September 17, 1998. Interview with Stuart J. Youngner, MD, Professor of Medicine, Psychiatry, and Biomedical Ethics, Case Western Reserve University. The interview is being conducted by Judith Swazey, PhD and Carla Messikomer, PhD at Dr. Youngner's office, University Hospitals of Cleveland.

SWAZEY: Stuart, let me start out by asking a little bit about your professional history and entry into bioethics, beginning with a little of the usual sociological questions about your family background, what your parents did, where you were raised.

YOUNGNER: My father is a virologist who has been a very successful academic researcher, was chairman of the department at the University of Pittsburgh for a number of years. He worked with Jonas Salk on the polio vaccine. My mother left college when she married my father and then finished it later when I was a kid. I grew up in Pittsburgh. I never had a real interest in going into the biological sciences and really wanted to be a psychiatrist from the time I was pretty young. I went away to prep school. I went to Swarthmore College and then came to medical school at Case. I did an internship in pediatrics and very briefly flirted with the idea of going into pediatrics but after doing my internship I decided I wanted to do psychiatry.

SWAZEY: What attracted you at a young age to psychiatry?

YOUNGNER: Freud. My idea of psychiatry was not biological psychiatry. My idea of psychiatry was being a physician and helping people through talking to

them and understanding what wasn't obvious. I read some Freud when I was pretty young and thought it was very interesting.

SWAZEY: What drew you into biotethics?

YOUNGNER: Well, in psychiatry I became very interested in consultation liaison psychiatry when I was a resident. In medical school I really liked clinical medicine, I thought it was very interesting. When I did psychiatry, going back into the parts of the hospital where medical and surgical patients were and looking at the psychology of what was going on with them, with the people who were taking care of them, and with the families, was very interesting to me. I knew in my second or third year of residency that it was psychiatry I wanted to concentrate on. It turned out that right about that time, right as I finished my residency and started on the faculty, our hospital was developing its first intensive care units. This was in the early 1970's, and for younger people now who weren't around to see all the transitions, the idea of intensive care units are sort of fixtures in hospitals; ICU's maybe take up 20% of the beds in hospitals.

SWAZEY: They are very recent.

YOUNGNER: They are. I remember when the first medical intensive care unit was formed here. The new director was very interested in having psychiatry involved. So I would make rounds up there and we would have an

interdisciplinary meeting once a week. I guess I should say, sort of stepping back even further, there is a second thread with bioethics that I certainly didn't identify as such. When I came to Case there was a requirement, it wasn't a masters degree but it was a requirement, that in our first summer we had to do a research project and we had to write a thesis. Two fellow students and I spent a summer at Cleveland Clinic hanging out with dialysis patients. This was when dialysis was very new also. We're talking about the summer of 1967, so it really was a new phenomenon. It was considerably before the end-stage renal disease program came into effect. So you had a lot of people turned down, without very clear criteria. The program that we were involved in was teaching people how to do home dialysis. People would actually come to the Cleveland Clinic and live there or nearby with their families for three months and start dialysis and then the families would be brought in. We had a supervisor who was a psychiatrist, Doug Bond from Philadelphia, his father was a famous psychiatrist in Philadelphia. He founded a hospital there that has a strange name. It's a psychiatric hospital in Philadelphia....

MESSIKOMER: It was the Institute of Pennsylvania Hospital; it's no longer but I thought that's what you were referring to.

YOUNGNER: That's it. His father founded that. Doug Bond was a very interesting guy, very dynamic. He had come to Cleveland and really founded the Psychoanalytic Institute here. Then had a huge fight...he brought some Viennese analysts here and then there was a huge fight between him and them, there was a split. He was, for all his faults, an extremely dynamic guy. We had trouble finding somebody to sponsor us doing this home dialysis teaching, and several hospitals wouldn't let us do it.

MESSIKOMER: Was your work with the dialysis patients something you and your friends thought up?

YOUNGNER: We thought it up.

MESSIKOMER: And so then you had to go shopping to find somebody to provide you with a supervisor.

YOUNGNER: Yes, we had to find the site and we had to find somebody to do it with us. We eventually found the Cleveland Clinic and we eventually found Doug Bond. He thought it was a great idea and so we'd meet with him. It was the summer and once a week we'd go over to his house and he'd have a 6 pack of beer and we would sit and talk about what we were seeing.

MESSIKOMER: You liked this guy, I could tell! (Laughter)

YOUNGNER: Right, it was a really great experience. He was an analyst and listening to these people talk about their dependency, life and death issues, and also

about the interaction with the machine. It was a time when that was new. Now it's become kind of routinized, but then it wasn't, so people were more willing to talk about it or more willing to listen to people want to talk about it or whatever. We didn't think of it as ethics. It was really a psychological thing but obviously there were all kinds of ethical issues that were imbedded in what was going on. We actually wrote our thesis and Doug Bond sent it to a psychiatrist named Harry Abrams.

SWAZEY: Oh, Renée and I knew Harry well.

YOUNGNER: Doug Bond said to us, "Harry thinks it's great, you should publish it." We thought, "Oh, bullshit! He's being nice." And so we never did. Years later I read a paper by Harry Abrahms who quoted from our paper. And then had a footnote saying, "Unfortunately, this was never published." So he meant it, and we should've done it.

MESSIKOMER: And you blew it!

YOUNGNER: And we blew it. So I had that experience. Then as a consultation liaison psychiatrist I had the experience of being in the intensive care unit and seeing ventilators for the first time, people using them. I think ventilators were a big, big part of it. If you look at the history of bioethics and the end of life decision part, the whole brain death thing is a ventilator-created issue. From Karen Quinlan to a number of other cases, there's something

about turning off a ventilator; it's harder to mask what's going on than other treatment limitations. It's so vital. Hanging out in this intensive care unit, what you became aware of very quickly was that people were faced with decisions they'd never had to make before. There was no law to guide it. There was no Hastings Center guidelines, American Medical Association guidelines, blah, blah, blah. There was nothing. So people really struggled with this stuff. As I psychiatrist I heard them struggling and I began to struggle. Then I wrote a couple of papers and then I did a fellowship. The NEH used to have these wonderful fellowships; I did one of those. I began reading bioethics literature and going to meetings. What I found that was so incredible for me was that there were people who were talking about these issues in a way that my psychiatry colleagues and my other medical colleagues, by and large, absolutely could not talk. I found it just incredibly refreshing and helpful. It wasn't because they had psychiatric insight, they didn't. I think that's a contribution I've brought to the field and I think it's an important part of the field, but they brought a language. And the philosophers...I'd never taken a philosophy course in my life; in fact I did take one in college and it freaked me out and I dropped out. It's the only course I've ever dropped out of. And yet when I met the philosophers I found them terrific. What I really liked about them

was not that they could quote Aristotle and Kant but that they were clear thinkers and users of language, and doctors in general and psychiatrists in particular were sloppy, I think because of their power and authority in this society, so they could get away with all sorts of things and nobody questioned. And these people began questioning them, not just right or wrong but "What are you saying?" Sort of parsing out what people were really saying and making them clarify. I found that, just as I was struggling with those things, incredibly helpful. I began meeting people and forming professional- personal friendships with people around the country and writing more about it. The next thing I knew people were calling me a bioethicist, whatever the hell that is.

SWAZEY: That's a question we have for you! (Laughter)

YOUNGNER: A bioethicist is anybody that a newspaper reporter calls a bioethicist, or that a hospital public relations department identifies as a bioethicist in the hospital to talk the press. That's the cynical definition.

SWAZEY: Do you consider yourself a bioethicist at this point?

YOUNGNER: What is a bioethicist?

SWAZEY: You're called a bioethicist.

YOUNGNER: I'm called a bioethicist. I'm called an ethicist. I'm called a biomedical ethicist. I'm called other things which I won't repeat, but.... I'm called all

those things. I rarely say, "No, I'm not" when people do that. I try not to do it myself just because I'm not really sure what it is, but I think more and more that it is something. At some point I'll try to tell you what I think it is, although I think it's one of these things that's evolving and it's not clear where it's going to go and it may become less clear what it is. But I think there is a history now and there are more and more people that newspaper reporters are calling bioethicists and they have certain things in common. So maybe they are bioethicists.

SWAZEY: Are there people that you would say, "Yes, I think so and so is a bioethicist"?

YOUNGNER: No.

SWAZEY: So it's basically somebody from a particular discipline who works on ethical issues in medicine.

