *Goodness for Free* generally come from the sense that when we can cause something good to happen at little sacrifice to ourselves, this good is for someone else. We are therefore depriving someone (or at least some sentient being) of some good that we could have easily provided for them. But if the good is for someone that doesn't exist and wouldn't exist if not for the specific deed in question, I am not so sure that we do owe this possible patient of our good action any doings on our part. In this sense, I am not so sure that *Non-Person Affecting Goodness for Free* is a tenable moral principle. But, moreover, I am not so sure how we can think of it as a "plausible moral principle" if its plausibility relies on our intuitions about cases utterly foreign to our deliberation.

This is not exactly an argument against the principle *Goodness for Free*, but it does highlight the ubiquity of how our intuitions about "outlandish cases" have a grip on us. I invite Mr. Hedberg to further examine how and when our intuitions are reliable, and how and when they are suspect.

For instance, how should we approach our intuitions about less outlandish cases? With suspicion or with open-mindedness? When is a case sufficiently different from our own that we should start being suspicious of it? Mr. Hedberg argues that the Abstract Asymmetry relies on the case of "genuinely costless procreation"—a scenario that is so foreign from our own that it warrants our suspicion of our intuitions surrounding the case. But there do seem to be some ways that we should be allowed to idealize our current situation to determine which of our intuitions are based on the moral implications constitutive of procreation and which of our intuitions are based on the implications of living in an unjust society. So rather than contrast the Real World Asymmetry case against the case of "genuinely costless procreation," it may be fruitful to contrast Real World Asymmetry case against the case of "cost neutral procreation."

I submit to you the following world: Procreative technologies have advanced to the point that both men and women can carry a fetus to term (not such a distant possibility, given the fact that uterine transplants have already generated living babies). Second, less realistically yet, but still on the horizon, a world in which our culturally enforced norms have shifted so as to equalize the burden of childrearing to both men and women. This likely will be in large part due to an effort to minimize the personal burdens that any individual must bear in order to bring a happy person into the world: imagine universal daycare and healthcare, generous parental leave policies, easy adoption/foster care policies that minimize the stigma of bearing children that one doesn't plan to raise, etc. In such a world, remote yet possible, we can imagine bringing a child into the world would carry net neutral value of burdens and benefits. After all, parenting does seem to be a rewarding experience for many. In such a world, procreation would not be costless,

but it would be plausibly cost neutral. Moreover, in such a world, women would not be the ones bearing the brunt of the burden.

My intuitions about such a world are that the Asymmetry still stands. We have a moral obligation to not bring a miserable child into the world, but NOT a moral obligation to bring happy children into the world. Given my intuitions about this case, I find the following moral view compelling: It is relatively easy to deny that the "creation of a person with a happy life is a morally good thing." Rather, I think the more intuitive principle is that "for the people that we do create, it is a morally good thing to make their life a happy life." Bringing happy people into the world is morally neither here nor there. I don't know if I should trust my intuitions about this case. Are the circumstances of the case so different from ours that we should not turn to our intuitions on the matter? If no, why not? How is the case of cost-neutral procreation normatively different from the case of "genuinely costless procreation"?

This leads me to the final set of questions about the role of intuitions and outlandish hypothetical cases in our philosophical thinking. Why do we even consider our intuitions about these outlandish cases in the first place? There seem to be at least two related purposes: (1) We come up with these cases in order to isolate our intuitions about the morally salient features of a question rather than being distracted by the noise introduced by any real-world situation. Mr. Hedberg is right to highlight the limitations of such a function. Often philosophers fetishize these outlandish cases, thinking there is some interesting truth about them absent what they can teach us about our own ethically messy world. (2) We come up with these cases in order to shake us out of our ossified ways of thinking when it comes to certain partisan debates. What we think are pre-theoretical intuitions about a case may actually already be shaped by the evaluative commitments and biases that have developed as a result of living in this unjust world.

Take J.J. Thompson's violinist case. This is a powerful thought experiment, and our intuitions about it matter because the case allows us to shed some of our motivated thinking about the highly contentious and partisan debate surrounding abortion. Everyone thought that all the ethical action was located in the question of the moral status of the fetus. It is hard to disassociate one's intuitions as to whether a fetus is a person or not from one's moral commitments about whether a woman has a right to an abortion. What the outlandish case of the dependent violinist does is to momentarily lower the ethical stakes of our thinking. Once the real-world implications of our philosophical thinking are not so evident, we have the capacity to be more open to where our reasoning will lead us. And our conclusions may surprise us when we return to their implications for our world. If we can only trust our intuitions about cases that are markedly similar to our actual world, we have no way for our philosophical thinking to transcend what we already think we know.

Given all this, I wonder if we should be so quick to reject our intuitions about the Abstract Asymmetry. I share Mr. Hedberg's sense that there is something wrong with

how it idealizes away certain ethically salient features of procreation, but it doesn't seem that its general unfamiliarity is what warrants our distrust.

Moral Heroism, Living Organ Donation, and the Problem of Winning by Donating

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I. INTRODUCTION

Living organ donors frequently describe their donations as constituting a tremendous opportunity, and the experience of donating as especially beneficial—for them. It is a commonplace in testimonies from living donors that the act of donating is described as “a euphoric and rewarding event,” as “wonderful and rewarding,” that to have the chance to donate is to be “blessed,” that the scars from the surgery “bring joy to [the donor’s] heart,” and even that “[p]eople who haven’t done it [donated] . . . don’t know what they’re missing!”¹ Living donors say, consistently, that donating “gives [the donor] satisfaction and has enriched [her] life.”² Consider one more example:

Personally I just feel very honored to have been able and allowed to do this for my friend . . . I wish I as a donor could explain my feelings regarding donation in such a way that people could comprehend **the incredible gift I walked away with. PRICELESS!** (formatting original)³

I will call what is expressed here the *winning by donating* claim: the donor’s welfare is often (strikingly) advanced by the act of donating. My focus here will be on how the *winning by donating* claim complicates our understanding of living organ donation as an instance of special moral achievement. It would be odd to persist with the very common way of addressing living organ donors as heroes⁴ if their acts of donating were just surprising, indirect ways of advancing their own welfare.

Initially, the case for such praise is pretty compelling. It’s well known that a shortfall in supply of suitable organs contributes to the preventable deaths of thousands of people each year.⁵ The only presently available means of combating this ongoing tragedy is organ donation.⁶ Living donors are the front line of resistance against this creeping moral disaster, giving kidneys, liver lobes, and lung lobes, filling a desperate need with each donation. Anonymous living donations of both the directed and nondirected sort appear to be especially good candidates for moral achievement, and in a context of great and unrelenting need, it doesn’t seem inappropriate to call such actions morally heroic. The *winning by donating* claim appears in testimonies that span the various kinds of living donations.

