Special Section: First Voices

The Accidental Bioethicist

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Introduction

Albert Jonsen in *The Birth of Bioethics* notes that his career in bioethics began with a phone call to him from soon-to-be colleagues at the University of California at San Francisco Medical Center.[1] Bioethics didn't begin with a bang but as an accident in the root sense—something that happened, not by necessity, but rather by chance. Indeed, the opening chapters of Jonsen's book chronicle a series of accidents that helped to create the field of bioethics. Principal among these was the fact that physicians and biomedical scientists who became puzzled about the moral dimensions of their work and began to think about these puzzles sought help in doing so from moral theologians and philosophers. These physicians and scientists, for the most part, were university people. They thought broadly, not just deeply, about their work, but they just as well could have defined themselves by their academic discipline and departments and not reached beyond these familiar and comfortable intellectual confines to the "culture" of the humanities disciplines and departments. The theologians and philosophers whom these physicians and scientists sought out were also university people who also happened to have generous views of the intellectual life in their disciplines—atypical of the time, especially in philosophy. If C. P. Snow[2] had been altogether right and if ungenerous self-understanding of their work by physicians, scientists, philosophers, and theologians had prevailed, bioethics might not have happened at all.

The Accidental Bioethicist

My career in bioethics also started with a phone call, in June of 1974. At the time I was beginning work on my dissertation in philosophy at The University of Texas at Austin. The Department of Philosophy at the University has "produced" many professional bioethicists in the second generation of bioethicists—but more on this later. My dissertation concerned Leibniz's principle of individuation and its origins in, and debt to, the work of later or second-Scholastic philosophers.[3] I had used up my allotted 4 years of departmental support and had been talking to one of my professors, Irwin C. Lieb, about support that he might find for me in his new position as the University's Graduate Dean. Chet called to tell me that he was still working on finding funding (which caused my heart to sink) but that he had received a call from Tris Engelhardt, then at the Institute for the Medical Humanities at the Uni-

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versity of Texas Medical Branch at Galveston and whom I happened to have met earlier at the dissertation defense and celebration dinner of Thomas Bole. I had no idea what the "medical humanities" were, but when Chet told me that Tris had a job for a research assistant for his just-funded National Endowment for the Humanities summer seminar for health professions educators, that the job would pay enough in its 5-months' duration to let me save enough to come back to Austin for 7 months and work full time on my dissertation, and that this new area of medical ethics might "strengthen my vita" (I remember those words exactly), I said I would be very interested in taking this position. Chet said he would call Tris to that effect and that I needed to be in Galveston in 2 days. Now, of course (how easily one now uses this phrase 25 years later), one enters the field of bioethics by going to graduate school to concentrate in bioethics, completing as a medical student an ethics concentration such as the "Ethics Track" at my medical school, or completing a fellowship after one has completed a residency or advanced degree.

The differences between Austin and Galveston were two: the temperature was the same (Americans think that it is hot in Texas in the summer; they are wrong, it is very hot) but the humidity was not; and the buildings on the Medical Branch campus were all in "Hurricane Architecture" style, for good reason, given the history of The Island's storms. In my first week in Galveston Tris took me to the audiovisual center in the Medical Branch, where I met Robert White, M.D., from the Psychiatry Department and sat with Tris and Bob while their director ran a videotape of a disfigured burn victim by the name of Donald Cowart. A week before, I had been reveling in the work of people long dead, whose suffering I now realized was long over but does not show in their work (certainly not in Leibniz's, ever, as near as I can tell) and who left us their beautiful texts to explore to our hearts' endless delight.

