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Suite 1032 - B985
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Phone/Fax: +1.530.482.3248
info@bioethicspress.com
www.ethicsandmedicine.com

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MANUSCRIPTS FOR PUBLICATION SHOULD BE SENT TO

C. Ben Mitchell, Ph.D., Editor
Ethics & Medicine
1050 Union University Drive
Jackson, Tennessee 38305 USA
Phone: +1-731-661-5915
Fax: +1-731-661-5118
bmitchell@uu.edu

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PROF. DR. G. A. LINDEBOOM INSTITUUT
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Phone: +1-417-353-8830
Fax: +1-419-353-8920
info@philinfo.org
www.philinfo.org

TYPESETTING

Typesetting by Andrew DeSelm
andrewdeselm@gmail.com

PRINTING

Kelvin Printing (1993) Pte Ltd
Michelle FM Loke
michelle@excelprintmedia.com

Contributors

Justo Aznar, MD, PhD, with Extraordinary Prize from the University of Navarra (Spain) is Head of the Department of Clinical Biopathology and Coordinator of the Biochemical Research Unit, at La Fe University Hospital in Valencia, from 1974 until his retirement in July 2006. From 2005 to 2016 he was a Corresponding Member of the Pontifical Academy for Life. He is currently Director of the Life Sciences Institute of the Catholic University of Valencia. He is a member of the Royal Academy of Medicine of the Valencian Community and corresponding of the Royal National Academy of Medicine. He currently resides in Valencia, Spain.

Ondřej Beran, PhD, is a Researcher at the Centre for Ethics (Department of Philosophy), University of Pardubice, and the Deputy Head of the Centre. His recent publications include the book *Living with Rules* (Peter Lang 2018) and the co-edited book *From Rules to Meanings* (Routledge 2018). He works in ethics and the philosophy of language. He currently resides in Pardubice, Czech Republic.

William P. Cheshire, Jr., MD, MA, is Professor of Neurology and Chair of the Medical Ethics Committee at the Mayo Clinic in Jacksonville, Florida. He is Senior Fellow in Neuroethics at the Center for Bioethics & Human Dignity. In 2019, the Christian Medical & Dental Associations awarded him Educator of the Year. The views expressed herein are his own and do not necessarily reflect the positions of the professional organizations with which he is affiliated. He currently resides in Ponte Vedra Beach, Florida, USA.

Jay Hollman, MD, MA, has enjoyed a long career in cardiology, practicing at Cleveland and Ochsner Clinics and educating fellows, residents, and students. He now teaches medical students and residents at LSU-New Orleans Health Science Center.

Michal Pruski, PhD, MA, AFHEA, MRSB, is a trainee Clinical Scientist (according to British nomenclature) in Critical Care Science at the Manchester University NHS Foundation Trust. The theoretical component of the training is undertaken at Manchester Metropolitan University. The author has no conflict of interest to declare and wishes to acknowledge Toni Saad, Daniel Rodger, and the anonymous reviewers for comments and suggestions. He currently resides in Manchester, UK.

Julio Tudela Cuenca, **Pharm, PhD,** is Professor at the Catholic University of Valencia and Director of the Master in Bioethics of the Catholic University of Valencia. He is Member of the Life Sciences Institute of the Catholic University of Valencia. He is Member of the Research Ethics Committee of the Catholic University of Valencia and the Research Ethics Committee with Medicines of the Valencian Oncology Institute Foundation (Spain). He currently resides in Valencia, Spain.

Ferdinand D. Yates Jr, MD, MA (Bioethics), is a medical staff member at Children's Healthcare of Atlanta, and has a private pediatric practice in the Atlanta area.

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EDITORIAL

When Self Determination Runs Amok

C. BEN MITCHELL, PHD

I take it that it isn't plagiarism if one identifies one's source. In this case I have borrowed the title from an essay by the estimable Daniel Callahan from another journal, *The Hastings Center Report*.[1] In this essay, Callahan argues on several grounds against the legalization of physician assisted suicide and euthanasia, not least on an unbridled and undisciplined notion of patient self-determination. Likewise, philosopher Carl Elliott has explored the limits of self-determination in his ground-breaking volume, *Better Than Well: American Medicine Meets the American Dream*.[2] Elliott interviews patients who self-describe as "amputee wannabes" or call themselves an "amputee-by-choice." These are individuals who see their limbs as alien to their bodies and ask physicians to remove perfectly healthy limbs because of a perfectly unhealthy body dysmorphic disorder.

Although it is demonstrable historically that medicine has sometimes—or more properly, physicians have sometimes—been guilty of strong paternalism, adopting it's polar opposite, absolute patient autonomy, seems too radical for the well-being of both patients and the treatment they sometimes desperately require. Yes, Hippocrates is credited with saying, "Life is short, and the Art long; the occasion fleeting; experience fallacious, and judgement difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals co-operate" (Aphorisms). And this can certainly be taken to entail strong paternalism. "Making" the patient, and everyone else, cooperate is quite a prescription.

Nevertheless, such a potent paternalism is not endemic to proper medical care and, as both Callahan and Elliott argue, neither is potent patient autonomy. I would argue that the physician's covenant to use her training and gifts for the well-being of the patient should be accompanied not by a patient's determination to do whatever her or she wants to do, but by a negotiated compliance with the physician's recommendations with the acknowledgement that physicians are not right all the time, and neither are patients. In other words, just as the physician joins a covenant to heal, so the patient joins the covenant to comply and be healed.

Granted, there are extremes to be avoided and, granted, the patient's body is the patient's property, as it were. But medicine deserving of the name cannot be governed by naked self-determination. After all, the word "patient" comes from a root that means "sufferer." The sufferer is compromised by *dis*-ease that he or she presumably cannot remedy. So the patient appeals to the physician who is pledged to aim for the good of the patient. The medical covenant is, therefore, more like a dance than a DIY project. In a dance the partners both have an important role to play. One leads and the other follows, but neither works independently of the other; neither partner is autonomous, and there are rules and patterns to follow.

Contemporary patient care is in desperate need of an ethic that avoids both the extremes of paternalism and autonomy. The patient is a person, as the late Paul

Ramsey put it, and so is the physician. The healing dance—or the treatment tango, if you will—requires partners who are willing to respect one another, negotiate their relationship, and take steps together that move the patient toward well-being. E&M

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GREY MATTERS

Lifting the Impenetrable Veil: Ethical Implications of Neural Vision Decoding

WILLIAM P. CHESHIRE, JR., MD

As virtual reality from within the nervous system becomes competitive with real reality in terms of resolution and believability, our experiences will increasingly take place in virtual environments. – Ray Kurzweil[1]

Abstract

The neurobiological capacity for vision and electronic digital imaging technologies are similar in that both construct visual representations of the natural world. They are fundamentally dissimilar in their structure, function, and purpose. Incremental advances have begun to decode the nearly inscrutable brain states that correspond to subjective visual perception, which is a prerequisite to connecting these two systems. Some predict the eventual development of visual brain-computer interfaces that could allow a computer, if fed data from the brain, to reconstruct and display subjective visual thoughts or to feed visual information directly to the brain. Extending such technology, if it were possible, to enhance normal vision, to create realistic artificial experiences, or to detect private thoughts, would lead to a spectrum of ethical difficulties. The intriguing possibility of detecting and recording the visual imagery of dreams leads to further questions, including what kind of ethical framework should apply to dream experiences.

Introduction

Tapping into neural signals deep within a cat's brain, a team of neuroscientists at the University of California in Berkeley succeeded in producing digital movies that reconstructed in fuzzy yet recognizable detail scenes of what the cat was seeing in the world around it. In this first direct demonstration that spatiotemporal natural scenes can be reconstructed from experimentally recorded neural spike trains, they recorded the bursts of neuronal activity by use of depth electrodes implanted in the lateral geniculate nucleus of the thalamus, where visual signals from the optic nerves are processed and then relayed to the visual cortex.[2]

Twenty years later, advances toward brain-computer interfaces (BCIs) that merge the neural activity of natural vision with computed digital imaging continue to flicker forward. The ultimate goals of these technologies are to understand how vision works in the brain, to restore vision to the blind, and optionally to enhance vision for those who can see.

In surprising ways, this trajectory of engineering science seems at times to be matching Ray Kurzweil's accelerating timeline of forecasted innovations[3] in which he predicted in 1999 that, by 2019, eyeglass-mounted navigation systems would be

developed for the blind. Such devices are, in fact, in development.[4] If Kurzweil's prediction for the next decade becomes reality, then by 2029 a range of neural implants will be available, offering high-bandwidth direct connections to the human brain "to enhance visual and auditory perception and interpretation, memory, and reasoning."[4] Not all of Kurzweil's predictions have come true.[5,6] Nevertheless, it is interesting to consider prospectively the ethical implications of such technologies. Whereas the previous Grey Matters paper addressed neural speech decoding,[7] this discussion considers neural vision decoding.

Some Nontrivial Technical Challenges

The conceptual and technical difficulties of linking the brain's visual systems to a computer are extremely challenging, if not practically insurmountable. Detecting and decoding the neural spikes corresponding to human visual perception is a task of colossal complexity. The next step, developing a working visual BCI, is a daunting challenge from the perspectives of both electronics engineering and neuroscience.

The task of translating neural information to a digital electronic format is more problematic by orders of magnitude than translating one human language into another. From the perspective of electronics engineering, patterns of neural activation and modulation are fundamentally different systems than the flux of electrons in computer circuits. They differ in how they encode, transmit, process, store, and retrieve information.[8,9] A blip here or a spike there in one system does not correspond to a meaningful signal in the other. A simple coupling of one to the other is quite impossible. A partial coupling might be something like trying to represent a Rembrandt painting by a paragraph of prose; much meaning and nuance would be lost in translation.

From the perspective of neuroscience, how the brain creates subjective visual impressions from patterns of light and, moment-by-moment, interprets them in exquisite detail is still largely unknown. The neural substrates of visual perception are widely distributed in the brain, interfacing with many functional regions in a vast three-dimensional network within which there is no one location where all perception converges. This condition of neurobiology touches on a longstanding philosophical problem. If consciousness is nonlocalizable, then no electronic interface can tap into the brain at any one particular location and thereby directly contact a unified sense of perception or thought.

Surgical Risks

Though a brilliant computer engineer and inventor, Ray Kurzweil is not a physician and lacks experience caring for patients with deep brain electrodes. His optimism underestimates the potential hazards of inserting any type of hardware into the human brain. Deep brain electrode implantation, while relatively safe, is an invasive surgical procedure not without risks, both intraoperatively and long-term. These risks include infection, hemorrhage, infarction, seizures, headache, lead migration, lead disconnection, and loss of effect.[10] Currently the overall rate of procedure-related complications is approximately 11%.[11] The device-related complication rate is 0.3% per electrode per year.[12] These risks are considered acceptably low for treating

patients with neurologic disease but would be unacceptable for interventions on healthy persons for enhancement purposes.

Potential Uses and Ethical Concerns

Suppose, for the sake of argument, that visual BCIs are developed and become available as consumer products. Suppose also that such devices are safe, reasonably affordable, and display visual information in high definition. A number of ethical issues would accompany the technology as surely as would high price tags.

One concern is the potential social division that could occur between the enhanced and nonenhanced. Someone with a visual implant that supplied the brain with tenfold better optical resolution, or extra wavelengths such as infrared, or displays of additional data such as distance or wind velocity, would have a distinct advantage in athletic competition or military exercises, among other pursuits. Someone with a visual implant that interpreted subtle emotional cues in others' facial expressions would have an advantage in business and social relationships.

Those preferring to remain natural might then face the choice of opting in and using the technology or else becoming disadvantaged or functionally obsolete. Individual autonomy would not be the only deciding factor, as external incentives would come into play. A high school student aspiring to enroll in college on a golf scholarship and competing against other students who were equipped with vision-enhancing implants might think it undesirable, if not career-ending, to remain unenhanced. A neurosurgeon might opt for a vision-enhancing implant in order to perform delicate operations at a higher level of performance and safety; her colleagues who are visually enhanced might already be charging higher fees for their technology-enabled performance edge. Automobile insurance companies might offer lower rates to drivers who chose to undergo visual enhancements that were shown to reduce the risk of collisions. An oceanside hotel might be more inclined to hire a visually enhanced lifeguard to watch over children swimming in the surf, and, if given the choice, the parents of those children would likely agree.

In all of these examples, plus many more, a visual BCI might be hard to refuse. Several years later, when a more advanced model rolls out, what was once the top of the line quickly becomes outdated and less desirable. It may not be possible to switch out a device that is irreversibly fused to the brain without mutilating and destroying brain tissue. The user may be stuck with the model first chosen and ineligible for further upgrades as the technology advances. Even the enhanced would be left behind by younger adopters of the next wave of enhancements.

Another concern is whether developing and manufacturing expensive visual BCIs would be a wise use of limited resources. As the implantation of these devices would require a surgical procedure, healthcare resources allocated for BCI implantation and maintenance would compete with those for more basic, and currently incompletely met, health needs.[13]

A further concern is the potential social impact of visual BCIs, which may only magnify the problems cell phones have introduced. Just as pedestrians, with their faces buried in handheld screens, are increasingly seen walking around in public oblivious to their surroundings, and automobile drivers distracted by incoming text

messages take their eyes off the road, visual BCIs could lead to further distraction and withdrawal from the real world and from genuine human interaction.

These concerns are not lessened by aspirations to construct virtual reality images and immersive experiences so realistic as to be indistinguishable from reality. If the interface of brain and computer were seamless (a doubtful possibility), then a device able to read mental images might also be able to manufacture and insert credible images. The resulting visual ambiguity could render the consequence and meaning of moral acts uncertain. To the extent that virtual reality, supplied in lifelike detail by visual BCIs, approximates or claims to improve upon natural reality, questions of moral agency arise. Kurzweil predicts that it is "likely that society will accept practices and activities in the virtual arena that it frowns on in the physical world, as the consequences of virtual activities are often (although not always) easier to undo."[14]

Exploring his point a bit further, even if crimes committed in virtual reality were not counted as criminal, or, for that matter, charitable acts counted as virtuous, participating in virtual reality still would seem to have the potential to shape character, which has implications for attitudes and behavior in the real world. A skeptic might argue that engaging in violent or sinister activities in virtual reality is no different than watching such things on television, as they are already ubiquitous. In response, it might matter to a parent hiring a prospective babysitter whether the stranger had recently watched a fictional television show depicting the police pursuit of a serial killer or had committed serial murders in a stunningly realistic virtual reality video game.

There is a technical solution for most of these ethical concerns. Rather than develop invasive brain implants, it would be better for society to develop and for people to use devices that are useful for specific praiseworthy purposes and are then removable.

Exposing Private Thoughts

Deeper still are the ethical concerns regarding visual BCIs that might detect private thoughts. Suppose a noninvasive device—a scanner rather than implanted electrodes—capable of reading the fleeting images that appear in the imagination were available. Suppose also that the police had in custody a suspected terrorist who had passed a traditional polygraph test, and time was running out in the search to find a ticking bomb. Most people, if asked where they had hidden a bomb of which they retained a visual memory, would find it impossible to suppress a recollection of its image and visual details of its location. The brain-scanning device, if sufficiently sensitive and accurate, would hopefully show the police enough information to guide them to the bomb in time.

But suppose the suspect had been arrested by mistake and was innocent of any terrorist activities. The same device, in scrolling through the images that flashed before his mind, might discover unexpected, even embarrassing, information about his personal life. Should anyone have access to his most private thoughts? Should others, or he himself, be told if the device were to detect unconscious biases regarding, for example, racial attitudes? Some such discoveries might be actionable, in that they could lead to insights that the person being scanned might want to have in order to

reconsider his views. Other discoveries might only cause blame, shame, or personal risk.

Suppose further that the secret police in some remote country unconcerned about human rights or personal privacy found such a device to have certain other, useful applications. In the wrong hands, a device able to detect images of private thoughts could become a powerful weapon to identify political adversaries, select ideological opponents for enforced re-education, or decisively rout out perceived enemies.

Perchance to Dream

Still other visual thoughts reside in the ephemeral, subconscious, often forgotten world of dreams. A link between specific dream content and focal patterns of brain activity is predicted by the principle of perceptual equivalence, which postulates a shared neural substrate for visual perception and mental imagery.[15] An implication of perceptual equivalence is that technology interfacing with the neural substrate of visual perception could potentially scan the mental imagery of unspoken thoughts during wakefulness, perhaps also the thoughts of daydreams and perhaps even thoughts during sleep. Dream images not recalled upon awakening might also be detectable by such hypothetical technology.