Moral exemplars have had a steady presence in moral theory, yet rather little care has been taken to distinguish

among types of moral achievement. In what follows, I’ll first develop an account of moral heroism that distinguishes it from nearby kinds of moral achievement, such that acts of living organ donation are possible instances of moral heroism. I’ll then argue that it is not incompatible with that account of moral heroism that the hero should benefit from the heroic act under certain conditions. Since moral heroism is, as I’ll argue, principally characterized by actions that constitute significant sacrifices, and since donating an organ while alive seems a paradigmatic sacrifice, this is initially plausible. But the *winning by donating* claim is a problem here, since it reveals a striking way in which the donor benefits, in which case it’s less clear that any sacrifice is actually being made.

II. WHAT IS MORAL HEROISM?

The first distinction I draw is between the qualities of the act itself and how the act is received, or what effects the act has on others. This is to distinguish *being a hero* from *being someone’s hero*. The latter embodies what we might call a relational view of heroism. The focus of the relational view is less on the hero or the heroic act itself than it is on the reception or construction of heroism by the rest of us.⁷ The relational view responds to an important dimension of inquiry regarding heroes: How do we create, mythologize, and respond to them? The view captures one side of a distinction I want to draw between what we might call personal heroes and moral heroes. *Being someone’s hero* is different than doing something morally heroic. When asked to identify their heroes, many people mention family members.⁸ This seems to reflect a relational status that obtains between the survey respondent and her family member, namely, that the former was a role model who inspired and spurred the respondent on in some way. But this result is plainly compatible with the idea that the cited family members have not done anything morally heroic. Being a good parent is obviously a worthwhile and challenging feat, but it is doubtful whether, even on their best days, good parents should be considered moral heroes. The suggestion is that heroism as a species of moral achievement has a lot more to do with the nature of the act than with the way others receive the act. The isolated moral hero is no less heroic than one that happens to have an adoring audience, and being a moral hero is compatible with failing to be anyone’s personal hero.

The way Michael Jordan is a hero to many is through his excellent displays of awesome competence in a skillful domain (playing basketball).⁹ I won’t insist that this is the basis for a hard and fast distinction, but the idea is that what makes an agent eligible to be someone’s hero is often her outstanding competence. Moral heroes, as opposed to personal heroes, are probably not aptly characterized this way. What we need now is a general way of characterizing the kind of actions that are the basis of moral heroism that would further distinguish it from personal heroism. This is the first of two tasks I propose for a general characterization of moral heroism.

Here is the second task that a general characterization of moral heroism should be up to: it should position us to distinguish moral heroism from other kinds of moral achievement. Much of the discussion in the literature is

inattentive to the (as I think) rather obvious fact that most moral heroes are, despite their heroism, not morally perfect people, or anything close.¹⁰ Moral heroes needn't aspire to a more morally excelling life outside a single morally heroic act in order to be properly considered heroes: heroes aren't saints, generally speaking. Yet moral heroes are also to be distinguished from ordinary altruists—helpful, generous people performing quotidian acts of good will. Despite the fact that these kinds of moral achievement are different, they are, one suspects, not unrelated. A general characterization of moral heroism should account for differences among them but also position us to make sense of each of them as a variety of moral achievement.

J. O. Urmson offers an account of moral heroism hinging on a notion of overcoming fear and attachment to self-preservation.¹¹ Resisting fear—of bodily harm and death, among other things—is surely an important element in many acts of heroism. But as a general characterization of moral heroism, it struggles with each of the two tasks I have set. First, it doesn't help distinguish personal heroism from moral heroism. Michael Jordan may well have overcome a lot of difficulty, having quelled a powerful fear of failure or injury, for example. Someone who overcomes a crippling fear of spiders to succeed in sustaining a family pest extermination business may well be—for precisely that reason—a personal hero to other family members. Yet she doesn't, for that reason alone, look like a moral hero.

Urmson's account runs into similar problems with respect to the second task as well. Here the more general idea of moral achievement is overcoming—saints are to be distinguished from heroes in terms of what they overcome. Whereas heroes overcome fear, saints overcome self-interest.¹² Ordinary altruists, we may surmise, overcome self-interest as well, only to lesser degrees. This account is at once too narrow and too broad, and as such fails as an account of moral heroism within a broader category of moral achievement. It's too narrow in that there are moral heroes who don't overcome fear. Indeed, many moral heroes act in such exigent circumstances that there is no time to feel fear, much less feel it and then overcome it.¹³ More reflectively, it's not clear why overcoming fear should be thought a hallmark of moral heroism. Should we find our rescuers were not afraid, this seems not to impugn the heroic quality of their act.¹⁴ On the other hand, some organ donors overcome a fear of needles and painful surgery to go through with their donation.¹⁵ To attribute moral heroism to them for this reason is, I suggest, to miss the point.

The account is also too broad in that plenty of people overcome fears in ways that totally fail to resemble moral heroism, such as the arachnophobe described above. Overcoming obstacles is an important dimension in our practices of allocating praise and dispensing admiration, but it isn't the right rubric for distinguishing among kinds of moral achievement.

The insight captured by Urmson is that the heroic action isn't without downside, and perhaps that heroism is relatively rare for reasons that are readily understandable and durable. Instead of focusing on fear as a typical reaction to the downside (which might be grave bodily harm or death,

after all), the proper emphasis is on the downside itself. Moral heroism consists, in the first instance, in embracing the downside so that someone else might be free of it or some other undesirable state of affairs. This is to say that moral heroism is characterized by *sacrificing for others*. Though I cannot argue for it here, I think the best view of what sacrificing is entails an objective hardship that is also experienced as such.¹⁶ What it means to sacrifice, on this view, is to choose against one's own welfare where an alternative is available such that one suffers some objective diminution in welfare and experiences hardship as a result. Insofar as we are truly indifferent to forfeitures we make, those forfeitures will not look much like genuine sacrifices. And insofar as we fail to actually forfeit some good, experiences of hardship will similarly fail to instantiate sacrificing. This way of analyzing moral heroism is able to account for the kind of overcoming Urmson rightly points to.

