The Ethical View
April 2012

Clinical Ethics Consultation: The Very Idea

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Letter from the Editor
Elizabeth Crowder, ‘12

The Ethical View is released annually by the Medical Humanities Program of Davidson College in an effort to raise awareness about healthcare issues and their ethical ramifications. The theme of the publication corresponds to that of the Frederick Womble Speas Symposium (see page 4 for details). The event will bring disciplinary experts together on campus to discuss a particular healthcare theme, which this year is Clinical Ethics Consultation: The Very Idea.

The Speas Symposium is a great opportunity to interact with other students and professionals from the medical and bioethical fields. The event will give you an opportunity to hear from various experts and to discuss the topics within this issue, as well as other ethical concerns about ethics consultations.

The articles in this publication were written by Davidson students and professors. The subjects cover a broad range of topics in bioethics, including but not limited to exploring Clinical Ethics Consultations.

What are the pros and cons of ethics consults? Can and should loneliness be diagnosed as a medical condition? Should physicians be required to participate in capital punishment?

These questions, along with several others, are addressed within these pages.

To respond to any article or issue presented in this publication, please see the contact information on page 14.

About the Editor...

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The Sunshine Act
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Supporters of the Physician Payments Sunshine Act failed to take into account how expensive “sunshine” would be. Requiring drug and medical device manufacturers to publicly report virtually every payment they make to physicians, physician groups and teaching hospitals will end up costing far more than the $224 million estimated for just the first year of compliance. The biggest cost will be the valuable, socially useful physician-industry collaborations that simply won’t occur. In 2007, the measure’s original sponsors, Sens. Chuck Grassley, R-Iowa, and Herb Kohl, D-Wis., argued that shedding light on industry payments to physicians would be good for the system. The Pew Prescription Project, alarmed by findings that more than 90% of physicians receive payments of some kind from the pharmaceutical industry, opined that patients deserve to know whether their doctors are on the take. Sunshine supporters always affirm that many financial relationships between medicine and industry are necessary and beneficial. However, the measure’s title implies that such relationships need detoxification by exposure to “sunshine,” the best disinfectant. The new law stigmatizes payments and deters accepting them. But it’s utopian to suppose that doctors will give their time and effort for free to do socially useful research and peer education. In fact, many physicians won’t want to be enshrined in this hall of shame. They’ll require higher payments to provide what even “sunshine” supporters agree is valuable work. How much higher? That depends on how our most talented and innovative physicians price their time and how much compensation they’ll charge for loss of anonymity and insinuations of corruption that a sunshine listing implies.

The measure’s supporters foresee only benefit devoid of risk. But they’ve done no credible cost/benefit estimate. Reporting errors, misattribution and mistaken shaming will occur. To its credit, the government candidly acknowledges that it has no empirical basis for estimating the frequency of improper payments, the likelihood that reporting will reduce them, or the likely effects on reducing the costs of medical care.

Education and Expertise in Medical Ethics
Elizabeth Crowder, ‘12

Consultations by clinical ethicists in healthcare settings are becoming increasingly prevalent and necessary. The required training, education, and certification of these ethicists are not clearly delineated and remain topics of discussion amongst healthcare professionals of all degrees. The field of bioethics itself covers a wide range of disciplines—law, psychology, sociology, medicine, philosophy, economics, anthropology—an extensive and by no means exhaustive list. Does acquiring knowledge within these disciplines make one a “professional” bioethicist and clinical ethics consultant? A growing number of training programs in bioethics and humanities are appearing at academic institutions around the country. Those who study in these programs can gain a wide range of competency, from M.A, and Ph.D. degrees to Certificates and Fellowship programs. Many of these programs are still in their infancy, and graduates may go on to work in a wide range of bioethics- or medical humanities-related jobs—including but not limited to clinical ethics consultants. While the American Society for Bioethics and Humanities has developed a set of core competencies for health care ethics consultations, standardized training, education, and certification have not been clearly identified. If more standardized training were required, the danger exists of simply learning for the test and neglecting to study important but perhaps not defined topics. Furthermore, identifying the key elements seen to be as necessary for competency could be challenging, considering the broad and constantly morphing skills needed for the job. In addition to debate concerning the degree of education and certification required of “professional” medical ethicists, there is increasing discussion over the professional status and expertise that clinical ethicists possess. While a physician is qualified as an expert because of his or knowledge and skill relating to the healing of the human body, defining such expertise or skill for a medical ethics consult has proven troublesome. Some critics of medical ethics consultation claim that no such expertise can exist in such a broad field, yet the field’s defendants suggest that such specialized knowledge does exist. If such a specialty did exist, there would have to be some sort of objective and definable moral knowledge. Studying the hard cases of ethics consults proves such a theory false, medical ethicists are not making black and white decisions. Medical ethicists often disagree, yet such disagreement does not make one professional more qualified or expert than the other. Questions concerning the certification and expertise required or possessed by medical ethicists will not go away, and it is likely that a consensus between opposing parties will not be reached. Continuing this exploration into defining the idea of a clinical ethicist is one of the main goals of the 25th Annual Speas Symposium, and such considerations are important for the future of healthcare as a whole.
Ethical consultation has undoubtedly helped prevent violations of patient autonomy, breaches of confidentiality, and the administration of irresponsible care. However, application of ethical principles may also lead to patient suffering and even death. Ethics consultation can protect patients from the dogmatic beliefs of their doctors (perhaps allowing an ill woman to receive a much needed abortion) but it can also justify parents withholding life-saving treatment from their children (as can be the case with Jehovah’s Witnesses). While few would argue that ethics consultation is anything but good for the medical field, it is important to remember that decisions based on ethical principles can come at a cost.