This further extension of technological potential signals an enormous leap in ethical concerns, for which reason it is necessary to pause and consider first whether it is even feasible to detect the content of mental images during sleep. Proof of concept has, in fact, come from a computational neuroscience laboratory in Japan, where investigators utilized artificial intelligence to decode the functional magnetic resonance imaging (fMRI) patterns of brain activity corresponding to categories of visual imagery during sleep. Healthy volunteers were allowed to sleep at regular intervals while being monitored by fMRI and electroencephalography (EEG). When the rapid-eye movement (REM) stage of sleep was identified, the volunteers were awakened and asked to report the visual content of their dreams. After many repetitions, machine learning technology identified content-specific patterns of visual cortex activation that corresponded not only to specific categories of reported dream content but also to fMRI patterns induced by the volunteers viewing natural images of items from those categories. The machine was then able to predict the category of dream images with 60% accuracy.[15]

The meaning of dreams has been a subject of speculation for as long as humans have reflected on life. Some dreams recapitulate memories drawn from actual experiences,[16] but most others present the dreamer with unreal scenes in which shapes, sounds, spatial proportions, movement, time, action, causation, and other conditions of the ordinary world are distorted, rearranged, bizarre, or incoherent. Neuroscience has shown dreaming to correlate with activation of selective frontal, parietal, and temporal brain regions, which suggests that dreams are not just passive visual experiences but also involve thinking regions of the brain.[17] The sometimes intense emotional content of dreams suggests, further, that the neurobiology of sleep may have implications for understanding, and potentially managing, emotional regulation.[18] From a psychoanalytic perspective, some have suggested that the interpretation of dreams may lead to the detection of hidden sources of guilt or even to an understanding of the conscience of the dreamer.[19]

Some of these neurobiological correlates of dreaming connect with brain regions involved in moral thought, and it may be tempting to speculate that dream content could be relevant to a person's moral character when awake. Dreams, however, seem to arise without the dreamer's volition, and they play out in the absence of the sleeper's voluntary control over dream scenarios, at least in the way that decisions influence real life during wakefulness.[20] The dreamer, who is in a restricted state of consciousness, would seem to lack the capacity for intentionality that is a necessary condition for having moral responsibility. Further, the dreamer would seem to be unable to consider in any meaningful way the potential consequences of decisions made in dreams, if consequences can be evaluated at all in a transitory imaginary realm. For these reasons, ethics makes little sense in the strange world of dreams.

This may be the reason that we are amnestic for most dreams. If we remembered them clearly, we might be inclined to feel—inappropriately—responsible for our thoughts and actions during them. There would seem to be a relevant moral distinction between embodied acts during wakefulness and imagined acts during dream sleep. That distinction could blur if technology were able to manipulate dream states in such a way as to bring intentionality into dreams or cause one's choices and actions in dreams to have consequences in real life.

Neurologic illness sometimes provides examples that help to clarify ethical questions. There is a pathological condition known as REM sleep behavioral disorder, in which patients enact their dreams. During normal sleep, a chemical switch in the brain disconnects dream actions from physical bodily movements. While sleeping, patients with REM sleep behavior disorder do not lie still but will move their legs as if running, swing at or punch their bedpartner, or even act out violent semi-purposeful behaviors that they would not do if awake and aware. Their nocturnal behaviors are involuntary and in no way reflect their character or habits when fully conscious. One's actions during dream states are held to a different ethical standard.

If We Could, Should We?

If technology were to make possible imaging of the visual content of dreams, the overarching ethical question is whether anyone ought to look. If it is good for us not to remember our dreams, then it may not be good for others to gain access to them. Dream content is highly personal and should be treated as private and, if accessible by technology, highly protected information. Persons should have the right to decide whether their dreams are imaged and whether information thus gained is disclosed.

Images of dream content should not be interpreted as evidence of the dreamer's personal identity or character, as might a video recording of that person's activities while awake. Even dreams drawn from personal memories are fragmentary and reflect the person's identity no more accurately than would a torn piece of newspaper viewed through a distorting lens indicate a reliable account of current events.

Suppose, though, that in the future there are those who want to image their dreams. The curious may decide to program their scanners, record whatever dreams occur during the night, and then watch them the next day. Their motivation might be to gain insight into their own psychology, or it might be entertainment. Some might choose to share their dream videos with friends or romantic partners. Others might craft from their dreams recordable art or music.

Perhaps future technology could make it possible to enter into dreams at will or, while dreaming, to retain some degree of conscious awareness or intention of action. The user might seek to act out any manner of fantasies. As in virtual reality, the dream world would seem to lack moral consequence. It is uncertain, however, whether repeated intentional actions, even in the dream world, might eventually reshape one's character and moral sensibilities during wakefulness.

If dream images could be scanned, perhaps in time they could also be manufactured and, through a visual BCI, inserted into the mind of an awake person. It might become possible to record and share one's dreams, or at least their visual content, directly with another person. Such technology could become the watershed for a dream entertainment industry promising custom dreams or subscriptions to dream libraries. The dreams of celebrities, recorded, edited, and sold for reuse, could fetch a high price in the dream-sharing market. It seems unlikely that such dreams would ennoble their voyeuristic fans. It might be difficult to enforce legal restrictions on hateful or violent dream recordings. The potential for a pornographic dream industry is equally disturbing.

Conclusion

In regard to noninvasive methods for detecting visual imagery in the brain, no current or foreseeable technology is adaptable for home use for purposes of entertainment, self-improvement, or curiosity. The cost, size, and technical complexity of these devices, which in elaborate research settings detect only hints of visual information, are well beyond the reach of the consumer market. No one will be sleeping at home in the tunnel of a personal fMRI machine in the conceivable future. For now, no one should lose sleep worrying about dream detection technology. And yet, about such prospects some will nevertheless dream.

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William P. Cheshire, Jr., MD, MA, is Professor of Neurology and Chair of the Medical Ethics Committee at the Mayo Clinic in Jacksonville, Florida. He is Senior Fellow in Neuroethics at the Center for Bioethics & Human Dignity. In 2019, the Christian Medical & Dental Associations awarded him Educator of the Year. The views expressed herein are his own and do not necessarily reflect the positions of the professional organizations with which he is affiliated. He currently resides in Ponte Vedra Beach, Florida, USA.

CLINICAL ETHICS DILEMMA

The Art of Informed Consent

JAY HOLLMAN, MD, MA; FERDINAND D. YATES, JR, MD, MA (BIOETHICS)

Editor's Note: *This column presents a problematic case, one that poses a medical ethical dilemma for patients, families, and healthcare professionals. As this case is based on a real situation, identifying features and facts have been altered in the scenario to preserve anonymity and to conform to professional medical standards. In this case, the cardiologist must explain to the patient about the treatment-care plan initiated by another cardiologist in the same city.*

Column Editor: Ferdinand D. Yates Jr, MD, MA (Bioethics) is a medical staff member at Children's Healthcare of Atlanta, and has a private pediatric practice in the Atlanta area.

Question

Does the physician have the responsibility of explaining the difference between living longer and living better to a patient?

Case Report

A 50-year-old gentleman is hospitalized for heart failure for the third time in the last year. He has been on "evidence-based medicine" but is tolerating only the smallest doses of beta blocker and ACE (angiotensin converting enzyme) inhibitors. He has required increasing doses of loop diuretics over the last several months. He has been limited in his activities and is short of breath, even when walking to the bathroom.

At his last hospitalization, he was admitted to another hospital in the city and was seen by a cardiologist who met him for the first time. After the patient had been stabilized with intravenous loop diuretics, the cardiologist recommended that the patient have an implantable cardioverter defibrillator (ICD). When the patient asked why, the physician replied, "You need to have this device implanted; it will make you live longer." The family in the room at the time quickly sided with the physician, and the device was implanted the next morning. He left the hospital the following day and returned to the public clinic for a follow-up a week later.

When seen back in the charity clinic, the staff cardiologist is surprised to see that the patient returned with a defibrillator. Previous discussions of the implantation of ICD documented the patient's preference not to have such a device. Now that he has the device, he does not recall earlier discussions and is content to do the follow-up for the device and have the device tested on a regular basis. He is disappointed, however, that his symptoms were not improved by having the device implanted.

Informed Consent for an Implantable Cardioverter Defibrillator (ICD)

The decision to implant an ICD is complicated. While there are evidenced based reasons for the implantation of a defibrillator the actual decision to implant an

ICD is complex. A reasonable start to informed consent might begin by telling the patient that there are two ways patients die with heart failure: they can experience progressive symptoms of shortness of breath and decline in heart function until they die of progressive heart failure or they can experience sudden death. Sudden death as an alternative must be carefully considered. There are many positives with sudden death the most important of which is that indeed it is sudden and usually relatively painless. Some are even blessed to die quietly in their sleep. Sudden death can save the patient from the experience of further decline in function and hospitalizations.

The patient also needs to understand the limitations of an ICD. If the patient does not have a broad electrical impulse or the need for a pacemaker, the patient will not have an improvement in symptoms with an ICD. This patient was surprised to realize that this expensive device did not improve his heart failure symptoms. It is easy for the medically unsophisticated to conflate living longer with living better. In fact, there are separate potential benefits of any medical intervention.

A patient will live longer only if the ICD detects a potentially lethal cardiac arrhythmia and gives a life-saving shock. Follow-ups of the randomized studies that established the benefit of an ICD for primary prevention demonstrated that only 19% had received an appropriate (and potentially a life-saving) shock by an average of 2.59 years of follow-up. Studies, which have been done since these trials, have suggested an even lower rate of appropriate shocks: just 2.6% of patients at 2.5 years of follow-up. It is simplistic for a physician to say that an individual patient should expect to live longer because he has an ICD implanted. In fact, the majority die without a life-saving shock.

Ethical Informed Consent Versus Legal Informed Consent

The written legal informed consent in most practice facilities spans several pages that would require several minutes of reading in order to be easily understood. Frequently these are given to the patient with billing and insurance release forms to sign. A one-to-two sentence explanation of each form may be given to the patient by the hospital clerk or nurse. Eventually, the permit for the procedure is also signed by a witness and the physician performing the procedure. This process is legal and efficient but does not constitute an ethical permit.

An Ethical Informed Consent Should Have These Elements

The ultimate goal of informed consent is that a patient thoroughly comprehends the benefits and risks of a procedure or operation in order to make a decision that will be best. The physician should know the patient's co-morbidities (the patient's other conditions that might affect his/her survival and quality of life) in order to give an accurate estimate of risks and benefits. The physician should also understand the patient's desires and expectations well enough to know that the patient is making an informed and reasonable decision.

This said, there are some caveats to consider:

1. Informed consent must be somewhat driven by the circumstances. In emergency situations, the explanation can be brief. In the case of presenting with a heart attack, the consent for the patient to go with emergency intervention in a heart lab might be

as simple as: "you are more likely to survive the heart attack and have fewer acute complications if you consent to go to the heart catheterization laboratory and have your artery opened. The duration of acute chest pain will also be shorter if the artery is opened." This brief but accurate informed consent is appropriate when time is critical. In urgent cases, like a heart attack or an acute trauma surgery, the patient's cognition might be compromised by pain or low blood pressure. A long explanation of all possible consequences is inappropriate; delaying the procedure more than a few minutes will diminish any benefit.

2. Elective procedures are just that, and patients should have time to consult family members, pray about their decision, and review educational materials regarding the procedure. (There are several educational videos that give the patient a balanced view of the risks and benefits of an ICD). If the physician gives a complete presentation of potential risks and benefits, then the patient should sense a certain degree of ambiguity. Most patients, given balanced information, will be able to make a quality decision that will be best for them.

Some patients might feel overwhelmed by the information and may not be able to make a decision, even after they appear to understand the explanations and have had time to discuss with family members. They might ask, "Doctor what would you do?" This can be frustrating, but the physician should take this as a compliment. The patient is really saying, "You are an ethical person who understands the potential benefits and risks better than I do. What is the best choice?" If the choice is clear, the physician should be quick to tell them. However, sometimes, the consenting physician must ask more questions. The patient is not asking what the physician would do with his health conditions and social circumstances but what the patient should do given who they are. In trying to make a decision for a patient, the physician must really understand the patient, what the patient expects from life, and the probability that the device will help achieve these life goals.

Discussion: The Physician as a Fiduciary

A common teaching among medical ethicists is that we are not to consider costs when making a decision regarding a medical therapy. We are taught that we should always do the best for our patients, regardless of the cost, and that the cost of care for an individual patient, no matter how great, will not greatly impact the recognized problem of excessive health expenses in the United States. Our current medical system, through third party payments (insurance or government), is quite good at obscuring the costs of a procedure or therapy. It is difficult to know in advance what insurance will pay and what the out-of-pocket costs to the patient will be. This ethical view is presented in part because it is believed by some that there should be no monetary value set on human life. Moreover, some feel that the introduction of costs into the decisions regarding medical therapy has the potential to introduce biases, such that the less deserving or the less financially well-off will be excluded from a valuable treatment.

I would take a contrary view for several reasons. First, there is likely to be out-of-pocket expenses for insured patients, and these should be known in advance whenever possible. It would be wrong to implant an ICD in a self-pay patient without their knowledge that the cost would be $50,000 or more. (Most hospitals

will not allow elective admissions for self-pay patients needing an ICD without a substantial payment in advance). Medicare patients without a Medigap policy would be responsible for 20% of the Medicare allowable charge. Medicare patients with Part A only who have an ICD implanted as an outpatient will find that their Medicare Part A does not pay anything for outpatient procedures. To think that introducing costs into the equation will confuse the issue or cause patients to make a bad decision diminishes patients and their decision-making capacity. Just as an unsophisticated stock market investor needs a fiduciary rather than a stock broker salesman, so the patient wants the physician to weigh all the information, including financial costs to the patient, when recommending an ICD. Although it is not always appropriate to discuss costs with the patient (such as the above patient with an acute myocardial infarction), I find that when I include the potential financial costs in the discussion, the trust bond with the patient is strengthened. Equally important, there are no major surprises when payment is required.

Societal Stewardship

If some consider it unethical to discuss co-payments and of out-of-pocket expenses, even more would think considerations of societal costs with patients clearly out of bounds. To the contrary, I find that teaching regarding actual costs is of value to residents and medical students and, when used selectively, is also helpful to the patient.

There is no question that the treatment of heart failure with reduced ejection fraction has improved greatly over the thirty-seven years that I have been practicing Cardiology. There are at least three classes of drugs that have been demonstrated in randomized trials to reduce mortality in heart failure and thus have the highest endorsement for use by the American Heart Association and the American College of Cardiology (see table 1).

Drug/device	Clinical trial	Reduction in mortality	Annualized reduction	Cost per year
Beta blocker	Capricorn	3% at 1.3 yrs	2.3%	$40
Ace inhibitors	SOLVD	8% at 37.4 months	2.5%	$40
spironolactone	RALES	11% at 24 months	5.5%	$40
ICD	SCD-HeFT	7% at 45.5 months	1.8%	$50,000+ first year

Table 1. The results of various therapies for heart failure and their annual costs. Beta blockers, ace inhibitors, and spironolactone are all on the Wal-Mart list of $4 per month or $10 for 3 months. The reduction in mortality among the various heart failure studies is not exactly comparable as the heart failure severity differs between studies. All studies involved patients with heart failure with reduced ejection fraction.

The effect of these drugs on mortality is of similar magnitude to that of an ICD. (Direct comparison between studies is not possible since the study populations are different). In addition, all three medications, when taken as prescribed, will improve symptoms in addition to improving survival. The differences in cost is three orders of magnitude. While I do not require it, I explain to heart failure patients that I would expect them to demonstrate compliance with drug therapy prior to proceeding to the implantation of an ICD. My patients, who are predominately Medicaid funded,

would have essentially no out-of-pocket expense associated with an ICD. Yet they can still understand the importance of doing their part, prior to society investing so extravagantly in them. It also helps them to understand the relative benefit of an ICD and appreciate being offered this option. I also think that it improves their compliance with drug therapy. Awareness of costs, especially out-of-pocket costs, are important, especially when the benefits are less than certain.

Conclusions

Informed consent done ethically requires giving information to assist the patient to make the best decision. Medical professionalism requires the physician to place the patient's interests above his own. I was not present for the informed consent given by the cardiologist and can repeat only the family's summary. I realize that busy cardiologists covering my patients at another hospital have many pressures and that our medical system does not reward detailed discussions of risks and benefits. This patient has had no complication from his device but also no life-prolonging shocks.

Some even fear that if they fail to implant a defibrillator in a patient with a guideline-based indication that they will be sued by the family if the patient experiences sudden death. This is an unlikely circumstance if a detailed discussion is given. Doing the ethically correct thing is not always easy and at times might be misunderstood. Yet such is our duty.