Helping to prepare the final version of "Please Let Me Die," which has been used in countless philosophy classrooms and medical school lecture halls to teach bioethics, was very different. I recall vividly a conversation between Tris and Bob about whether to leave in the soundtrack the cosmetics ads that were playing on the local, Black radio station while the attendant hosed down the naked Mr. Cowart in the Hubbard tank. They left the ads in, a detail I think on whenever I think about this now canonical bioethics "case."[4]

I helped Tris with the many chores of getting the summer seminar together; rather, he taught me how to help him get these things done. More than that, Tris gave me his own work in progress to read and about which we argued intensely. At the University, Ignacio Angelelli taught me to be a scholar and Chet Lieb taught me to think like a philosopher; Tris continued my philosophical education and has continued to do so to this day; at this writing I am reading a draft of his new book, *The Foundations of Christian Bioethics*.[5] Tris also asked me to help edit the papers that became the first volume of the *Philosophy and Medicine* book series, the oldest and largest book series in the field.[6] I learned from this experience how much famous academics owe to editors like Tris.

According to the Personnel Office at the Medical Branch I was a research assistant. According to Tris, I had voluntarily waived the protections of the 13th Amendment to the American Constitution. I became the first "slave," a line of students, many of us from the University of Texas Philosophy Department, that continues to this day.[7] In this indirect way, the University has "produced"

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people for the field. In this capacity, I was worked, hard, and received as a consequence the education of a lifetime.

In this capacity also Tris occasionally lent me to his colleague, Chester R. Burns, M.D., Ph.D., a historian of medicine. Chester sent me to the extraordinary rare books collection in the Medical Branch Library to work on translating Latin texts of medical deontology. I discovered that this medical ethics had a history and that Chester was one of the few people in the world, along with Tris, who knew and cared about it. They both encouraged me to make the bridge from Leibniz to medical ethics and bioethics through history, which I did, eagerly.

My first philosophy teacher at Williams College, Daniel O'Connor, taught Introduction to Philosophy by using historical texts. In our first class in the fall of 1965 he explained to us that it was a deliberate choice on his part that all of our readings represented the work of dead people. His explanation for this was that, because these people were among the greatest minds of the Western tradition and that they were therefore smarter than we were, perhaps they understood the world and the human condition better than we did. That we came after these thinkers did not necessarily mean that we had made progress or that we were better philosophers than they were; we were accountable to them perhaps more than they were to us.

I learned when I got to graduate school 6 years later how deeply against the grain Dan O'Connor's view cut. Catherine Wilson has recently described the intellectual atmosphere in which historians of philosophy worked in the 1960s and 1970s:

> In many departments it was regarded as somewhat shameful to be a full-time practicing historian of philosophy: the implication was that what one did was not very different from what undergraduates did. . . . Those historians who worked with evident zeal and purpose because they were looking for philosophical truth through historical writings were a positive embarrassment to their colleagues, for they appeared to be searching for timeless wisdom about the human condition or to be preoccupied with questions such as Idealism or The State, about which it is impossible to say anything new or precise. A graduate student of this era who happened to get interested in competing interpretations or formulations of a doctrine, or its reception, or the influence of one philosopher on another, or the role of a "minor" historical figure was conceived to have left philosophy and to have gone over to intellectual history.[8]

By teaching in a liberal arts college, I sometimes think, Dan O'Connor freed himself to some extent from this form of intellectual tyranny. By going into medical education (I discovered 2 years later that this is what I did in the summer of 1974), I freed myself from this tyranny—for the simple reason that medicine and medical education are not beholden to the sociology of knowledge and the passing styles of academic philosophy.

This liberating effect of academic medical centers on philosophers who joined medical faculties should not be underestimated in its influence on the formation of the field and on its continuing development. The medical schools that hired bioethicists (they were not called by that name in the 1970s, as I recall) freed them to challenge accepted views of their home disciplines,

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including philosophy, as well as to challenge ahistorical conceptions of bioethics that were strongly influenced by their home disciplines. It is fair to say that bioethics lacks a sufficiently well developed understanding of its own history, especially in the "long tradition" of medical ethics, as Jonsen has so aptly named it.[9] This ahistorical and therefore impoverished conception of bioethics is held in resistance to the conception offered in the standard reference work for the field, both editions of the *Encyclopedia of Bioethics*, which, very much to Warren Reich's credit, include a lengthy section devoted to the history of medical ethics.[10] To the extent that bioethicists understand their field to have no history and to the extent that bioethicists are unwilling to subject themselves to intellectual scrutiny and accountability from the critical perspective afforded by studying the history of medical ethics, to that extent bioethics lacks maturity as a field of the humanities.