The most obvious incidence when ethical consultation detracts from patient care is when doctors are forced to deviate from what they see as an optimal treatment plan in order to accommodate ethical policy. Patients may refuse care for many reasons, be it distrust in their doctors, religious belief, or fear of the treatment itself. In these cases, an ethics consultation can result in the decision to respect the patient’s wishes and forgo or alter the care doctors provide; even at the cost of the patient’s life.

Sometimes it is not the patients who want to stray from the optimal treatment plan but the doctors, hospital administrators, or government. A patient suffering a slow, painful, and inevitable death may beg for a lethal dose of their pain medicine or the suspension of life-sustaining treatment out of a desire to end their misery and die with dignity. Frequently, an ethical consultation will conclude that this is not an option, as it is “wrong” for one human to deliberately end the life of another. The patient is denied their wishes and forced to suffer based on an abstract principle of what morality says we can’t do. While these instances may be few and far between, evaluation of them can be controversial, the fact remains that a consultation of ethics resulted in more deaths and more suffering.

The pitfalls of ethical consultation are exacerbated when moral principles are applied inconsistently, or in a confusing manner. Laws governing patient confidentiality differ from state to state. Questions regarding the appropriate treatment of patients in vegetative states pass through court after court without reaching any satisfactory answers. The debate rages on concerning respect of religious beliefs, treatment of the terminally ill, and the weight of a doctor’s duty to heal versus his duty to respect patient autonomy. As these issues become more heated, a resolution seems to drift further away.

When bioethical principles are presented arbitrarily or made helplessly controversial, the entire system of ethical consultation suffers. Doctors become confused and frustrated with the processes they must go through, eventually losing faith in the underlying intent of medical ethics. If ethical principles are so flighty and politically charged, can they still be said to protect patients? Or has the whole system eroded into a forum for the fanatically opinionated, a tool for vote-seeking politicians, and a purse for health industry lawyers?

At the end of the day, ethical consultation is a necessity for any morally responsible hospital and its effects are essentially beneficial. However, medical ethics is an imperfect science, which is in constant need of improvement. The only way for this system to move forward is through an active, yet non-combative, participation by the various doctors, hospital administrators, government officials, patients, and family members. This is a difficult task when the stakes are so high but, as is often the case in medicine, as we waste time the patient’s outlook becomes worse and worse.

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A doctor assists a patient from her first to her last breath. Through the many stages of the patient's life, the doctor stands at the bedside as a guardian of health. Yet a physician's work extends far beyond black and white medical matters into the grey realm of ethics. Important health events correlate with significant legal, social and spiritual milestones for a patient. Therefore, it is not surprising that the physician's intimate involvement in these events may require them to make important decisions about ethically and legally ambiguous situations.

Society expects a doctor to be a perfect all-in-one package that includes physician, confidant and ethicist. While physicians should have characteristics of the latter two professions, this public desire seems problematic at a practical level. Many years of schooling and residency undoubtedly prepare a physician with the expertise necessary to treat physical ailments in their specialty. But do the tests, dissections, and rounds leave time for adequate instruction on every ethical and legal tenant? It seems unlikely. Isn’t it unrealistic to expect doctors to be specialists in an area they didn’t receive a complete formal training for? One wouldn’t want their brain surgery to be done by a cardiac surgeon... would they? Unusually difficult and complex situations are best left to the experts. Yet, doctors still often find themselves in situations of responsibility that they are not sufficiently prepared for (ex. making decisions during end of life care). Despite public expectations, patients cannot insist that doctors play every role, nor should they want them to. The paternalistic rhetoric that was invoked in earlier decades is now obsolete, physicians do not always know “what’s best,” especially in an ethical context.

Ethic consultations provide the solution to this problem; they are absolutely critical in order to properly navigate morally complex situations. The consultation panel often consists of ethicists, theologians, lawyers and other doctors, who each bring unique and valuable perspectives on a situation. The ethics consultation provides an opportunity for the family, physician and experts to consult together on the best course of action. Open discussion and dialogue between these groups ensures that the final consensus takes into account all the details, perspectives and beliefs relevant to the patient. Working together as a group allows the committee to be far more informed and ethically judicious than any physician or individual attempting to make a decision alone. While every doctor should remain involved and informed in ethics, it seems best for physicians to set aside the role of moralist and present the most ethically complex issues to a group specialized for such a duty. The ethics consultation panel represents a vast improvement in the hospital decision-making process and will continue to play a crucial role in health care.

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Diagnosing Loneliness? Two Students Respond.

SSOLUS (Sustained SOcial Unfulfillment Syndrome) as a Recognizable Medical Condition

Michael Lawrence, ‘12

In the past three decades, clinical studies have shown a connection between self-reported loneliness (SSOLUS) and a multitude of health problems, especially in middle-aged and elderly persons. One such study found that lonely individuals exhibited a greater increase in systolic blood pressure over four years than non-lonely individuals in addition to reporting higher SBP values at the outset of the study. A similar study concluded that “the physiological effects of chronic loneliness accrue gradually to accelerate increases in SBP.” Additionally, SSOLUS appears to adversely affect sleep quality. Further studies indicate that SSOLUS has significant negative psychological effects as well, including a 51% increase in risk of developing Alzheimer’s disease for each increase of one “loneliness point” (a measure of the individuals’ perceived severity of loneliness) on a five-point scale. SSOLUS also shows strong correlation with depression, where self-reported SSOLUS is significantly predictive of an individual’s exhibiting depressive symptoms in middle-aged and elderly persons. Finally, social isolation presents a major risk factor for greater morbidity and mortality rates across the board, with one study comparing the magnitude of risk that SSOLUS presents to the risks associated with obesity or even smoking.