Patients, when confronting an elective procedure or operation, should not consent until they understand not just the potential for complications as the consent usually emphasizes but also answers to two pivotal questions: Will it help me to live longer? Will it help me live better? Certain procedures, such as joint replacements, are designed to reduce pain long-term and make one's life better, but they will not offer any survival benefit. Other procedures, such as a heart valve replacement, have the potential to increase both the quantity and quality of life for the patient. Procedures that are only for the prolongation of life are especially difficult. The patients must know the probability of their life being prolonged compared to the costs. The physician in his counsel needs to know the patient well, not just the patient's medical problem and prognosis but also the patient's expectations, social circumstances, and religious beliefs. Joint decision-making is the new term for this type of informed consent. It is the duty of an ethical physician. In practice, joint decision-making requires great art by the physician. The patient must fully engage in the process, understanding risks, benefits, and costs. Yes, this will take time, but it will lead to better medicine and will deepen the doctor-patient relationship.

Editor's Comment

Much has been written and said about informed consent. In fact, it has been noted that there are two problems in obtaining informed consent: one is the word "informed," and the other is the word "consent."

Proper informed consent should consist of 1) medical information that is delivered in an understandable form, 2) medical information that the patient can receive, process, and verbalize, and 3) a decision process that is free from coercion.[1]

Most patients and healthcare agents can negotiate this task and enjoy proper and appropriate medical care.

However, the notions of living longer and living better are more difficult to explain and understand, and, consequently, demand much care in obtaining proper informed consent. In addition, financial concerns must not be ignored, and the patient is entitled to know how healthcare insurance will likely interface the proposed procedure. Pellegrino acknowledges this issue in terms of effectiveness, benefits, and burdens.[2]

The days of "doctor knows best" are long gone. Joint healthcare decision-making is recognized, expected, and often demanded.[3] At least the doctor knows what has been said—when he/she says it to the patient!

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Jay Hollman, MD, MA, has enjoyed a long career in cardiology, practicing at Cleveland and Ochsner Clinics and educating fellows, residents, and students. He now teaches medical students and residents at LSU-New Orleans Health Science Center.

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Professional Objections and Healthcare: More Than a Case of Conscience

MICHAL PRUSKI, PHD, MA, AFHEA, MRSB

Abstract

While there is a prolific debate surrounding the issue of conscientious objection of individuals towards performing certain clinical acts, this debate ignores the fact that there are other reasons why clinicians might wish to object providing specific services. This paper briefly discusses the idea that healthcare workers might object to providing specific services because they are against their professional judgement, they want to maintain a specific reputation, or they have pragmatic reasons. Reputation here is not simply understood as being in good standing with a professional body. Rather, reputation is treated in the sense that a craftsman might wish to be known for providing a specific type, quality, and style of service. Professionalism is understood as acting according to the philosophical and scientific principles that are the basis of healthcare (such as acting for the benefit of the patient's health and following well-evidenced treatment pathways).

Prologue

I wish to start by highlighting what this paper is not about, why it has been written, and what I think it contributes to the discussion of healthcare objections. This paper does not tackle the issue of what we as healthcare professionals (HCPs) are meant to do; it is not about how we can follow Christ's footsteps by making patients whole and growing in virtue. Rather, this paper is a response to the need for us to protect ourselves from cooperation with evil, particularly in places where there are no rights to conscientious objection (CO) and where objections might be best phrased in a way that utilizes secular, liberal, and pluralist train of thought. Hopefully, this will allow some to more effectively justify their objections in a CO hostile environment.

As such, this paper will frame the issue of healthcare objections as professional objection (PO). The article will outline four categories that can be utilized to make a PO, and in this process, it will rely heavily on the craftsmanship analogy. These four categories should enable one to raise a PO to a wide variety of procedures, for which one would want to raise a CO. PO, nevertheless, is not promoted as a form of deception. Rather, reasons that fall into these four categories are what make us conclude that something is either bad medicine, and hence should not be done, or makes us refrain from specializing in these types of activities.

While the PO framework does not justify healthcare anarchy, it certainly lacks the tools to signify what good healthcare is. Perhaps it is a vain hope, but the realization of the consequences of a PO framework might prompt some who largely subscribe to a secular worldview to reflect upon the teleology of medicine and moral absolutes.

Yet, as Christianity itself is not monolithic, these points should still be acceptable, at least to an extent, by a Christian audience.[i]

Introduction

This article briefly discusses POs and how they might relate to a HCP's right to express professional freedom. By professional objections, this article refers not to what is often discussed as CO but to a wide variety of other reasons that might motivate HCPs to object to participation in certain procedures, often ignored in the CO debate. It is the point of this article to demonstrate that objections can be raised, utilizing reasons that do not involve deontological religious commandments; these are:[ii]

1. Clinical judgments based on a philosophical understanding of healthcare
2. Clinical judgments based on the evidence of healthcare science
3. A right of HCPs to shape their professional practice and reputation
4. For pragmatic reasons relating to running their institutions

While these have been listed as distinct points, there is overlap and interdependence between these categories. The latter part of this paper will demonstrate the value of these specific points, as well as their interdependence.

Within the current CO debate, these reasons have not been featured prominently. While the British parliament is debating changes in the legislation governing CO,[1] it is important to acknowledge that HCPs are not only moral agents but also professionals dedicated to caring for their patients. It is, hence, imperative that the CO debate is not limited to matters of freedom of religion, but the debate should include the four aforementioned points. This will not only acknowledge the reality of the work of HCPs but will also make the legislation more applicable to those who profess no religion.

Professional Judgement and the Essence of Healthcare

Philosophical understanding of healthcare relates to the scope of practice one believes he/she should undertake as a HCP.[iii] This might relate to the pursuit of particular goods one believes healthcare is concerned with (e.g. the good of the patients holistically understood).[2] These goods relate to what one believes healthcare is—a therapeutic art and science concerned with the restoration of health.[3,4,5,6] Based on such an understating of healthcare, HCPs might refuse certain services that are generally thought to fall within their scope of practice, for they do not believe that these services are compatible with the goals of healthcare. Even those who object to CO do accept such an objection (i.e. based on an understanding of what a HCP's job entails), and they even accept that there are certain goods people seek to pursue through healthcare.[7] Force-feeding prisoners can be regarded as torture rather than healthcare, and it is not something that HCPs should be forced to do.[8,9] While some might argue that this is an example of CO, a HCP might not object to law-enforcement agencies using torture to defend a nation's interest but might simply not want to participate in the process, as they do not perceive it as falling within one's scope of practice. Another such procedure that many HCPs could potentially engage based on their skillset—but might not regard it as part of their job—is the provision of purely

cosmetic procedures, which do not, strictly speaking, fall within the bounds of health care.[10] However, the same procedure might fall within the bounds of healthcare when performed in a different context (e.g. that of a victim of trauma).

Professional Judgement and Evidence-Based Practice

HCPs are competent practitioners of their disciplines. They should understand the efficacy of various treatments and procedures, the risks attached to them, and how they relate to their patients' conditions. In the UK, patients do not have a right to demand a particular type of treatment, especially if it is medically futile.[iv, 11,12] It is the prerogative of HCPs to exercise their clinical judgement, and refusals on these grounds of professional opinion are clearly distinct from those that are conscience-based.[13] Moreover, even those opposed to CO agree that objections based on considerations of beneficence and non-maleficence are valid reasons to refuse a particular treatment, so as to ensure that they are helping patients and not harming them.[14] For HCPs, such a refusal might be primarily about the good of the patient, as well as avoiding future litigation, losing licence to practice, or professional registration. Refusals are also about professional pride and reputation, mainly for those who compete for patients or funding (i.e. related to some of the other aspects of PO mentioned in the introduction.) Examples of such a PO might be the refusal to amputate a healthy limb from a patient suffering from body integrity identity disorder who claims that amputating the limb will improve their wellbeing. It might be the refusal to perform gender reassignment surgery for someone suffering from gender dysphoria. The HCP might refuse these because they believe that the evidence does not indicate that the procedure will solve the underlying problem, but that it will only damage the patient's body and well-being, hence being bad healthcare.[15,16] Similarly, an HCP might object to the provision of homeopathic remedies, even if privately they have nothing against them. HCPs should not be forced to provide treatment that they believe to be damaging towards the patient and which will not provide any real health benefits. Such decisions relating to professional standards of patient care are proper to HCPs[17] and should not be the subject of external coercion.

Shaping One's Reputation

The maintenance of a good reputation is not understood here as the right against slander or as being in good standing with a professional body, but in a wider context like that in which one could understand the reputation of craftsmen (e.g. a tailor or a goldsmith). Some might object to the comparison of a HCP with a craftsman or artist, yet such an understanding of healthcare has been present at least as far back as the writings of Plato and Aristotle.[18,19,20,v] Moreover, in recent times, medicine has also been presented as a craft or art from the perspective of how it is performed in its direct physical dimension and with reference to the type of judgements a practitioner of medicine needs to make.[21,22,23] With its practical application of knowledge and skill, as well as interpersonal interaction aimed at understanding the needs of the patient, healthcare (while operating on a different substance) is not that different from other crafts. This is not to say that the matter with which HCPs deal, (i.e. human health) is equivalent in its gravity to the matter with which other craftsmen deal. That human health is more important is self-evident, and, as such, it is right that the

legal consequences for sloppily making a ring are different from sloppily performing surgery. Yet this does not mean that the craftsman analogy is wrong or demeaning to HCPs, it only highlights the gravity of the considerations that need to be made regarding healthcare.

Good reputation is understood here in the context in which a craftsman can have the reputation of producing high quality products, providing a reliable service, or having products executed in a certain artistic style. Importantly, such a reputation might not be forged to have a universal appeal; quite the opposite—a craftsman might be creating products that appeal only to a specific group, be it because the craftsman shares the group's sense of aesthetics or noticed an unexploited niche. As such, it becomes clear that craftsmen might have various motivations that influence the reputations they acquire. HCPs, like craftsmen, should be able to freely shape their professional associations, practice, and reputation in a pluralistic and liberal society.

While there are many facets to the issue of professional reputation, they can be broadly divided into the issues concerning institutions (both private and public) and individual HCPs. In some of these settings, reputation is more important, as those working in small private practices (e.g. physiotherapists, general practitioners, and dentists) need to compete for clients much more intensively than anaesthetists at a big tertiary centre. Similarly, healthcare organizations often compete for patients (e.g. private clinics or even NHS Trusts), and hospital units might be paid for the number of patients or procedures they have performed. As such, even big nationalized institutions do not want to fall into disrepute, as this might negatively affect their funding and the likelihood of private donors (such charities) supporting them or lead to penalties imposed by regulatory bodies. Moreover, institutions might rely on their reputations to attract the best specialists in their field to further raise the profile of their departments. Medical organizations, small or big, private or public, might limit the type of service they provide to be able to specialize in certain procedures and develop a reputation as centres of excellence for it. As such, they may not carry the relevant equipment needed to perform a procedure outside of their expertise. Centres or practices might also refuse to perform a type of procedure they deem them too risky, though, technically, they might have the resources to perform it. Rather, they refer the patient to a different centre.

There are several reasons why reputation might be important for HCPs beyond those that are important for institutions. HCPs might perform auxiliary jobs aside from their main occupations, such as expedition or sports medics, into which they might be recruited based on their reputation. A HCP might refuse to work in a hospital with a bad reputation or participate in a procedure that will risk creating scandal, as it might leave a permanent mark on their CV and affect their future employability and career progression.

Professional reputation might influence whether one gets the patient or becomes unemployed. HCPs (and centres) can already specialize in various fields, and HCPs often further specialize to become experts in a specific procedure (e.g. orthopaedic surgeons specializing in operations on a specific limb). Being able to refuse certain procedures (e.g. to maintain a reputation among a specific clientele or to devote one's time to master a particular procedure) is not much different from being allowed to work (or train) within a particular specialty. Similar to the development of healthcare

specialties, this might benefit patients. While a group of HCPs running a palliative care centre in a country where euthanasia is legal might themselves be in favour of euthanasia, they might have discovered that some patients prefer to be treated in centres where this procedure is not undertaken. These patients (and their relatives) might be more comfortable knowing that they will not be offered a procedure with which they fundamentally disagree, even in a moment of weakness, and might take comfort knowing that the HCPs taking care of them do not engage in an activity the patients themselves regard as unethical.[24,vi] Similarly, some women (e.g. those holding strong pro-life views) might be more comfortable knowing that abortions are not performed in the clinic in which they are about to give birth.[vii] If individuals are allowed to run groups that pursue specific goals (even if the purpose of the group is to restrict its membership to people of a legally protected characteristic, such as sex and ethnic group[25]), then HCPs should be allowed to set up clinics that cater to those who follow a particular worldview (even if the HCPs themselves do not follow that worldview). This includes the right of Christian HCPs to develop their reputations in a manner that will attract Christian patients or gain influence in Christian professional bodies.

Pragmatism

Additionally, medical institutions might refrain from performing certain procedures on pragmatic grounds. These might relate to the complex socioeconomic situation, liability, and other practical issues originating from the specific work environment in which certain HCPs and institutions operate.[26,27,28,29] Hence, even if the institution or the HCPs are allowed to provide the service in question, it might be more pragmatic for them not to provide it. Compelling HCPs or institutions to provide such a service (even if they are not morally opposed to it) might have a negative impact on their work (such as costs, stress, or dissatisfaction), manifesting itself in, for example, moral distress.[30,31,32] Therefore, while some pharmacists in regions where they can prescribe contraceptives might not morally object to such prescriptions, they might still refrain from providing these services.[33,34,35] While some services are clearly linked with each other (such as the provision of postoperative care to the provision of surgery) others, such as the provision of good antenatal care, does not depend on the provision of abortion services, and, for pragmatic reasons, a centre that wishes to provide the best possible antenatal care might not have the resources to provide abortion services.

Building on the Craftsman Analogy

While HCPs are subject to more scrutiny than goldsmiths or tailors, due to the nature of the subjects of their trade, the craftsman analogy provides a convenient framework for discussing the reasonableness of PO. Goldsmiths might refuse to use materials unless they have been ethically sourced, yet they might have no moral interest in the provision of such materials. They provide them to attract customers that do care about the source of the materials or to get some form of certification or guild membership that would professionally benefit them. A tailor might refuse to make a jacket according to the customer's design, for the design is such that the jacket is likely to fall apart soon. This, in turn, might lead to someone claiming that the tailor produces poor quality clothing or try to get a refund for the product. The tailor might

refuse this commission simply out of professional pride or to avoid deterring future customers or to not have to commit time to then pay the customer a refund (or for all of these reasons simultaneously). Bakers might wish to avoid certain associations between their product and a particular event, even though, under other conditions, they might be willing to provide the product to the same customer.[36,37] Their decisions might be based on CO reasons but could also be understood as the exercise of a "right to freedom of dissociation."[38] Such a freedom of dissociation could be invoked in some situations to, for example, avoid discouraging a specific group from using one's services, for campaigners from a wide spectrum of ideological and political backgrounds have tried to persuade businesses, through various campaigns and petitions (including boycotts), to cease or commence different practises.

Craftsmen express their professional freedoms and take care of their businesses by both providing what their customers want or by not engaging in commerce with them, and they are motivated to do this by a wide variety of reasons. But each of these reasons to act in a particular way does not always operate in isolation. The craftsman who uses ethically sourced gold might do it for both ethical reasons and the professional advantages associated with it. Tailors who refuse to make a jacket to the client's specification might not do it as much out of concern for their reputations, for they would simply hate for their customers to experience disappointment. The baker might have as much acted out of religious convictions as from reasons related to reputation. Who, in a liberal society, is to decide that one reason is better than another (though some limits relating to such actions will be discussed further down) or that CO is more convincing than PO? Certainly some of the aforementioned PO decisions are easier to comprehend from a secular standpoint than some CO decisions, at least partly due to a lack of a shared moral vocabulary between those invoking CO for religious reasons and their audiences in the secular space.[39]

To build on the types of PO mentioned throughout this paper and to relate it to the parallel of craftsmanship, it is worthwhile to analyse in more detail an example of an HCP objecting to a specific procedure—abortion.[xiii] For pragmatic reasons or reasons relating to reputation, a medical centre might not wish to provide abortions; the centre might only have facilities to provide antenatal services or might not deal explicitly with issues relating to maternity, and in order to expand the provision to such services, they would have to jump several administrative hoops and dedicate funds that they wish to spend on more pressing needs. Ophthalmologists might refuse to perform an abortion—a procedure outside their specialty—not necessarily because of lack of competence in the procedure (they might have previously worked as obstetricians) but because they chose not to pursue a career in obstetrics. Further, even those without a religious belief might regard every human as a person, and, hence, view foetuses as deserving healthcare.[ix] HCPs caring for pregnant women and subscribing to the aforementioned definition of personhood might wish to not perform treatments that are harmful to the foetus. For them, a pregnancy presents two patients whose goods should be sought. This is a professional statement, supported by science and a long standing philosophical tradition, and while arguments to the contrary exist, it is certainly a reasonable opinion to hold. Finally, HCPs' CO against abortion due to a religious commitment does not exclude a simultaneous PO to abortion for any of the aforementioned reasons. It is more than likely that their religious CO is accompanied by a philosophical understanding of medicine that is incompatible with abortion. In

such situations, it seems unreasonable to understand their objection only from the perspective of CO.