Whatever Michael Jordan's virtues, sacrificing for others is a plausible way to distinguish his brand of heroism from moral heroism.¹⁷ It also puts us in a much better position to distinguish heroism from saintliness and ordinary altruism while making all three intelligible as kinds of moral achievement—all three feature sacrifices, but of different kinds. It's not quite so simple as placing them on a scale of lesser to greater, for heroes sometimes make great sacrifices without thereby becoming saints. So the question of what makes some sacrifices saintly, some altruistic, and still others heroic is a complicated one. It seems the distinction between (mere) altruists and moral heroes might be captured largely in terms of the value of what's given up in sacrificing, with heroic sacrifice being across some threshold of seriousness from the lesser sacrifices of altruists who give their time, money, labor, etc.¹⁸ On the other hand, the distinction between saints and moral heroes seems more complex. Saintly sacrifice is typically all-encompassing, pervading every aspect of an agent's life and identity, such that the life of the saint is in no small degree characterized by service to the chosen ideal.¹⁹ Heroic sacrifice tends to come in the service of a particular end that is more completely realized by the act of sacrificing.²⁰

On this view of moral heroism, living organ donors seem to be good candidates: they sacrifice their comfort, safety (to whatever extent there are risks involved in surgery and subsequently living without whatever they donate), time and wellness (for a time), and either part of a vital organ or the whole thing in order to spare someone else ongoing illness, burdensome treatment, and death. But the *winning by donating* claim threatens this implication, inasmuch as it suggests that what's been done has not been a sacrifice at all. To sacrifice is to choose to lose where one might have won instead—so if donors come out ahead, it's not clear how their actions could actually constitute sacrifices, and so only less clear how they could be morally heroic.

III. HEROIC SACRIFICE AND WINNING BY DONATING

If all we knew about a recent choice someone made was what we are told in the *winning by donating* claim, we would surely not be tempted by the conclusion that what had been done constituted a sacrifice. So now we must

ask whether it is possible for an act that produces great benefits for the agent to nonetheless constitute a sacrifice on the part of that same agent.²¹

The most promising suggestion here is that if the winning and losing take place in quite distinct dimensions of well-being, then you could lose even while you also win. This way of handling the *winning by donating* claim relies on something that initially looks like incommensurability (the impossibility of precise comparison by measurement in a single unit) or incomparability (the impossibility of ordinal ranking)²² of values in different dimensions of well-being. But what is directly at issue here is not incommensurability or incomparability, but instead, as Vanessa Carbonell has argued, the idea that “gains and losses from different sources of wellbeing can *compensate* for one another.”²³ I call the denial of this claim the *non-compensation hypothesis*, and it is a weaker claim than incommensurability and incomparability: even if gains and losses in distinct dimensions of well-being are commensurable and comparable, they could still be non-compensating. Whether non-compensation characterizes the relation between a gain and a loss depends on how they interact, and in particular on whether the former makes up for the latter.

Consider a case where compensation is an apt way to characterize the relation between a gain and a loss. Suppose you give a stranger \$10, assuming that is the end of the matter. But, contrary to your expectations, the stranger shows up the next day and gives you a \$15 gift card to your favorite store. The loss you incurred has been made up for (and possibly more).²⁴ In a quite straightforward sense, the act of giving the stranger the \$10 has been worthwhile, independently of whatever positive feeling you derived from giving.

The benefits described in the *winning by donating* claim don’t have the effect of making up for the loss of what the donor gives up. In the first place, the gains and losses occur in quite different dimensions of well-being. As a way of capturing the dramatic terms in which the benefits of donating are described in the various instances of the *winning by donating* claim, it would not be unfair to say that the gains are largely comprised of meaningfulness.²⁵ Susan Wolf gives an example of a woman who has experienced a great deal of hardship in being a parent to her child.²⁶ Faced with the question of whether she considers herself to be all-things-considered better off for having adopted the child, Wolf surmises she might not even care whether she is or isn’t—the fact she finds being a parent to this child meaningful is an independent source of reasons to endorse the choice. Wolf’s arguments include a number of commitments I needn’t take on to make my point here. The claim I wish to make is in support of the *non-compensation hypothesis*. The meaning a parent derives from being a parent doesn’t have the effect of making up for all the hardship parenting undoubtedly entails. It instead transforms the hardship by recruiting it to a meaningful enterprise. When parents or living organ donors say of the hardships they’ve borne that they were all worth it and they would make the same choices again, we should understand them not to mean that there is some bottom line on which

by their own lights they’ve come out ahead in the end. Instead, what is meant is that they found the sacrifices worthwhile, the hardship was not in vain. I propose we say of some losses not that they are compensated for by later benefits they bring, but that they are vindicated.²⁷

Donating an organ provides donors with meaning, and this kind of benefit interacts with losses not by compensating for them, but by transforming them. Their scars, still a source of physical discomfort in some cases long after the surgery is over, become a source of joy and pride precisely through the worthwhile suffering they represent because of how that hardship became part of a meaningful endeavor. When the benefit a sacrificing agent derives from her sacrifice is that it contributes to making her life meaningful, this way of winning does not compensate for a donor’s losses, but it might vindicate them. We might consider this point an amendment to Victor Frankl: “In some way, suffering ceases to be suffering at the moment it finds a meaning, such as the meaning of a sacrifice.”²⁸ To vindicate hardship through producing meaning, we might say, is to transform it—but not to erase it.

Many sacrifices can turn into what we might be tempted to see as winning propositions in this fashion—sacrificing is, as an act type, a singularly important way in which we express what really matters to us and what provides us with meaning in our lives. To be associated with others for whom one is willing to sacrifice, to have convictions that beckon sacrifices—these are important avenues of generating meaning.²⁹ But the achievement of meaning should not fool us into overlooking the lasting and uncompensated nature of the hardships endured and experienced. This is to say that the significant benefits the *winning by donating* claim picks out are compatible with viewing the act of donation as a sacrifice, even a heroic one.