In Galveston in the summers of 1974 and 1975 I also learned from Tris the necessity of bringing philosophy into the clinical setting, a task I daily undertake as a medical educator who happens to be an academic philosopher and bioethicist. Philosophical concepts cannot be brought to the clinical setting whole and unaltered, as if they are not accountable to the realities, constraints, and uncertainties of patient care and clinical research. The goal of bioethics should be to create and sustain a critical discourse in which philosophical concepts are subject to critical scrutiny from the clinical and research perspectives, so that the taken-for-granted dimensions of those concepts become clear and therefore open to critical assessment and even revision. So, too, bioethicists in the clinical setting must be willing to subject clinical practice and research, as well as the basic sciences, to critical scrutiny, so that their taken-for-granted dimensions become clear and therefore open to critical assessment and revision. In particular, bioethicists should accept the challenge to turn philosophical concepts, such as autonomous decisionmaking, into (so far as possible) reliably measurable concepts, so that their clinical and research utility is increased. Ruth Faden and Tom Beauchamp pointed the way to this form of bioethics in their work on informed consent.[11] The National Institutes of Health have now established a program of support for this type of research on ethical issues in human-subjects research.[12] The field should respond to this opportunity and to the challenges that it presents with sustained energy and first-class research.

After a second summer in Galveston and completing my dissertation, I went on to a postdoctoral fellowship at the Hastings Center, as a result of the strong sponsorship of Tris Engelhardt. At this time (1975–1976), Hastings and the Kennedy Institute of Ethics were the leading research centers in bioethics. Hastings specialized in bringing together interdisciplinary groups from various universities and medical centers to work on challenging problems, both focused and large. Dan Callahan and others at Hastings did what they were convinced universities at the time could not, or worse, would not, do—genuine, sustained interdisciplinary work.[13] This has changed. The kind of research that I called for in the previous paragraph is necessarily interdisciplinary in nature, and more and more universities and academic medical centers (including my own) now conduct it. The Hastings Center, as it were, became an exemplar for what is now its competition.

During my fellowship year, Warren Reich gave me my first opportunity to publish in the history of medical ethics, in the form of a contribution to the

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history of medical ethics section for the first edition of the *Encyclopedia of Bioethics*.[14] He did so at the urging of Tris Engelhardt, who was one of Warren's area editors. To do the research for this encyclopedia, I went into New York City, to the Library at the New York Academy of Medicine. Warren wanted an entry on eighteenth-century British medical ethics. I already knew, from being lent to Chester Burns and studying with him, about Thomas Percival.[15] In the card catalogue at the Academy, I found an entry for a Scottish physician, John Gregory. When I read his *Lectures on the Duties and Qualifications of a Physician*[16] for the first time, I was convinced that Gregory had relied deeply on David Hume's principle of sympathy and its attendant virtues, a historical interpretation I was later able to establish in great detail. Here was a physician doing what the bioethicists thought they had invented only in the 1960s or perhaps as early as the 1950s: using philosophical concepts to address clinical topics such as truth-telling to dying patients, confidentiality, and setting limits to aggressive clinical management of life-threatening disease. Gregory was doing bioethics as we were doing it, addressing these very topics, two centuries before we thought to do it.[17] My ideas were not enthusiastically received at the Hastings Center, but they were by Warren and Tris.

