
George Annas serves a critical function as an incisive commentator on the interactions between law and medicine and law and public health. Along with Alex Capron, Dena Davis, Rebecca Dresser, and Larry Gostin—to pinpoint a few—Professor Annas analyses legal aspects of a spectrum of medicolegal issues both in a forum and in a manner that makes them accessible and understandable to a broad community of healthcare providers. His latest book, Some Choice, continues that valuable tradition. The bulk of the volume (17 out of 22 chapters) is drawn from essays originally published as the “Legal Issues in Medicine” feature of the New England Journal of Medicine.

The topics include such staples of patients’ rights debate as the boundaries of informed consent, authorization of medical experiments, and physician-assisted suicide. A treat is the inclusion of less frequently covered issues, such as access to health information concerning presidential candidates and constitutional bounds of limits on cigarette advertising.

This book should be useful to Professor Annas’ intended audience—the nonlawyer healthcare providers and administrators who must cope with the looming omnipresence of law in their professional lives. He excels at translating complex legal concepts into understandable terms. These include brief excursions into informed consent doctrine (pp. 57–60, 65–67), federal pre-emption of state law (in the context of regulating cigarette companies), and due process in the design of appeal machinery following denial of insurance coverage for medical services (pp. 36–39). At the same time, Professor Annas injects a healthy awareness of the instances in which legal norms fail to accomplish their intended objects, as when informed consent doctrine does not produce autonomous patient decisionmaking or when institutional review boards fail to safeguard patient interests.

Because Some Choice is a compilation of separate essays, it suffers somewhat from an episodic or uncoordinated quality. Professor Annas does suggest some underlying themes for the compilation. One such theme is the illusory nature of patient self-determination in the face of circumstantial strains and pressures. That theme surfaces in discussions of informed consent, human experimentation, and physician-assisted suicide. Another theme is that patient autonomy (or surrogate choice in the case of incompetent patients), while a keystone of medicolegal doctrine, must sometimes yield to countervailing concerns. That notion emerges with regard to allocation of health resources in a way that favors preventive over cura-
tive medicine and thus tends to limit medical options in critical-care contexts (pp. 48–49), as well as in the discussion of human cloning where “parental” choice yields to concerns about the cloned beings’ welfare and concerns about putative social harms (pp. 14–16, 20–22). This muting of enthusiasm for pure autonomy furnishes a subtheme for the book but does not eliminate the episodic quality.

As Jay Katz has noted, George Annas communicates a passion for his perspectives that distinguishes him from many other contemporary commentators. Sometimes that passion is infectious and persuasive. Sometimes it merely impels arguments that finesse real dilemmas by appeal to utopian values. For example, use of immigration laws to limit spread of infectious diseases is ridiculed in part because it is inconsistent with Professor Annas’s vision of a model world community (in which freedom of mobility would apparently be a major value) (p. 180). And preoccupation with poor mothers’ spread of AIDS to fetuses is ridiculed as distracting from correction of the underlying social conditions that produce poverty, drug abuse, and alcoholism (p. xv). Readers can appreciate Professor Annas’s knack for viewing the entire picture, including the social background of medicolegal issues, but the appeal to international norms and to redistribution of resources may seem too utopian for many.

George Annas’s positions are often not only provocative, but carry a distinctive Annas spin. His take on physician-assisted suicide provides an example. On the one hand, Professor Annas subscribes to the notion that physician-assisted suicide would be a precarious prerogative because of various social and economic pressures on vulnerable dying patients (pp. 214, 240–41). This argument about the hazards of abuse is a mainstay of opponents of assisted suicide and was a prime factor in the Supreme Court’s upholding of the constitutionality of bans on assistance to suicide. On the other hand, Professor Annas argues forcefully that the common understanding of assistance to suicide is too broad. He encourages physicians to supply prescriptions for analgesics that can, in large doses, be fatal. He asserts: “Physicians legally can, and as a matter of good medical practice should, supply prescriptions for potentially lethal drugs that have an independent legitimate medical use to their terminally ill patients upon request if they believe that having these drugs is likely to permit the patient to live better” (p. 220; see also pp. 213–14, 232). The underlying legal point is that a physician is not guilty of the crime of assisting suicide unless the physician acts purposefully to promote the suicide. Thus despite knowledge that the dying patient might accumulate analgesics and use them for suicide, the facilitating physician commits no crime so long as the physician’s intention is to promote legitimate medical ends such as relief of anxiety or pain.