NOTES

1. These are all direct quotes from different donors. See K. A. Bramstedt and R. Down, *The Organ Donor Experience* (Lanham, MD: Rowman and Littlefield, 2011), pages 53, 44, 64, 126, and 84, respectively.
2. Massey, et al. (2010), p. 1448.
3. *Living Donors Online Message Board*.
4. See, for example, www.beaherobecomeadonor.org
5. Since 1995 about 70,000 people have been removed from the waiting list in the United States for kidneys for the simple reason that they died. An additional 25,000 have been removed from the list over that same interval for the similarly unwelcome reason that they became too irreversibly sick to transplant. Early in 2014 the waiting list for kidneys crested 100,000 patients; many of them will make it off of the list only through worsening illness or death. (All data are from the Organ Procurement and Transplantation Network.)
6. That might change through technological innovation, such as xenotransplantation or bioprinting. It could also change if policies made a kidney market possible (only in Iran are such policies in place at present). Neither development seems terribly likely to help in the near term.
7. See S. T. Allison, and G. R. Goethals, *Heroes: What They Do and Why We Need Them* (New York, NY: Oxford University Press, 2011), for a developed view of this kind.
8. See *ibid.*, p. 26, for the results of one survey.
9. Michael Jordan is still often cited as a hero by survey respondents asked to identify their own heroes. *Ibid.*

10. Oskar Schindler is probably a good example of a moral hero whose moral career was nonetheless a decidedly mixed affair. See D. Furrow, "Schindler's Compulsion: An Essay on Practical Necessity," *American Philosophical Quarterly* 35, no. 3 (1998): 209–29.
11. J. Urmson, "Saints and Heroes," in *Essays in Moral Philosophy*, ed. A. Melden, 196–216 (Seattle: University of Washington Press, 1958). See pp. 200–201.
12. *Ibid.*
13. Urmson's account includes a reference to a standard fear that most people would not overcome. I object to this account based on the idea that fear is not a necessary condition of moral heroism. The presence of the standard doesn't improve matters since if there is no fear, then there is no overcoming of fear.
14. Some living organ donors explicitly disavow feeling fear ahead of surgery. See Bramstedt & Down (2011), p. 54, for example.
15. See Bramstedt and Down, *The Organ Donor Experience*, ch. 3, for example.
16. Some other features of paradigmatic sacrifice I argue for elsewhere (in a yet-to-be-published manuscript—sorry!) concern the voluntariness of the act, the motive and guiding intention, and the lack of regard for future reciprocity. Cf. V. Carbonell, "The Ratcheting-Up Effect," *Pacific Philosophical Quarterly* 93 (2012): 228–54; M. C. Overvold, "Self-interest and the Concept of Self-sacrifice," *Canadian Journal of Philosophy X*, no. 1 (1980): 105–18.
17. A family member who is a personal hero isn't heroic in that she sacrifices for others, *per se*, but in that she sacrifices for the particular person to whom she is a hero. The utterance "You're my hero" we should therefore expect to come in response to a display of awesome competence or a directed way of benefitting the speaker. We should not necessarily endorse the utterance "You're a moral hero" in response to those same phenomena.
18. See C. S. Rosati, "Self-Interest and Self-Sacrifice," *Proceedings of the Aristotelian Society* 109 (2009): 311–25, for a plausible beginning of such an account. She posits "life, limbs and loves" as objects of sacrifice that would constitute "self-sacrifice." In her terminology, we could then say that self-sacrifice is morally heroic.
19. See Carbonell, "The Ratcheting-Up Effect," for a recent account.
20. One way this distinction shows up in something like this form in the literature is in connection with two different ways in which a moral duty might be thought excessively demanding. On the one hand, there is a worry that moral duties become so encompassing that they exclude other important values (see S. Wolf, "Moral Saints," *Journal of Philosophy* 79 [1982]: 419–39). On the other hand, there is the worry that an emerging circumstance could require me to immediately surrender everything, including my life (See P. Unger, *Living High and Letting Die* (New York: Oxford University Press, 1996)).
21. A possible answer might come from what is perhaps the most prominent contemporary view of moral heroism. Philip Zimbardo (*The Lucifer Effect* [New York, NY: Random House, 2007], p. 466) adduces, as one of four distinguishing features of moral heroism, a necessary condition that the act "must be without secondary, extrinsic gain anticipated at the time of the act." Zimbardo's account allows a kind of benefit: unanticipated gains. So as long as the agent wasn't in a position to anticipate the benefits of her action, even if she did ultimately benefit from acting, it might still be true that her action was a sacrifice. Of course, "anticipated" is problematically ambiguous. It might mean merely foreseen, or it could mean something more closely connected to motivation, like "eagerly awaited." The closer to infiltrating an agent's motivations the putative benefits get, the more difficult it will be to see what the agent is doing as making a sacrifice. Instead, it will seem that she is taking an unusual or unfortunate path to doing what is best for her. It is quite plausible that mere awareness of possible benefits is compatible with performing an act that is, despite that awareness and despite the benefits, a sacrifice. In screening potential donors, social workers, psychiatrists, and clinical ethicists are looking for more than just an awareness of possible secondary benefits. Instead, they are screening for something more like motivational attachment to such benefits (see Reichman et al., "Anonymous Living Liver Donation: Donor Profiles and Outcomes," *American Journal of Transplantation* 10, no. 9 [2010]: 2100). But merely anticipated benefits to the agent could be so great ("PRICELESS") and the hardship borne so slight that we would be little tempted to say of the act that it was a sacrifice. Imagine giving a dollar to charity, knowing that doing so enters you into a drawing for an amazing vacation, and that you win the vacation and go on it and meet the love of your life. Even if none of the possible benefits informed the motivational structure of your act of giving a dollar, the outsized way in which doing it benefited you undercuts any sense in which it was a sacrifice to do as you did. And it is also true that part of the point of living donor testimonies like those I have cited is not simply to make people aware of how donating actually benefits donors, but to motivate them to donate. So we need to look elsewhere for a more compelling affirmative response to our question.
22. See R. Chang, "Introduction," in *Incommensurability, Incomparability, and Practical Reason*, ed. R. Chang, 1–34 (Cambridge: Harvard University Press, 1998). I note that these terms are not used uniformly with the meanings I stipulate above.
23. Carbonell, "The Ratcheting-Up Effect," 237.
24. For this example to work, we should assume no hardship in the interim due to the lack of \$10.
25. Susan Wolf (*Meaning in Life and Why It Matters*) argues that meaning is not only a distinctive dimension of well-being and value but also a historically overlooked variety of motive, to be contrasted with the more historically influential categories of self-interest and morality. Neera Badhwar ("Altruism Versus Self-Interest: Sometimes a False Dichotomy," in *Altruism*, ed. E. F. Paul, F. D. Miller Jr., and J. Paul, 90–117 [Cambridge: Cambridge University Press, 1993] makes a related point in arguing that self-affirmation through acting in ways that sustain values one identifies with can be simultaneously self-interested (because they serve an interest in affirming one's sense of oneself) and altruistic (because what one values often directs the action to promoting the interests of others). What Badhwar calls self-affirmation would often enough go by "meaningfulness" instead.
26. Wolf, *Meaning in Life and Why It Matters*, 53.
27. Cf. Douglas Portmore, "Welfare, Achievement, and Self-Sacrifice," *Journal of Ethics and Social Philosophy* 2, no. 2 [2007]: 1–28, where he speaks of "redeeming" sacrifices (fn. 26).
28. Victor Frankl, *Man's Search for Meaning* (Boston, MA: Beacon Press, 2006), 113.
29. Speaking of sacrifice this way is echoed in descriptions characterizing sacrifice as a species of self-transcendence. Cf. M. Halbertal, *An Essay on Sacrifice* (Princeton: Princeton University Press, 2012).