YOUNGNER: Well, if it's a biomedical ethicist then it's medicine, if it's a bioethicist then it could be ethical issues in biology or science. Yes, there isn't a profession now. There's not a clearly identified profession. And you're right, this is one of the questions that's going to come up. Is there such a discipline? You can look at it two ways. Is there an academic discipline or is there a profession? They're not exactly the same thing. I think that's an open question. I mean, it's a field, an area of study and practice that I

think most people would agree exists. If you write about certain topics, people say, "Yes, that's bioethics." People who have done that are people trained in other academic disciplines and/or professions and have brought that perspective and their methodology to it. But in my view, the people who are most interesting and have the most to say borrow heavily from other disciplines in what they write about in their perspective. I think that's been a real strength to the field. Now whether you can take somebody and put either pieces of other professional training or other academic disciplines together and call it a "bioethicist" in a new way, or that there's a new area of knowledge or new methodology, remains to be seen. I don't come out of a heavily academic tradition in the sense of hanging around universities and PhD programs. I've been pretty much isolated in medicine, which is a very different pursuit, less rigorous academically and less traditional in many ways. But it seems to be increasingly in the last decade or two decades there has been interdisciplinary scholarship, not just in this field but in many fields. Of course, whenever you try to understand the world in an academic way you develop a methodology, a discipline, a history, a perspective, that sheds light on one part of it, but it's limited and in some way that division is artificial. And I think that a lot of the interdisciplinary work that's gone on

in the last couple of decades is a reflection of that artificiality and how understanding things often requires a combination of perspectives. Now here's where my own experience and knowledge are limited. Obviously, you can look at it two ways. One is that individual disciplines are so stodgy, so set in their own methodology and way of looking at the world, that unless you either blend them with others or create new ones you're going to get a very slanted view of the world. On the other side you say, if you continually dilute the methodology and the rigor of disciplines, blend them together, you're going to just get pablum and it's not going to be worth anything. And I'm sure both things are true. The question is: How do you do it? When is the time for pure disciplinary work? When is the time for interdisciplinary work? When is the time to just give up a discipline and say, "Okay, we're going to train you in X humanities studies or something like that." We're going to have this discussion tomorrow about starting a PhD in bioethics. I think Tom's thinking of having two kinds of tracks, one empirical and the other more traditional humanities research. I think one of the things about bioethics that's been very good has been the contribution that empirical studies made to bioethics. I'm talking about the methodology of health services research and epidemiology. I think that is very important. I've done some of that so I

think it's important. It doesn't answer moral questions but it provides information that can help answer moral questions. I've talked with Renée about this, who I've always felt was uncomfortable with it and didn't really understand it.

SWAZEY: Is that how Tom's using "empirical"?

YOUNGNER: I think so. People use it different ways. So there's that side of things. Then there's the social science in a less quantitative, data-based way. The kind of stuff that you guys do, or anthropologists do. There's philosophy, there's law, there's medicine, psychiatry, psychology, there's religion, religious studies, nursing, and the other medical professions. All of these things have important contributions to make. Whether they make them and then it creates something new, that's the question.

MESSIKOMER: Kind of a whole constellation of pieces growing from each.

YOUNGNER: Is what I do psychiatry, or is it bioethics? I don't think it's just psychiatry. Psychiatry journals don't want to print a lot of it but things called bioethics journals print it. So it's bioethics in that sense. It's very different from the stuff that Dan Wikler or somebody else would write. So the question is, when does interdisciplinary, meaning different disciplines coming together and doing a kind of work, change to a field where people can just be trained in it? I haven't thought this through a lot...you guys really should

come to the faculty retreat tomorrow because it will be a fascinating discussion.

It's hard for me to imagine a PhD in bioethics. You'll never be a person who knows enough about health services research, social science methodology, law, psychiatry, etc. If somebody gets a PhD in all of those things...but, do you need that? I guess what I think is that you certainly need...history is another discipline I left out...you certainly need some kind of rigorous methodologic training. All these disciplines have a methodology and you need them to have the experience of looking at the literature of that field in a deep way over time because it's one field and you really get into it. I guess it's possible that you could be a bioethicist with different methodologies. I don't know, does that mean that ten years from now we'll divide it up? This is the history of disciplines and professions--they arise, they split up. Look at medical schools and how many departments there are in medical schools now.

MESSIKOMER: Corporations also; they merge and then they come apart and then sell off and come back together again.

SWAZEY: But I think I hear you saying, which a lot of people have said to us, that what worries them about degree programs and certification is that it's going to cut off a lot of seats at the interdisciplinary table and narrow the

field over time.

YOUNGNER: Why would it do that? If you have enough people doing it or to get ahead in the field, you have to do it that way.

SWAZEY: You'd have to have a Ph.D. in bioethics just to get ahead as a philosopher, particularly in an academic setting. You have to have a Ph.D. in philosophy and if the field is trying to become a discipline and set up essentially academic credentials, move towards professionalizing, over time and I think you would see it in the history of other fields and disciplines, if you don't have those credentials you may hang out around the edges of the table, but if you're not a certified bioethicist, in the sense of having a PhD in bioethics, you're going to be a much more marginal figure.

YOUNGNER: Well, for that to happen you'd have to have enough programs and you'd have to have the people who got ahead in the field publishing with administrative positions, be those people.

SWAZEY: That would take a couple of generations but you can look down the road.

YOUNGNER: It would take a while, if it were to happen. And then would it be a stronger field or a weaker field? Those of us who've come from disciplines might be concerned that it would be weaker.

SWAZEY: Virtually everybody in bioethics now has wandered in from someplace.

YOUNGNER: That's right. So maybe that's a bias that we all have.

SWAZEY: How much involvement do you have with the bioethics masters program here?

YOUNGNER: I teach in it.

SWAZEY: Can you tell us a little about it? Who comes to it and where do they go with their masters?

YOUNGNER: Our program is one year full time. We have a core course that everybody takes. It's a seminar that meets twice a week and is taught by a large number of our faculty. I teach maybe seven or eight of the sessions. I'm doing one tonight actually, on physician-assisted suicide. There also are electives they can take in bioethics, anthropology, philosophy, religion, and so forth. We have a list of courses they can take. And then they have a clinical experience which takes place at two of three hospitals. We have three hospital sites the Clinic, Metro, and UH. I sort of oversee that. They spend 200 hours in a clinical setting. Now what do they do with this...what does this degree mean?

SWAZEY: Who are your students, first of all?

YOUNGNER: Our students are all different kinds of people. We have people right out of college. Right now we have a 60 year-old orthopedic surgeon, a practicing orthopedic surgeon. We have a younger person who is an intensive care

unit physician. We've had social workers. We've had nurses. We have an accountant. Some of the younger people are people who want to go to medical school and didn't get in, or didn't take the right courses and are getting ready to do it.

MESSIKOMER: Kind of like their own post-bac program.

YOUNGNER: Right. We make very clear to people in our brochure and when they come that this is not a career degree. This will not get them a job, and if they're thinking of going into bioethics they should find a profession and make this an adjunct to it. So we really make very clear that we don't think this is a terminal degree. Now will we say that about our PhD? Probably not.

MESSIKOMER: How can you? (Laughter) I'd like to hear that discussion!

YOUNGNER: Right. I have to say that my own bias, and I'll identify this as a bias, is that if I heard somebody came out of a PhD program in bioethics I'd be a little suspicious of them.

MESSIKOMER: So if you start a PhD program and you graduate somebody....

YOUNGNER: Would I hire them? If I knew them. But the credential itself would be less than...for instance we're looking at hiring people right now.... Are you talking with Laura Siminoff at all?

SWAZEY: No.

YOUNGNER: She was trained by Ruth Faden and has a PhD in public health...I think it's

public health. She's trained as a qualitative and quantitative researcher; much more on the quantitative side, than you guys say, but she also can do interviews and work in that sort of semi-structured way. Ruth has a program now called something like Law, Health Policy, and Public Health, and her students are trained, I think, primarily, in how to do research. They also take philosophy courses and some bioethics stuff. I've interviewed a couple of faculty candidates who've come from there and these are people are sort of clones of Laura. They're very bright, they're real interested in bioethics.

SWAZEY: Where is Laura?

YOUNGNER: Laura is here. But she trained with Ruth at Hopkins, they know about both bioethics and research methods. Is the model that people doing that kind of research are just sort of technicians and somebody else tells them the ideas and then they figure out a way to study it? Of course, it's always better if they can share in understanding the concepts that you want to study. Just like it's good if somebody who has concepts knows a little bit about what research is so that they can work with researchers. The question is: if we train people here in a PhD, and let's say they are trained by Laura but it's not as rigorous in research methods as what Ruth's doing, so you have somebody who's not quite as rigorous but maybe has more

philosophy and more ethics training than her people--will that be a stronger person or a weaker person?

SWAZEY: That, I think, has always been one of the questions about a PhD or an SCD in public health. You have your concentrations in epi, or biostat, or whatever, but are you better off having your terminal degree in epi and taking some public health, say an MPH along the way? Public health is certainly an interdisciplinary degree.

YOUNGNER: Right. So these are tough questions. And then what kind of scholarship really contributes and contributes to what? I mean, what is the purpose of scholarship? I'm free-associating here because I haven't thought this through very much.

SWAZEY: It may help you get your thoughts in order for tomorrow's retreat.

YOUNGNER: I mean is scholarship for scholars so that they can read each other's work and look at their methodologies and sort of compete with each other in certain prescribed ways? Or is it to contribute to public knowledge and formation of public policy? Is it entertainment? Is it news? I don't know. Maybe there are different kinds of scholarship. Frankly, there may be stuff that's more superficial but broader, has a place in the continuum between the ivory tower and either clinical practice or public policy. The practical world...the trenches. So I'm sitting here thinking that with a PhD

in bioethics, people aren't going to write with the same rigor and depth as a really well-trained analytic philosopher, or a really well-trained medical anthropologist, or a really well-trained psychiatrist, but they'll be able to do things that none of those people could do and put out information, put things together in ways that are very useful. If not terribly scholarly, very useful.

SWAZEY: We talked quite a bit last night about whether, if Case starts a PhD in bioethics, there's going to be a bandwagon phenomenon. Because there is a very patterned tendency of emerging interdisciplinary groups or fields to want to professionalize, and certainly a hallmark of being a profession is something like a PhD program. There's going to be a bandwagon phenomenon.

YOUNGNER: That other people will want to do it. Well, if we get students...make money....

MESSIKOMER: We've talked about that too actually. (Laughter)

SWAZEY: We were talking about how Penn had a masters in gerontology program that collapsed mainly because it wasn't making enough money. In many ways the successor is the masters in bioethics at Penn. So there's sort of a history. Because bioethics, I think, is still a growth industry, it would be very interesting to see, as you said, depending on how many PhD students

you got, if other places try to clone your program, or set up their own.