Discussion

Those who work in healthcare, like in any craft, should be free to take pride in their work and shape their practices in a way that accords with their professional judgements and preferences, so as to gain a reputation that ensures patients will willingly use their services and so that they can find professional fulfilment. Objections based on professional opinion and ones that support specialization (for the benefit of patients requiring a specific service provision or to develop a sustainable business model for those working in private practice) should be understandable by legislators, other HCPs, and the general public. This might be easier to realize in independent practices than in big, private hospitals, where private contracts between the HCP and the institution might wish to restrict the HCP's freedom. While in such instances the freedoms of the HCP are balanced against those of their employers, it would be odd for the government to compel all HCPs to take up one philosophical view of medicine versus another, saying, for example, that vasectomies are a healthcare service and, as such, a trained HCP should provide them. Such compulsion would deprive HCPs of professional integrity.[40] A vasectomy is not a health restorative treatment, and HCPs might prefer to aid sick patients and participate in medical research or relief work, and are uninterested in providing services that they believe to damage patients' normal bodily functions.

This paper has shown that there are several reasons why an HCP might want to object to certain procedures on professional grounds and that these reasons should be respected in a secular and liberal society where people can freely associate and dissociate.[41] As respectable professionals, HCPs should not be compelled to forced labour, but should be allowed to specialize and use their professional judgements to build their reputations, as long as they do it without malice.[42] As such, we should not limit acceptable objections to just the issues of abortion, euthanasia, and assisted reproductive technologies. A wide range of possible objections would ensure respect for HCPs' professionalism and not treat them as mere automatons dispensing clinical procedures.

What this paper has not argued is that ethical and religious reasons do not play a role in a HCPs decision-making process. Indeed, there are good ethical reasons why a craftsman might wish not satisfy their customer; a military equipment provider might refuse to provide a customer with a suicide vest on ethical grounds, and a HCP might refuse participation in abortions and euthanasia on religious grounds. Ethical and religious considerations are of utmost importance, but the practice of objection cannot be limited to these considerations. CO and PO are both valid grounds for raising objections.

Addressing Potential Objections

One could raise an objection to the argument presented above and state that an HCP might wish to gain a reputation amongst members of the anti-vaccination movement by not providing vaccinations to patients requesting them and discouraging them from seeking them elsewhere. While the reasoning above would concede that the

HCP could not be obliged to provide a vaccinations service (e.g. a GP might only wish to provide a house call service and not keep a stock of vaccines),[x] it would not concede to the HCP advising any patients against vaccinations (presuming no established medical contraindications, such as an allergy to one of the components of a vaccine).

It is one thing to facilitate people's preferences, and it is another to deceive them. While many procedures to which PO can be raised are either non-controversial (such as the example involving the use of Botox for aesthetic purposes) or are generally regarded as matters of debate in a liberal society (such as the personhood of foetuses), in certain areas medical science has well established evidence of what constitutes best practice (e.g. with regards to vaccination). While science is in the habit of overthrowing previously established facts, HCPs are not clairvoyant and should only act on the facts they have in front of them. While the arguments utilized throughout the article favour a greater freedom of professional practice, they do not imply that anarchy should reign in healthcare. Though there is no facility to compel an HCP to provide treatment they deem medically futile,[43,44] giving advice contrary to scientific evidence would be valid grounds for questioning an HCP's fitness to practice and hence striking them from the register. If an HCP would knowingly encourage a patient in their mistaken belief (e.g. that vaccinations cause autism),[45] they would be acting in a maleficent manner towards their patient, contrary to the foundations of healthcare practice. Fulfilling malicious desires and fraud are not things that should be facilitated in a free society and should, at least in the sphere of healthcare, be grounds for criminal prosecution.[46]

Another potential objection is that if there is only a blurry line between PO and CO, could this not create a situation where an HCP could try to pass one off as the other? But this is the point on which we should refrain from judgment, for a HCP might simultaneously hold a CO and a PO against a specific procedure. Moreover, if neither of the two modalities hold a privileged status over the other, then does it matter whether an objection is presented as one or the other, as long as the statement is truthful? A doctor might have started work in an antenatal clinic (one that did not provide abortions) for matters of pure convenience—it was close to her house. Later, she espoused a pro-life perspective. Similarly, a doctor might have decided to work at such a clinic because of her religious views on abortion, which also translated to a philosophical outlook about the purpose of healthcare. Someone who objects to euthanasia on moral grounds (CO) is likely to also view killing as something that is not part of a HCPs job (PO category 1) and as something that has no scientifically proven benefit to the patient (PO category 2).[47] There is no way of judging that one of these aspects is more important than the other or that the pro-life view of one of these doctors is more genuine than the view of the other. This, though, warrants the conclusion that the practice of healthcare cannot be reduced to the professional matters discussed in this paper. But it does not warrant the conclusion that professional matters are meaningless or that PO is indistinguishable from CO—only that it is possible (and even likely) for a person to hold CO and PO views that coincide with each other.

The last objection is that medicine is practiced in a community and that practitioners should meet the standards expected by the community. Surely, these are the standards that allow for someone who seeks medical care to obtain it in a manner intelligible to them. Yet it is not the argument of this paper that HCPs have

the right to change the whole process of commerce or human interaction. Rather, that a degree of diversity within healthcare is the norm. For example, in the U.S.A., some physicians graduate with a M.D. degree, while some with a O.D. degree, where the philosophical assumptions about the practice differ. These together might have a different viewpoint on how health should be managed, compared to a chiropractor. Similarly, some pharmacies will sell certain products and not others, and certain specialists will provide some services and not others. Moreover, the literature is rich with varying opinions on how certain diseases should be treated. As such, the only thing that is needed to make PO comprehensible by community standards is an honest description of the services provided.

Conclusion

The debate surrounding the scope of an HCP's right to object to the provision of particular treatments should not be limited to matters of conscience, though professional opinions might often overlap with one's ethical viewpoint. HCPs are professionals who should be free to exercise their expertise in a manner respecting their wider worldview and scientific knowledge, allowing them to find fulfilment in their job and not burdening them disproportionally. Nevertheless, HCPs should not be free to harm their patients. While HCPs should not be compelled to provide all that a patient might seek, HCPs should provide healthcare and not act to the detriment of their patients' health. This is not to say that ethics is not important in healthcare but that there are other legitimate reasons for objecting to the performance of certain practices that are not within the scope of traditional CO objections.

Epilogue

While I believe that the arguments presented in this paper offer a useful tool for HCPs to object to certain treatments, it is somewhat obvious that this is not a model for how healthcare should be done and that, even within the context of objections, it is an impoverished model. It certainly does not tell us much about what we must do for our patients, for this a teleological framework is needed to direct HCPs towards their purpose. But this is not the subject of this paper. Moreover, the framework runs at the risk of proving too much, for how far should the freedom of dissociation extend? Perhaps this is a signpost to the limits of a liberal and pluralistic framework that was used here. But if a secular institution rejects the arguments presented here, they will have to explain why healthcare is different from other crafts or acknowledge that there are issues with their own arguments. As such, my hope is that this paper will also be a prompt for reflection on the philosophical basis of medicine for those who accept the arguments here presented and who recognize that there is more to healthcare than business and expression of personal choice.[xi]

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Endnotes

i. Christians might be, for example, as much Platonic as Aristotelian in their philosophical outlook and differ in their opinions on the evidence basis for various procedures. They will also differ in the specialisms they wish to pursue in their clinical special interests, and they will be subjects to the same material constraints that non-Hippocratic HCPs will face. Pragmatic (or practical) judgments are still necessary, though they should be prudent (and supported with prayer) and not just be clever in the eyes of the secular world.

ii. It is noteworthy that reasons 1 and 2 seem to be acceptable to at least some authors generally hostile to CO. Fiala and Arthur state that they accept objections based on "an obligation of doctors to their patients and to their professional ethics … based on evidence, medical ethics, and professional obligations" and hence "are not grounded on the individual personal beliefs of HCPs, they do not qualify as CO."[48] See also the later example from Savulescu and Schuklenk.[49]

iii. Scope of practice in general relates to the particular activities that one's professional body and employer has described as one's role. Yet here we emphasise that this is always interpreted by the individual within the context of a metaphysical understanding what healthcare as a craft/practice is (e.g. Hippocratic medicine is about healing, not harming, respecting confidentiality, etc.).

iv. The fact that futility is such a difficult concept, for which it is at times difficult to reach consensus, is part of the reason why such professional objections should be allowed. If it is a matter of licit

disagreement, then why should one be forced to comply with one reasonable opinion over another?

v. The concept of a craft-tradition is also discussed by Macintyre.[50] The notion of healthcare as a profession passed from mentors and professors to students, with its heroes and great discoveries, as well as learned associations with all their traditions, lends itself also to such an understanding of healthcare. But this is a broader concept than the one with which we are concerned in this analysis.

vi. This might be not possible in practice in jurisdictions where only a HCP, rather than an institution, has the right to refuse undertaking a particular procedure, like in Belgium.[51]

vii. Medical facilities have refused to perform abortions in the past for reasons other than ethical.[52]

viii. For an interesting discussion on abortion within the context of the recent referendum in the Republic of Ireland, see the article written by Dr Tuathail.[53] This article mentions some types of PO mentioned in this paper, such as abortions not being a routine part of general practice, as well as limitations relating to a practitioner's fluency in a procedure.

ix. While the pro-life movement tends to be associated in the west with Christianity, secular (https://www.secularprolife.org/) and other non-religious e.g. feminist pro-life groups (https://www.feministsforlife.org) do exist.

x. Objections to the provision of vaccines produced via human cell lines obtained from aborted foetuses are not mentioned here, as this is a matter of CO, not PO, and is strictly speaking not an opposition to vaccination.

xi. For such a teleological analysis of medicine and its relationship to practitioners objecting to the provision of specific services see Gamble, Nathan K. and Pruski, Michal 2019. Medical Acts and Conscientious Objection: What Can a Physician be Compelled to Do? *The New Bioethics* DOI: 10.1080/20502877.2019.1649871.

Michal Pruski, PhD, MA, AFHEA, MRSB, is a trainee Clinical Scientist (according to British nomenclature) in Critical Care Science at the Manchester University NHS Foundation Trust. The theoretical component of the training is undertaken at Manchester Metropolitan University. The author has no conflict of interest to declare and wishes to acknowledge Toni Saad, Daniel Rodger, and the anonymous reviewers for comments and suggestions. He currently resides in Manchester, UK.

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Social Freezing: Analysis of an Ethical Dilemma

JUSTO AZNAR, MD, PHD; JULIO TUDELA CUENCA, PHARM, PHD

Abstract

When eggs or ovarian tissue are not frozen for medical causes, the process is called "social freezing." In this case, there are two fundamental reasons why a woman might choose to undergo this procedure: The first is that she has not found a partner who she considers suitable for a matter as important as creating a family, and the second is for professional reasons. In the latter case, the woman considers that becoming pregnant at a young age—usually before age 35—could harm her professional career, prompting her to freeze her eggs for use at a later date. The biological reason that underlie social freezing are that women's fertility declines with age, especially due to a decrease in ovarian function, owing to a reduction in the number of eggs. Social freezing unquestionably presents ethical concerns. This practice entails objective negative medical consequences for the user and also for her child; it is hard to guarantee the autonomy of women to make such a decision if they are not provided with adequate information on the risks and benefits entailed in social freezing; a possible social inequality between groups of women and the convenience that social freezing should be supported with public funds; and the fact that fertile women, capable of conceiving and carrying a child naturally, renounce this, substituting natural conception for IVF.

Keywords

Social freezing, delay of motherhood, women´s fertility, autonomy, assisted reproduction

Introduction

Occasionally, and for various reasons, many women wish to postpone motherhood. The most common procedure used to achieve this is to freeze their eggs or part of their ovarian tissue while young. These are then thawed at a later stage when they wish to become mothers and used in a reproductive process, generally in vitro fertilization (IVF). When ovarian tissue is used, it is thawed and implanted in the woman's ovary so that its functions are activated, thus opening the door to procreation, either naturally or using assisted reproduction procedures.

There are essentially two reasons for delaying childbearing: medical and social. Medical reasons are when the woman, due to cancer or another disease, requires treatment that may affect her fertility. In this situation, her eggs or part of the ovarian tissue can be frozen before undergoing treatment, to be used at a later date when the therapy has finished and the woman has recovered her health.

When eggs or ovarian tissue are not frozen for medical causes, the process is called "social freezing." In this case, there are two fundamental reasons why a

woman might choose to undergo this procedure: the first is that she has not found a partner who she considers suitable for a matter as important as creating a family, and the second is for professional reasons. In the latter case, the woman considers that becoming pregnant at a young age—usually before age 35—could harm her professional career, prompting her to freeze her eggs for use at a later date.

The biological reasons that underlie social freezing are that women's fertility declines with age,[1,2] especially due to a decrease in ovarian function,[3,4] owing to a reduction in the number of eggs, since, in humans, around 85% of potentially useful eggs are lost before birth. From then on, their number diminishes from around 100,000 useful eggs at age 20 to 25 years to only 1,000 at menopause.[5,6]

Therefore, if women delay having children for any reason, their likelihood of becoming pregnant falls. This justifies obtaining eggs at around age 30—or earlier if possible—to freeze and then use from age 35 years (and especially from age 40), if at that time they wish to become mothers. Thus, the longer they delay freezing their eggs, the less of a chance they will have of having a child.[7] In this regard, evidence has shown that when the eggs are frozen at age 37 years, the probability of a live birth is 51.6%, but when the woman is younger than age 34, this probability may be greater than 74%. According to this study, most women who have frozen their eggs at age 34 have a 70% chance of having a child.[8]

History

Social freezing broke in the media when, in October 2016, two Silicon Valley business giants, Apple and Facebook, announced their intention to provide their female employees with the opportunity to freeze their eggs to delay motherhood, according to them, in order to attract and promote female talent.[9,10,11,12]

To that effect, Apple released a statement saying that they had introduced the policy because "we care deeply about our employees and their families." For this reason, "we continue to expand our benefits for women, with a new extended maternity leave policy, along with cryopreservation (egg freezing) and egg storage as part of our extensive support for infertility treatments." They continued, "We want to empower women at Apple to do the best work of their lives as they care for loved ones and raise their families."[13]

Not everyone agrees with this measure, though. Indeed, a group of German politicians from the Christian Democratic Party has publicly stated that Facebook and Apple's policy promoting social freezing is "an indecent proposal."[14]

Similarly, some feminists, such as Daisy Sands of the Fawcett Society, are not completely convinced of the measure, saying that "there's a danger that with this sort of policy companies give a signal—or even promote the idea—that a woman needs to postpone having children in order to succeed in the workplace." Sands continues, "In reality, probably a very small amount of women will take up the offer, but it again puts the onus on women rather than men to think about when to have children and how this will impact on their career." Sands adds that this policy could mean that other important structural changes are not introduced.[15]

A large group of scientists also advise against this procedure, according to Josephine Johnston and Miriam Zoll of the Hastings Centre for Bioethics in New York, in an article in New Republic.[16]

Nevertheless, Apple and Facebook are not the only establishments to promote social freezing. The United States (US) army also offer it, thereby seeking to compensate for the challenges imposed by military life when trying to have a family, extending their program to freezing the sperm of their military men.[17] The initiative is an attempt to make a military career more attractive to those who want to have a family and also to offer guarantees of having children to those who are wounded on the battlefield. As in any other company, retaining talent has become a priority in the US army because many women who are at the ideal age to have a family abandon their careers when they complete 10 years of military service.

"For women who are midgrade officers and enlisted personnel, this benefit will demonstrate that we understand the demands upon them and want to help them balance commitments to force and family. We want to retain them," claims North American Defence Secretary, Ash Carter.[17]

Oocyte Cryopreservation

A key aspect for evaluating social freezing is to understand as much as possible about all matters concerning the cryopreservation of oocytes (or eggs) because these are what are used. Consequently, the outcomes of social freezing depend largely on the particular characteristics of the cryopreserved oocytes.