Before I left for Hastings, Tris had convinced his former Dean of Students at Tulane University, James Knight, who had become the Founding Dean at the new Texas A&M College of Medicine, to hire me to its Department of Medical Humanities. I also held a joint appointment in the Department of Philosophy (where I taught introduction to logic) at A&M from 1976 to 1979. Jim's support and confidence in me were enormously important to me as I began to become a medical educator. Sam Black, Ph.D., then Chairman of Microbiology and the finest medical educator with whom it has been my privilege to work, taught me how to teach medical students in the preclinical curriculum—no small challenge. Would that a Sam Black graced the lecture halls and laboratories of every medical school! At A&M's teaching hospitals in Temple, Texas, Scott and White Memorial Hospital and the Veterans Affairs Hospital, I began in earnest my career as a clinical educator, teaching medical ethics to students and residents. I had a great deal to learn and, thanks to very experienced and supportive colleagues, especially Paxton Howard, M.D., and Kermit Knudsen, M.D., in Temple, I began to learn how to be effective at teaching philosophy in the clinical setting.

In Temple, I encountered and taught about very low birthweight babies (then circa 800–1,000 grams) and patients at the VA with serious brain injury and disease that impaired cognitive function. I recall especially two patients. One was a 6-month-old infant who had been born prematurely and experienced necrotizing enterocolitis, with subsequent surgical resection that left him with too little gut to survive independently. (This was long before the current, experimental surgery to lengthen the gut.[18]) He had been on total parenteral nutrition for almost his entire short life, and the TPN was now killing his liver. His parents were a very young couple from a small town in central Texas and were clearly overwhelmed by the catastrophe that had befallen their innocent child. The case conferences on this child concerned whether it was time to stop. Additionally, the patient's parents had no insurance and there was concern expressed about the dislocation on the hospital's charity budget by this one patient's very large costs. Medicine had clearly reached its limits in its ability to prevent this child's death, and issues of scarce resources arose, at the institutional not societal level, with no public policy to guide us. About scarce

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resources, I began to think locally and act locally—make sure that fiduciary responsibilities to the patient are met—and, because we still lack public policy to guide us, I still think this way about the management of scarce resources in the clinical setting.

The second patient was a World War II veteran with a brain injury that had robbed him of his memory. Like Billy Pilgrim, he had become unstuck in time;[19] unlike Billy Pilgrim, his condition was permanent. Here was a patient who would take over another patient's room, conjure up a past to go with the personal effects, such as photographs, in the room, and then go on to another room and do the same. For his own safety, he was on a closely supervised ward. Concepts of patient autonomy collided in this patient with the necessary and sufficient conditions in the human central nervous system for having and exercising the capacity for autonomous decisionmaking in the first place. This case prompted me to think about how philosophical concepts must take account of science and clinical experience, in this case neuroscience and the experience of psychiatrists and psychologists who care for such elderly patients. I continue work in this area—it is now called geropsychiatry.[20]

From Texas A&M I went on to Georgetown University's medical school and the Kennedy Institute of Ethics, where Warren Reich hired me to his new Division of Medical Humanities in the Department of Community and Family Medicine in the medical school. I have in my files a letter of appointment to the Kennedy Institute of Ethics signed by its founding Director, Andre Hellegers, M.D., but he died before I moved to Georgetown in the summer of 1979. There is a booth with a plaque honoring the memory of Dr. Hellegers at The Tombs, across from where the Institute used to be located. Part of entering the field now should, I think, require sitting in his booth and celebrating Dr. Hellegers's contributions to the field of bioethics as one of its visionary and determined founders[21]—as I often did during my 9 years at Georgetown.

Tris Engelhardt was already at Georgetown, and my chairman in philosophy at A&M, John McDermott, played a significant role in bringing the position there to my attention and in supporting my successful application to it. John was the second (Manuel Davenport, who preceded John, was the first) in an unbroken string of superb and talented administrators under whom I have served and been able to make my academic career. How the field of bioethics has been adversely affected by the opposite type of administrator might be a history worth writing.

Washington, D.C., as the capital city of the world's most powerful nation, lives by, with, and for power, money, and sex—and has often in its storied history confused the three. It is not a city in which academic work is valued, although the reflected glory of all that glitter and power fell on Georgetown. The version of Potomac fever that I found especially infuriating took the form of colleagues who thought that they were important people because they lived and worked in this capital city, a delusional and deadly trap.