YOUNGNER: Another interesting take on this, a very personal one, is one of the things I really like about the masters program. I'm somebody who never had taught at graduate school, I've always taught in professional school. What I like about teaching in the masters program is having students who are intellectually interested in the things I'm teaching. There's an occasional medical student who is, but it's really an exception, so having a class full of them who do all the reading and read more because they are interested in it, is wonderful. It's a great experience. I've never had it before. And seems to me a PhD might be even more fun. I could teach a seminar where I could get into even more depth in things I'm interested in and have students who challenged me, asked questions, etc. I don't know if that's a justification for anything except for selfishness, but that's a real thing too. You get people who are interested in an area to really go into depth about it, but of course, what's the methodology? That always remains the question; what's the methodology? When I teach these courses I guess I'm not using any methodology I guess. I'm certainly not being a doctor or a psychiatrist, I'm certainly not being a philosopher or social scientist. I'm borrowing from all of those and discussing these things with the students. But I don't know that I am teaching them a rigorous way of approaching

anything.

MESSIKOMER: You probably are laying out some kind of a conceptual framework for them where you are drawing on whatever body of knowledge it is that you have under your personal framework.

YOUNGNER: There are several frameworks, right. But is it enough for them to have that or do they need somebody who says, "This is a methodology that I really want you to master."

SWAZEY: Well, in a masters program, first of all I'm not sure they can.

YOUNGNER: No, I mean in a PhD program

SWAZEY: I think they need some of that, but again that says there's going to be concentrations, just as you can now get a PhD at Georgetown in philosophy with a concentration in bioethics. But you certainly, as you said, can't say to a PhD student in bioethics that you have to master the methodology of law, the social sciences, clinical medicine, etc. Unless you want to plan on a fifteen year course.

YOUNGNER: Are you folks going to talk to Bill Winslade?

SWAZEY: We may eventually.

YOUNGNER: Because he is somebody who's done that.

SWAZEY: Yes, Bill has.

YOUNGNER: He has a law degree plus a PhD in philosophy and he's trained as a

psychoanalyst.

SWAZEY: Right, there are over-achievers everywhere you look! (Laughter) How many students roughly do you get in your masters program?

YOUNGNER: About 15. Are you going to talk to any of the students?

SWAZEY: Not this trip. We would like, at some point, to get a separate grant to look at the institutionalization and organizational development of bioethics, because that's not a little topic.

MESSIKOMER: We'd also have to look at what the MA students are doing after they are out and talk to them then too.

END OF SIDE ONE, TAPE ONE

SWAZEY: Let's shift and get your perspective on bioethics' relationships with different disciplines, which we certainly talked about some today. Is there any discipline that you think has been the dominant player since you've been involved in bioethics? You said you were amazed and overjoyed by the way philosophers approach the issues.

YOUNGNER: I think when I first got into it, philosophy was definitely the dominant profession. Some philosophers would like to think that they still are, and some of them are. But this is a struggle that's gone on for a while now between the analytic philosophers and other people in the field. I think a reflection of that politically was the effort to form the American

Association of Bioethics and then the eventual merger of the three organizations, which I think was a defeat for people who thought that one profession should dominate the field, and a victory for the interdisciplinary approach. But a lot of the leaders in the field have been philosophers and analytic philosophers from the beginning: the people at the Hastings Center, Ruth Macklin, Sam Gorovitz, Art, Tris Engelhardt, Bob Veatch.

SWAZEY: Of course, when they trained, analytic philosophy was what you studied in most philosophy programs to get a graduate degree.

YOUNGNER: That's right. So I don't know whether it was the analytic philosophy they trained in whether it was that they were particularly bright, aggressive people who were very good at doing bioethics and became leaders. But now there are other bright, aggressive people. I think philosophy still remains a central, very important part of it. But when the good philosophers write about these things, Dan Brock is another example, I don't think they write just as philosophers. And of course, pure philosophers don't like what philosopher-bioethicists do. What other fields? I think medicine has been very strong in medical ethics. The number of people who are very prominent and doing good work. Law, religious studies....

SWAZEY: Do you think religion has been a fairly prominent strain the whole time

you've been in bioethics, or has it gone through phases?

YOUNGNER: It's gone through phases. I think it's been marginalized from the beginning, but I think now there's been a big resurgence in general about religion claiming territory that it had lost or given up in previous decades. It's true of psychiatry, for sure. In the 1950's, 1960's and 1970's psychiatry took over a lot of religion's territory and now religion is taking it back.

SWAZEY: So you're seeing a resurgence of religion generally?

YOUNGNER: Generally in this society. And I think that in bioethics there have been voices. Did you talk to Steve Post at all?

SWAZEY: I know Steve.

YOUNGNER: Steve's a very strong advocate of that. I have mixed feelings about it. So the question is: If you believe in understanding people, believe in autonomy, or even if you believe in paternalism but you want to help people, you have to understand them. To ignore religion is a tremendous error, just like to ignore psychology, because that's who people are and that's what motivates them. The question of whether religion has a methodology to contribute to the field is a more problematic. I'm an atheist, first of all. But even if I wasn't, there are religious traditions that have worked through some of these issues and made arguments that I think are secular arguments that can be used to illuminate secular things. But if

somebody answers a question by saying this is what's written in the Bible, or this text, and therefore it's right, is that a methodology in an academic discipline? I don't think so.

SWAZEY: Were you brought up in any religious tradition, Stuart?

YOUNGNER: Atheism. (Laughter) My mother was a militant atheist! She was the daughter of a militant Greek Orthodox woman who became, just like her mother, a militant atheist. She believed in atheism the same way her mother did and tried to impose it on her children the same way her mother did it to her. I'm just an easy going atheist. I don't want to impose it on anybody. (Laughter) I just really don't think there is a God out there, but it doesn't bother me that other people do.

SWAZEY: I have two questions. First of all, are there particular religious traditions that you think have contributed to bioethics?

YOUNGNER: Catholicism for sure. A lot of the beginning of bioethics came out of Catholic traditions, and a lot of the contributors came from Catholic traditions, Pellegrino, Al Jonsen, McCormick. But what does that tradition contribute? I don't think it contributes when somebody says, "Well, the ten commandments..." or "the Pope says this is what you should do." That's not the contribution. The contributions are careful arguments that are rational, not based on the word of God. And the

tradition that's made the biggest contribution is, I think, Judaism. I'm not a religious scholar so I'm not the best person to ask, but maybe I am a good person because maybe I'm typical of a lot of people in bioethics who don't know that much about religion. My impression is that if you look at mainstream American religions that have thought about and spoken about many of these issues, it's Catholicism and Judaism. They have longer traditions than the Protestant religions and I'm just not aware of a body of Protestant work dealing specifically with medical ethics issues. Whereas in Catholicism and Judaism there certainly has been. So I guess what I'm saying is that religion is certainly important if you want to understand society and peoples; it's an integral, deep part of it. So that's one aspect, and to ignore it, or minimize it, or be ignorant of it, is a mistake just like it would be to be ignoring some other important reality. The methodology of religion as a contributor to bioethics, I'm not certain about. Now religious studies is not the same as religion as far as I can see. Tell me if I'm wrong, but there are people who are atheists who are experts in religious studies. There are people who aren't religious who are in religious studies. Religious studies accepts the methodology of the Enlightenment and non-God ordered, scripture-based answers to things, or methodology. But is there a place for religion itself in bioethics? It's not obvious to me that

there is.

SWAZEY: But you're saying there is a place for religious studies?

YOUNGNER: Yes, it's a study of something that is very important. And it's a study that can shed light on the way we think and understand things.

SWAZEY: We all bring our value sets to whatever we do, so you have certain value framework both as an atheist and as a psychiatrist. Other people may be bringing their religious value sets to what they do. Don't those at least may need to be made explicit by the people coming into bioethics?

YOUNGNER: What our own positions are? Absolutely, absolutely.

SWAZEY: We've talked to some people who have observed that there are bioethicists trained in moral theology or religious studies who will write in a very secular voice for Hastings and in a very different voice for something like The Journal of Religious Ethics. So it's one sort of bifurcated person. I think it's partly because I think we still are very uncomfortable about being explicitly religious in American society, unless you are a fundamentalist, and because religion is still at the second row of seating at the bioethics table.

YOUNGNER: That religion is?

SWAZEY: Yes.

YOUNGNER: I don't have any doubt about that, even religious studies. No question

about it. And I think there has been an antipathy and a suspicion between the people who came out of religious studies and the analytic philosophers. That hasn't bothered me at all because I like people who say things that help me understand, and I don't care what their background is. I don't like it when people start preaching to me, regardless of what their background is, and there are analytic philosophers who preach too.

SWAZEY: Oh yea!

YOUNGNER: So either way I don't like it very much.

MESSIKOMER: That's a certain kind of evangelism, an academic evangelism, that some people in all disciplines are excited about engaging in.

We wanted to save our discussion of clinical ethics until this afternoon, but a question I have now is the following. At the beginning of our discussion this morning you mentioned looking at bioethics as maybe a profession and maybe an academic discipline, looking at it from two perspectives. And then as you speak about the place of religion and religious studies it sounds to me like maybe you're talking about religious studies being in the academic discipline of bioethics and religion being in the clinical side.

YOUNGNER: You're putting words in my mouth.

MESSIKOMER: You didn't say that, but I wondered if that's a correct interpretation of

what you're saying?

YOUNGNER: Right. On the clinical side what's the place of religion? I guess what I'd say is that in helping people in a clinical setting with their struggles with ethical decisions, religion and religious people have a tremendous place. I've done clinical liaison psychiatry for years and what I do as a clinical bioethicist overlaps a great deal.

MESSIKOMER: That's one of the main areas we want to talk to you about.