History

The first child conceived using frozen eggs was born in 1999,[18] and in the United Kingdom, frozen eggs have been used for the treatment of infertility since 2000.[19] The first pregnancy reported after egg freezing in a cancer patient was in 2007.[20]

Only three children have been born to date after fertility preservation for oncological reasons,[21,22,23] and very few articles make reference to the birth of children from egg banks for reasons of advanced age.[22,24]

At the end of 2012, the American Society for Reproductive Medicine (ARSM) and the Society for Assisted Reproductive Technology (SART) announced that oocyte cryopreservation would no longer be considered simply an experimental technique,[25] thus paving the way for its clinical use; however, in 2013, both societies expressed their doubts about the use of frozen eggs, due to scant data on the safety, efficacy, cost effectiveness, and emotional risks for healthy women.[25]

In 2014, the American College of Obstetricians and Gynecologists endorsed the recommendations of the ARSM and SART. Despite these calls for caution in its use, social freezing has significantly increased,[26,27] and indeed has practically tripled in the last 5 years.[28] This may be linked to a number of complex and interrelated reasons for delaying motherhood, including personal, professional, financial, and psychological factors.[29]

In Spain, in 2014, 816 women attending 65 different clinics froze their eggs for future use, almost triple the number who did so in 2009, which was 284 women from 34 clinics.[30]

According to their own data, the Valencian Institute of Infertility (IVI) reported that, as of December 2014, 5,842 children had been born in their clinics using vitrified eggs. Most of the women who froze their eggs were aged between 37 and 39 years, while 18.9% were aged between 31 and 35 years and 16.2% were aged 40 or older.

Technique

Egg cryopreservation is a process that involves ovarian hormone stimulation, transvaginal retrieval, and subsequent freezing and storage of the eggs. The most widely used technique at present is vitrification, which uses cryoprotective agents and ultrarapid freezing in order to solidify the cells as quickly as possible to avoid the formation of ice crystals. This technique increases the survival of the cryopreserved eggs and improves pregnancy rates.

Survival of Frozen Eggs

The ASRM and the SART estimate egg survival following vitrification and warming to be around 90% to 97%, with a fertilization rate of between 71% and 79% and implantation rate of 17% to 41%.[25]

With respect to the length of time that eggs can be kept frozen, according to the Human Fertilization and Embryology Act, in 1990 it was claimed that eggs could be stored for more than 10 years and embryos for 5.[31] More recently, though, this time could be extended up to 55 years.[32]

Efficacy of the Technique and Birth Rate

The efficacy of the technique is measured by the live birth rate. This rate was initially 21.6% per embryo transfer using vitrified eggs,[33] but has been increasing over time such that, in 2014, Grifo and Noyes reported a birth rate of 57% per embryo transfer.[34]

In 2017, Massarotti reviewed and summarized various studies that evaluated the live birth rate using vitrified eggs, finding values of 22.6%,[35] 25.5%,[30] 38.6%,[36] and 36.4%.[37] This variation largely depends on the age at which the eggs were obtained. In a recent meta-analysis of ten studies, the birth rate was 31.3% in women aged up to 25 years old, falling to 13.4% among women over age 40 years.[38] In another multicentre study, the decrease in the number of births per year was 7%; when natural eggs were used, the decrease was 8%.[39]

Adverse Effects of the Vitrification Process

The largest review conducted to date found that the use of vitrified eggs had no adverse medical effects for the mothers nor objective perinatal problems for the children born, although according to its authors, further studies with a large sample size are required to confirm these conclusions.[40]

Reasons to Justify Social Freezing: Benefits for Women

There are four main benefits for women who use social freezing:

a) To facilitate female participation in the field of employment.

Many women think that delaying pregnancy could benefit their career progression in many different aspects, so some consider the possibility of postpon-

ing having children. For this reason, they use social freezing.[41]

b) Possibility of waiting to find the right partner.
Some women wish to find the right partner to have children with, so they may feel pressured when they get older and have not done so. In this respect, the possibility of egg freezing means that when they meet that partner, they can use IVF to have children with them.[29,42,43]

c) To wait to be emotionally, psychologically or financially ready to be a mother.
The possibility of freezing eggs and using IVF allows women and their partners to have children at a time of their choosing.

d) To be able to have children with a different partner.
If a woman wants to have the option of having children with a partner other than the one she currently lives with, social freezing could be the answer.

e) Using social freezing could also reduce the risk of having aneuploid foetuses due to age.[44,45]

Possible Negative Side Effects For the Mother

Women who decide to use cryopreserved eggs should be objectively informed of the possible complications of a late pregnancy, such as hypertension, preeclampsia, gestational diabetes, placental insufficiency, decreased intrauterine growth of the foetus, and caesarean delivery, all of which are higher for older compared to younger women.[25,46] Even maternal mortality increases around four-fold when the pregnancy occurs after age 40.[47]

Perhaps the greatest risk associated with social freezing, however, is ovarian hyperstimulation syndrome, secondary to the process used to obtain the eggs. This may be moderate with fatigue, nausea, headache or abdominal pain, painful breasts, and irritability, although these adverse effects can be easily controlled.[48] Nonetheless, 0.1% to 2% of women who undergo an ovarian stimulation cycle can experience severe ovarian hyperstimulation syndrome, which can trigger blood clotting problems, severe abdominal pain, dehydration, and vomiting; on most occasions it requires hospital admission, and, rarely, can even cause death.[49]

Risks for the Child

Medical risks can also increase for the child born using social freezing. In addition to prematurity and low birth weight, there is evidence of a moderate increase in the risk of congenital abnormalities, and some experts suggests that there may be a small increase in the risk of cancer and cardiac abnormalities owing to the use of IVF.[50]

Financial Aspects

In the United Kingdom, the process of obtaining eggs, then freezing, warming, and implanting them, can cost around £15,000.[51] In Australia and the United States, the cost of freezing eggs varies between $10,000 and $15,000. According to Apple and Google, the total cost of egg freezing is around $20,000.[3,52]

Furthermore, according to the calculations of the US Department of State, the estimated cost of social freezing for the armed forces is about 150 million dollars over five years. "As many families know all too well, these treatments are very expensive and often require multiple attempts," explained Matthew Allen, spokesman for the Department of Defence to the New York Times, so "providing this benefit across the board would result in a significant cost for the department."[17]

Social Assessment

One reason to justify social freezing is to present it as a social advance, one further step towards women's equality with men in professional aspirations. We believe, however, that this statement raises many questions.

In accordance with this, Geraldine Gallacher, head of a company specializing in advising women returning to work after having a baby (particularly in law offices and banks), says that it is "a high-tech solution to a human problem. It's trying to change nature rather than the organisation." Gallacher says that companies go to great lengths to keep their female staff happy—such as providing breakfast and even beds at work—but that this is "a step too far."[53] The one thing that companies could do to make a returning mother's life easier is give them more autonomy over their hours, she argues.

Private insurance coverage for employees who use social freezing may cause them to feel pressured to freeze their eggs, often stressing the benefits that social freezing may have for them, while ignoring the risks involved in this practice.[41,54,55,56]

Several Swedish studies show that Swedish women aged between 30 and 35 years have a positive attitude to egg cryopreservation for non-medical reasons.[57,58,59] All these findings seem to suggest that the practice of egg cryopreservation for non-medical reasons is gaining social acceptance.[45]

In relation to social freezing, another aspect of interest is to determine the opinion of assisted reproduction professionals on this issue. This was assessed in a recent article, which surveyed 201 professionals in four public hospitals in Spain between May 2013 and March 2014.[60] The survey found that 41.8% of gynaecologists think that social freezing should be offered to all young women, compared to 62.7% for other specialists. Among nurses, 48.9% would offer social freezing to all women. Remarkably, only 4.9% of participants are opposed to this practice.

In terms of the maximum recommended age for social freezing, most gynaecologists establish it at 35 to 38 years, while other specialists and nursing staff would offer it up to age 40. However, they could be giving false hope to women who use social freezing by assuring them that they can achieve their goal of having a child when they are older.[51] In this respect, the British Fertility Society (BFS) and the Royal College of Obstetricians and Gynaecologists (RCOG) have issued a joint statement saying that, while they approve this practice for medical reasons, they do not do so "as a way to delay childbearing as a lifestyle choice."[61] BFS chairman and RCOG spokesman, Adam Balen, also says that encouraging social freezing is going too far because the technique does not guarantee a baby and also introduces objective risks for the woman, for the ovarian stimulation and necessary IVF that she will have to undergo are not risk-free.[61] In the same article in The Telegraph, Professor Winston,

a pioneer in assisted reproduction techniques, is very critical of social freezing and believes that it is being "grossly oversold."

Ethical Assessment

Aside from the aforementioned biomedical and social problems, social freezing unquestionably presents ethical concerns. In our opinion, the main one is that, although not explicit, it implicitly objectifies the woman by prompting her to make a decision that is disguised a good for her when, as reported, this practice entails objective negative medical consequences for the user and also for her child. According to Martinelli et al., "Social egg freezing is a paradigmatic demonstration of how the medicalization of women's bodies can be used to mask social and cultural anxieties about aging [...]."[62]

However, we believe there is another ethical difficulty, derived from the fact that it is hard to guarantee the autonomy of women to make such a decision if they are not provided with adequate information on the risks and benefits entailed in social freezing, something that is not always easily verifiable, as previously mentioned.

Another ethical problem that social freezing may pose is the possible social inequality between groups of women who work in economically powerful companies, which can bear the costs of social freezing for their employees and those who work in companies that cannot do so. Another question therefore arises: to avoid social injustice, should social freezing be supported with public funds? We believe the answer should be that, given the myriad of objective medical problems that exist—some of vital importance—and that have to be treated with these funds, would it not be creating a problem of distributive justice? Finally, it should also be pointed out that social freezing implies that fertile women, capable of conceiving and carrying a child naturally, renounce this, substituting natural conception for IVF. This not only reduces the possibilities of eventually becoming pregnant but also, as mentioned, increases the health risks for mother and child. It must be carefully considered whether the advantage of using young eggs compensates for the risks derived from the processes required in social freezing, described in this paper.

Conclusions

The cryopreservation of oocytes used in cases of healthy women in which it is not sought to overcome an infertility but as a means of postponing a pregnancy for social reasons, entails serious ethical difficulties derived, fundamentally, from the risks that the procedure entails for the health of the mother, resulting from ovarian hyperstimulation, gestation at an older age, and the lower probability that it will eventually occur, and for the child's health, related to the risk of medical problems that assisted fertilization techniques—which a mother resorts to in order to achieve a pregnancy—present about their gestation and future development. The need for adequate information to the candidates about the risks involved in the procedure and the chances of success is essential for them to exercise free consent.

To try to facilitate these techniques to all women on equal terms to avoid discrimination would involve devoting important public resources to a non-medical problem, taking them away from other more urgent care needs.

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Justo Aznar, MD, PhD, with Extraordinary Prize from the University of Navarra (Spain) is Head of the Department of Clinical Biopathology and Coordinator of the Biochemical Research Unit, at La Fe University Hospital in Valencia, from 1974 until his retirement in July 2006. From 2005 to 2016 he was a Corresponding Member of the Pontifical Academy for Life. He is currently Director of the Life Sciences Institute of the Catholic University of Valencia. He is a member of the Royal Academy of Medicine of the Valencian Community and corresponding of the Royal National Academy of Medicine. He currently resides in Valencia, Spain.

Julio Tudela Cuenca, **Pharm, PhD,** is Professor at the Catholic University of Valencia and Director of the Master in Bioethics of the Catholic University of Valencia. He is Member of the Life Sciences Institute of the Catholic University of Valencia. He is Member of the Research Ethics Committee of the Catholic University of Valencia and the Research Ethics Committee with Medicines of the Valencian Oncology Institute Foundation (Spain). He currently resides in Valencia, Spain.

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Addiction as Degradation of Life

ONDŘEJ BERAN, PHD

Abstract

The paper discusses equivocations involved in the concept of addiction and suggests its understanding in terms of one's (degraded) way of leading one's whole life. I argue against common conceptions of addiction, identifying its core either in a physiological (substance-induced) condition of craving or in weakness of will as insufficient. Using Fingarette's notion of "central activity," I explore addiction as a peculiar kind of central interest, pervading and predating on one's other interests and characterized by a corrosion of a sense of temporality and responsibility. Since addiction is a response to events in the addict's life (a personally specific lack of healthy sources of positive reinforcement), therapy—consisting in reestablishment of the capacity of navigating responsibly one's activities and interests—must proceed in a way that takes the particular aspects of each case into account.

Keywords

Addiction, will, central activity, degradation, and reinforcement

The term "addiction" triggers a richness of associations. There are various images of drugs and drug use in media, fiction, or movies. Addiction is often associated with the life of people afflicted by crime, poverty, and social exclusion, but it also occurs among "better people." There are reference books to help us recognize when our loved ones have a drug problem and how to address this problem.

On the other hand, biochemistry or medical science research drugs intensively, and we already have very precise knowledge concerning their physiological or psychoactive effects. This research concerns specific questions of biology, physiology, and pharmacology and may seem disconnected from the stories we are told about people we know to have a drug problem.

There is also a rich diversity of *philosophical* discussions about the issues of will, its weakness, and *akrasia*. In many cases in which a direct extrapolation to addiction is made,[1] a reader may again experience a disconnection from the known drug stories and examples, just as when science discusses which brain centre is stimulated by a given drug and through what kind of biochemical process.

There thus seem to be (at least) three discontinuous points of view on drugs and addiction. In this article, I would like to offer a clarification of the concept "addiction," as it is used in the first of the mentioned meanings: a commonly known problem occurring in people's lives. I will suggest where and in what sense I see connections to, and disconnections from, the other two kinds of approach. I will only pay limited (necessary) attention to the subtleties of the discussions of weak will. Instead, I will focus on how the concept "addiction" highlights important aspects of lives that, as wholes, are corrupted or degraded.

It might seem obvious that what distinguishes addiction from other kinds of life problems is the presence of a substance that, injected or digested or smoked, has physiological as well as psychoactive effects on human organism. However, I will argue that a proper appreciation of addiction cannot rely solely upon physiological or pharmacological effects of a substance on the organism. After all, phenomena, like pathological gambling, is called "addiction" as well. It is more appropriate to look at what a person's life looks like in general: what addiction has to do with a distinct sense in which the life is (not) good. I am not going to try to offer a definition of what it means, exactly, that one's life is or is not good. But something constitutive of a good life seems clearly missing from the life of the people whose relationship to a drug became a "problem." I hope this supposition will gradually gain sharper contours.

In section 1, I characterize some influential, typically naturalistic or reductionist, conceptions of addiction and suggest where they may prove insufficient. In section 2, I discuss more complex or promising philosophical conceptions and explore what they can offer, in my opinion, to a more balanced view on addiction. In section 3, I discuss equivocations lurking in the concept of addiction and various options for its specification or replacement. In section 4, I propose an alternative, more complex conception of addiction, relying on Herbert Fingarette and Carl Hart's works: as a way of leading one's life. In section 5, I discuss the parallels of this view in various existing ideas concerning the way out of or recovery from addiction. Although I will not delve deep and very explicitly into these issues, I only note here that my overall perspective draws some inspirations from the Platonic or Aristotelian anthropology and ethics. They illuminate the notorious question of whether or not the addicts' will is incapacitated and whether or not they are responsible for their actions as a simplifying and, in effect, misleading alternative.

1. Unsatisfactory Concepts of Addiction

Before addiction became the focus of medical professionals, drugs (usually alcohol) were regarded as God's gift or, in turn, a curse. In the latter case, excessive drinking ("excessive" might sometimes have meant "any") was considered the drinker's moral lapse. In the 19th century, people who effectively disqualified themselves from the "good society" by their alcohol or opium dependence that got out of control were supposed to be moral failures or wrecks and drinking to be a manifestation of this moral breakdown.[2] It seems naïve and inappropriately moralistic now, and no wonder such views were more or less abandoned. It is, however, unfortunate that the valuable intuition that addiction may be connected with what kind of life one leads and, indeed, what type of person one is was abandoned as well.

The succeeding alternative approached the issue from the medical point of view and identified addiction as a certain kind of *disease* (programmatically, as seen in Jellinek[3]). Alcoholism, the kind of addiction Jellinek focused on, is a condition of a primarily physiological or physiopathological nature, and, as such, it can only be cured in the same way diseases are cured, if at all. The development of alcoholism follows the inborn predisposition of a drinker: the higher this is, the faster alcoholism can develop following the first encounters with alcohol. Just as with other diseases, alcoholism has stages that follow one after the other in a regular sequence.