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Heroism, Meaning, and Organ Donation: A Reply to Fruh

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Kyle Fruh presents us with a perplexing difficulty: If many living organ donors describe their experience as deeply rewarding—and so as advancing their own welfare—how can it simultaneously be the case that their actions are accurately described as "morally heroic"? More specifically, if donors benefit substantially from the act of donating, then isn't the element of significant sacrifice, traditionally required for this kind of special moral achievement, thereby eliminated? Aren't we left with a situation in which donating an organ advances the interests of the *donor* in such a way, and to such an extent, that it no longer appears to be a sacrifice? I agree with Fruh that there is something extremely counterintuitive about this way of talking about organ donors, and so an alternative account of this phenomenon is certainly needed.

Fruh attempts to resolve this difficulty by suggesting "that it is not incompatible with . . . moral heroism that the hero should benefit from the heroic act under certain conditions" (p. 23). On his view, a moral hero ought to be distinguished from both a "personal hero" and an "ordinary altruist." Personal heroes are those people who someone admires for her "outstanding competence" in a particular domain, such as sports or music or parenthood (p. 23). A moral hero does not need to be someone's hero in this way

for her to be properly characterized as "heroic." Indeed, Fruh astutely observes that someone can perform a morally heroic act in isolation.

By contrast, ordinary altruists seem to have something in common with moral heroes, namely, that they perform acts of a sort that count as specifically *moral* achievements. Fruh describes ordinary altruists as "helpful, generous people performing quotidian acts of good will" (p. 23). Like moral heroes, ordinary altruists (1) are not saints (in that they may have committed immoral acts in the past), and (2) perform other-interested acts. However, the acts of ordinary altruists don't place particularly onerous burdens on them, whereas moral heroes make quite serious sacrifices. Moral heroes undertake actions in which they forfeit some significant good for themselves (comfort, safety, time, wellness) in order that someone else may be made better off. Further, the sacrifices made by moral heroes entail "objective hardship[s] that [are] also experienced as such" (p. 24). This means that for an act to be an act of moral heroism, the person performing it must *feel* that she is enduring a hardship. Losses or forfeitures of one kind or another that the agent does not experience as bad for her therefore don't count as sacrifices on this view.

Having provided us with this background, Fruh proceeds to explain just how it is that an organ donor can be understood as both morally heroic (as having made a serious sacrifice constituted by the experience of hardship) and as having had a rewarding donation experience. He does this by making three main claims. First, he notes that "if the winning and losing take place in quite distinct dimensions of well-being, then you could lose even while you also win" (p. 24). Secondly, he argues that at least in some cases, gains in one dimension of well-being do not compensate for losses in another dimension. Finally, he claims that organ donors forfeit a measure of well-being by undergoing hardships such as the pain, discomfort, fear, and recovery time that organ donation requires. This forfeiture constitutes the sacrifice that makes their acts morally heroic, but the act of donating *also* provides them with a boost in the separate dimension of well-being associated with meaningfulness. This resolves the apparent difficulty with characterizing organ donors as moral heroes when they claim to have benefited from the experience of donating their organ. The gains they received are not able to make up for the sacrifices they made, even though both the gains and losses are equally real, and tied to the same act. Fruh explains that "to *vindicate* hardship through producing meaning, we might say, is to transform it—but not to erase it" (my italics, p. 25).

I have two main worries about this account. My first worry is connected to a very different view of what it means to be an organ donor as it is characterized in the literature on effective altruism. My second worry concerns the account of well-being that grounds Fruh's view.

In *The Most Good You Can Do*, Peter Singer describes two people who opted to become anonymous kidney donors. Their donations were non-directed, so they had no idea who would benefit from their kidneys. One of the donors, Zell Kravinsky, comments that "the reason many people didn't

understand his desire to donate a kidney is that 'they don't understand math'.¹ Singer explains that what Kravinsky meant "is that they did not understand that, because the risk of dying as a result of donating a kidney is only one in four thousand, not to donate a kidney to someone in need is to value one's own life at four thousand times that of a stranger."² Since most people don't think their lives are four thousand times more valuable than anyone else's, it is simply logical to become a donor.

The other donor, Chris Croy, asserts that

I don't think what I did was all that good. . . . GiveWell.org (a non-profit that advises philanthropists on how to most effectively allocate their money) says it costs about \$2,500 to save a human life, so as far as I am concerned giving \$5,000 to anti-malaria efforts is a greater deed [than donating a single kidney].³

Neither of these donors seems to regard what he did as heroic. On the contrary, they seem to suggest that the risks and inconveniences they undertook were quite insignificant relative to the benefits that would accrue to someone else. Granted, the risks and hardships were no doubt more extensive than most people are willing to undergo for a stranger, but perhaps the point here is that what matters is the *relationship* between the sacrifice and the payoff, rather than simply the size of the sacrifice. This conflicts with Fruh's claim that "it seems the distinction between (mere) altruists and moral heroes might be captured largely in terms of the value of what's given up in sacrificing, with heroic sacrifice being across some threshold of seriousness from the lesser sacrifices of altruists who give their time, money, labor, etc." (p. 24). By contrast, the donors Singer discusses seem to imply that what is required by moral duty—as opposed to what is heroic or supererogatory—depends on the size of the costs to the donor in relation to the size of the payoff to the recipient. Indeed, if we understand what it means for an act to be "vindicated" in terms of whether or not it is "justified" or "warranted," then we can claim that their donations were vindicated because taking in the interests of all affected, their acts were utility maximizing.

This way of looking at organ donation need not explain such acts in terms of meaningfulness gains at all. Instead we might think that when organ donors describe their experience as having been enriching or rewarding, what they mean is just that they are satisfied with having done their moral duty. On this type of view, such satisfaction is hardly surprising since most of us don't perform our moral duties on a very regular basis. Further, on this account organ donors aren't moral heroes at all. They are merely doing what is required of them while the rest of us are not. Finally, with a utilitarian framework in the background, there is not even any real puzzle to be solved here, since it is perfectly normal for the morally correct act to have both costs and benefits for the agent while also having benefits for others such that overall the act ends up maximizing utility. This also makes sense of the notion that the hardships donors endured were "not in vain" (p. 25).