At the medical school I had the good fortune to have as my chairman Robert Huntley, M.D., and division chief Warren Reich, both of whom nurtured my scholarly development, gently corrected my mistakes, and protected me when I needed protecting, for which I am forever grateful. I taught and learned pediatrics, neonatology especially, and excellent doctoring with and from Siva Subramanian, M.D., then and now Chief of Neonatology at Georgetown University Hospital. In the Kennedy Institute we argued well and long, focused around the Tuesday

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lunch seminar when a colleague would present work in progress. Tom Beauchamp and I completed a book together,[22] an introduction to scholarly collaboration that has set the pattern for my subsequent work. I also became the best sort of colleague (i.e., a student) of Isaac Franck, with whom I taught in the Institute's well-known summer intensive course in bioethics.

In the early 1980s and with the support of the National Endowment for the Humanities, the four medical schools in the Washington area (Howard, George Washington, and Georgetown universities and the Uniformed Services University of the Health Sciences) collaborated to offer a 1-month elective in medical ethics for fourth-year medical students and other interested parties. Students spent 1 week on each campus taught by the ethics faculty at the host campus, with a core faculty from all four schools meeting with them regularly. In the spring of 1983, Frank A. Chervenak, M.D., then a fellow in maternal-fetal medicine at Yale and now Chairman of Obstetrics and Gynecology at Cornell Medical College, enrolled in the course, having to use his vacation time to do so. At the end of the course, he asked me if I would like to work with him on ethical issues in maternal-fetal medicine, an invitation that has led to a scholarly collaboration and friendship of 17 years.[23] I travel regularly to New York for weekends of intense work, writing, and teaching with Frank.

A crisis in leadership led to the appointment of a new Director of the Kennedy Institute, Edmund Pellegrino, M.D. However, major departures soon changed the Institute significantly by the mid 1980s. William May and Tris Engelhardt went to Texas, and Isaac Franck died with no successor named. The relationship between the Kennedy Institute and the medical school, usually distant and at times strained, grew tense—not the vision that Dr. Hellegers had brought to his founding of the Kennedy Institute.[24] Indeed, by 1987, the leadership of the Kennedy Institute undertook to marginalize Institute faculty whose primary appointment was in the medical school. Happily for me, at that very same time Baruch Brody invited me to apply for the position that I currently hold, and in 1988 I returned to Texas and became Professor of Medicine and Medical Ethics in the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston. From the capital city of the United States I went southwest, toward Texas, toward home.

At Baylor I have experienced collaborative research and teaching with colleagues from many disciplines and specialties, including general internal medicine, psychiatry, geriatrics, pediatrics, geropsychiatry, surgery, obstetrics and gynecology, and health-services research. We have begun to contribute to a new genre of research, evidence-based ethics research. The purposes of the research and its hypotheses are generated in large measure by ethics and its methods. The hypotheses are tested, however, by empirical methods, such as those of health-services research. In this way, whether ethical inquiry has beneficial effects on patient care or clinical research can be reliably measured. All of medicine is becoming evidence based; bioethics needs to become evidence based. In particular, we are working on strategies to improve long-term care decisionmaking[25] and the consent process for potentially vulnerable subjects of clinical research and to measure the effect on their capacity for autonomous decisionmaking of doing so. With respect to the latter, we are developing and validating the first measure of autonomous decisionmaking.

With colleagues at the University of Houston Law Center, Baruch Brody and I are preparing the first comprehensive collection of codes, statements, and

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opinions on medical ethics produced by the major national organizations of physicians.[26] These documents, from general and specialty associations, constitute a major source of insight into the ethical standards of medical practice and have been neglected by the field.