Though Jellinek's analyses are less straightforward, the important points of the disease concept, as exemplified by his book, shape the conception promoted by Alcoholics Anonymous. In their view, drinking blunts the drinker's self-control. While Jellinek admitted various degrees of the liability to succumb to alcoholism after the first drink, the AA are unambiguous: drinking leads quickly to the state of *powerlessness.* Drinker must admit, loudly and to themselves, that they are powerless against alcohol, just as they would be, as people, powerless against genuine diseases like flu. (This is not simply a dogma, nuanced defence of good reasons behind AA's philosophy.[4]) Consequently, the drinker's responsibility is weakened at best; it is difficult, if not impossible, to blame one for one's actions caused by a disease from which he/she suffers.

The disease concept, though originally coined from a medical viewpoint, has always been more popular among laypeople than among physicians or psychologists. Comprehensive criticisms have been raised by many authors, most notably Fingarette or Peele.[5,6] Fingarette points out that extensive national surveys in the US have shown a wide, quite un-disease-like, variety of forms that drinking problems take. The emphasised "loss of control" sometimes occurs with drinking but other times not; sometimes it also brings about financial, job, or family problems, while other times it does not. And unlike the case with genuine diseases, many people are able to just "grow out" of their former drinking problems. The "unique sequence of stages and regular pattern of symptoms" postulated by Jellinek fails to be there.

Peele also mentions that surveys of drinkers who underwent the AA programs displayed a significantly higher rate of relapse than among those who were able to help themselves through individual, self-administered methods.[7] The successful individual strategies dealing with addiction problems often relied on cognitive coping techniques that helped the addicts made themselves *see*, for instance, the negative impact of smoking or drinking on health or finances.

More recently, the prevalent view of drug scholarship, as exemplified by the representative handbook by Hart et al,[8] tends towards seeing addiction phenomena as more complex than a kind of disease. It seems that alcohol dependence, for example, is more often a *secondary* issue derivative of problems with anxiety or depression. There is no test capable of discovering the underlying cause. In fact, despite growing knowledge about the mechanisms of alcohol effects in the human organism, we still do not know what the underlying cause of alcoholism is and are not certain that there is such a thing (whether genetic or physiological). What is more important, there is no idea of any kind of addiction treatment that would have the form of a "cure" to a disease.

In substantially broadened, bio-psycho-social terms, alcoholism might be considered a disease in a sense similar to high blood pressure or erectile dysfunction. These diseases are multifactorial, without have one clear, underlying cause, and the suggested cure often consists in treating the symptoms, while the required change of lifestyle cannot be prescribed by a physician. Only if thus broadened, bio-psycho-social concept of disease comes in here, it may not seem, as Hart et al put it, so "far-fetched" to characterize alcohol dependence as a kind of disease.

Certainly, some of the aspects of the disease concept are compelling. It shares one assumption with the view of addiction that pervades many philosophical discussions

of the issue. The compelling power results from its *naturalism* and *reductionism*; addiction is *caused* by means of the substance's pharmacology, by its effects on the *organism*. It is, as such, a *physiological* state of the addict's organism. This is clearly doubtful; it leaves unexplained why high percentages of people who have taken a drug at some point (even repeatedly) do not develop a harmful pathological habit, despite having taken the same substance as those who did. Not to mention cases where a "substance" is missing altogether (pathological gambling).

Action theorists are not, however, that interested in the actual physiological mechanisms of addiction and its cure. Rather, they investigate addiction as a peculiar state of mind or volition. Alfred Mele introduces a thought experiment, relying on characteristic tacit assumptions about what addiction is, where he speculates about an electronic device capable of eradicating immediately the addict's craving and thereby solving the problem.[9] Here, we see addiction portrayed as an isolated problem of *will*, weakened or broken by *craving* stronger than will itself. What is sought after is a "prosthesis" that would strengthen the will to resist craving or that would eradicate the strong bodily state of craving altogether. This prosthesis can be provided by medication (substitute treatment, for instance), but, perhaps, otherwise (Mele's electronic device).

Mele revisits, again, the traditional image of *akrasia* that already Plato and Aristotle considered problematic. The addict recognizes something as the better thing to choose but, pushed by overwhelming desire (craving), acts in an alternative, worse direction. Interestingly, it is assumed self-evident that addicts know what they want and that they want something specific, only they cannot achieve it. That thing is *to overcome the "ill habit," to get rid of it.*

In what sense the addict truly wants this could be questioned using Socrates's arguments against folk opinions about the so-called *akrasia*. Here it might suffice to point out that so many addicts clearly do not fight against their dependence. Such an idea may not even enter their minds. Their activities and what they think about can include many varied things, and the desire presumed by Mele needn't be one of them.

The weak points of craving-oriented conceptions of the nature of addiction can be shown, I believe, even more clearly using the example of *economic* models of addiction. There are multiple such models. Some analyse addiction as a rational investment of time and energy into a perceived future profit, while some criticize this position.[10,11] Some argue that the addict's perception is distorted and falsely pictures the present profit as outweighing the future losses; the addicts' considerations of their actions take the shape of hyperbolic discounting. The most important proponent of this model is George Ainslie.[12]

Just as Mele presupposes that this addict has a target to achieve, laid out in front of him, so the economists assume that the behaviour of addicts can best be described as resulting from performed cost-benefit calculations oriented towards the future. At least the perceived present profit must outweigh, in the addicts' eyes, the future losses, because, otherwise, they would not take the drug. The underlying assumption is the same: they *know* the drug is *bad* for their future and, without a counterbalance, they would prefer *not* to take it. If only i) their will was strong enough, which is the problem in Mele's view, or if only ii) they were able to calculate the ratio of profits

and losses correctly and see properly the drug as not worth it, which is the problem in Ainslie's view. In both versions, craving is to blame.

However, other studies point out that future profits or consequences may play no significant role. Drug-taking triggers and is sought after for the experience of the "cancellation of time," as in the case of nicotine-smoking.[13] Or it deepens or facilitates experiences of *absorption* and a focus on the present, highly valued in various spiritual traditions and exercises (see Nelson's reinterpretation of the putative cannabis "amotivational syndrome"[14]). A similar phenomenon is described beautifully by Proust as "pure phenomenalism," in which any future problem can be dismissed by a present gesture of bravado.

The phenomena connected to the so-called amotivational syndrome or the *empty* heroic confidence Proust describes suggest that the future plays only a vague and reduced role here. The inability to follow the real *future* consequences of one's actions or to take the real effort that future plans may require is among the characteristics of drug-related states, experiences, lifestyles, or phenomena. Time, or its full awareness, is, as it were, cancelled in favour of a certain experience (or conception) of one's life located fully in the present moment. In this light, addiction could be as well described as a life disorder with a distinctive cognitive or perceptive dimension, rather than weakness of will or disease. The disorder consists in the inability to see what future commitments are entailed by one's present actions or by the present situation (see Brandom's concepts of commitment and entitlement[15]). In a sense, the addict may be seen as not wanting to get rid of addiction, at least not really or sufficiently; after all, drugs offer various pleasurable experiences.

2. More Satisfactory Views on Addiction

The naturalistic conceptions of addiction I talked about in the previous section show addiction as a physiologically conditioned state of organism, against which one is, as a person, similarly powerless as against a disease. However, the views on addiction informed by theory of action sometimes tend to adopt an opposite standpoint. Thus, for example, Foddy and Savulescu in their remarkable proposal of a "liberal account" of addiction retain the notion of addiction as underpinned by the neuro-chemical, etc., processes caused by the consumption of the drug.[16] Yet they abstain decidedly from the common way of describing these phenomena as pathological. Such a way of putting it is, as they say, "illiberal"—that is, judgmental and moralising.

According to them, though drugs affect the dopamine receptors in the brain, they do not differ fundamentally from other desires that we strive to satiate. Pleasure-seeking behaviour is not in itself unnatural or unreasonable; we are only accustomed to seeing it as such in connection to illicit drugs, while in connection to sex, coffee, or other legal sources of pleasure, we do not judge the pleasure-seekers badly. Also, seeking the pleasure that is contained in coffee, sex, or movies is not considered pathological or irrational; what people do, motivated by these desires, is neither irrational in itself, nor does it testify to the agent's disturbed or incapacitated rationality or, in effect, impaired *responsibility.* So why should drugs be treated differently?

Although this was not the principal aim of Foddy and Savulescu's article, it opposes the "demonization" of drugs. They try to show that agents seeking pleasure

in drugs do not differ fundamentally from those seeking it elsewhere. In all cases, it is still appropriate to judge their behaviour and attribute responsibility for their actions. Even earlier, there were attempts at interpreting the phenomena of addiction in a way quite opposite to the naturalistic reductionism. Heyman's complex interpretation of addiction as a "disorder of choice" attempts to show that though nobody chooses or decides, properly speaking, to become an addict, that does not make the objects of addiction genuinely irresistible. "Everyone can stop using drugs, when the costs of continuing become too great," he says.[17]

And, on the very end of the scale, Davies argues that the concept of addiction as something that makes people do things against their will is a "myth". "Most people who use drugs do so for their own reasons, on purpose, because they like it, and because they find no adequate reason for not doing so; rather than because they fall prey to some addictive illness which removes their capacity for voluntary behaviour."[18] (p. 13). Davies does not deny the far-too-numerous cases of people who got stuck in a cycle of substance abuse with tragic consequences. But he insists that to see addiction as something that simply *happens* to people is fundamentally flawed. Addiction results from a complex interplay between one's environment and one's choices, decisions, and preferences. There is, thus, no reason to exempt addicts from the realm of agents held answerable for their actions. (At the same time, Davies speaks very vigorously against anti-drug policies that urge sanctions against drug use as such as illegal.)

These accounts share the conviction that, as far as it makes sense to judge and approve or reprehend addicts' actions at all, there is no need to call for a special, different measure, taking into account that the particular regime in which the self-control of addicts works. I am not sure that it is that easy. We are acquainted with the phenomenon we describe as "falling into drugs and not being able to get out of it." There *are* such cases one can recognise in their environment, among their acquaintances. And there are sedimented, differentiated patterns of responses to actions performed in such a context: "It's the drinking that's speaking for him— it's not him, he would never say such a thing." Usually, a long and painful history of experience is needed before it turns out that there is no "him" anymore besides the alcohol that is speaking out of him. Often the distinction in response to people and to their actions "caused" by alcohol never fully vanishes, as it is based on a more primitive attitude of love, friendship, loyalty, care, or compassion that one has for addicts. That is not to say that this ineradicable attitude cannot in effect harm the addict (see Seeburger's criticisms of co-dependency[19]). But neither is this to say that such trust cannot bring its fruits later.

It is impossible to show that "falling into drugs" is only a neurophysiological pathology; we still know too little about this. But neither is it easy to "fully" blame people for their drug consumption and the actions conditioned by it. We tell very *different* stories about drugs and addiction (alcohol, especially, has a complex buffer of connected culture; let us just compare images of drinking in *John Barleycorn*, *The Brothers Karamazov*, *Under the Volcano*, or Hemingway's professions of love for drinking). A lot of further, additional facts decide about our judgment of a particular case, facts about the abovementioned interplay between the context and the agent. These facts decide whether the case is one of "just drinking" or of *dependence* on

drinking—whether one should be held responsible or rather shown compassion as the victim of bad moral luck.

In his books of memoirs from advisory practice, Theodore Dalrymple tells stories of encounters with prisoners with heroin addiction.[20] His anecdotal evidence seems to question whether there is such a thing as *irresistible* heroin addiction at all. The "insurmountable" craving often only lasts until the moment when the patient sees that the doctor is really *not* going to prescribe the dose to him. Dalrymple is far from being sentimental towards his patients or making excuses for them. On the other hand, though he is very sceptical about craving as overestimated, he does see the *complex* problems his patients obviously *do* have. If the problem was neurophysiological, it would be rather easy to cure. As he says, "[I]t is easier, after all, to give people a dose of medicine than to give them a reason for living. That is something the patient must minister to himself."[21]

Though sceptical concerning the theories of drugs as incapacitating one's will by means of craving, Dalrymple is reserved in *condemning* his patients morally. The people in whose life a drug problem is visible often fail to meet one or more of the conditions of an action deserving unmitigated condemnation, such as being performed with full awareness, intentionally, with apprehension of purpose and consequences. Dalrymple's numerous case anecdotes seem to suggest that addiction, as far as it constitutes a problem (e.g. in those who ended up in jail for drug-related crimes), has more to do with the way one leads one's life than with an irresistible neurophysiology. It is a life from which something seems missing. Dalrymple calls it "a reason for living"; but it can also be called purpose, sense, organization, or even an alternative source of positive reinforcement.[22]

3. Excursus—the Equivocation of "Addiction"

Some confusions about the definition of addiction can be attributed to the equivocation inherent to our use of the term. There are a lot of drug-related phenomena or conditions, interconnected rather loosely. It is good, for the sake of clarity, to distinguish between them because they often do *not* co-occur.

(1) There is the *short-term effect* (typically psychoactive) of the drug on the organism while it is still present in it: the hallucinations caused by LSD, the peculiar kind of relaxation induced by marijuana, etc. There is variability in it, depending—apart from many other things—on one's predisposition to further conditions that may be triggered by drug use or depending on one's created tolerance to the substance. However, the mechanism of producing these momentary effects of drug consumption is well known, and much can be predicted.

(2) There are the *chronic effects* of the long-term use of some addictive substance on the organism. It is debatable to what extent the health problems of, say, long-time heroin users are caused by heroin itself. Ultimately, the best (maybe only) example of the chronic effects of a drug use (expected to be harmful) might be liver damage caused by long-term excessive drinking.

(3) More specifically, some of the physiological effects of drug consumption are closely connected with what is often taken for addiction itself: *physical dependence* on the drug. Its clearest symptom is the occurrence of the *withdrawal syndrome*

that follows the established tolerance of a drug and withdrawal of its regular use. (Medical professionals nowadays prefer talking about *dependence*, which easier and more precise to define and diagnose—it is appropriately classified by the Diagnostic and Statistic Manual of the APA—rather than about addiction, a concept notoriously unclear and ambiguous.[23])

(4) Apart from physical dependence manifested typically in the withdrawal syndrome, there is also *psychological* or *behavioural dependence*. This generally means that it is difficult for the person to get along without using the drug and that procuring and using it requires much of the person's time. It is also characterized by repeated, unsuccessful attempts at stopping its use. These attempts are supposedly blocked by various forms of craving or compulsion, but these obstacles needn't always take a physical form (such as the withdrawal syndrome).

Serious research studies have been performed that map the mechanisms of (1) through (4), and the causal link or correlation to the use of addictive substances has been rather well known in (1) through (3). Less known, however, is how the behavioural dependence works in cases like pathological gambling where no psychoactive substance is used, despite the similarity of the typical symptoms to the cases of substance abuse. "Addictive" patterns of behaviour occur, even where they cannot be accounted for in naturalistic terms (human physiology influenced by a substance).[i] The naturalistic link is also missing, however, in the case of other effects attributed to the working of drugs.

(5) As suggested, philosophers' discussions concerning addiction often centre around a *weakness*, *defect*, or *disruption of will*, or *akrasia* caused by drugs. It is, however, unclear how exactly such a thing can be caused by the common psychoactive substances. Not least because we are not able to locate unequivocally such a condition in the human organism: what exactly is happening, and where in one's body is it happening, when one experiences a "breakdown of will caused" by drugs? (This is far more complex than the effects of the kind of Rohypnol consumption.) There are no satisfactory answers. Additionally, again, it also occurs where no substance use is involved (gambling); weak will is routinely blamed as the root of the inability to succeed in attempts at stopping.

(6) More generally, drugs and their effects on their users purportedly amount to generally *anti-social and/or criminal behaviour*. (Here is why the "war on drugs" was declared.) It seems even more difficult to establish a link here between drug use and these tendencies than in (5). There is a huge variety, depending on the culture or sub-culture where one is at home, in what counts as anti-social behaviour. As for drug-related criminality, many of the statistical results are a by-product of particular legal settings; making drug possession (even in small amounts) illegal clearly raises the amount of "drug criminality." Local experiments with prescription heroin (such as Dr. Marks undertook in the early 1980s) show that the notorious petty theft, etc., can be significantly diminished in this way. It is also less and less clear that drugs *directly* cause violent crimes, as these seem to be a part of more complex social problems related to poverty, low education, and social exclusion.[25] Most common drugs were designed to work as relaxants, stimulants, or hallucinogens. It is perhaps *alcohol* rather than the most important *illicit* drugs that has the connection to the cases of

exacerbated violence or aggression. (But, again, even the mind-altering effects of alcohol consumption are highly individual.)