Currently, SSOLUS is not a recognized medical condition. However, given the associated health problems discussed above, SSOLUS invites debate regarding its legitimacy as a medical condition. I will argue that despite the difficulties involved, SSOLUS ought to be a recognized and diagnosable medical condition. My discussion will focus on issues surrounding diagnosis, the efficacy of certain treatments, and why these treatments ought to be assigned to a physician.

I. What is loneliness?

To understand the difficulties involved in diagnosing SSOLUS, we must first understand what SSOLUS is by drawing a distinction between SSOLUS and social isolation. Socially isolated individuals have objectively little contact with others; mathematically speaking, these individuals spend more time alone than not. SSOLUS, on the other hand, is “a distressing feeling that accompanies the perception that one’s social needs are not being met by the quantity or especially the quality of one’s social relationships.” The key difference between the two conditions is one of objectivity versus subjectivity: while social isolation is an objective, numerical measure of social contact, SSOLUS is a subjective appraisal of one’s social well-being. While in normal circumstances one has great influence over how much social contact one has, the inception of SSOLUS is generally beyond the purview of one’s control. It presents itself without invocation as the result of “a change in an individual’s actual or desired need for social relationships.” These characteristics of SSOLUS—namely, its subjectivity and the difficulty of controlling it—contribute to the problem of diagnosis.

II. The problem of diagnosis

SSOLUS takes two forms, based on its genesis: episodic SSOLUS brought on by a specific life stressor (e.g. divorce or death of a friend), and chronic SSOLUS, which is not well understood but has certain risk factors such as low socioeconomic status, social isolation, poor physical health, and physical limitations. Episodic SSOLUS generally dissipates after a period of time as the individual heals or compensates for his or her altered need for social relationships. Left unattended to, however, episodic SSOLUS may become chronic through self-reinforcement—Hawkley and Cacioppo posit that “lonely people actively distance themselves from would-be social partners even as they believe that the cause of the social distance is attributable to others and is beyond their own control.” At this point, the problem of diagnosis becomes clear: how can the attending physician discern which form of SSOLUS the patient is suffering from, given that episodic SSOLUS can become chronic? Sadness and depression present similar difficulties. Sally Satel, reporting on a recent book entitled The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder by Horwitz and Wakefield, notes the notorious difficulty of diagnosing mental disorders. She asks, “How do we know, for example, that a person diagnosed with major depressive disorder...is not actually suffering from a bout of natural sadness brought on by a shattering loss, a grave disappointment, or a scathing betrayal?” The concern here is for false positives on diagnostic tests, which could subject patients to unnecessary treatment and distort figures on the prevalence of the condition, possibly misinforming public policy initiatives.

To counteract the difficulty of discernment, Horwitz and Wakefield suggest that physicians should take context (e.g. stressful events) into account when distinguishing real mental disorders from natural emotions. In the case of SSOLUS, a contextual measure might help distinguish between chronic and episodic SSOLUS if symptoms persist long after the resolution of their episodic cause.

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However, as Satel notes, persistence of symptoms does not necessarily differentiate a true mental condition from episodic emotional responses, as differentiating true conditions from episodic ones according to time constraints on the persistence of symptoms is somewhat arbitrary and uninformative. Unfortunately, unlike physical illnesses that are well understood, there is no clear timetable for dissipation of SSOLUS symptoms like there is for conditions such as broken bones or strained muscles. Thus, it is extremely difficult to determine whether a patient is suffering from lingering episodic SSOLUS or if the symptoms have progressed to the chronic condition.

However, this difficulty merely stems from a lack of understanding about the mechanisms of SSOLUS and how untreated SSOLUS can become chronic. Like any illness, we know little about it at first, but by continuous, careful study, we slowly come to understand it better. Depression is a prime example of this. Currently, depression is a recognized and treatable medical condition, and while we understand its physical cause as a chemical imbalance, much of it remains a mystery. Medicalizing SSOLUS would not fall outside the scope of accepted medical practices given that depression sets a precedent of diagnosing and treating a condition that is not fully understood. Furthermore, difficulty in diagnosis is hardly a reason to forego medicalizing a condition, especially in light of our incomplete understanding and the many health risks associated with the condition. Thus, one cannot dismiss SSOLUS as a medical condition simply because it is difficult to diagnose properly. Our ignorance calls for more research, not dismissal.

III. Treatment

While the previous section provided rationale for not dismissing SSOLUS as a medical condition simply because it is difficult to diagnose, this section will provide a positive argument for why SSOLUS should be medicalized as its own condition. An analysis of numerous SSOLUS intervention methods by Masi et al. (2011) posits that there have been four basic methods of treatment: social support enhancement, social opportunity enhancement, social skill enhancement, and “addressing maladaptive social cognition.” The first two methods focus on reducing social isolation, while the latter two focus on improving quality of social interaction. Masi et al. find reducing social isolation ineffectual. They write, “The surprisingly small effects of interventions to increase social interactions or enhance social support suggest that reducing social isolation does not necessarily reduce loneliness.” However, they also find that interventions to improve the quality of social interaction show promise, but caution that such interventions are still in the early stages of development and require extensive improvement. But what sorts of interventions are supposed to improve the quality of social interaction? Masi et al. found that most studies focused on “conversational skills, speaking on the telephone, giving and receiving compliments, handling periods of silence, enhancing physical attractiveness, nonverbal communication methods, and approaches to physical intimacy.”

“What is to stop us from medicalizing every adverse emotion? To what extent should we treat distressful emotions as health problems?”