YOUNGNER: I bet if you talk to the hospital chaplain he'd say the same thing, and so would a good social worker. This is what social workers used to do. There is a certain level of coming into a situation, even if you have a background as a social worker or priest, where you're going to do a certain amount of psychiatry or psychology. You're going to do a certain amount of enhancing communication, mediation; all the things that we talk about that ethics consultation does, a lot of these people do in other ways. I think they are very good candidates to become part of clinical ethics. To give you an example, we're now developing a project. About 25 years ago a psychiatrist and a Rabbi in town here, a Rabbi who is also a psychologist, said, "Look, clergy are so often the first people to see people with mental illness that it would be very helpful to teach them more about recognizing it so that they could refer people." So if they see someone

who is schizophrenic or depressed they can send them to a psychiatrist, but also have some understanding of psychodynamics and psychopathology in their own work. They started a training program where local clergy would come and take a course. It's been very successful; they've done it for over 20 years. Somebody in my department did the program, so I was aware of it over the years. I had the thought about a year ago, why not do the same thing with bioethics? We have all these clergy. Who's in a better position than clergy to talk about living wills, end of life decision, reproductive issues, in the hospital and out of the hospital. A lot of them are woefully ignorant, not about what's right and what's wrong; they have their own notions about that whether personal or through their traditions. But they can learn what a living will is, how they're helpful or how they're not helpful, when to bring it up to somebody as something that is helpful, or if somebody brings it up, how to talk to them about it. There are a variety of issues, including how to be an advocate, because I think a lot of clergy come into the hospital like everybody else; it scares them. They don't know their way around, everything is strange. They feel powerless. So part of what we would do would be to have a seminar where we dealt with some very practical issues. Also have a clinical experience for them. Have them spend some time in an intensive care unit so that they're not as

intimidated by the hospital and get the idea that then they could be helpful. So in that sense, I would say that's bringing religion into the clinical side.

SWAZEY: In June I was talking to Al Jonsen about religion and bioethics, and he obviously had a lot to say about it. He said one of his concerns in seeing a resurgence of religion in bioethics, which I think most people are seeing with slightly different glasses on. The extent to which the predominant religious groups entering bioethics may be very conservative, fundamentalists groups who become really organized as groups in bioethics, is what worries him because of the rigidity and polarization. So that's another current we'll just have to watch.

YOUNGNER: That's happening in lots of places in our society, and in societies all over the world.

MESSIKOMER: Why don't we stop now and start again after lunch.

YOUNGNER: Let me plant the seed of the idea that I was going to talk about in terms of clinical ethics, but I think it's something true of bioethics also. It really came up in the clinical bioethics consultants task force's work. I call it...it's really not schizophrenia, it's more of a dissociative kind of thing, but in the popular language it's schizophrenia about bioethics: that bioethicists, and particularly people in clinical ethics, have a secret, or not so secret, idea that they are going to make the world a better place, that

they have a mission. And a very easy extension from that is that as bioethicists, whatever discipline they belong to, that they have special knowledge, that they actually know what a better place looks like and how to get there. They become advocates, missionaries, do-gooders, judges. And yet at the same time they would be very repelled by that description and see themselves as intellectuals who argue, present the sides, and then help people logically choose what's best. I think that many, if not most of us, have that schizophrenia. What came out in the task force is that there were people who really see themselves in a role of being moral police--they wouldn't agree with that term, I'm using it. But they are really out there to set an example and to find problems and make things better, stamp out evil, nurture good. If anything in the task force threatened to blow it apart, it was a disagreement about that issue. In the discussion of character, some people thought character was really important and that we had to emphasis character. Others, myself being one of them, said, "Well, of course we have to say something about character because everybody does, but let's not get too (I used the word) 'precious' about it." That became kind of a code word for getting people pissed off in the task force because what are we saying? We're better than other people or that it's more important for us to be moral than for doctors or nurses? I don't think

so. I think they make a lot more important decisions everyday than we do, so it's actually more important for them to be moral than we are.

MESSIKOMER: But the question then is: Who judges who's moral?

YOUNGNER: Let me tell you what it is. As they then tried to describe these things, the virtues, honesty, integrity, there was one task force member who actually thought that bioethicists should be heros. That you're really not doing your job unless you start getting into trouble in some way, by challenging.

MESSIKOMER: Throwing yourself on the railroad track and saving somebody.

YOUNGNER: Exactly! I'm just saying that I think that's a current thing in bioethics.

MESSIKOMER: A civil disobedience kind of thing too.

SWAZEY: A long time ago, sort of at the start of bioethics, I guess it was at some point in the 1960's, Dan Clouser wrote what I thought was a very important piece saying the role of the bioethicist is not to make moral pronouncements and tell people what's right and wrong. It's to help them recognize the issues, analyze them and make the decisions they have to make.

YOUNGNER: Everybody on the task force would agree with that, but then when you start talking about character.... So when you press people they say, "Of course, I'm not better than anybody else!" Then why should you be in a position to do what's "right"? If you believe that when people see things that are

wrong they should try to right them, even if that involves putting themselves on the line, why is that any more true of a bioethicist than of a nurse, or a doctor, or a janitor, or anybody? But people really feel we have a special role in doing....

MESSIKOMER: A calling.

YOUNGNER: A calling. And that's there, it really is in there.

SWAZEY: Moral evangelism.

YOUNGNER: It's really in there and people don't like to have it pointed out. When we argued and when I tried to pin people down by asking, "Are you better than others?", They said, "Well, no, of course I'm not better than others. But in this role...." It does look bad if a bioethicist does something really immoral.

So it's a really interesting thing. It came out in clinical ethics but I think it's true in bioethics more generally. I've heard Dan Wikler talk about this, ad nauseam. He's a great example of the schizophrenia because he makes these impassioned statements about how bioethicists are no better than the man on the street and should never give their opinions. I'll never forget he and Alta Charo writing a letter, I think in response to something Art Caplan had done, to The New York Times laying this position out. I've heard him do it a hundred times. Then two days after the

letter Dan was quoted in the Times on some issue saying what he thought was the right thing to do. And he'll also say, "I think that we should be advocates, that we should be agents of change." How do you reconcile those two positions? When you do that do you say, "Well, I'm not doing that as a bioethicist. I happen to be at this conference, on this ward, in this setting because I'm a bioethicist, or a philosopher, or whatever, but I'm not doing that, I'm just being an advocate." Of course people, whether they are patients, newspaper reporters, whatever, want people to get in that position.

SWAZEY: Sure, "tell me what I should do, Doctor."

YOUNGNER: Tell me what I should do. Tell me what's right, even if it's only to fight with you about it. They want a parental, priestly figure. They want their doctors to do it, but their doctors don't want to do it so they call in the bioethicists. And it's very seductive. I think it's a central issue that the field has not resolved. And it's staying there and it will stay there.

SWAZEY: Almost by the nature of what people do.

YOUNGNER: Yes, and part of it is that the people who go into bioethics want that, and part of it is that society wants it. They want really good arguments to figure out but they also want somebody to fill this religious role.

SWAZEY: It's like the physician's Aesculapian authority.

YOUNGNER: That's right. You know, I wrote a piece in the latest issue of The Hastings Center Report with two other psychiatrists, about why psychiatrists shouldn't be the gatekeepers for physician-assisted suicide. The argument is that psychiatrists shouldn't be mandatory gatekeepers because it puts them in the role of being a priest and under the aegis of science having authority that they just shouldn't have.

One more comment and then I'll let you go to lunch. The other thing that I didn't say about philosophy is, if you say, "What if philosophers offered bioethics?" And when I say that I mean me, because if you love philosophy and you want to read philosophy, they've offered that. I don't. What has their methods and their scholarship offered me? What it's offered me is, number one, a kind of clear thinking and use of language that physicians are just horrible at. Psychiatrists and psychoanalysts, at least in my training, were the worst. "If I say it, it's so. No matter what, I don't have to define it." Just unbelievably sloppy with both concepts and words. Number two is philosophy of science and philosophy of medicine. Unbelievably helpful stuff, to me. Concepts of health and disease, just wonderful! And again, I was raised in an analytic tradition; I'm not an analyst but my psychiatric training was all by analysts. I thought about being an analyst for a period of time, and was absolutely phobic about the philosophy of science because the philosophy of science asked questions analysts just didn't want to answer about their methods and about the nature of the knowledge they had and about their categories. I could tell wonderful stories about things analysts said to me about

homosexuality and all kinds of things. It was because Freud said it, that's what it boiled down to, or because "I say it and if you question it, maybe you'd better go talk to your analyst and find out why you're resisting." It wasn't an open intellectual process. And so I came from medicine that was just sloppy and arrogant, and psychoanalysis that was really insular and arrogant. All of a sudden these philosophers were really challenging people and asking the questions in a way that put you right on the end of the sword and you couldn't get away. And that was wonderful, that was really great! It was so exciting for me. I had never experienced that in college or high school. I'm sure people do when they study these things, I just never did.

MESSIKOMER: Well, you dropped your philosophy course! (Laughter)

YOUNGNER: It was logic.

MESSIKOMER: Oh, logic! That's good!

YOUNGNER: So here I was in the midst of all this stuff. Hearing this stuff from the analysts, hearing this stuff in medicine in the intensive care unit, and all of a sudden this group of people that could put this stuff in a context and describe it, that was just wonderful. It was so exciting! It was such an exciting time for me.

SWAZEY: You're like your MA in bioethics students are. You had that same excitement you say you see in them which makes it exciting for you.

YOUNGNER: Right.