The problem with the equivocation is that these six conditions needn't occur all together; sometimes only some of them co-occur, while sometimes we witness only one of them. These are independent cases: i) someone whose life is marked by overwhelming alcoholism; ii) a person who only drinks a few beers on "special occasions" and is induced into a "mood"; iii) a once-heavy-drinker with a damaged liver leading a now quite sedate life; or iv) a philosopher succumbing to an irresistible compulsion to take a piece of fine Belgian chocolate (to borrow a typical kind of addiction example employed in philosophical articles). Any of these can be imagined without any of the characteristic aspects of the others.

It is the problematic and presumptive condition (6) that is also perhaps closest to capturing what the word "addiction" commonly refers to. This, however, constitutes, again, a separate subject of distinction, not identical to any one of (1) through (6):

(7) *Addiction* as a certain problem that one has with one's life, a problem that may be difficult to see at first but that may end in clear, visible degradation of that life. "Symptoms" of such degradation, described in relative agreement by many guidebooks for the public,[26] include things such as abusive, destructive, self-destructive, and secretive behaviour; decline in one's health (or interest in one's health); minor criminal troubles like shoplifting; money missing from households; a decline in responsibility towards school or work; unexplained absences or delays; lack of motivation; excuses and pretexts; complete unreliability of what one says; etc. Although these anecdotal observations help efficiently to spot the start of drug troubles, it would be hard to explain how such a diverse bundle of "symptoms" (those, again, never occur all at once) could be caused by a substance through a physiological process. (Further distinctions within (7) can be made[27]).

Addiction in the sense of this heterogeneous cluster is different from and broader than any of (1) through (6). And the guidebooks about "addiction" for parents that try to enable their readers to recognize and face the problem, or social programs of drug prevention that try to eradicate it, address *this* problem, not necessarily *any* drug use. The point is not to ensure that children never once try marijuana or alcohol, for instance. Much more important would be, even if the children tried it, for them to form a reasonable attitude to drugs, resulting in no malignant, problematic "lifestyle." (For some, this may mean complete abstinence.)

This harmful condition, addressed by guidebooks and prevention programs but also referred to, for example, in our small talk about people of our acquaintance who have a "drinking problem," is what best corresponds to cases covered by the use of the umbrella term "addiction." Its connection to drug use itself (either sporadic or repeated) is far from straightforward. Neither is it self-evident that what lies at the heart of addiction is a weakness of will, so favoured in philosophical discussions. However, the persistent identification of weak will as the core of addiction problem deserves some comments.

Various authors suggest that being an addict consists in having a problem with the proper functioning of one's will.[28,29,30,31] These analyses often refer to addiction as a kind of *akrasia*; one may be aware that keeping the drug habit is bad, but, due to a desire for the pleasure provided by the drug, there is not a strong enough will to take

reason's advice, and the drug habit, therefore, remains. Addicts, then, continue to do what they know is bad. *If* the problem with addiction is about *akrasia* in this sense, it is about considering alternatives of *action* in terms of better and worse (taking the drug vs. not taking drug [anymore]) and not being able to carry out the result of one's judgment.

This emphasis on the *individual episodic actions*, characteristic of the recent accounts of *akrasia*, may, however, be problematic. Why should such an action not in accord with one's reason be such a problem? Addiction does not consist in taking the drug alone against one's better judgment. If I have drunk two beers instead of one yesterday evening, and I regret it now, it does not mean that I am an alcoholic. If I did the same thing ten times during the last year, it still needn't mean that I am an alcoholic. True, if I am an alcoholic, it can manifest itself in my drinking one-beer-too-many several times during a time-span. But "being an addict"—addict *qua* akratic—does not mean exactly either the drinking episode or the chain of drinking episodes by themselves. If it did, one might ask: was I alcohol-addicted when I was drinking the second beer but not when drinking the first? Was I addicted in the meantime, between the alcoholic evenings? Was I addicted only during those evenings when I (afterwards) regretted the second beer? (I may have thought the second beer was quite alright on some occasions.)

When addiction is located, through a particular conception of weak will, into episodic actions, these questions are inevitably asked. But something important goes amiss this way. Levi argues that asking whether or not one's will is weak is a question ill-suited to capture anything beyond episodic actions;[32] however, it is exactly the *habitus* of who one is over an extended period of time where problems with alcohol reside. Aristotle, too, talks about *akrasia* as about something habitual or chronic, a state of the person.[33] This is not just due to the repetition or multiplicity of the akratic "events." What one is like, in terms of their character, does not result, as a conclusion, from a chain of events. On the contrary, these events—to the extent that they assume a personality or a character, so to speak—result from the state of one's character. To say that one is an akratic—or, for that matter, an addict—thus expresses more than a description of episodic incontinent actions concerning a drug. It is a description, a judgment of the person's life.

The important thing is that there is more to a person than actions. One's character involves the complexity of one's actions, as well as thoughts, desires (including desires that are "only" experienced but not satisfied), inclinations, emotional reactions to or judgements of other people's actions, etc.[34] In these terms, it makes sense to say that one is an addict even between the "episodes" or that a recovered addict is still an addict, though he/she may have been "clean" already for years. Wittgenstein's former student Maurice Drury, a practicing psychiatrist, remarks with palpable irony that what makes an alcoholic an alcoholic is not the actual abuse accompanied by symptoms like shaking hands or a red nose. It consists, rather, in an "abnormal" and "sinister" *relationship* to the drug and the pattern of its consumption.[35] The abnormality needn't have much to do with frequency or amount.

Focusing on will often takes the shape of investigating a "capacity" inherent to episodes of one's ability or inability, in the decisive moment, to perform a particular action. But the problematic actions of an addict have to do with the addict's problem

and disordered *character*, which is still "there" even when one is neither actually drinking, nor still intoxicated, and perhaps "only" experiences the craving (that may or may not be overcomed) that overclouds the *perception* of the surroundings. The episodic focus on weak will does not help us understand what is going on in the addict's life *between* the episodes of drug-taking, although the problem pervades there, too.

4. Addiction as a Way of Life

The previous excursus has aimed to show that the confusion clouding the discourse of addiction is due to 1) the equivocation inherent to the concept within which seven (or perhaps even more) different things can be distinguished and 2) the too-episodic interpretation of the conflicting states of human personality reported as "weak will." The inappropriateness of locating addiction within the episodic actions (related to drug-taking) of an addict is a call to consider the need to investigate what the life of an addict looks like as a whole.

Herbert Fingarette suggests that addicts shows themselves in the way they perform in other domains of their lives *not* directly related to addiction.[36] This is not a matter of the enumeration of what one is able to do but rather of the manner. For such purposes, Fingarette introduces the concept of "central activity." Such a central activity or interest is one that plays a principal role in the way we organize and prioritize all our activities and interests, what far-reaching choices (with respect to other-than-central interests) we make, what dispositional attitudes we adopt, etc. Typically, for many people, such attractors as their families, their jobs, or their beloved hobbies occupy the role of the central activity, rather than heavy drinking or the like.

The "central activity" serves as a particular tool of orientation and helps others understand the course of the addict's life (or a "family guy's" life or a work-dedicated person's life), including those of its domains where the central activity or interest is not thematized. The reference to the central interest may produce the reply: "Ah, now I can see why he behaves in so-and-so a manner; now it does make sense to me!"

If I introduce someone's central activity, it enables me to characterize this person aptly, and this characterisation is widely useful. If I provide the information that someone is (even quite often) drinking alcohol, and I am talking about a person that is, nevertheless, not in a "central" kind of relationship to drink, I do not provide a useful clue. I do not illuminate the particular work performance or interpersonal relationships or the peculiar choice of leisure time interests and personal investment in them or anything else. It tells us or explains practically nothing about many people when we learn that they are not teetotallers, except for the rather uninteresting fact that they sometimes drink.

It can tell us a lot if the info about a person's drinking states their central interest or activity. To paraphrase it in Williams's terms, it is a "ground project" that tells one's identity.[37] To say that people are alcoholics means to provide information about *who* they are; that doesn't mean that they are not also someone's spouse or daughter or an artist or a convinced Marxist. But to omit the information that they are also an alcoholic means to fail to characterize how they typically behave and act as a spouse, an artist, or a Marxist political activist. Actually, a lot of their actions in these domains may be unintelligible without this information because we only make an

incomplete or distorted picture of their personal "project(s)" and, consequently, of who they are. Their actual actions or responses may then be unexpected or surprising in ways they usually are not in people whose central interests we know well. For these people, "surprise" means an ingenuous birthday present; in the addicts' case, it may be that they steal a sum of our money *out of the blue*.

The central activity usually influences the non-central interests so that it limits their space or the amount of attention paid to them, rendering them secondary. "Secondary" does not need to mean unduly neglected. Most people have more than one important interest or focus of attention in their lives, and they, for the most part, pay acceptable amount of attention to all of them. But typically only one of them is the single most important thing in the person's life. If we know what it is, it can help us understand the reasons for the secondary position of one's occupational responsibilities, for instance.

However, in contrast to other central interests, addiction seems to have a more aggressive and predatory relationship towards non-central activities; very often, the addict truly *neglects* them. Even if it is the most important thing for people to devote much time and attention to a spouse they love dearly, they still needn't be *completely indifferent* to their jobs during working hours (they just may not pay any extra attention to it beyond what they simply have to). Addiction, as is listed among its informal "symptoms," often brings about the inability to keep this balance with respect to what one would acknowledge as something one ought to do (even though it is not truly crucial for one's life). If a focus on sexual adventures or jobs disrupts, in a comparable manner, non-central activities, their attitudes to the central activities are pathological; in short, it is a problem of the kind of addiction. Steve McQueen's 2011 movie *Shame* is a good illustration of a life "infected" by the problem of addiction.[ii]

It is tempting to identify, as the core of addiction, the predatory nature of one's central interest disrupting one's other interests. I think this would be overinclusive. People for whom political career is everything—to the extent that they lose their families and all their friends and no longer have any hobbies or leisure interests—could be called "politics-addicted." But the concept of "addiction" would become too stretched. What distinguishes the excessive focus on politics from addiction in a narrower sense is that engaging in politics means engaging in activities and projects with a rich and complex internal structure of a *temporal* nature: politics involves planning, strategies, and differentiated reactions to the moves of those who one perceives as rivals, or allies, etc. Politics does not centre round the simple pleasure it provides that would lie at the very heart of all political activities and that, if necessary, could be obtained and consumed in a cheaper, surrogate form. One could indeed be infatuated by political *power*, but that is the *end* result, the attaining of which requires a complex succession of steps that cannot be easily substituted by "cheaper" power that one might get relatively quickly. The blurred temporality and the economics of cheap surrogates, characteristic of genuine addiction, is shown graphically in McQueen's film.

Also, apart from their predatory and aggressive nature, addictive central interests are, according to Fingarette,[38] also characterised by *self-deception*: not so much a self-deception about whether "one has a problem" as about its *nature*.[39,40] The underlying self-deceptive assumption is that addiction is something that *happens to* a person,

just like a disease, and that people are not culpable for their actions while under its influence. Let us just remember the familiar phenomenon of excessive excuses and pretexts frequently applied by addicts, as listed in the reference books describing the symptoms of addiction (7). Referring to one's addiction may serve as another welcome excuse for getting rid of responsibility one would have to face.

The self-deceptive nature of addiction can help us appreciate why—even though addicts seem not to be blameless and helpless in the same sense people suffering from a disease are—it is difficult, too, to hold them fully responsible. Pacovská's fine analysis shows that a self-deceiving wrongdoer does not and would not want to embrace intentionally, consciously, and lucidly the chosen alternative of action under the description of a "wrongdoing."[41] The judgment of their responsibilities for the *actions* in such cases often needs to move towards judging their *characters* comprising this epistemic vice.

Analogously, a part of the addicts' condition is their steadfast failure to see that there is *a* sense in which addiction is a matter of a wrong turn in their lives, as people, and that this wrong turn has *something* to do with things they can intelligibly regret or feel remorseful about. Francis Seeburger proposes to see addiction, instead of as a condition or a property of behaviour, as one of the fundamental possibilities of human life.[42] Addiction is on a par with such possibilities as finding or losing oneself or living fully or barely living. He says, "It is a way in which we can be." Addiction should be understood through understanding the addicts' lives as a whole. But in what respect does this particular life possibility differ from others? Seeburger's answer is that addiction is a form of enslavement, a case of life ceasing to be one's own life. (Unfortunately, this analysis opens the possibility for the label "addiction" to include phenomena one might not be that ready to call "addiction"—e.g. when one surrenders her whole life to the authority of a religious cult leader.)

Empirical studies of addiction offer alternative, more detailed answers. Hart et al suggest that the specificity of addiction relates to the role of *reinforcement* in life.[43] Some of the things we do are followed by effects that raise the probability of repeating the actions: with drugs, this is typically their pleasurable, mind-altering effect. But the mechanisms of reinforcement are not always physiological; they also include motivating reactions like others' applause to one's artistic or athletic performances, etc. Positive reinforcement, a "feedback" that keeps and confirms us in our particular line of repeated behaviour, is a powerful motivating factor and can account for non-physical dependency, as well.

Although there are attempts at explaining the mechanisms of reinforcement by dopamine effects in the human brain, they do not seem satisfactory. Reinforcement itself is a complex phenomenon, and many addiction cases require investigating the variety of possible sources of reinforcement for the agent. Hart suggests that it is mostly the general lack of *alternate* sources of positive reinforcement, rather than the actual reinforcement provided by the drug alone, that is to blame for the occurrence of drug problems.[44] The *perceived* availability of other areas of interesting self-realization is crucial.

Hart offers a characterizing summary of these alternative sources of positive reinforcement: "The ability to earn income, learn a skill, or receive some respect based on your performance in some sort of way (…) skills that are employable

or marketable, education, having a stake or meaningful role in society, not being marginalized".[iii] According to him, this lack is typical of a certain *social* standing, occurring most often among the poor, stigmatized, marginalized, and deprived people—the culture of poverty, in short. At least in the US, poor black communities and the neighbourhoods they inhabit exemplify this culture. The association of drugs as something that civilized society is in war against and the image and lifestyle of people living in such neighbourhoods is also corroborated by the media pictures of what "typical" drug users look like. Yet, in reality, these are images of a larger problem of a *social* nature, with *poverty* and social exclusion at its heart.

The remarkable "Rat Park" experiments, performed by Bruce Alexander and his colleagues, seem to corroborate the importance of other, non-drug sources of reinforcement for limiting the attractiveness of drugs.[45,46] Though their "subjects" were rodents only— creatures whose psychological and social life differs significantly from human life—their findings are not without interest. From another, purely philosophical angle, a complementary argument is offered by Amélie Rorty's analyses of *akrasia*. According to Rorty, *akrasia* needn't be a *conflict* situation of a will blocked by an insuperably strong tendency or desire that opposes reason; quite often, the akratic alternative is simply the easiest to choose since the other alternative, the "right" one, is weak and feeble and lacks motivational salience.[47] This deliberation is often unconscious; we make lot of practical decisions of this kind based on *habit.*

Insightful as Hart's analyses are, I do not think they are exhaustive. After all, a "drug problem" also occurs in families or social classes where poverty is not the primary issue. The abovementioned "money missing from households" is a very typical symptom, yet one that reflects a certain socio-economic status (of a "middle-class" kind): there has to be some considerable amount of money present for it to disappear, yet not so much money that the family would not notice or care about the difference. The lack of positive sources of reinforcement can have causes other than social and systemic ones and can also reflect the individual and psychological aspects of the particular case (such as growing up with cold, unloving parents who are rarely satisfied with—and not really interested in—their child), along with its moral atmosphere, so to speak.