Professor Annas makes quite a valid point about the narrowness of criminal responsibility for assisting suicide. And my normal inclination is to applaud encouragement of healthcare providers to ease and/or hasten the dying process for egregiously suffering patients. Yet Professor Annas’s valid point also underscores the artificiality and hypocrisy of the current framework governing end-of-life medical handling, especially assistance to suicide. Let me explain.

The scenario Professor Annas apparently envisions is the gradual stockpiling by the dying patient of quantities of a potentially lethal analgesic. The physician perceives immediate patient need for the analgesic or sedative (for relief of pain or anxiety) and hopes...
that the patient will not ultimately need to resort to a fatal dosage. There can be many deviations from that scenario. Suppose the dying patient is already suffering egregiously (rather than merely confronting anxiety about a future decline). And suppose that the cooperating physician, moved by the extreme suffering, now wants the patient to use the analgesics to accomplish the patient’s demise. In theory, the physician is disqualified from cooperation with the stockpiling patient because the physician’s state of mind is now to promote the suicidal act. In fact, the physician can still avoid criminal responsibility (the indeterminacy of specific intent being what it is) by maintaining a pretense of wanting only to provide temporary palliative relief. Current law cultivates this charade in which a healthcare provider may feign a desire that the patient refrain from suicide while actually intending to facilitate the patient’s demise.

Other questions plague the Annas suggestion of readily providing potentially lethal palliatives. What quantities of analgesics are to be prescribed by the physician? If the prescribed quantity is geared to the immediate palliative needs of the patient, the patient will presumably have to divert some quantities (for purposes of stockpiling a lethal amount) and thereby forgo some intermediate relief. If the physician prescribes quantities clearly in excess of immediate palliative needs, the physician might be subject to a contention that the actual intent was to facilitate suicide or to a contention that the prescription practice was reckless and therefore within the bounds of malpractice or unprofessional behavior. Moreover, what happened to the assertion by opponents of legalizing assisted suicide (including George Annas) that assisted suicide risks abuse of vulnerable patients? The prescription practices that Professor Annas endorses will occur in the privacy of the physician–patient relationship without special scrutiny of competency or undue pressures.

The fault, I suggest, is not in Professor Annas’s worthy effort to encourage easing of the dying process for suffering, dying patients. Rather, the defect is in a legal framework that bans some humane end-of-life practices while leaving a loophole only when the practice is performed under the pretense of a pure state of mind—a mind free from intent to promote death, even a dignified death for a suffering and gravely deteriorated patient.

Other Annas quirks surface in Some Choice. The discussion of medical futility (in the context of life support for an anencephalic infant) provides an example. On the one hand, Professor Annas offers astute legal analysis of the claim that federal law compels continued life support for an anencephalic infant (pp. 84–86). He notes that Congress could not have intended to mandate all medical intervention no matter how inconsistent with prevailing medical standards. He also correctly sketches the legal boundaries of surrogate responsibility: parents of infants are entitled to discretion in shaping their children’s medical course so long as the chosen course is not abusive or inhumane. And he notes that prior medical handling of permanently unconscious patients conveys a message from the medical profession that continued life support is not inhumane, given that the preserved patients are not suffering. The ultimate issue becomes whether life-extending intervention on behalf of a permanently unconscious being is intrinsically degrading and therefore intolerable. All that seems correct and helpful. The deviation is Professor Annas’s puzzling comment that the hospital should have continued discussions with the infant’s mother (who insisted on continued life support) until a resolution
had been reached (p. 83). The suggestion is puzzling because there is no apparent accommodation of the parties’ irreconcilable positions. Moreover, where the ultimate question is whether a surrogate’s insistence on life support is so inhumane and degrading to the patient as to be abusive, a court seems an appropriate forum for the dispute resolution. While the reader must thus be alert to occasional Annas quirks, they don’t detract from what is an enjoyable and incisive exploration of interesting medicolegal issues.

—Norman L. Cantor

Notes

4. Of course, so long as all persons surrounding the dying patient are comfortable with the patient’s chosen course, no one is likely to raise or press these points.


Classical American pragmatists, such as William James, John Dewey, and C. S. Peirce, have had little influence on the development of bioethics. Glenn McGee and the other authors whose essays make up this book believe that this is a mistake. They maintain that the work of these pragmatists constitutes an original and effective method for understanding and resolving bioethical dilemmas. Their collective goal is to convince the rest of us that they are right.

As I see it, if these authors are to meet their goal, they must accomplish the following:

1. They must clarify the central concepts and doctrines of American pragmatism to combat the widely held misconceptions that scholars have of them—in particular, the misconception that this philosophy amounts to a doctrine identifying what is “right” or “true” with what is expedient. Most bioethicists are fearful of allowing such reasoning to influence their moral deliberations and will reject any method that they believe espouses it.