This brings me to my other worry. I am not altogether persuaded that meaningfulness is a dimension of well-being that is distinct from other dimensions in the way suggested by Fruh's account. His view, as I understand it, relies on the idea that meaningfulness is a source of benefits or a dimension of well-being sufficiently distinct from other dimensions of well-being, such as freedom from physical pain, that there can be discrete, non-compensating simultaneous gains in the former and losses in the latter. This picture suggests to me that meaningfulness is something that can be somehow detached from other elements of well-being. For instance, on this model it seems like someone could have a very good—but meaningless—life, if all other dimensions of well-being were present at a very high level. Or someone could be undergoing unbearable torture but refuse to betray her country, and so she could have a high level of well-being *qua* meaningfulness but in all other respects be in a completely miserable state. I think it is counterintuitive to say in the first case that the person has a genuinely good life. It also seems wrong to describe the second case as one in which some element of her *well-being* has been preserved, regardless of what other admirable characteristics she may be demonstrating.

These examples suggest to me that meaningfulness is not the kind of thing that should be understood as a dimension of well-being, or source of "benefits" or "gains" at all. Rather, meaningfulness should be understood as a feature of other acts or behaviors or relationships, which themselves may either detract from, or increase, my overall well-being. Take Susan Wolf's example of the parent who "doesn't care" whether she is or isn't better off—all things considered—from having adopted a child. Fruh explains this by saying that "the fact she finds being a parent to this child meaningful is an independent source of reasons to endorse the choice" and so the hardships involved in it are transformed "by recruiting [them] to a meaningful enterprise" (p. 25). But I don't think the hardships are transformed at all. It is just as possible that the hardships detract from her overall well-being. The meaningfulness of being a parent is not a gain she makes in well-being at all, but just an aspect of an enterprise that is worthwhile for reasons entirely independent of her own well-being. These could be reasons of principle, for instance, or else reasons grounded in the well-being of others. All that is needed here is a conception in which there are multiple sources of value—with well-being as only one of them. These other sources could give me (sometimes decisive) reasons to do things that are unrelated to, or that considerably detract from, my own well-being. This suggests that when organ donors describe themselves as having been enriched by the act of donating, their acts are best understood not as characterized by losses in one dimension of well-being and gains in another, but rather as acts that were worth doing but that nevertheless made them worse off.

NOTES

1. Peter Singer, *The Most Good You Can Do* (New Haven: Yale University Press, 2015), 87.
2. *Ibid.*
3. *Ibid.*, 70.

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BOOK REVIEW

Dr. Susan Love’s Breast Book, Sixth Edition

Susan M. Love, M.D., with Karen Lindsey and Elizabeth Love (Boston: Da Capo Press, 2015).

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If you have had breast cancer, or if you have ever wanted detailed information about it, you may well have encountered previous editions of *Dr. Susan Love’s Breast Book*. Hailed by *The New York Times* as “the bible for women with breast cancer”¹ and thoroughly updated every five years, the book is an unparalleled resource for the non-specialist. The seven parts of this new edition indicate its comprehensiveness: “The Healthy Breast and Common Problems,” “What Causes Breast Cancer and How Do We Prevent It?,” “Finding Breast Cancer,” “Decisions,” “Treatment in the Age of Personalized Medicine,” “After Treatment,” and “Recurrence of Breast Cancer.” Each of these seven parts is divided into self-contained chapters—a boon for readers seeking information on specific topics. The book ends with an epilogue (“Eradicating Breast Cancer: Politics and Research”), followed by an appendix listing resources, an appendix giving a pathology checklist, a glossary, and an extensive index.

As a bioethicist who barely made it through Zoology 101-2 half a century ago, I am hardly in a position to judge the book’s scientific accuracy. But this puts me in an excellent position to judge its intelligibility to the non-scientist. I can also detect inconsistencies and, in the process, discuss the many ethical issues the book raises.

EXPOSITORY STYLE

The book earns top marks for intelligibility. The clear writing makes complicated scientific material accessible and frequently even interesting to the non-specialist, often employing helpful and imaginative similes, such as that the staging system of cancers, which

based only on the size of the tumor in the breast, the number of lymph nodes involved, and clinically detected spread to other organs . . . is a static system based on a snapshot in time when we know that cancers are a dynamic disease in evolution. *It is like looking at students who cut classes in high school and predicting that they will grow up to be irresponsible in the workforce.* (226, italics added)

Such clarity pervades the book, outweighing the flaws in the writing style. One flaw is its heavy dose of clichéd, self-help psychobabble, such as, “Be gentle with yourself. The important thing to remember is that cancer is something that happened to you but is not who you are” (458). Some readers will find this reassuring, but others will find it hackneyed and patronizing. Also problematic are formulaic statements like “As women we are socialized not to question authority, especially when we’re sick” (201). This trite and conventional claim overlooks the fact that American culture is a conglomerate of subcultures, some of which press women to question authority, especially male authority. Further marring the exposition is the sexism of “This device was first called a ‘biopsy gun.’ I assume the inventor was a man—who else would think of aiming a gun at women’s breasts?” (183). Of course, this is partly facetious, but imagine the feminist outcry if a man made an equally derogatory joke about women.

It is not always easy to tell when Love is being facetious. About exercise, she says,

And it is never too late to begin! I am a born-again exerciser, having started running at age fifty. I learned to enjoy the stress reduction from my regular slow run as well as the sense of moral superiority I feel for the rest of the day. (136)

Does Love really feel that runners are morally superior to couch potatoes? *Morally* superior? Moreover, does she really believe in miracles? This latter question arises from her claim that

occasional long survival may occur because the cancer is just very slow growing, which has little or nothing to do with the therapy. Some people may think of it as a miracle, and until or unless we can prove otherwise, it’s as good an explanation as any. (521)

Maybe readers shouldn’t take “miracle” literally enough to infer that this eminent doctor and medical researcher really believes that divine intervention is as good an explanation as the commonsense view that there is a scientific explanation we just don’t know yet. But her remark “I often pray for my patients” (447) supports this literal interpretation, which reduces the book’s credibility for atheist readers like me (while probably increasing it for some religious believers).

An additional expository problem involves inconsistency. For example, Love’s unoriginal objection to “the warrior or battle imagery used for those dealing with a cancer diagnosis” (468) hardly accords with her recruitment of what she dubs an “Army of Women” (and men) “who are willing to participate in research” (570, italics added).