These cases, not related directly to the culture of poverty, can offer a valuable specification of the aforementioned important difference of drugs from other central activities or sources of reinforcement: their peculiar temporality complementing the predatory and self-deceptive nature of addiction, highlighted by Fingarette. As I suggested, the more "respectable" central activities usually exhibit a degree of internal connections spanning through time. To be invested in one's love for someone or in one's job means to recognize and endorse the internal connections between what one does (or what is happening) *now* and what one may need to do *tomorrow.* The commitment to these connections requires understanding that an investment of time and endeavour is often due. (To achieve anything worthwhile, be it in a job, a hobby, or a sound interpersonal relationship one can rely on, an investment of time and endeavour is usually needed.) Drugs, on the other hand, appear to have the capacity to give their users "something for nothing," as it were, and to give it *on the instant.*

Bruce Alexander's recent comprehensive work attempts to show the complex network of social relationships behind addiction.[48] He identifies "adaptation to

social dislocation" as the principal form that addiction takes; he also identifies the free-market competitive values default in Western countries, defining them as the environment that more or less necessarily triggers forms of social dislocation. These forms are various, covering the range from the culture of poverty and crime in socially excluded neighbourhoods to the coldness and consumerism that occur among the rich (emotional and moral poverty).[49] Somewhat analogously, Rorty aims to show that the very set of values promoted in the societies based on free-market individualism may exhibit inconsistencies of the *akratic* kind: success in the competition among individuals may require selfish and callous practices that the same society disapproves of, at least verbally.[50]

What the authors I refer to sympathetically here share is their suspicion that addiction (7) is not the *cause* of anti-social or criminal tendencies (6), but is rather a *manifestation* of a certain disintegration or degradation of the life an addict leads, including its possible anti-social or criminal aspects. The *source* of the condition is heterogeneous in its nature. The individually psychological and moral aspects can be blamed (addiction as a manifestation of a morally poor or psychologically underdeveloped character), but there are also social aspects at play (addiction as a symptom of the culture of poverty and social exclusion).

5. Ways Out

In order to tackle addiction properly, a focus on successful ways of emancipating oneself from it might be instructive. Again, it is finding a "healthy" way of leading and organizing one's *whole* life that is the point of therapies, rather than "injecting" an artificial prosthesis for a weak will into the addict's organism. Addiction manifests itself in a corrupted sense of responsibility, along with a lack of realistic interest in oneself and the world outside that relates to a predatory central activity with a defective temporality, which provides positive reinforcement "for nothing." Redirection towards a life centring around a healthier central activity, thus, arguably requires work on responsibility; the way to recovery involves a restitution of its sense.

According to Seeburger, the sense of responsibility has to be "enforced," giving the responsibility to the addict to take care of.[51] Similar to little children, still more difficult and demanding tasks are imposed on the subject who is supposed to deal with them. This is why therapeutic programs work often with tasks such as taking care of a plant or an animal; the addict's attention is attracted by an object, demanding an interconnected complex of work and responsibility. Subjects should keep a survey and stick to the routine by their own capacities. Here, addicts are not an object, i.e. something to perform an expert procedure on. The therapy treats them as *subjects*, people, agents capable of making choices, giving reasons for them, and taking responsibility for them.

Of course, to address an addict as a subject (a person) rather than an object to perform an expert procedure on is not easy. The vital difference of the therapist's attitude is that which lies between handling a case according to a manual and encountering a person, who can never be fully reduced to a cluster of general diagnostic criteria. An autonomous *subject* can be entrusted with responsibility and success or failure *matters* and is something that makes sense to work on further with

the purpose of growing as a person, while a broken object is only repaired or fails to be repaired by an expert mechanic.

Approaches taking these considerations into account (such as the remarkably successful recovery approach promoted by Mark Ragins[52]) centre round rebuilding motivation. Clients proceed towards finding a sense in their own lives again. Although support by medication in addiction recovery may also be useful, or even indispensable, the key is to identify what is meaningful in the particular client's life and to rebuild (awake) motivation towards it.[53] There is no single thing to use as a motivator equally for all addicts. The recovery of a complex of endeavour and motivation—the idea of there being a "sense" to one's life along with the conviction that it makes sense to make decisions and assumptions directed to the future—is to be established in a unique, individual way in each case.

The *core* of addiction therapy, as suggested by the approaches sketched above, seems to consist in various types of work and practical activities, rather than in psychoanalysis or another kind of "talking therapy." However, therapists or any helper-and-companion can create favourable conditions and an environment for the addict's therapeutical "work on oneself" if they pay due attention to the particular events of the addict's life that would be useful or necessary. If both the addict and the helper-and-companion attain some clarity about the origin and history of the former's addiction, possible directions for future recovery will suggest themselves more clearly. These directions will differ, just as the histories of what "led" to one's addiction.

The answer to the question of the drug's attractiveness cannot consist in pointing at its actual or long-term *physiological* effects; these are rather similar in most users. But most people using a drug once or even repeatedly never develop a habit or dependence. We have to capture the decisive points of the addict's life and to explain how it could happen to *that person in particular.* This question is not trivial. The story of one's disintegrated life may need to take many different things into account.

In a similar vein, Fingarette warns that the fatal mistake that the proponents of the disease concept he is criticizing make is that they see alcohol dependence as being a problem *impersonal* in nature.[54] They overlook that excessive drinking is a form of a *particular person's response* to the particular events (problems, troubles, etc.) of life. If the question is "why does XY have a drinking issue?", then the answer "it is because of what dopamine does in her brain" is rather lame. To say that a man has a drinking issue because, say, his wife has left him and he cannot come to terms with it may be a simplification, but a simplification that tells us something interesting and important about his life and, by the way, about his relationship to alcohol as well.

The explanation lies in the drinker's life, not in a textbook description of the effects of alcohol on the human organism. Therapy that is interested in what was missing from one's life and what could fill the putative X in "say No to drugs, say Yes to X" approach has to proceed on a case-by-case basis. No two cases of addiction can be cured by the same "medicine" because drug-taking in each case responds to a somewhat different need or lack.

Although approaches proposed by Seeburger or Ragins involve (or result in) certain "will-strengthening," their methods do not address the client's ailing will directly and explicitly. They tend to aim at leading the addict to a particular "central

activity" of a non-addictive kind. This central activity has a proper, internally complex structure with a temporal dimension and links of responsibility instead of reinforcing clients in their searches for "something for nothing." The sense of responsibility thus instilled should help clients keep some equilibrium between their central activities and other non-central ones that are nonetheless important as well.

It is, I believe, noteworthy to mention a few important differences from the therapeutic philosophy embraced by AA. While Fingarette, Seeburger, or Ragins would stress the importance of knowing oneself better for understanding and tackling addiction, AA lacks *this kind* of interest in the individual varieties. For AA, the explanation lies simply in alcohol, in its making the addict powerless; and knowing why one has started drinking is a piece of information practically useless for achieving the aim of *abstinence*. Consequently, therapy in a Fingarettian spirit would not require a complete eradication of alcohol from one's life; the important part is to keep it safely away from the "central" position. AA, on the other hand, cannot really imagine any motivation for still drinking. As Levi puts it succinctly in his overview of these differences: "Why would I want to start drinking again just to show that I can control my drinking, when I know from long experience that I cannot do so?"[55]

This austerity of understanding may prove counterproductive, though. Alcoholics, unlike someone who "merely" drinks now and then, are not simply powerless against cravings but drink excessively in order to numb a feeling of void in life. Understanding better this feeling might help them find other, better-suited ways of filling the void, which is something else than simply quenching the thirst.

Concluding Suggestions

I have tried to show that there are arguments indicating that addiction—in the sense of (7): a complexity of problematic behaviour symptoms harming both the agent and environment, as the reference books for the public list them—is not something straightforwardly caused by a drug. Rather than preceding or founding the overt problem in a person's life, the disruptive drug use seems to be one of its symptomatic aftermaths.

I do not want to deny that the attractiveness of a drug and the difficulty of breaking through the craving and withdrawal has much to do with what the drug does to one's body (organism). But to reduce the problem to this aspect means to obfuscate the nature of the problem. (Let us just remember that the detoxication programs *precede* the actual therapeutic process.) The pleasurable effect of a drug offers positive *reinforcement* to the user. This reinforcement is of a unique kind, bypassing the complex internal structures of temporality and responsibility connected to the *alternative* sources of reinforcement (emotional support one gets in personal relationships, appreciation of one's effort, and achievements in work, etc.). It is typically in their relative absence that the way to building a relationship, with a drug offering the instant kind of reinforcement, is open.

Addicts *centre* their life activities round such a source of reinforcement. Usually, one's central activity co-exists with the non-central ones, even though it shapes one's performance in these domains. However, the drug-related central activities are rather untypical, as they tend to *predate* on the other activities (such as one's work or family life). I mentioned here the underlying deterioration of one's sense of the

internal logic that connects one's actions stretched through time. As this deterioration is characteristic for the way one seeks reinforcement (pleasure) in drugs, it affects also the balance one would be otherwise able to keep between central and non-central activities.

The resulting way of life suffers from pervading degradation. Despite the common intuition that addiction is "happening" in the episodes of one's will too weak to face an irresistible temptation, I tried to show that addiction involves, at least equally importantly, a degradation of one's attitude towards various aspects of life also in between the weak-will episodes, when no perceived irresistible temptation needs to be present. Instead of addressing one's weak will directly, the methods of therapy aim at reconstructing one's whole life as centring round an activity that provides an alternative, healthy source of positive reinforcement. As addiction responds to particular events in each addict's life, so must therapy (the specific orientation of one's life reconstruction) be individualized and taking these particulars into account.

There are known and established ways of helping people with drug problems. Some clearly seem to be working better (such as various forms of community work) than others (such as the so-called war on drugs). Thus, there is a space for trained professionals employing methods that have proven reliable. Medicine, with its insight into the mechanisms of mind-altering and dependency and its methods to tackle craving and withdrawal, plays its role here, too, as it should. There is, however, much more to addiction than a medical problem. Addiction always concerns the ailing soul or spirit. Helping professionals need to consider this.

Though a person's ailing soul plays a central role in addiction, our lives are not disconnected from our environment. Analogous pressures of social, cultural, or economic kind urge on many individuals; in response to these pressures, many individual traumata often share some constitutive features. That is one reason why analogous forms of therapy can help many different individuals. It also enables us to understand why, in Bruce Alexander's view, even the spiritual treatment for addiction, which helps many people, is in its essence again nothing else than a way of tackling social dislocation.[56,iv]

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Endnotes

i. Cf. the curious and remarkable study of "Harry Potter addiction" made by Rudski et al.[24]

ii. "The film's protagonist Brandon (played by Michael Fassbender) impersonates various elements of addiction casuistries. The movie does not show him down and out, but rather in the precarious position of someone who is still maintaining the façade of normality, behind which, however, little normal is left. It shows how his habit, even outside the moments of consummation or pursuit, pervades his whole personality, psychology, and concentration (leaving little space for normal personal relationships or a standard attitude to his work). Especially interesting is also his self-loathing reaction after the failure of his attempted romantic relationship: he frantically throws out all the "toxic" contents of his life (incl. his laptop), but this purge is followed shortly after by a similarly aggressive relapse. The cyclic nature and blurred temporality of episodes from Brandon's life also exemplify the weakened temporality and uncertain prognosis characteristic of addiction.

iii. In an interview for http://www.alternet.org/drugs-addiction.

iv. The publication was supported within the project of Operational Programme Research, Development and Education (OP VVV/OP RDE), 'Centre for Ethics as Study in Human Value', registration No. CZ.02.1.01/0.0/0.0/15_003/0000425, co-financed by the European Regional Development Fund and the state budget of the Czech Republic. I would like to thank Kamila Pacovská for detailed comments on a previous version of the text, Jan Trnka for suggestions of further readings, and the (mostly non-academic) audiences of my presentations of bits and pieces of this material.

Ondřej Beran, PhD, is a Researcher at the Centre for Ethics (Department of Philosophy), University of Pardubice, and the Deputy Head of the Centre. His recent publications include the book *Living with Rules* (Peter Lang 2018) and the co-edited book *From Rules to Meanings* (Routledge 2018). He works in ethics and the philosophy of language. He currently resides in Pardubice, Czech Republic.

Book Reviews

When Harry Became Sally: Responding to the Transgender Moment

Ryan T. Anderson. New York: Encounter Books, 2018.
ISBN 978-1-59403-961-4, 251 PAGES, HARDCOVER, $15.89.

As a devout Roman Catholic and natural law ethicist, Anderson writes from a Christian worldview, addressing a wide range of topics surrounding what he calls our "transgender moment" (9). Crucial to understanding Anderson's motive and purpose in writing are, first, the stories told by detransitioners—accounts routinely ignored by the media and suppressed by transgendered activists. Second, "What is the most loving and helpful response to the condition of gender dysphoria (1-2)? And, finally, a desire to bring reasoned argumentation, and not mere emotion and rhetoric, to the discussion.

Anderson makes a careful distinction between transgendered people, those struggling with gender dysphoria, and transgendered activists. He supplies numerous examples of activist rhetoric, allowing them to be heard in their own words. This material reveals an *all or nothing* ideology—"People *are* the gender they prefer to be" (emphasis original, 29). Activists insist on *only* "gender affirming" treatments. However, this doesn't comport with the stories and voices of detransitioners. One young woman summarized, "Transitioning was all about trying to get away from what hurt us and detransitioning is finally facing that and overcoming it" (75). The moral of these accounts is clear, "Transitioning is not the 'only solution' to gender dysphoria" (72). Time and again, detransitioners expressed their wish that someone would have taken seriously the pain and trauma that led to their dysphoria and helped them work through it.

The current treatment for gender dysphoria is fixated on the body. Anderson argues for concentrating on the mind. This consideration results from the ongoing and serious psychological trauma that continues in the lives of transgendered people, as well as the lack of any biological genesis for the condition. This standard of care is especially important in the treatment of children. This is shown by the dangers and possible "locking-in" effect of puberty-blocking drugs and the fact that the overwhelming majority of children who experience gender dysphoria will "naturally grow out of a gender-discordant stage" (123)—between 80-95%. This approach, focusing on the mind, is found in the work of Drs. Paul McHugh and Lawrence Mayer of John Hopkins University and Dr. Kenneth Zucker former Psychologist-in-Chief at Toronto's Centre for Addiction and Mental Health.

Anderson wants to engage the culture with sound and thorough scholarship. The differences between the meaning of sex and gender, as well as cultural displays of gender is discussed in chapter 4. The importance of knowing one's biological sex—which is determined by chromosomes and the body's constitution to reproduce—is vitally important to life-long health and medical treatment. Abnormalities away from normal development are also briefly discussed. The failure of finding any biological basis for gender dysphoria is discussed in chapter 5. The psychological trauma associated with the lives of transgendered people is also presented. Chapter 7 discusses the dangers of treating gender as nothing more than *merely* a social construct. Anderson uses the foundation of natural law ethics upon which to build his understanding of natural goodness. However, even if the reader is not a natural law ethicist, she will find a well-supported argument describing the differences between boys and girls and men and women. Chapter 8 interacts with policy implementation based on ideology instead of common interest. Anderson provides copious illustrations of political overreach, the exclusion of competing interests, and the lack of clear and scientific definitions of pertinent terms and categories.

In the conclusion, Anderson offers a six-step strategy for dealing with gender dysphoria: 1) avoid stigmatization, 2) devise good standards of care, 3) engage culture through scholarship, 4) defend the truth in the public square, 5) pastoral and religious care, and 6) the need for lawyers and politicians equipped to protect the rights of all sides. I highly recommend this book for those who want to be educated concerning gender dysphoria and transgenderism. Those who are tired of the confusing rhetoric and want to consider the facts surrounding these issues will find this book extremely helpful. Finally, this book is for those who embrace the timeless truth, "love thy neighbor."

Reviewed by Michael Muñoz, D.Be.

Why Have Children?: The Ethical Debate.

Christine Overall. Basic Bioethics Series. Cambridge, MA and London: MIT Press, 2013.

ISBN 978-0-262-vERBACK, $18.95.

In this compelling manuscript, the author addresses the philosophical and moral arguments for and against the decision to have children. She maintains that the burden of proof for the desire to have children should be shifted from those who do not want to have children to those who do. She presents her arguments from a feminist perspective, maintaining that women bear the brunt of conceiving, gestating, birthing, and rearing children. While she essentially agrees that there is not one ethic for choosing to have children, she believes that having children is morally risky and thus should include rational arguments that take into account the future well-being of the child, the prospective parent/s' resources to care for the child, and the global problem of overpopulation. After dismissing what she considers to be the typical deontological and utilitarian arguments that people put forth for having children, she posits the following as the optimal motivation: "The lifetime of parent-child interaction is, I believe, key to understanding what is good about procreation" (p. 212). She offers a resounding "Yes" to anyone seriously considering having children who ask her opinion. This book is extremely well-researched, organized, and referenced. The author addresses a significant question that most of us do not consider from a meta-ethical and meta-philosophical perspective—namely, why have children? The discussion is rich and broad on both sides of the question. The only weakness is that it is doubtful that the average prospective parent would or could engage in such deep philosophical thinking about whether or not to have a child. Nevertheless, the book's foray into developing possible rational reasons make a fascinating read, primarily for philosophers and ethicists.

Reviewed by Donna Yarri, PhD., who is Professor of Theology at Alvernia University in Reading, PA.

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