One other major area of collaboration, with Robert Baker, a philosopher at Union College, is in the history of medical ethics. As university people and as well read in the humanities, the founders of the field of bioethics brought with them, in many cases, a keen appreciation for and knowledge of the history of their disciplines. With the steady development of the field and its relentless focus on the "cutting edge" issues of biomedical science and clinical practice, bioethics has become focused on the present. Since its founding and with its professionalization, bioethics has become less a field of the humanities because it does not incorporate into its self-understanding and practices an awareness of its history, including the history of medical ethics, as do the other disciplines of the humanities. Moreover, as the field becomes international, it lacks a sense of itself as having a global history before bioethics. With the support of the NEH and private foundations, Bob Baker and I have been successful in assembling a distinguished group of bioethicists and historians of medicine to write a comprehensive history of medical ethics in its global perspective.[27]

Concluding Tentative Observations

The study of history—in my case, the histories of philosophy, medical ethics, and ideas generally—cautions us that attaining historical perspective on one's own life and on recent events is difficult if not impossible. I therefore offer the following observations about some main themes of the above autobiographical sketch as tentative and more properly the subject of critical inquiry by historians in the future.

The history of bioethics can usefully be thought of as a series of accidents; there certainly seems to have been no necessity to the origin or subsequent development of the field. If they had been too busy or uninterested, Al Jonsen might not have gone to UCSF, Andre Hellegers might have continued his studies of fetal physiology, Dan Callahan might have gone on with the lay Catholic movement, and James Knight might not have granted Tris Engelhardt a leave from his medical studies to go back to the university for his doctorate in philosophy. These individuals took considerable intellectual and personal risk to respond to the opportunities that accidentally came their way. My motivation for doing so was simpler: the job market in philosophy had gone south by 1974 (not the late 1980s or early 1990s, as the leadership of the American Philosophical Association seems to think) and, as a survival-positive person, I was glad to have a job. The growing financial crisis in American academic medical centers may make such quotidian attitudes salient once again.

Being a creature of accidents and being focused so much on the present and, perhaps, being influenced by the need of folks in the field to remain employed in it, bioethics lacks historical perspective. Bioethics needs very much to incorporate its history into its self-understanding. Like the other disciplines of the humanities—and unlike medicine—bioethics of the present and future needs to hold itself accountable to the past, to appreciate that just because we come later does not mean that we are smarter than such major figures of the

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history of medical ethics as John Gregory (1724–1773) and Thomas Percival (1740–1803), the two pivotal figures of English-language medical ethics in the eighteenth century.

Bioethics needs to bring its philosophical concepts even more deliberately into the clinical setting and to do so in collaborations between clinicians and bioethicists. For example, I write no clinical ethics alone any more. I am not sure that anyone should—except those with double degrees—and I am not sure about this exception.

The founders of the field set out to change social institutions and practices, medicine and healthcare chiefly among them. American medicine currently is undergoing enormous conceptual change, with the rise of molecular medicine, and structural change, with the rise of the managed practice of medicine.[28] These changes share in common the demand for evidence of what works and what doesn't. Bioethics should submit to the same demands willingly, making itself evidence based. It is not simply enough to win arguments and expect that social institutions and practices will accordingly change; it is foolhardy to think this way.[29] Indeed, this self-understanding of bioethics is a surefire formula for its systematic marginalization by the very social institutions and practices that it seeks to critically evaluate and improve.

The reader will have noticed the many names of my mentors. The Hippocratic Oath is not the only source that enjoins us to acknowledge and celebrate our mentors, and I do so from the freedom conferred in obligation. The future of the field depends on others having the mentors and experiencing the kind of collaboration that have gotten me to where I am.

Finally, I am in Texas. My wife, who has the good sense to be a native Texan, tells me that I am happy in Texas because it is a big place and I have a big ego and so we are meant for each other. There is truth in this claim. The claim can, perhaps, be generalized: place is an important factor in and influence on bioethics. This is especially the case when one recognizes that bioethics has become international in the past two decades.[30,31,32] Bioethics, I submit, is not necessarily international; it may be very much local—that is, national. It surely displays national variation. To what extent place in bioethics is problematic or advantageous is worth considering for the future of bioethics.[33]

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