These methods of improving the quality of social interaction do not appear to be intrinsically medical. Indeed, we typically expect education in these areas from family members, close friends, or mentors. However, lonely people do not have any such person to implore for remediation in these areas. No matter how many people might be willing to help them, lonely people’s perception is that there is no one for them. This is why SSOLUS should be medicalized. Currently, there is a significant portion of the U.S. population (as much as 30%) afflicted with chronic SSOLUS and the perception that no one can satisfy their need for social relationships. Who better to help them than a physician? Indeed, a psychiatrist seems to be well suited for handling cases of chronic loneliness. With psychiatric treatment placing an emphasis on therapeutic dialogue between the psychiatrist and the patient, the patient is already progressing toward enhancing social skills. Moreover, if SSOLUS were medicalized, health insurance companies could provide coverage for this debilitating condition, allowing those who need intervention to seek and receive the treatment they need. Thus it seems that making SSOLUS a recognized medical condition is the best course of action, as this would provide an avenue of relief for those who are otherwise bereft of options.

IV. Conclusion

Medicalizing SSOLUS is of course controversial. To begin with, elevating an emotional state to a medical condition is counterintuitive and perhaps even somewhat alarming. What is to stop us from medicalizing every adverse emotion? To what extent should we treat distressful emotions as health problems? Critics of medicalizing SSOLUS will point out that the American Psychiatry Association’s Diagnostic and Statistical Manual of Mental Disorders does not recognize excessive anger, which is an emotional problem for many people as well, as a legitimate medical condition. I have no reply other than to say that in time, we may come to better understand other excessive emotional problems as well, know the health problems they cause, and find ways of treating these. Moreover, though it is perhaps imprudent to promote medicalization from a pragmatic standpoint, treating SSOLUS will likely be more cost-effective in the long run than treating its ensuing medical complications, as these complications compound over time and appear to speed up the aging process, causing further health problems sooner. Its difficulty in diagnosis is not a reason to forego medicalization; we simply need to understand SSOLUS better to improve diagnostic testing. Finally, people afflicted with SSOLUS have nowhere to turn; medicalizing SSOLUS would provide experts to help them recover, and if we can provide some measure of relief for the suffering, that would be no small victory for medicine.

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The Modern Hippocratic Oath

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug.

I will not be ashamed to say “I know not,” nor will I fail to call in my colleagues when the skills of another are needed for a patient’s recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

http://www.pbs.org/wgbh/nova/doctors/oath_modern.html
Loneliness as Disease
Kris Hendershot, ’12

Doctors are able to diagnose and treat previously incompressible diseases. These treatments, developed largely by pharmaceutical companies, have launched the medical profession into one of its most successful eras. Such success has tempted doctors to diagnose and treat normal facets of life. Loneliness is one such aspect that may become medicalized and classified as a disease. The question of whether loneliness should be medicalized can be addressed independent of whether loneliness meets the poorly defined criteria for being a disease. What matters is that the strong correlation between loneliness and adverse health effects warrants the attention of health care professionals. The strong correlation with illness justifies the medicalization of loneliness—indeed of its categorization as a disease.

Loneliness is difficult to define as a disease, risk factor, or symptom partly because the condition itself easily eludes definition and identification. Social epidemiologists define loneliness as “low levels of social integration, indexed by fewer and less diverse social connections with others” (Heffner 932). However, these conditions are neither necessary nor sufficient for defining loneliness. By the above definition, an introvert who partakes in a lifestyle that involves more time in solitude than with others would be defined as lonely without considering whether the individual chooses and content with such a lifestyle. The distinction is that the introvert experiences the physical state of being alone, without the emotional or internal state of loneliness. Conversely, an individual who has high levels of social integration but feels alone when surrounded by friends should be considered lonely, although not by the above definition. Therefore, loneliness can be defined as an internal state determined by the individual’s perception of being alone, which can be classified as the sadness and emptiness associated with experiencing a lack of spiritual, intellectual, and emotional connections with others, regardless of a particular physical state (e.g. being surrounded by loved ones or being alone). This is not to say that external factors cannot contribute to the internal state, but that the physical state alone is not necessarily the cause of loneliness. The internal and physical states can interact in each of the following ways: one can feel lonely without being alone, one can feel lonely while being alone, one can be alone without being lonely, and one can be alone and feel lonely. The interactions of these states is important when considering how to medicalize loneliness, as the different interactions will require different treatments. Heffner confirms that it is the individual’s perception and not the physical state of being alone that dictates the health correlation by stating, “even individuals with seemingly ample numbers of social ties report feelings of isolation and loneliness, and such perceptions may carry health risks as well” (932). It is the perception of being alone, not the physical state that should be the focus when considering the following evidence for a relationship between loneliness and illness.

