Symposium Articles

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Introduction: Reflections on Emerging Technologies at the Centennial of Organ Transplantation
Robert M. Sade

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The God Squad and the Origins of Transplantation Ethics and Policy
Albert R. Jonsen

The era of replacing human organs and their functions began with chronic dialysis and renal transplantation in the 1960s. These significant medical advances brought unprecedented problems. Among these, the selection of patients for a scarce resource was most troubling. In Seattle, where dialysis originated, a "God Committee" selected which patients would live and die. The debates over such a committee stimulated the origins of bioethics.

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The Use of Nonhuman Animals in Biomedical Research: Necessity and Justification
Gary L. Francione
Discourse about the use of animals in biomedical research usually focuses on two issues: its empirical and moral use. The empirical issue asks whether the use of nonhumans in experiments is required in order to get data. The moral issue asks whether the use of nonhumans can be defended as matter of ethical theory. Although the use of animals in research may involve a plausible necessity claim, no moral justification exists for using nonhumans in situations in which we would not use humans.

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Markets in Health Care: The Case of Renal Transplantation
Troyen Brennan
This article explores the ethics and economics of a market in donated kidneys in the United States. With the impending changes in the health care system, the author argues that a full turn to the market for distribution of kidneys is not appropriate. However, he would sanction a regulated market, as outlined in the article.

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The Injustice of Enforced Equal Access to Transplant Operations: Rethinking Reckless Claims of Fairness
H. Tristram Engelhardt, Jr.
The globalizing or totalizing imposition of a particular understanding of justice, fairness, or equality, as seen, for example, in Canada's single health care system, which forbids the sale of private insurance and the purchase of better basic health care, cannot be justified in general secular terms because of the following limitations: (1) the plurality of understandings of justice, fairness, and equality, and (2) the inability to establish one understanding as canonical. The secular state lacks plausible moral authority for the coercive imposition of one such account on peaceable, consenting adults. This state of affairs, with regard to the weakness of human moral epistemological powers, means that the secular state fails to have the moral authority to forbid coercively the sale and purchase of organs. It further lacks the secular, moral authority to impose equal access to organ transplantations. Assertions of such authority amount to reckless claims of fairness, and for this reason, health care policy must be set within the constraints of limited, constitutional regimes.
The concept of brain death has become deeply ingrained in our health care system. It serves as the justification for the removal of vital organs like the heart and liver from patients who still have circulation and respiration while these organs maintain viability. On close examination, however, the concept is seen as incoherent and counterintuitive to our understandings of death. In order to abandon the concept of brain death and yet retain our practices in organ transplantation, we need to either change the definition of death or no longer maintain a commitment to the dead donor rule, which is an implicit prohibition against removing vital organs from individuals before they are declared dead. After exploring these two options, the author argues that while new definitions of death are problematic, alternatives to the dead donor rule are both ethically justifiable and potentially palatable to the public. Even so, the author concludes that neither of these approaches is likely to be adopted and that resolution will most probably come when technological advances in immunology simply make the concept of brain death obsolete.

Gene testing can not only provide information about diseases but also their prevalence in ethnic, gender, or other vulnerable populations. While offering the promise of significant therapeutic benefits and serving to highlight our commonality, genetic information also raises a number of sensitive human rights issues touching on identity and the perception thereof, as well as the possibility of discrimination and social stigma. It stands to reason that the results of individual screenings could haplessly be used to make general assumptions about entire ethnic or gender groups. In this manner, genetic information can directly influence identity by impacting and perhaps even redefining conceptions of group rights and dimensions of self-identification, thus importing constitutional scrutiny on questions of dignity and discrimination in particular. Is there a risk of collective stigmatization deriving from discrete testing of self-identified individuals? Would such stigmatization impinge on individual dignity by the exogenous imposition of ethnic or gender/sexual identity? If so, what norms can most adequately respond if and when individual and group interests diverge? These questions are examined from a comparative perspective.
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Letters to the Editor

Dear Editor

In “To Tell or Not to Tell: Disclosing Medical Error” (Journal of Law, Medicine & Ethics 34, no. 4, Winter 2006), William Winslade and E. Bernadette McKinney describe a case in which an anesthesiologist’s error in the operating room eventuates in a death. In such instances, the authors recommend that physicians should, upon discovering such an error, disclose that information to hospital administrators and then to the family. However, the authors have a differential standard when it comes to the timing of each of those disclosures. They say that the hospital administrators should be informed right away, but with reference to the specific case under discussion – they say that the patient’s family should be advised about the error only when it “becomes clear that the patient has not and is not likely to regain consciousness.” They do say that this disclosure should be made as fully and as honestly as possible, but it’s not clear to me from the arguments presented why the family should be kept uninformed until the full and final force of the error is clear and, in this case, irreversible. Why not make the disclosure of error as soon as the error is disclosed to hospital administrators? Or at least as soon as the apparent medical effects of the error become evident? Or at least at some point prior to the established irreversibility of the medical error? Certainly, it shouldn’t be just the irreversibility of the error that mandates its disclosure.

Even if a patient falls into unconsciousness and remains unconscious because of a medical error, disclosure of that error can be useful to family members or other surrogate decision makers early on, even before determination of what the overall effects of the error might be. For example, given information about a mistake, patients or their surrogates might wish to change medical providers or hospitals, in other words take steps to limit further care from the very folks that made a mistake in the first place. This is to say that the timing and point of disclosure are ethical issues. If I read the rest of the Winslade and McKinney article correctly, the arguments there even point in the direction of early disclosure, not disclosure only in the fullness of time. Or at least, I can’t see from those arguments why one shouldn’t start to engage the patient and/or family about the error as soon as the hospital gets its information about the error.

Timothy F. Murphy
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The Authors Respond

Professor Timothy Murphy has raised an important question: When should a patient or a surrogate be notified of a medical error? In the case we discussed, only the anesthesiologist knew that he had made an error. But he remained mute. The anesthesiologist should have informed the surgeon, the hospital administration, and the patient’s family as soon as possible. When the surgeon told the family that the patient had not awakened from the anesthesia, he did not know that the anesthesiologist failed to restart the ventilator. The surgeon told the family that the possible causes of the patient’s continued unconsciousness were being investigated. That was all he knew at the time.

In general, when something unexpected in a patient’s care is discovered, several steps should be taken. First, the attending physician should inform the hospital administration so an investigation can be initiated. Second, the patient or the patient’s family should be informed of what is and is not known as soon as possible and that the causes are being investigated. Third, quality of care issues should be examined to determine if the unexpected outcome is due to medical error. If so, action should be taken to prevent similar errors in the future. However, unless it is verified that the unexpected outcome is a result of medical error, it would be premature and misleading to attribute the unexpected outcome to medical error.

Professor Murphy suggests that we imply that truthful disclosure to the patient or surrogate should be delayed until a final prognosis is determined. The sentence in our article from which he quotes may be misleading. We hope that our response makes it clear that what is known, including known error, should be disclosed as soon as possible to all of the relevant parties. However, mere suspicions or speculations should be avoided. Disclosures about medical error must be based upon verified information, not unverified possibilities.

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