2. Since none of the classical American pragmatists themselves ever systematically articulate what the pragmatic method is, these authors must show that the concepts and doctrines developed by these pragmatists in their work constitute such a method.
3) These authors must also establish that the pragmatic method is relevant for addressing the kinds of issues that bioethicists encounter in their work. The method must not only allow for new approaches to old problems, it must also put bioethicists in a position to grapple with new problems as they arise.

I find that these authors, at times individually but most certainly collectively, succeed at each of these three tasks. Because of spatial limitations I cannot discuss each essay in explaining why I came to this conclusion. I will, however, discuss a representative sample.

I begin with Jonathan Moreno’s “Bioethics Is a Naturalism,” an essay that I find makes an important individual contribution to the three tasks. What Moreno is concerned with is the classical American pragmatists’ version of naturalism. He argues first that this version is similar to the one identified with the work of Quine in that it rejects foundationalism and agrees that the methods of science best permit the acquisition of knowledge. However, it diverges from the Quinean version by refusing to accept that science is “the ultimate authority on the nature of the world.” Pragmatists accept only that scientific method affords the best opportunity for gaining knowledge and should therefore be the model for all other types of inquiry. Next Moreno explains how the pragmatists’ naturalism is a “contextualist” approach to moral problems. Pragmatists recognize that “what counts as a moral problem is tied up with a matrix of conditions that both define the problem and render it perceptible” (p. 11). Thus, they maintain that moral problems will not be solved by making a foundationalist appeal to an “a priori metaphysics of moral principles” but only by understanding the matrix of conditions defining the problem and tailoring solutions to them. Finally, Moreno argues that bioethicists in their approach to moral problems are already naturalists in this pragmatic sense. He insists that “The naturalist strain emerges insofar as the views that cash out do so influenced as much by the problem at hand as by any prior theoretical views that participants bring to the table” (p. 14).

An essay that works well with Moreno’s is McGee’s “Pragmatic Method and Bioethics.” By focusing on Dewey’s notion of “inquiry” as it is developed in Logic: The Theory of Inquiry, McGee succeeds in providing a textual basis for Moreno’s claims about the pragmatic method. McGee makes clear that for Dewey an “intelligent method” for solving social problems is one that models itself after the methods of science but also retains a keen awareness of the contextualized nature of those problems. More specifically, it is one that views solutions to social problems as experiments whose success is context dependent.

Joseph Fins, Matthew Bacchetta, and Franklin Miller, in “Clinical Pragmatism: A Method for Moral Problem Solving,” clarify the pragmatic method further by emphasizing that the goal of this method is “to reach consensus on good outcomes . . . by a thorough process of inquiry, discussion, negotiation, and reflective evaluation” (p. 30). They then apply the pragmatic method to a specific moral problem, one where family members request treatment that is deemed futile by the attending physicians. They show quite persuasively how a problem that initially seems intractable can be resolved once its contextual parameters are understood and all those involved work together to reach consensus about a course of action.

Two others essays bring out the pragmatists’ emphasis on community. In
“Collaboration and Casuistry,” Mary Mahowald does this by drawing on the work of C. S. Peirce to address the obvious connection between a pragmatic ethics and casuistry, the case-based approach that has recently been revived by Jonsen and Toulmin. She argues that Peirce’s pragmatic method “acknowledges the validity of this approach while pointing to its pitfalls and suggesting ways of overcoming them” (p. 73). According to Mahowald, Peirce would agree that casuistry succeeds in resolving conflicts that traditional approaches leave unresolved. However, Peirce would also find that casuistry, at least as it is defended by Jonsen and Toulmin, lacks a mechanism for determining whether its solutions are true. Peirce would insist that casuistry must be supplemented with the idea of a “community of inquirers” collaboratively engaged in the pursuit of knowledge. Mahowald contends that by linking casuistry’s case-based approach to this notion of a community of inquirers, Peirce’s pragmatic method avoids the charges of “anti-intellectualism and relativism” that have been leveled against Jonsen and Toulmin’s account of casuistry.

Micah Hester highlights a different aspect of pragmatism’s emphasis on community in “Habits of Healing.” For pragmatists, a community arises when individuals cooperate with each other to achieve a common end. However, they contend that this does not require people to be the same or to make the same contribution to the community. A true community is established only by finding the proper balance between individual and social interests. Hester argues that medical professionals must incorporate “habits of community” in their practices and attitudes. That is, they must develop habits such as discipline, intelligence, patience, and acceptance that foster a sense of community. This, in turn, will lead medical professionals to view their patients as individuals with interests of their own. It will also help them to recognize the validity of these interests and keep them from acting paternalistically towards their patients. Finally, it will encourage medical professionals to work with their patients in trying to satisfy these interests.