[LUNCH BREAK]

MESSIKOMER: Let's spend the next hour or so talking about this whole concept of clinical ethics and also the practice of it that you touched upon earlier. I thought maybe we would start by taking off from the comment you made this morning, about how you define the role of a clinical ethicist and bioethicist. And given your disciplinary background and how you practice, how you distinguish, if you do, between liaison psychiatry and clinical bioethical consulting.

YOUNGNER: Let's start with what the role of the ethics consultant is; maybe we should talk about definitions. I would define bioethics as the study, examination of moral problems and biological sciences. I would define biomedical ethics as moral issues that arise in medical science and the practice of medicine. And I would define clinical ethics as applied biomedical ethics in the clinical setting, either through policy, teaching, or actual consultation and advice on cases. There could be other definitions but when I talk about things that's what I mean. I think that the role of the clinical ethics consultant...what's the difference between a clinical ethicist and a clinical ethic consultant? I think the consultant consults, and so there's a very specific consultative role that's requested. The task force spent a lot of time dealing with that and came up with some very specific recommendations which I endorse. Something I think we all were pretty

much in agreement about is that consultants are there to facilitate resolution of moral problems that come up in the delivery and practice of medicine. And that they are not particularly agents of anybody, including patients. That's one of the big debates about clinical ethics and one of the criticisms of ethics committees, or one of the normative arguments about ethics committees by somebody like Robert Veatch and maybe George Annas, people who are very patient advocate, rights-oriented argue that advocacy is what the role of a clinical ethics consultant is, whether it be done by a committee or individuals. The task force really disagreed with that. There is a role in the hospital or in health care settings for patient advocates, and in some settings a big need for it. But that is a different role than an ethics consultant who really has a more global approach and is there to help resolve problems, not advocate for any one particular person. Having said that this is the model or the approach we endorsed, we called an ethics facilitation approach. What we meant by that is that it's some place between the two extreme approaches: the philosopher king approach, which would be the consultant goes in and says, "Here's what's right and here's what's wrong," and a pure facilitation approach which would be, "We'll just help you decide, and it really doesn't matter what you decide as long as everybody is happy and they come to an agreement." What we

thought was that the ethics consultant has a responsibility to help people communicate. If there's knowledge to bring to it, to bring the knowledge about the law, other similar cases, to facilitate a discussion, but the solution had to be within the bounds of socially accepted norms. For example, one of those norms in our society right now is that competent patients have a right to make their own decisions, and if a decision was made counter to the patient's, it wouldn't be okay even if everybody agreed with it. Then you would say, "That is an unacceptable moral decision in our society." These things are often framed by institutional policies, laws, by religious arguments if it's a religious institution, and so forth. So in a Catholic hospital a clinical ethicist could say that abortion is not possible, that's not on the table. We spent a fair amount of time talking about how much ethics consultants should impose or share their own personal views. We thought it was probably unrealistic and undesirable to say they should never do that, but that whenever a person had their own point of view and asserted it, they should identify it as such. In other words, if they said, "Well, here's what I think is the best thing to do for these reasons." They should also say, "That's my opinion and there are other options, but here's why I think this is the best thing." So the consultant needs to try not to play to the wish of other people for you to

783 come in and tell them what to do, or to use it in more malicious ways to
784 cower or to silence other points of view. On the other hand, not to say,
785 "Well, I just go in there and lay out the options and I don't even say what I
786 think is the truth." There are obviously a lot of judgement involved in
787 making these distinctions and lots of potential for problems. I don't know
788 if you have read Giles Schofield at all?
789 SWAZEY: No.
790 YOUNGNER: He's a lawyer who has been very, very critical of ethics consultation. He
791 was very, very critical of the task force. He actually had things printed in
792 journals that didn't use much editorial discretion, because they very
793 inappropriately attacked people. If you read this stuff it's pretty clear that
794 he is a very bright guy who has some very good ideas and sort of went
795 over the edge. That's my view.
796 SWAZEY: Does he practice health law?
797 YOUNGNER: He's had a number of jobs and can't seem to stick around anyplace. It's
798 worth reading some of his stuff just because he anchors an extreme view
799 which has some merit in itself, which is that individuals applying ethics in
800 a clinical setting is anti-democratic and is a usurpation of the freedom of
801 individuals to make their own moral judgements. He sort of takes that and
802 runs with it, it saw this task force and bioethics organizations as

professional cabals that are trying to take over power and rule the world. Frankly, he actually wanted to be on the task force and wasn't asked and he is very bitter about that. Even in some of his writing he complains that he wasn't put on the task force. I think it would be worth your while to read some of his stuff, just to see an extreme view of people looking at bioethics, and particularly ethics consultation.

SWAZEY: What sort of places is he published in?

YOUNGNER: HEC Forum, Cambridge Quarterly. He wrote a review of the Canadian Task Force that shouldn't have been published; it was so ad hominem and nasty and he could've made criticisms in another way. If you look in the bibliography of the task force, some of his writings are there. I think that issue is always there and it's something we have to be very careful about. One of the challenges of the task force was, in a way, how much should the practice, or whatever you want to call it, of ethics consultation be professionalized? This was a theme that ran through the whole thing. Professionalization became, in some ways, a bad word, sort of like "rationing" or "liberal"; it was a word that set off all kinds of feelings in people. But my argument, and I think the reason for having the task force is that there is such a thing as professionalization, which means behaving increasingly like a professional without being a professional. There's no

question that ethics consultation is becoming professionalized without any formal effort to do so. Ethics consultants are identified, they are named, they are asked for advice, they work in hospitals, they affect patient care. If you're not going to just stop it, which I guess is what Giles would like to do, just say, "It can't happen because it's bad," then the questions are: how much, if it is happening, should we make efforts to have some kind of quality control and have some standards for doing it, for evaluating it, both for the people who are doing it and for the institutions that want to hire them? It was a very, very difficult task. As I said, there are some people who said we shouldn't have even done it because it was, in itself, a de facto recognition of it as a profession. And in Giles there was actually this sort of taking over. And there of course are other people who thought we should go right to credentialing people to do this. I think that part of my motivation and the motivation of the organizations that started the task force was that it's a fact that people are doing it and affecting the lives of patients and their families and health professionals. It's not going to go away.

END OF SIDE 2, TAPE 1

YOUNGNER: We spent a lot of time discussing recommendations about what to do, how far to go in terms of setting standards, or how to set them. If we didn't do

that, sooner or later, and probably sooner, someone, whether it was an individual or an organization like the AMA or JACHO, or like John Fletcher or Mark Siegler, was going to suddenly say, "Here is what the standard should be" and get some big organization to back them up and suddenly be credentialing people. So part of this was to head off what I think the majority of us considered to be the potential for an idiosyncratic or rogue, impulsive, not well thought out move to take control of the field. So that was part of our motivation, and a big part of my own motivation. John LaPuma already had written standards for a hospital in Chicago for credentialing ethics consultants, and of course they were only physicians. And he had lobbied the AMA, which very early on in the course of our task force work actually passed a resolution that doctors should be paid for doing this. For one thing the task force made a statement that people shouldn't be paid individually, shouldn't charge individually for this. How can you possibly charge for something when you haven't defined what a good result is? So in a way, the task force was a very political entity that was made up primarily of academics but included people from all fields who had worked doing ethics consultation. There was a firm commitment to the interdisciplinary nature of the field and people had varying ideas about credentialing. There wasn't uniformity and we picked

the task force so John Fletcher was on the task force. The people who were on the task force were clearly opposed. So that was the task force.

SWAZEY: It started out as a task force on standards, but if I remember correctly, it ended up issuing guidelines.

YOUNGNER: Guidelines are a form of standards.

SWAZEY: Okay, but a more subdued, or modified, or less binding form?

YOUNGNER: Oh yes. It didn't start out any stronger than that. It started out asking the question: "Here are people doing this, affecting things, it seems to be growing; should there be standards for doing it, teaching it, and evaluating it? If so, what is the nature of those standards specifically, and how rigorous should they be?" And the possible answers for that ranged from zero to we should have state boards that give credentials to people and limit people in the field and here's the test they should pass. We were agnostic, undecided about the extent, but we did ask the question; "Should there be?" What we came up with was a very moderate set of guidelines, though some people like Giles were very upset by it and saw it as the first step towards professional hedging by clinical ethicists. Then other people were very disappointed, mostly people who were doing it and earning money doing it and wanting to limit other people from doing it, which is what a lot of this is all about. (Laughter)

SWAZEY: It's a familiar story.

YOUNGNER: So if you are implying that we really set out to do something more rigorous and then backed off. That's not....

SWAZEY: No, I was just curious as to whether that first name, standards, implied something more than guidelines.

YOUNGNER: Guidelines are a form of setting standards. Guidelines can be ignored. Guidelines can be followed, guidelines can become through case law or other adaptation by organizations or institutions, more formalized. A lot of things could happen.

SWAZEY: Have you gotten much feedback on the final report?

YOUNGNER: We got a lot of feedback all the way through. We really made a big effort, for moral reasons and political reasons, to involve as many people in this process as we could because we knew it was controversial and would make people upset. So we published on the Internet summaries of our meetings as we went along. We put together an initial draft and put it on the Internet and sent it to every member of every bioethics organization. Then at a meeting in Baltimore last year we had a session where 200 people came and made comments. We took comments over the Internet. We wrote them all down and categorized them, discussed them at a task force meeting, greatly modified the document in light of those comments.

I don't think we changed anything major. Even the criticism we got wasn't major; people were pretty pleased with the report. And a lot of the criticism was very good and there were things we left out that we put in. It was overwhelmingly positive. I don't know what people are saying behind our backs, (Laughter) but to our faces it was good. So it'll be interesting to see what happens with this.