Further inconsistencies occur elsewhere. On one hand, the section on the healthy breast and common problems toes a conventional self-help line in saying, “Forget everything you’ve learned about what breasts are supposed to look like. These are your breasts, and they look fine” (16). On the other hand, Love calls some breasts “very deformed” (20) and even, in connection with what she calls “severe

asymmetry," says, "for a woman who is bothered by this, plastic surgery can help achieve a reasonable match" (23). Whatever happened to "These are your breasts, and they look fine"?

An even more glaring inconsistency occurs in the statement, "Approximately one-half of all women undergoing mastectomy and breast reconstruction experience postoperative pain syndromes. Fortunately, this kind of pain is not common" (470).

Fifty percent is not common?

A different sort of infelicity is in a comment about two particularly horrible (and fortunately rare) forms of local recurrence. One involves "many nodules in the skin [that] merge and act almost like a coat of armor across the chest and even into the back and the other breast" (517). The other involves "large tumor masses on the chest wall that weep and bleed" (517). Love says, "These cases are very upsetting for the doctor and patient" (518), as if the doctors' and patients' feelings were on a par—which some patients suffering from these horrors may reasonably resent.

BIOETHICAL STRENGTHS

Love's bioethical outlook has some impressive strengths. One is that, in contrast to the simplistic self-help passages criticized above, Love is often refreshingly unconventional.

A prime example involves her discussion of breast cancer in old women. In discussing the "studies showing that older women aren't treated as aggressively" (323) for breast cancer, Love points out that "a special effort has to be made to ascertain what the patient wants, what is appropriate for her cancer, and what her state of health can handle and to not permit physicians to act solely on their own assumptions" (323-24). She criticizes the assumption that octogenarians "won't care enough about their looks to want" (324) breast reconstruction. Even more unconventionally, she adds,

Those who live into their nineties tend to be healthy, or they wouldn't live to that age. We can't just assume, as many doctors do, that they'll be dead in a year or so and forget it—more and more of them are now living to over one hundred. (325)

What a welcome contrast to the mean-spirited and widely discussed view of the prominent doctor and bioethicist Ezekiel Emanuel that life is not worth prolonging after 75!²

Love provides a valuable corrective to Emanuel elsewhere as well. In an extremely influential article co-authored with Linda Emanuel two decades ago, he identifies four models of the physician-patient relationship: the paternalistic model, where "the physician presents the patient with selected information that will encourage the patient to consent to the intervention the physician considers best" (68);³ the informative model, where the doctor provides "all relevant information" (68) and the patient uses this information to make his own decisions according to his own values; the interpretative model, where "[t]he aim of the physician-patient interaction is to elucidate the

patient's values . . . and to help the patient select the available medical interventions that realize these values" (68); and the deliberative model, in which "[t]he aim of the physician-patient interaction is to help the patient determine and choose the best health-related values that can be realized in the clinical situation. . . . The physician's objectives include suggesting why certain health-related values are more worthy and should be aspired to" (69).

Although granting that different models may be appropriate under different circumstances, the Emanuels favor the deliberative model as "the shared, paradigmatic reference [exceptions to which] would require justification based on the circumstances of a particular situation" (74). But it is not only situations that vary. So do patients. Patients vary in medical knowledge, in interest in acquiring medical information, in respect for medical authority, in clarity and consistency of values, and in desire for guidance. The Emanuels defend the deliberative model on the grounds that "physicians should . . . promote health-related values" (75) and "our society's image of an ideal physician . . . is a caring physician who integrates the information and relevant values to make a recommendation, and . . . attempts to persuade the patient to accept this recommendation" (74-75). This overlooks the diversity of patients. While some patients seek a doctor who follows a deliberative model, those who have well-defined values and value independence of judgment reasonably regard such a doctor as intrusive. Even the informative model may reasonably seem too authoritarian to a present-day patient who gets medical information online.

Love is much better at acknowledging this diversity. She recounts how her participation in a "pilot study on how patients decide their treatments and what kind of decision-making had the best psychological results" (193) taught her that "different patients have different needs" (193). She learned that

Some women preferred to deny their cancer as far as possible and have their doctor take care of it for them. They did better with old-fashioned paternalistic surgeons. . . . Others . . . did better with surgeons like me, who wanted to discuss everything with them. Still others wanted a great deal of information but deferred to the doctor for decision-making. There is no right or wrong style. (193-94)

She adds that, when she was in practice, she and a paternalistic surgeon at the same hospital "sometimes . . . referred patients to each other . . . we were both able to help people while remaining true to our own styles and philosophies" (194).

Love's open-minded respect for individual differences also enhances her discussion of end-of-life issues. In contrast to such doctors as the late and hugely prominent Sherwin B. Nuland, whose self-described ideology was to "always try to guide [patients] in making decisions that . . . will lead to relief of their suffering" (249)⁴—even if it meant earlier death and the patient considered that a poor trade-off—Love respects patients who "want to have whatever chance

there is to go on living, even if that chance is minute" (561), as well as respecting those who do not.

Conventional wisdom echoes Nuland's one-sidedness.⁵ The bias against aggressive life-prolonging medical treatment is found even in some documents that purport to be purely informative. For example, consider the Rhode Island Durable Power of Attorney for Health Care, whose page headed "Commonly Used Life-Support Measures" includes the sentence, "For the dying patient, however, mechanical ventilation often merely prolongs the dying process until some other body system fails."⁶ It could have instead offered an even-handed description, such as, "Mechanical ventilation prolongs a dying patient's life without reversing the underlying illness. Some dying patients consider this worthwhile, and some do not." The rarity of such even-handedness makes Love's respect for individual differences noteworthy . . . as far as it goes.

BIOETHICAL WEAKNESSES

Unfortunately, Love's even-handedness has limits. For example, she says,

Some women want to see the wound [from surgery] right away; some prefer to put off looking at it for a week or two. Either way is fine. . . . But it's important that you look at it at some point. It's amazing how, if you're determined to avoid looking at your body, you can do so . . . but this is the body you're going to be living with, and you need to see it and accept it. (363)

You do? Even if you don't want to? Whose body and whose decision is it, anyway?

A similar lapse involves the claim, "Open dialogue is critical in [the] process" (500) of breast cancer patients' sexual and romantic relationships. But not all couples want to engage in "open dialogue" about sex, nor do all women agree that "the husband's involvement in the decision-making process, hospital visitation, early viewing of scars, and early resumption of sexual activity are important for couples to function optimally" (500). Some cancer patients may be in no mood for sex. Some may even choose not to consult a spouse when making their own decisions about their own bodies.