Although loneliness is difficult to define and challenging to categorize, its strong relationship with illness is impossible to deny. In a seminal study consisting of 6,928 residents of Alameda County, California, researchers found that participants who reported few social interactions were significantly more likely to die over a 9-year period than those with many social connections (Berkman 186). The authors concluded that social interactions are associated with the risk of mortality and, therefore, in this context loneliness can be seen as a risk factor for mortality. Marriage and close friendships were better predictors of lower risk of mortality than were church or club memberships due to the higher level of intimacy in the closer interactions (Berkman 200). This result confirms the importance of the internal nature of loneliness and does not support the importance of the mere presence of other individuals as a way to lower the associated health risks. The study suggests it is the quality and not necessarily the quantity of the interactions that decreases the risk of mortality. More specific studies have focused on the correlation between loneliness and cardiovascular disease. The results of these studies show that loneliness increases the risk of developing heart disease, as well as decreasing the possibility of survival following the onset of heart disease (Heffner 933). Thomas Vogt performed a more comprehensive study that focused on the incidence of ischemic heart disease, stroke, and cancer incidence and survival in the context of social isolation. A reduced network size and, most importantly, a reduced scope (i.e. limited to one domain of interaction, such as family) resulted in an increased risk of mortality across a 15-year period (Vogt 659). Although loneliness was a powerful predictor of the risk of mortality associated with these diseases, it was a weak predictor of incidence (Vogt 659). Another study focusing on loneliness and heart disease, found that in a sample of 736 Swedish men without disease at the beginning of the study, those with low social integration had almost four times the risk of developing heart disease across a 6-year period when compared to those with higher social interaction (Orth-Gomer 41). Loneliness and smoking had similar levels of impact on the development of cardiovascular disease (Orth-Gomer 41). Based upon this study, the Vogt study, and the study conducted in Alameda County, the effects of loneliness as a risk factor seem to occur over the long term. The effect of a short period of loneliness following a traumatic event may not have a significant influence on an individual’s health as far as incidence of disease. Health problems may arise if loneliness persists, suggesting that monitoring a patient’s loneliness would be an appropriate form of medicalization. If the condition continues, loneliness can further be medicalized by the suggestion of medication or involvement in clubs. The appearance of loneliness as a long-term risk factor could be a result of the context that it is presented in, notably chronic diseases, such as heart disease.

A study by Sheldon Cohen suggests that in addition to having a relationship to chronic disease, loneliness also plays an important role in the occurrence of acute illness.

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This study focused on the relationship between social factors and the development of the common cold (Heffner 934). Participants reported their social connections and were exposed to varying doses of the cold virus (Heffner 934). Individuals with lower levels of social integration were 4.2 times more likely to develop an upper respiratory infection compared to those with higher levels of social integration (Heffner 934). The results suggest that loneliness can be a short-term and long-term risk factor. This dual nature of loneliness increases the need to medicalize the condition, as its scope of relationships to diseases is quite broad. All of the studies above suggest a correlation between illness and loneliness but the exact cause for the connection is unclear.

In order to medicalize loneliness, the mechanisms behind the correlation with illness need to be understood. Loneliness is difficult to diagnose and, therefore, medicalize due to the lack of diagnostic tools or any significant observable tendencies of an individual experiencing loneliness, as discussed above in detail. Loneliness is a qualitative condition that can manifest into some quantitative features that may be responsible for the discussed health correlations. Low social integration can result in "higher levels of stress hormones, higher resting blood pressure, and weaker immune responses compared to those with more social ties" (Heffner 934). An unstable emotional state would cause high biological stress responses, such as increased hormone release and high blood pressure, and could affect the amount of rest an individual accumulates, which would affect the individual’s immune system. Treating these biological factors would not have an effect on the individual’s feeling of loneliness, although the treatment of the loneliness could eliminate the occurrence of these biological risk factors. However, the treatment of these biological risk factors could decrease the correlation between loneliness and illness without directly affecting the feeling of loneliness, if these biological manifestations are the cause for the correlation.

A less direct, yet equally important mechanism, for the correlation between health and loneliness is the influence that others have on one’s involvement in healthy behaviors. “With few social ties, there exists little or no external influence on decisions about health behaviors” and removes the important existence of a check and balances system of healthy living (Heffner 934). Trusted individuals can help sway someone away from a hazardous habit, such as excessive drinking, or encourage a better lifestyle, such as a healthier diet. A lack of social interaction could result in the correlation with diseases caused by bad habits (e.g. the connection between heart disease and obesity or smoking). Orth-Gomer concluded that a "lack of social integration was associated with an unhealthy lifestyle, manifest in a higher prevalence of smoking and lack of exercise" (Orth-Gomer 41). Even if loneliness does not directly result in disease, as was suggested with the increase in biological risk factors, it can cause bad habits to form that can eventually lead to disease (e.g. smoking is a bad habit that can increase the risk of lung cancer). Therefore, loneliness has a direct and indirect way of causing disease and should be medicalized in order to prevent disease from developing.

Feelings gathered from social interaction are important to mental health as those who are “socially isolated have higher rates of depression and anxiety,” which can relate to poor physical health and the occurrence of disease (Heffner 934). Loneliness is closely related to depression, as both are internal states involving the perception of one’s sadness. The distinction is that loneliness involves the actual or perceived lack of human interaction. Loneliness can lead to depression and depression can result in loneliness. In this relationship loneliness behaves as a risk factor and as a symptom, respectively. In this example, regardless of the category in which loneliness is considered, it should be medicalized to decrease the sadness and suffering of the individual. Loneliness can work through numerous proposed mechanisms to cause severe diseases and should be addressed by physicians without too much contemplation about its classification as a disease.

Broad definitions of disease, symptom, and risk factor will suffice for the discussion of the medicalization of loneliness because the need to medicalize the condition is independent of its status as a disease. Disease can be defined as an “illness or sickness, often characterized by abnormal sensations (symptoms) and physical findings (signs)” (Webster). Loneliness fits this definition, as there are objective physical findings, such as imbalances of neurotransmitters and increased blood pressure, and subjective symptoms, such as feelings of sadness and emptiness. However, there are contexts where loneliness is caused by the occurrence of a disease and in this situation loneliness is a symptom of the initial disease. For instance, if an individual is depressed and does not desire to be around people, they will begin to perceive themselves as lonely. In this case loneliness maybe viewed as a symptom, which is defined as, "any subjective evidence of disease … [which] only the patient can perceive them" (Webster). This definition accounts for the internal nature of loneliness that is based upon perceptions, but it lacks the inclusion of the associated objective physical findings, such as the imbalance of neurotransmitters and increase in blood pressure. Additionally, both of the above definitions fail to address the most important facet about loneliness in the context of medicalization—the strong relationship with illness. In this context loneliness appears to be a risk factor, which is defined as “something that increases a person’s chances of developing a disease” (Webster). Depending on the context in which loneliness is considered, the category to which it belongs changes, although the need to reduce the associated suffering remains constant. There lacks a clear distinction between loneliness as a risk factor, symptom, or disease and any minor difference discovered through in-depth analysis would be negligible when considering whether to medicalize loneliness. The decision to medicalize any condition rests upon the causal relationship with health, not upon its definition as a disease.