MESSIKOMER: What would you hope would happen to it? Was there discussion of that, and was there disagreement or consensus or what?

YOUNGNER: I think there probably is disagreement but I think that everybody thought that five years from now it ought to be reassessed and see where it should go. Nobody really knows where it's going to go. I think that most of us really thought, this is the most we can say at this time and five years from now maybe there will be more data, more experience that will tell us whether we went too far or if we didn't go far enough. Most people felt that, in general, formal accreditation wasn't going to be a good idea. For one thing, it's so difficult to objectify what you're doing and the results of what you're doing. If the role was a patient rights advocate you probably could measure and say, "Okay, did it accomplish that?" But this role is pretty amorphous and pretty general, so what do you measure? There hasn't been good research about that.

SWAZEY: No, and I think from the time John started proposing credentialing a lot of us kind of laughed about "what's your test going to be?"

YOUNGNER: Right. But on the other hand, to let people go and do it and then say, "Well, they can do whatever they want, we're not going to even think about whether it's good or bad, or try to figure that out,." that's not responsible either.

SWAZEY: And anybody now can do it.

YOUNGNER: Right. So this is the dilemma. You have this activity that's very hard to define, to measure how it's operating, with a theoretical framework that you can't really quantify very well. And it has bits of roles of lots of other people in the hospital, patient rights advocates, social workers, psychiatrists, etc, etc. So I don't know what's going to happen. This seems to me to be a good balance, which is sort of saying, the more people know about this, probably the better job they are going to do. It's not like "just go do it." There are some things you have to read about and if you're going to be involved in talking with people, you ought to develop some skills in talking with people, and that probably involves some kind of supervision, or somebody watches you do it.

MESSIKOMER: Who are the guidelines directed toward?

YOUNGNER: Anybody who does ethics consultation, including people who sit on

committees or people who do independent consultation.

MESSIKOMER: And any organizational structure in which they come?

YOUNGNER: Right.

SWAZEY: I must say, as we read the competencies that the task force is recommending, or suggested were elements needed, it's a pretty daunting list.

YOUNGNER: Oh yes.

SWAZEY: I think most of us would read it and say, "Nobody is going to master all those."

YOUNGNER: I think we say in the document that we understand that. Obviously, if you have somebody on an ethics committee in a small hospital that meets once every three months, their ability of mastering it is smaller than somebody who's doing it full time in a clinical setting. You know that's the part of the report that I was most uncomfortable with. It's so arbitrary, too. How do you decide what they should learn? How do you say it? But I guess that's true in any profession; you list things. "Should we list these? Should we list those? Should we make a test?" But in this field it's particularly hard because it's so new and it's so subjective.

MESSIKOMER: The other thing you mentioned in this morning's discussion is the issue of having a group of people moral judgements about who can do this kind of

thing and the kind of character that person has to have. You start to say to yourself that you would hope that in that kind of profession you would have people who have some kind of moral character, just as you would hope that physicians would and that nurses would and everybody else would!

YOUNGNER: Right, but we also know that no profession, whether it's clergy, doctors, nurses, ever does very much about weeding out people with bad character. They do nothing!

MESSIKOMER: No, they don't!

YOUNGNER: They have to do something really, really, really bad! You have to do like a felony.

SWAZEY: And sometimes it still doesn't happen!

MESSIKOMER: It usually has to be financial, not moral. (Laughter)

YOUNGNER: So you say these things. What are you going to do about them? That's part of what professions do, they say them.

SWAZEY: They are not very good a self-policing.

YOUNGNER: No, they're terrible. And of course when you think about, how would you self-police it? That's not so easy either! It was real interesting in the task force that the people who were strongest about putting character in as very important, and listing and defining all these virtues and so forth, were also

the ones, by and large, who were most worried that the task force was going to encourage professionalization of bioethics. One of the things that identifies a profession is a code of ethics. And so these people were against a code of ethics, by and large. But on the other hand they really wanted us to emphasize character, to say how important it was. In the report we specifically disavow that it should be better for bioethicists and clinical ethicists than anybody else. But that was a compromise. There were people who said, "If that goes in, we're going to have to say this, we don't want anybody to get this idea." I was one of the group that was against emphasizing character. What is character? Is it something people are born with? Can you teach them? It's a very difficult thing. I was for a code of ethics, not called a code of ethics and not to intentionally professionalize. But if character is so important and these people have positions of responsibility, for example, shouldn't we be willing to say that an ethics consultant should maintain confidentiality? Shouldn't we say that somebody who does this shouldn't take financial or sexual advantage of people that they have this authority over? And if we're not willing to say that, then how can we possibly talk about character? We don't call it a code of ethics, which I think is fine because I think that sounds too much like a profession. We call it conflict of interest or abuse of power. Those

are the don'ts. The do's are be a virtuous person...it becomes very general. And the don'ts are very specific. So I think we have a balance of both of those, and I personally think the character stuff is nice. Shouldn't you be virtuous? Of course you should be virtuous. Be honest? Of course you should be honest. Faithful? Yes! Blah, Blah, Blah.... "Okay, well so what?" That's my view. You've got to say it but let's not get carried away. On the other side you should say that this person is in a position to take advantage of other people or use them and there are some very specific things we can say about them not doing that.

SWAZEY: How do you, Stuart Youngner, distinguish between when you're doing liaison psychiatry and bioethics consultation? How much do the roles weave together?

YOUNGNER: When I do it they weave together a great deal depending on the case. There are some cases where they're very, very different. If somebody calls me and says, "This patient is depressed, could you treat him?", they will not call my bioethics colleagues to do that. And likewise, if there is something that is clearly an ethical choice that has to be made, then it's clear that it's a bioethicist. People have written about this: you get called for a psychiatric problem that's really an ethical problem; you get called for an ethical problem but it's really psychiatric problem. Not

infrequently, our CL psychiatrist will call and ask for an ethics consult, or when we do an ethics consult we'll say, "You better have that patient see a psychiatrist. You ought to get a psychiatrist because it's a competency issue." Now, do I ever do both of those things? Usually not, because I almost do no CL. I'm not in the department of psychiatry anymore, I'm not on the CL service. What does a CL psychiatrist do? Often, they try to enhance communication, promote autonomy, they often end up like ethicists do when there's a kind of a vacuum of clinical leadership or case management in a case. You know there are a bunch of specialists and nobody is taking responsibility. And then the clinical liaison psychiatrists come in and see that whatever they were called in for, the problem is basically that nobody's in charge, and they sort of do that. So there are those kinds of things that they have in common. It would be a competency evaluation because you could say, "Well geez, only a psychiatrist can do that." But to really understand competency you have to understand ethics and moral reasoning, because competency is both a clinical and a moral question. And there are plenty of psychiatrists who don't really understand the other side of it and their evaluations are extremely superficial because of that. And there are plenty of bioethicists who don't know how to recognize depression. Although in some ways, recognizing

the cause of the poor judgement is not as important as the poor judgement. In terms of treating the patient or correcting it, then it's very important. So I guess I'd say I have been called in both capacities to evaluate competence. And I think I'm great at evaluating competence because I have both. I've written about competence and I think the stuff I write about competence is informed both by reading Brock and Buchanan and writing about it, and also by having taken care of patients and understanding how patients are and what depression is and so forth.

SWAZEY: When you were doing a lot of liaison psychiatry, did that overlap with when you were doing bioethics consultation?

YOUNGNER: Not for very long but to some degree.

SWAZEY: During whatever that time period was, did your psychiatry colleagues wonder what you were doing as a bioethicist consultant, why couldn't you be doing this as a liaison psychiatrist?

YOUNGNER: Well, we started a formal ethics consultation service after I left the department of psychiatry. So I never had that exact same role simultaneously. But as I did consultations, I began bringing in those issues and talking to my fellow psychiatrists about them, bringing that dimension in, and got mixed....

MESSIKOMER: Reviews, or results?

YOUNGNER: Yes, or interest or ability to tune in to that side of it. Although I think psychiatry is sort of finally getting on the ball and getting involved. But I don't think ethics kept psychiatry out; I think psychiatry just didn't want to get involved. I think they are more involved now. In our masters program one of the clinical rotations that we have the students do is hang out on the consultation liaison service. They love it. And the CL psychiatrists love having them there. I think that's a very positive thing.

SWAZEY: Can you give us an example of a "pure" bioethics consultation?

YOUNGNER: Well, I don't think there is such a thing as a pure bioethics consultation. A pure bioethics consultation would be if you were going to Harvard and you were getting a degree in philosophy, and you were sitting in a philosophy class someplace, and somebody gave you a pure case and asked you to answer it with your philosophy skills. But that's not the way it is. Every case has some other dimensions to it, and this is true of almost all applied endeavors. The answers are in a context that involves psychology, social issues, religious issues, financial issues, etc. This is a long answer to your short question but no, I don't think there are either pure psychiatric issues or pure moral issues, but there are issues that tend to line up more that way. Is it a Jehovah's Witness who's refusing blood, can we do that? Is it moral to do that? Now, you get into the case and you find out, is the

person really a Jehovah's Witness? Are they depressed? There may be issues that become the real issue. They're saying they are Jehovah's Witnesses but they want the blood but their family is upset. So often times, most of the time, there is some of that stuff. I think that would be a pure ethical question. Does a competent adult who's a Jehovah's Witness have a right to refuse blood and die? Does a surgeon have an obligation to operate on a Jehovah's Witness even though they can't give them blood and the morbidity statistics are going to be greater? It seems to me if somebody asks you that, if you were a good ethics consultant you would go out and talk to the people. You'd read the chart and you might find there were a lot of other things going on in one of those other dimensions that really was the problem. I fully believe, having done hundreds of them, that the answer or the resolution to most ethics consults cannot be found in a textbook of moral philosophy. They have to do with getting people to talk to each other, enhancing communication. Doing what I said philosophers were so helpful to me is really helping people speak the same language. Identify the choices and options and their consequences in a consistent, clear, unconfusing way, deal with psychodynamic issues, assure people about what the law is, deal with professional power struggles, personality conflicts. You have to deal with that stuff and most

of the time there's an ethical issue there but the resolution doesn't come from saying, "Well, you know, we figured out this is the right thing to do and that's the wrong thing to do." That's just a part of it.