Love's devotion to "open dialogue" and family involvement also weakens her discussion of end-of-life decisions. Thus, she proclaims

the importance of talking with your family and friends in advance, discussing the options open to you and how you feel about them, and listening respectfully to your loved ones' feelings. Your illness and your ultimate death will affect those who love you deeply, and it's important to involve them in your decision-making process. Understanding your feelings and sharing theirs with you will make it far less likely that they'll go against your wishes when the time comes. (560)

Some patients will find this advice useful, but it is disappointing that Love fails to acknowledge that others are apt to think, "Whose death is it, anyway?" Love's open-mindedness in recognizing that patients vary in their desire for aggressive life-prolonging treatment is unfortunately unmatched by a similar recognition that patients vary in their desire for "open discussion," "sharing" their feelings, and having their families participate in their personal medical decisions. And she overlooks an alternative way to make it "far less likely that they'll go against your wishes when the time comes": state your wishes very clearly and specifically in an advance directive and add that your family is not to be consulted. Not all patients will want to do this, of course, just as not all will want to follow Love's advice to avoid making your living will "so specific that it precludes your agent from [overriding it in] unforeseen circumstances" (561). To each her own.

A similar lack of respect for diversity arises in the clichéd statement,

The prevailing belief used to be that it was better not to tell patients they were dying. But this sets up an unhealthy climate of denial. . . . Such denial can keep you from finishing your business—clearing up relationships, saying good-bye, saying the things you won't get another chance to say to the people you love, giving them the chance to say those things to you. (558)

Rather than replacing the old one-size-fits-all approach with a new one, why not respect the fact that some patients want to know that they are dying and some do not? This means giving honest answers to a patient's questions about prognosis, but not inflicting "You're dying" on a patient who chooses not to ask. Love's conventional lament that doctors "tend to look at [death] too much as a defeat" (559) overlooks the fact that some patients look at it that way too—and, unfashionable as it may be, cannot bear to face the fact that they are dying. Again, to each her own.

Another failure to respect diversity is reflected in Love's discussion of "benefit finding" in cancer. She gushes,

As usual, it takes doctors and researchers a while to catch up to what patients have known all along—that there are many positive things that you can take from this experience. I often hear women say that although they would not wish cancer on anyone, they find themselves living more fully: they "don't sweat the small stuff," they cherish their families, and they truly value each day. (496-97)

She adds, "Those of us who have had to face squarely the possibility of death for whatever reason are in some odd way lucky. We certainly grow from the experience and learn that life is precious" (562).

It would be pointlessly cruel to rain on the parade of breast cancer patients who feel this way. But it is at least as cruel not to recognize that, for some patients, the pressure toward "benefit finding" is an additional burden when they already have more than enough to contend with. As science

writer and former breast cancer patient Barbara Ehrenreich points out,

Two researchers on benefit finding report that the breast cancer patients they have worked with “have mentioned repeatedly that they view even well-intentioned efforts to encourage benefit finding as insensitive and inept. They are almost always interpreted as an unwelcome attempt to minimize the unique burdens and challenges that need to be overcome.” (41)⁷

Ehrenreich’s book appeared in 2009, and the article from which it quotes appeared in 2002. So Love is remiss in her totally uncritical 2015 discussion of “benefit finding.” Ehrenreich, however, has her own agenda. She wants breast cancer patients to be leftist activists, filled with “outrage over the disease and the available treatments” (25). Her book, whose scope is not limited to breast cancer but criticizes positive thinking in general,⁸ ends with these words:

The threats we face are real and can be vanquished only by shaking off self-absorption and taking action in the world. . . . We will not succeed at all these things, certainly not all at once, but—if I may end with my own personal secret of happiness—we can have a good time trying. (206)

Ehrenreich deserves credit for calling activism her own personal secret of happiness rather than representing it as everyone’s idea of a good time. But someone who realizes that cancer patients may resent being told to engage in benefit finding should realize that they may likewise resent being told to “shake off self-absorption.”

Love also has an agenda for breast cancer patients. She says, “Often, the need to ‘give back’ and find a positive side to this experience can be channeled to helping other women with breast cancer” (495)—through one’s job, volunteer work, political action or participation in research. The book’s fervent proselytizing for participation in clinical trials made me feel pressured to become one of the “brave experimenters” (291)—and I have never even had breast cancer.

CONCLUSION

I am still awaiting the ideal breast cancer treatise for the non-scientist: a treatise that not only presents clear and comprehensive medical information but refrains from pressuring patients to find silver linings, engage in dialogue about their feelings, participate in research, or become activists. In the meantime, Love’s book is a marvelously valuable resource when it comes to factual material, and some readers will find her outlook inspiring. Others can ignore the moral pressure, psychobabble, and self-help slogans—or have a good time debunking them.⁹

NOTES

1. This remark is quoted on the book’s front cover.
2. <http://www.theatlantic.com/magazine/archive/2014/10/why-i-hope-to-die-at-75/379329> (accessed 12/26/15). See also my letter about this article: <http://www.theatlantic.com/magazine/archive/2014/12/the-conversation/382249> (accessed 12/26/15).
3. Ezekiel J. Emanuel and Linda L. Emanuel, “Four Models of the Physician-Patient Relationship,” in *Ethical Issues in Modern Medicine*, 4th ed., ed. John D. Arras and Bonnie Steinbock, 67–76 (Mountain View, CA: Mayfield, 1995).
4. Sherwin B. Nuland, *How We Die* (New York: Knopf), 1994.
5. For additional examples of such bias, see <http://time.com/735/the-long-goodbye/> (accessed 12/26/15); <http://www.nytimes.com/2015/08/25/health/a-racial-gap-in-attitudes-toward-hospice-care.html> (accessed 12/26/15); as well as my criticisms of them: <http://www.startribune.com/to-what-lengths-to-prolong-life/161996495> (accessed 12/26/15); <http://www.providencejournal.com/article/20150929/OPINION/150929293> (accessed 12/26/15).
6. <http://www.health.ri.gov/forms/legal/DurablePowerOfAttorneyForHealthCare.pdf> (accessed 12/26/15).
7. Barbara Ehrenreich, *Bright-Sided* (New York: Metropolitan Books, 2009).
8. Although the dedication of Ehrenreich’s book is, “To complainers everywhere. Turn up the volume!” the “everywhere” is disingenuous unless this leftist activist wants protesters at abortion clinics to “turn up the volume”—which, to put it mildly, seems unlikely.
9. I thank Sara Ann Ketchum for terrifically helpful comments on earlier drafts of this review.