So far I have mentioned essays that contribute more to the first and second tasks by clarifying central pragmatic concepts and showing how they constitute a pragmatic method for bioethics. Let me now mention a few that contribute more to the third task of establishing the relevance of this method by applying it to problems of current concern to bioethicists.

Kelly Parker, in “The Bioethics Committee: A Consensus-Recommendation Model,” draws on the pragmatic method to discuss the appropriate role of bioethics committees. Many who accept the traditional ethical theories think that the role of such committees should be to render decisions and judgments by identifying which of the relevant competing obligations has priority. However, Parker contends that bioethics committees have more success when they adopt a role that is more consistent with the pragmatic method. That is, when they work to “mediate conflict by developing non-binding recommendations based on open discussion and consensus” (p. 69). While committees that assume this role sacrifice the ability to render definite and unambiguous solutions to moral dilemmas, their willingness “to experiment with guides to action—and to tolerate ambiguity and uncertainty concerning fundamental questions in doing so—are virtues when a community finds itself functioning in complex and rapidly changing circumstances” (p. 69). These committees play an important role in medical practice by helping those involved reach decisions that
reflect their community’s current beliefs and values while also leaving room for revising these decisions once these beliefs and values change.

Herman Saatkamp argues in “Genetics and Pragmatism” that the pragmatic method provides insight into three issues that arise from the success of the Human Genome Project. First, he contends that pragmatism’s success in demonstrating the influence that culture and environment have on human behavior serves as a warning against accepting the simplistic explanation of behavior—“genotype causes phenotype”—that this project has (unintentionally) popularized. Second, he argues that pragmatism makes clear why it is undesirable to establish a specific set of principles guiding, and perhaps restricting, parental choice in obtaining and using genetic information. Such principles are inappropriate given the contextual nature of these decisions. Parents must be free to make the choices they believe are best for their children and they must be free to obtain the information—in particular, genetic information about themselves and their children—that they need to make intelligent choices. Finally, Saatkamp considers whether there should be an established social policy about the use of genetic information. He endorses pragmatism’s tenet that “social decisions should be made by those who will be most affected by such decisions” (p. 165). He concludes that individuals should be allowed to decide for themselves and parents should be permitted to make decisions for their children as long as a stable society and healthy environment are maintained.

Jacquelyn Ann Kegley, in “Community, Autonomy, and Managed Care,” argues for replacing the “framework of economic self-interested individualism” that drives our current managed care system with one incorporating the features of the pragmatic method. While she has much to say about how this shift will alter this system, I find her account of how this would lead to greater emphasis being placed on the social conditions that both hinder and facilitate informed consent most helpful. She argues that the current emphasis on individualism is responsible for stress being placed on “individual patient decision making, on individual competence, on noncoercion, and on the procedural process” (p. 210). However, these stresses fail to recognize adequately what pragmatism makes clear, namely, that patients make decisions “in a context of interdependence and social roles, responsibilities, and values” that strongly influences those decisions. As a result, too little attention is paid to the social conditions that lead people to make poor healthcare decisions, such as power inequalities, poor education, language, self-image, and paternalistic and prejudicial attitudes. Kegley contends that switching to a framework incorporating pragmatism’s emphasis on viewing people as “social beings” will do much to correct this.

I regret that I can discuss only these essays from the book. There are many others that certainly deserve to be mentioned, like William Gavin’s essay on “taming” and “untaming” death and Bruce Wilshire’s on alternative medicines, but spatial limitations prevent it, and I do want to state my one main criticism of the book before I end. This criticism has to do with McGee’s introduction to the book. I do not find it as helpful as it could, and really should, be. First, while McGee does acknowledge the ways that pragmatism has been abused by scholars as a result of their misconceptions of it, he does not make any attempt to convince his readers that these are abuses. Given how influential these misconceptions are, McGee misses an excellent opportunity to distance pragmatism from them.
right at the start. Second, McGee never provides a general summary of the pragmatic method. True, he does want the essays in the book to represent the "plurality of perspectives" that characterize the pragmatic movement in bioethics and he may have been concerned that by giving this summary he would suggest that there is a single method that all of the writers accept. Nonetheless, a general summary of the main tenets of this method could capture this pluralism while usefully introducing the reader to it.

Despite this fault, I strongly recommend the book. There is much here for anyone interested in bioethics, classical American philosophy, or both.

—Mark Moller