SWAZEY: I think anyone who does bioethics consultation has said to us that there is a huge overlap with liaison psychiatry, chaplaincy, social work. Do you have any ballpark estimate of how much of a consultation really requires training in bioethics at some level, or in philosophical analysis?

YOUNGNER: I think a lot of it does because there is a rich case history out there, and by that I mean both legal and ethical, where similar cases have been thought through and argued. And it's very, very helpful to know that literature, to have done that in looking at the particulars of the individual case that you are looking at. Philosophy is very helpful in doing that, even if you don't take philosophy, but that kind of thought, clear thinking, logical, parsing out meanings of things and so forth...clarifying language. I think that those other people aren't trained, aren't familiar with that part of things and that it's important.

SWAZEY: Should they be?

YOUNGNER: Everybody should be, sure.

SWAZEY: Can you get enough of that confidence by getting a masters in bioethics, in your program?

YOUNGNER: Not enough....

SWAZEY: Adequate?

YOUNGNER: Adequate.

SWAZEY: Well, you know, it's partly going back to this list of competencies.

YOUNGNER: Look at me. I don't have any training. So am I adequate?

SWAZEY: Not formal training.

YOUNGNER: No.

SWAZEY: No, but a lot of experiences and other good teachers.

YOUNGNER: Yes, experience, and I hang around with a lot of bright philosophers and talk with them and I'm sure I've learned an incredible amount...sociologists and other people. I know that I've learned an incredible amount that way. Maybe that's the best way to learn things. Since I'm in a position of power nobody is really evaluating me; if somebody did there would be plenty of things that I'm doing that I'm not doing that well, and I could learn something to do better, I'm sure.

It's really interesting to see this curriculum that we have for our masters students. I've never read a lot of those papers. There are bioethicists like Tom Murray and others who really know a little bit about everything and a lot about a few things, but there are whole areas of bioethics that I don't read in. I've certain interests where I keep up and

then other areas where, it's not like I don't care but...like genetic engineering and reproductive ethics. I just don't keep up with that literature. I couldn't teach it. I could read a paper and talk about it to an undergraduate group but not in any kind of depth. If you look at the task force and what we say people should know, I don't know all that stuff, a lot of it, though I know where to look for it or who to ask.

SWAZEY: What's your assessment of the relative influence of ethics committees and individual bioethics consultants?

YOUNGNER: That's a really interesting question. You have the ethics committee doing consultation and then you have the individual and then you have the team, like three people doing it. I think that in most cases just having a full committee do it is a very ineffective way to do a consultation. There may be exceptions to that but a consultation is going to be much better if there is primary data gathering by the person or team doing the consultation. You're not going to have a committee go to the bedside, read the chart, talk to the patient, etc. There are some people who are, I think...and this is a good example of a philosopher just not getting it, as far as the psychosocial side goes. But I remember years ago we had a philosopher here who was a patient rights advocate and her idea was that the way you protected patient's rights is that you have an ethics committee meeting and

invited the patient to come. In this case it was at Children's Hospital so it was parents. I'll never forget this meeting with a 15 year-old black woman whose baby was having difficulties. They wanted to let the baby die and she wasn't sure. They invited her to this meeting, and she shows up at this meeting with 20 doctors and nurses in a room someplace. I'm not sure that is really protecting her rights. She was scared and intimidated. You couldn't believe the way some of the doctors behaved and the way they talked in front of her.

MESSIKOMER: Sure we could!

YOUNGNER: This philosopher actually came away from that meeting thinking they really protected her rights. So there are things about ethics committees that aren't good in that way. If a sensitive ethics consultant or two had sat down with that mother alone and talked with her, I think that would've been very useful both in terms of getting information and in terms of making sure that she was empowered. That was not an empowering experience. I've seen executives who run boards go to ethics committees and act very confident, but most people aren't going to go into a room full of strangers who they see as authority figures and have some kind of meaningful dialogue. So I think that the most effective model is one where at least there are people who can go to the bedside, read the chart, gather

data in a primary way and have the flexibility to keep going back. Because it's not a snapshot; often you'll get information and need to go back and forth between people and say, "Now we get to get so and so and so and so to talk," and "Now I've talked to you, and I've talked to them and here's what they say, so what do you think about this?" And the idea of a one-time ethics committee meeting and doing all that stuff just doesn't work. Usually at an ethics committee meeting the doctor presents the data, so you get it through the doctor's eyes. On the other hand, the committees are better because you share responsibility more widely, you don't have the possibility of an idiosyncratic or personal view of one person determining what happens. That may be one of the advantages of having three people do the consults. The disadvantages of that is, how do you get three people together? The way we do it here, I'm not saying it's the best way, but it's the way we do it and it's the way we're most comfortable with, is that in everything but the Children's Hospital there are two of us who do the consults. We carry a beeper and we have an on-call schedule. One of us is always available to do a consult. The other person is a philosopher-nurse. We chair the ethics committee, which has a monthly, regularly scheduled meeting, and we try to bring some of our cases there for review both to educate the committee and to share with

people what we're doing. We're subject to peer review so in case we are acting way out of line people give us feedback. The other thing that we do is, say we get 60 to 70 consults a year, for probably about 5 to 10 of those we will go out and do the consult and then say we think the whole committee needs to look at this case. Some of these cases are so difficult that we just feel that we're real uncomfortable making any kind of decision about it. That's usually something where I think there are really good arguments on both sides. The other reason is, if it involves an institutional issue that I think the committee needs to hear and that the problem needs to be more fully shared in the institution, or the institution's going to have to take a stand on something. Then I try to get the whole committee to meet as a way of involving the institution. We have a high hospital administrator on the committee and we have a hospital attorney on the committee. And so it's a way for them to really hear what's going on and share in some of the decision making and responsibility for it.

SWAZEY: How much do you sense that either your committee, or other committees you know about, function in large measure as a CYA institutional group? Which certainly a lot of IRB's do, they are there to protect the institution.

YOUNGNER: What does CYA mean?

SWAZEY: Cover Your Ass. They are there to protect the institution legally.

YOUNGNER: I have no question that most hospitals support ethics as a risk management tool primarily. I have no doubt about it. When I go to my hospital and argue for my budget I always put that argument in. We head off and identify problems that can avoid lawsuits. Now having said that, I don't think we function as a risk management committee. There's a debate in the field about whether you should even have a hospital attorney on the ethics committee. We do but it's only because we have had people who have been willing to accept the idea that the legal questions are the last ones to be discussed and answered, not the first ones. And we've also had a series of lawyers who really believe that good clinical care and good ethical care will almost always mean good legal decisions. But we've gotten into some big debates. I've had some big fights with our hospital attorneys at the committee and everybody sits there and listens to them, and I think that's okay too. The fact is, when push comes to shove, who's the hospital administration going to listen to? They are going to listen to the lawyers. And I think that can be very destructive, if the lawyers take the most paranoid legal view and say, "Well, there's no law that says you can do this." "But there's no law against it either." "But there's no law that says you can do this and somebody could sue you." "Well, what are the chances you would lose?" "Well, we don't know because we don't

have any cases like that."

SWAZEY: But we don't want to risk it.

YOUNGNER: But we don't want to risk it. And if that leads to something that's clearly bad from a moral perspective, that's bad. My own view is that is a distorted view of law. What's interesting is that we've had on our committee an academic lawyer, Rebecca Dresser, and the hospital attorney. Rebecca always takes the more progressive view of the law and the hospital attorney tends to take the more protective view of the law. That's the reality and it leads to some very interesting debates.

SWAZEY: I saw Len Glantz and the hospital attorney do that when I was on an IRB at BU. Len finally got thrown off the IRB because he asked what the administration considered to be too many difficult questions. There was that real tension between the academic, tough lawyer with a lot of social science and ethical sense, and the hospital lawyer, because they were playing very different roles.

YOUNGNER: Right. But I think it's a place where the hospital attorneys can learn and this isn't so much academic versus practical, it's clinical versus legal. It's not just the bioethicist who thinks this is the right thing to do, the clinicians also think it's the right thing to do. But the hospital is worried about getting sued or getting bad publicity. So it's that tension. It's a

healthy tension. The committee has been a place where there's been a lot of debate, and I think the lawyers have learned a lot because of that.

YOUNGNER: You talk in the task force report about the competencies needed for bioethics consultation, and you and others also are talking about health care organizational ethics as an emerging area for bioethics consultants. What competencies is that going to need?

YOUNGNER: Well, this is another very controversial issue; it was controversial on the task force. We largely sidestepped it because at one point I and a couple of other people said, "Look guys, let's face it, we don't know anything about this." There's not much even descriptive literature about the kind of problems that ethicists are asked to deal with in corporate organizational ethics. Not only do we not have objective data, but we don't even have descriptive data. None of us have done it, or done have it once or twice, so we cannot write with the same authority about this as we have written about the things which we all have done. At least there is a rich descriptive literature about it. Now having said that, I think that there's great promise and peril in what we call ethics committees or ethics consultants branching out into organizational ethics. The promise is that in fact the organizational and financial issues affecting patient care have largely remained hidden from clinicians, patients, and the people who

make bedside decisions. This is the recent history of American medicine is that although money has been thrown at and poured into medicine, everybody's pretended that it's dropped out of heaven and there's no dirty business going on; it just drops into doctors pockets and hospitals without having business....