Even if a condition is not considered a disease but a treatment exists that would improve one’s quality of life it would be unethical to withhold such a
remedy. In the case of loneliness it would be even more unethical, due to the strong relationship with acute and chronic infections. The approach to medicalizing loneliness would be the same regardless of its consideration as a disease, symptom, or risk factor but would vary depending on the interaction between the internal and physical states of loneliness. For example, if loneliness was considered a symptom of an existing disease, such as anxiety, it could be treated with medication or with a suggestion to have more social interaction. The treatment would not depend on its consideration as a symptom but upon whether the individual feels lonely when alone or when in a loving group. If the loneliness is felt when the individual is in solitude, then an appropriate initial treatment would be to suggest social connections. If the loneliness is experienced when the individual is among friends, a more drastic treatment for the internal nature of the condition, such as therapy or narcotics to adjust the neurotransmitter imbalance, may be necessary. The main intention of the medicalization of a symptom is to relieve the pain and suffering without affecting the underlying disease. The medicalization of loneliness as a risk factor would involve the same treatments as discussed above and would still intend to decrease suffering. A possible difference between the medicalization of loneliness as a risk factor rather than as a symptom or disease lies within the intentions of the medicalization. When loneliness is medicalized as a risk factor the intention is to prevent disease from ever occurring. However when viewed as a disease or symptom, the intent seems to be curative, although it too can be viewed as preventative. By treating a disease a physician is preventing death and by treating a symptom a doctor is preventing pain. The medicalization of loneliness involves the same treatments and intentions regardless of its characterization as a disease, risk factor, or symptom. It is important to define a condition as a disease only when discussing the motivations for medicalization.

Any time that a condition is brought into the context of the doctor-patient relationship it is being medicalized. The main objection to medicalization presented by critics is that doctors and pharmaceutical companies create diseases out of normal aspects of life in order to make more money. However, making the suggestion to a patient that becoming a member of a club could decrease their risk of mortality does not benefit the physician in anyway, yet medicalization is occurring. Regardless of whether a condition is an illness or a normal part of life, if suffering is present then treatment should occur. Some critics have a problem with any suggestion that a natural condition is a disease because they believe that it will cause the patient to become biased and want to be cured of the fabricated disease. Patients want to be relieved of pain regardless of whether the doctor calls a condition a disease or a normal part of aging. Allan Horwitz and Jerome Wakefield believe that “mistaking a normal reaction for a pathological one can ‘prejudice’ the clinician into prescribing an antidepressant as if he were treating a true disorder” (Satel 39). However, the suffering from a ‘real’ disease can be no more severe than suffering from a condition not officially defined as a disease. Physicians are responsible for the wellbeing of their patient and would not prescribe a medication if they did not think it would ease pain, whether or not the intention was to treat a disease. Easing pain and suffering, and decreasing the risk of mortality are always the main goals of treatment, while disease is often the cause of those phenomena; its presence or absence is ultimately irrelevant.

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Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States. To make matters worse, it is the source of 99% of cervical cancer cases. In recent years vaccines that protect against the types of HPV responsible for 70% of cervical cancers have been licensed by the FDA. Measures are now being taken to make vaccination of young girls become mandatory in order for them to enter the 6th grade.

In ethical terms, mandatory vaccination against HPV may be argued as a beneficent and non-maleficent practice. Infection of an individual with HPV may lead to suffering and harm, both of which are greatly reduced through implementation of mandatory vaccination. It is important to note that a byproduct of a compulsory vaccination program is the reduction of the autonomy and liberty of the individual, as their decision to be vaccinated is removed. John Stuart Mill argues in his book On Liberty that “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.” The call for mandatory vaccination against Human papillomavirus serves as a case in point for Mill’s principle. The prevention of the harm of cervical cancer justifies the government’s exercise of power over American citizens when a mandatory vaccination program is installed. With regards to vaccines, the amount of harm prevented typically increases as the number of people vaccinated increases; the more individuals that are vaccinated in the United States, the lower the risk of HPV and cervical cancer. Because mandatory vaccination leads to more vaccinated individuals than does voluntary vaccination, it leads to more prevention of harm and therefore a greater benefit to public health. In supporting mandatory vaccination against HPV, the beneficence and non-maleficence and desire to prevent harm override the loss of the individual’s autonomy and liberty (Balog 2009:618).

A significant source of opposition to mandating vaccination is that there is still limited information available on the vaccine and its effects. Clinical trials thus far have involved relatively small populations (<12,000 participants) for a limited period of follow-up (5 years), and the vaccine has yet to be evaluated for its efficacy among the younger girls that mandatory programs target for vaccination (aged 9 to 15 years) (Gostin and DeAngelis 2007:1921). Despite the limited amount of information, “if the vaccination were administered nationwide, it would be administered to some 2 million girls and young women … the long-term efficacy is very difficult to determine as it is complicated by the fact that HPV antibodies are not detected in many women that have the infection (Javitt et al. 2008:387). With all of the uncertainty surrounding HPV vaccination, many feel that the “benefits from reducing an already low incidence rate of cervical cancer may be minimal” (Balog 2009:619). In summary, girls that are vaccinated face some risk of potential adverse events as well as a risk that the vaccine will not be completely protective against HPV, making the call for mandatory vaccination perilous.

Furthermore, screening for cervical cancer is already an effective alternative to reduce the threat posed by HPV and is able to catch the small percentage of women that develop cervical cancer when it is early and treatable. It is easy to see why many feel that mandatory vaccination against HPV is superfluous at this point. 90% of women clear HPV infection within 2 years and for the small percentage of American women with HPV that do develop cervical cancer, only 3,700 will die annually as a result (Gostin and DeAngelis 2007:1921). Although these deaths shouldn’t be overlooked, it is fair to argue that there are more serious and imminent threats that are taking a much greater number of lives, and that these matters should be attended to before the focus is shifted to reducing Human papillomavirus and cervical cancer.

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Adam ’13 is biology major from Myersville, Maryland. He is the Treasurer of the Bioethics Society.
Doctors of Death: Physician Participation in Capital Punishment
Grace Cheney, ‘13

Despite outcries from medical associations, many states call for doctors to be a part of capital punishment. What does it mean when a physician “participates” in capital punishment? In order to facilitate effective discussion, this question first requires delineation of a working definition of physician “participation.” It is notable that the extent of participation can vary tremendously from “being present as a physician” to “pronouncement of death” to “administering medications as part of the execution procedure” (Gawande 1223). Yet in the most fundamental sense, any involvement in administering the death penalty technically constitutes “participation.” Even if the amount of participation varies, any role in the procedure ultimately works to ensure that the inmate dies. It should be acknowledged that doctor involvement after the inmate has already been pronounced dead (ex. officially certifying death), does not constitute participation in capital punishment. The killing act occurred by means completely unrelated to the doctor and therefore he or she should not be considered a “participant” in the death. I would like to argue that physician participation in capital punishment, regardless of degree, violates some of the most fundamental ethical tenants of the profession.

Doctors practice medicine in order to preserve and restore a patient’s health, not to destroy it. Society grants doctors the incredible authority they possess only because the physician has expressly committed herself to the art of healing. Individuals who enter into medical vocations pledge themselves to beneficence, promising to act in the best interests in the patient. The Hippocratic Oath charges physicians to “use regimens for the benefit of the ill” and “from… harm and injustice… keep them.” These commands have evolved over time and consolidated into active pursuit of patient welfare and the principle of primum non nocere or “first do no harm.” Physicians may only act in ways that will ultimately help the patient; any action that does not benefit the patient breaches the oath. Therefore, physician participation in an event designed to bring about the death of an individual under their care clearly constitutes an ethical transgression. Even if the doctor doesn’t administer the drugs, participating during the procedure violates the fiduciary principle, which promises loyalty from the doctor to put the interests of those under their care before all others. A doctor participating in capital punishment acts to ensure the interests of the state rather than the patient.

Furthermore, the doctor has no right to act upon the inmate. Doctors can only ethically obtain the right to provide or administer medical services through the formation of an appropriate doctor-patient relationship. This relationship is based on contract between the individual offering to be a patient and the physician agreeing to examine the patient; the patient and the doctor have the equal right to withdraw their consent and thus end the contract. If agreed upon, the contract guarantees that doctors will have a fiduciary duty to their patients.

As discussed, a physician participating in capital punishment breaks this fiduciary duty and violates the beneficence principle. Other issues further confirm the unethical nature of doctor involvement; as Atul Gawande points out, it is impossible for a doctor-patient relationship to be formed because the inmate cannot end the contract. The state renders a potentially autonomous patient (the inmate) a non-autonomous patient. Although the government assumes an authoritative position similar to a guardian making decisions, it does not act in the best medical interests of the non-autonomous individual. The inmate does not have a choice in becoming a “patient;” the state, rather than the individual, provides the authority necessary to grant consent for the doctor’s involvement. A doctor can never ethically give medical treatment to a patient that damages their overall welfare, and being complicit in administration of a harmful medication to a patient without their consent represents a transgression. Even if verbally given, “consent cannot be voluntary in the execution chamber” (Ames 1517). The contract is not functional because the patient cannot make the agreement. They are no longer autonomous, and still subject to the state. As a whole, the profession cannot ethically participate in tasks which undermine its very tenants and principles. Some have argued that doctors must remain involved in the process in order to insure that the inmates do not suffer un-necessary pain. Although an admirable cause, the responsibility to administer justice without violating 8th amendment rights falls to the state and can occur without physician involvement. Capital punishment is inherently incompatible with the role of a doctor and therefore if a state chooses to exercise capital punishment, it must do so in a way that doesn’t compromise physician integrity. Although the “medicalization” of capital punishment has rendered the means of taking a life eerily similar to the means of saving one, doctors have no business serving the state’s interest to take the life of a person against their will. In this case, the physician’s intends to prevent unnecessary harm by being involved, but harm remains the ultimate goal of the “medical procedure.” The distinction must remain rigid; the medical profession should only concern itself with the preservation of life. Doctors should not apply their knowledge to situations beyond their sphere, especially in ways that undermine the restorative goals of medicine. This complicated and strange perversion of the doctor-patient relationship presents such an ethically troubling situation that medical board rulings preventing doctors from being involved seem appropriate.

Medical boards should be allowed to create guidelines which regard participation in capital punishment as unprofessional and unethical conduct. Physicians who chose to disregard this definition and participate in capital punishment should be disciplined in a manner consistent with other transgressions of ethical boundaries. Doctors are privileged with unique professional power and therefore must remain committed to maintain the highest standards regarding human dignity and value of life.

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The board has a valid concern in monitoring ethical standards and holding its members to them. Drawing the line, so to speak, constitutes a safeguard necessary to keep the profession autonomous from state interests. Unless policy measures improve the health of citizens, doctors should not become agents used to carry out the state’s political agendas. Capital punishment concerns criminal justice and social stability not healthcare or medicine.

While capital punishment has been ruled constitutionally acceptable, rights guaranteed by the 8th amendment must still be upheld. Technically, avoiding “cruel and unjust punishment” can be classified as a health concern since it affects the physical well-being of an individual that the state has assumed control over. Therefore it is understandable that physician presence has been included in statutes regarding capital punishment such as those discussed in Thorburn v Department of Corrections. The state seeks to respect the 8th amendment by adding an element of standardized legitimacy and ensuring proper administration without pain. Yet the matter can be resolved in a way that allows the state to accomplish its civic goals and prevents doctors from crossing ethical boundaries; individuals outside the medical profession should administer capital punishment. Physicians are not the only individuals capable of ensuring achievement of state goals. Since medical school training isn’t absolutely necessary for capital punishment to be carried out, medical boards have the right to rule physician participation in capital punishment as unethical. Yet if medical boards refuse to allow participation in capital punishment, they have a constituent duty to not withhold data that would provide the means for physicians not to participate. Reports originally conducted to protect patients (such as anesthetics studies, drug LD50’s and other studies) could be ethically compiled by non-physicians. Hiring state staff who have no medical role other than properly conducting executions removes the conflict of interests between a physician’s commitment to preservation of life and the obligation to carry out civic interests. Committing a temporary and minor transgression by training personnel for the task seems justifiable if provides a permanent safe-guard to physicians from constant interaction and entanglement with capital punishment.

References

A Global Bioethics?

Elizabeth Crowder, ‘12

Inherent in the definition of a pandemic is its ability to affect and threaten a large group of people, sometimes the entire world. Such circumstances necessitate global unity and a sharing of resources. The Western world (including but not limited to North America and Western Europe) often provides medicine, medical equipment, or medical care to either developing countries or to countries facing widespread disease outbreaks. Public health threats such as the AIDS pandemic in sub-Saharan Africa are global emergencies that are “dependent in important ways on relationships and forces that are global in scale.”¹ Such a sharing of medicine and resources from a developed country to a nation with fewer resources—while economically complicated—is an obvious morally humane response. It is important to remember that medical resources coming from the Western world do have ethical strings attached; every doctor, syringe, and medication comes with all its “Western packaging” that does not necessarily conform to all situations or beliefs.² Providing medical aid to pandemic-stricken countries entails much more than simply dropping antiviral medications from a helicopter and hoping for the best; treatment must involve doctors and an orderly allocation of goods. Such conditions necessitate the presence of bioethical standards, even in the face of widespread panic, but we should be wary of applying a westernized definition of ethical principals universally without first considering the value-systems and cultural environments already present.

The field of bioethics, particularly the sector relating to health and medicine, derives most of its standards from Western philosophical traditions. Such traditions mostly emphasize rights and duties over the development of character and virtue, and among this model’s chief complaints include its “perceived preoccupation with the maximization of individual autonomy” along with its inattention to social, religious, and cultural features.³ A set of essays entitled Beyond a Western Bioethics: Voices from the Developing World, written from the perspective of citizens of the Philippines, relates the

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experience of non-Westerners being asked to follow the Western model of bioethics. Differences between these two models are described as following: “The very character of ethics in the West contrasts with ethics in the Philippines not just in terms of the issues and solutions . . . but also in the very language and character of moral concern.” The writer goes on to note that “Whereas Western bioethics is almost always expressed in discursive terms, Filipino bioethics is a framework for thought, a conceptual system.” This account makes clear the limits of Western bioethical principles; while such paradigms fit smoothly within the sphere of North America and Europe, these pillars begin to collapse as we move across cultures. We cannot merely import medicine and medical aid into a country without considering how our ethical standards of treatment or allocation impact or conflict value systems already in place.

Godfrey Tangwa claims that the globalization of Western technology should not be accompanied by the globalization of Western ways of thinking and acting and that “other cultures should be able to beg, borrow, or buy Western technology without having to take it along with all its Western packaging, its entire surrounding value system.” This is a fair statement; but, while specifically westernized definitions of medical ethics need not be universally applied, some form of ethical standard is necessary whenever dealing with limited medical treatment and resources. Providing aid to a pandemic-stricken area does not include merely dropping off medical supplies, but neither does it consist of importing principles and practices established in the Western world without considering the affect that such beliefs would have upon a people and amending such regulations as needed.

While comparing the spread of a Westernized model of bioethics to a pandemic may be a bit of a stretch, accompanying medical aid meant for universal benefit with Westernized unchecked ethical standards could, like a pandemic, breed a global health community that is unhealthy and strained. The challenges in dealing with a pandemic are not limited to the presence of medical goods and services; aid must involve “creating conditions for mutual exchange and genuine reliance on local experience and expertise” and recognizing that a globally friendly bioethics may not be possible. While all humans are in need of healthcare, particularly during times of medical panic, the value systems and beliefs of how such medical resources should be disbursed may differ from culture to culture. Recognizing the limits of Western bioethical mantras and amending such standards in a specific manner can allow for pandemic responses that foster a healthier world in a respectful and emotionally sensitive manner.

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