SWAZEY: Nobody pays for it.

YOUNGNER: They don't pay for it and they don't have to think about money. It's just there. And of course it's been there in large quantities without many questions asked.

END OF SIDE 1, TAPE 2

YOUNGNER: I've somewhat turned off by the sanctimonious talk of a lot of doctors and health professionals about managed care and people worrying about money, because the fact is you have to worry about money, at some point the money has to come from someplace. As long as they are sending it and nobody is asking then you don't have to worry about it. But if there is a limited amount then you have to worry about it. Now that's not saying we shouldn't be concerned about how it's spent, or where it's spent, or why it's spent and so forth. But a lot of this criticism of managed care comes from...and believe me I know it because one of the things that I've found useful about being a psychiatrist is, I do use my own reactions to try

to understand what's going on around me. I was raised in the era where doctors were kings. Nobody questioned our authority, they threw money at us, and all of a sudden that's changed and it hurts. It's very painful. That doesn't necessarily mean every time I feel pain and anger it's because patient care is suffering, sometimes it's because I'm suffering. So I think that's a reality that's been hard for people to get through. I guess what I'm saying is that ultimately I think it's healthy that people realize that in order to provide good patient care you have to have business practices. Even if you had government run health care, you would still have to have business practices. The days of just throwing money in, whether it's an insurance company, the government, whoever, without managing the money, are over. So it's not bad for people to be aware of this, and to say things like, "We think the hospital should do this and this and this." " Well, if we do this the hospital will go under." "We don't want that to happen." "Well, how can we keep the hospital from going under?" You have to have a dialogue. Of course the dialogue's two ways. The people who run hospitals should know what good patient care is and the problems facing clinicians and patients and families, but it has to be the other way too. So in that sense just keeping them separate is a bad idea. But there are some real pitfalls there. One of them is, at the most innocent level, that the kind

of people who have been interested in doing good at ethics consultation are ignorant about business practices, don't have the time to learn about them or perhaps the inclination. I'll even take a step further: probably the personalities, the character traits to be good at clinical ethics and business ethics are not the same. They are different worlds. They operate under different premises. The players are different. That's the sort of benign caution. The more malignant caution is that people who work on ethics committees, by and large, are sort of naive about the real world, are usually not tough, tough people. The people who run hospitals are tough, tough people, and it's no contest. Especially since the people on the ethics committee are working for the people who run hospitals. I think in the clinical arena that doesn't become an issue so much, but there it would. You have a gross imbalance of power, and so I worry about it. There are people who've heard me say that and say, "You have a very cynical and distorted view of business people because business people are ethical just like everybody else and they care about things." And I think that's probably true of lots of business people, it's not true of all of them. It's not true of all doctors either but it's a different world and it operates in a different way. First of all, the clinical world is sort of an academic world. In academia it really is, but even out of academia it's like, "Well, what's

the truth?" That's not always the way things work in business. Sometimes it's just "shut up!!" Loyalty, don't ask, and to mix those two.... Frankly, and I'm not going to say this off the record, there are people out there who are saying, "Ethics committees need to get involved or they're going to become obsolete. They are going to become appendages. Either we join it and get in or we're going to be left behind."

SWAZEY: That also assumes that the management structure is going to want them involved.

YOUNGNER: Well, it assumes they're going to want them involved and if they want them involved, why do they want them involved? And the most troubling reason they would want them involved is as a rubber stamp saying, "Oh, we have an ethics committee that said our business practices are okay. Everything we do we subject to a business ethics review."

SWAZEY: In most corporations that have hired ethicists who are full-time staff, their real function is compliance. It has nothing to do with business ethics, they're compliance officers.

YOUNGNER: Compliance with?

SWAZEY: Laws, regulations etc. That's what they're there for and they call them corporate ethicists because it sounds great.

YOUNGNER: Is the head of my hospital going to call me and say, "Do you think our ads

are fair? Do you think what we're doing with marketing in the suburbs and trying to ignore the inner city, do you think that's a reasonable balance?" They don't want to talk about those things. Some people have told me that their corporations do want to do that, but I'm cynical about that.

SWAZEY: Larry O'Connell has been consulting with HMO's and managed care companies on certain codes of ethics and ethical conduct. I don't know if he's going to have any time at our board meeting next week to talk about it, but I'd like to hear about whether he thinks it's an oxymoron that he's engaged in.

YOUNGNER: The people like John Fletcher and Myra Christopher who are really pushing organizational ethics, are types that are probably very good and very comfortable sitting down at a board of trustees meeting of a big hospital and schmoozing with people and telling their views. Whether they're being co-opted or people are really listening to them and care about what they say, I don't know. But most people on ethics committees aren't comfortable with that; I'm not.

SWAZEY: Do you have to wonder, a little cynically, how much people in bioethics pushing this really see it as another niche, or another growth industry?

YOUNGNER: That's my feeling, absolutely. But on the other hand there is that other

argument about why should they be kept separate? I've invited and I like to have people from administration and management on the ethics committee so that they can see the consequences of their decisions. They can see systemic problems, and then if they want to do something about them they can. A lot of our ethics consults identify problems and they are not doing anything about it because nobody can do anything about it. Lack of continuity of care in the hospital, people being taken care of by strangers, zillions of strangers who change everyday. I'd say at least half of the problems we see every day are generated because of that environment. People don't trust each other, communication is garbled. You know the game "telephone"? I did a little study with a medical student a few years ago which we presented at a meeting but we've never published it. We did this in the summer. We picked six wards and we picked patients who had been in the hospital on their third day. And he went and asked them, "What's the name of the doctor in charge of your case?" Half of them didn't know...more than half. Then we looked at demographics and other things like that. A lot of the problems that we see are generated because of that kind of thing. I got an ethics consult last week from a nurse in the surgical intensive care unit who was furious because the surgeon was insisting.... There was a woman who had heart

surgery and things went bad and she was comatose on a ventilator, her kidneys were failing, she had a living will. Her daughter was saying, "enough is enough". The surgeon kept coming and saying, "She can make it, she can make it." This is the story heard from the nurse. I said, "Did you talk to the surgeon?" "No." "Why don't you go talk to the surgeon?" "I think before I go talk to the surgeon, you should talk to the surgeon. I go off duty in 2 hours and then I have 6 days off." That kind of thing happens all the time. You go and actually try to work on something with people and then they're gone. This is a big problem.

SWAZEY: What happened?

YOUNGNER: Well, I tell them about it but what are they going to do? Change the whole medical system?

SWAZEY: No, in this particular case. I'm being case specific. Did you talk to the surgeon?

YOUNGNER: No, I didn't call the surgeon. No, I won't do that. I said to the nurse, "Call the surgeon and say you'd like an ethics consultation." Here's the way we operate. If, which is a political and moral compromise, we're called by a doctor in charge of the case, the attending, we will go and do everything. Talk to the patient, read the chart, talk to anybody we want to. Anybody else can call us, house officer, nurse....

SWAZEY: Patient or family?

YOUNGNER: If the patient or family calls us, we'll go regardless.

MESSIKOMER: And do everything?

YOUNGNER: And do everything.

MESSIKOMER: Okay, so it's the attending physician and the patient/family you'll do everything for.

YOUNGNER: Right, anybody else we'll go out and talk to the caller. We'll help them but we won't talk to the patient or write a note on the chart without the attending physician's agreement. And that's, in part, a compromise with the reality of the power structure. Now , in fact, it's never happened that an attending physician has refused to have us. So what I'll do is if I go out and ask the attending physician and the person says okay, and the attending physician says no. I'll pick up the phone and call the attending physician and say, "What's happening? I hear you don't want me to come." And then they usually say okay and want me to come. But we have that procedure there for that reason. Well, that nurse never called the surgeon. I'll be damned if I'm going to call the surgeon if the nurse who's upset about the problem doesn't want to call the surgeon.

MESSIKOMER: And knows it first hand when you don't.

YOUNGNER: I can't call and say, "This nurse called me and said you're acting badly."

I'll get shot with that surgeon fast!

SWAZEY: You will, and that nurse will get zapped fast too.

YOUNGNER: So what we've tried to do with things like that is empower the nurses. A few years ago this was happening in the surgical intensive care, and Barb Dailey, who is the nurse philosopher, got the nurses to meet in their own local ethics committee and invite the surgeons to come to it. A lot of it was that they were just chicken to confront the surgeons, but when they did in a constructive thoughtful way, which is to say, "You know we have a disagreement here, let's sit down and talk about it,"-- it is very hard to get surgeons to sit down, first of all, and to talk, second of all--but when they did that, these surgeons respected them. They needed them desperately to take care of their patients. And a lot of times they could work things out.

SWAZEY: I was talking last week to a philosopher who does business ethics at the Darden School, which is the school of business at the University of Virginia. She's got a project running on organizational ethics in health care because, she said as they looked around they didn't think anybody was really working seriously on it and decided they would. It would be really interesting to get a group like the one that Pat's assembled interfacing with some of the people in bioethics.

YOUNGNER: I think that should be the next task force. There should be a group that really starts thinking through some of these things, partly to head off organizations using bioethicists as rubber stamps for what they're doing.

SWAZEY: I think there's that danger, and there's also the danger of somebody thinking that because they're "a bioethicist" they can run off and do organizational ethics.

MESSIKOMER: Yes, it's the "all things to all people" we talked about.

YOUNGNER: I know hardly anything about business; it's just an area I don't know.

SWAZEY: Well, if you ever decide to get a task force going I can get you in touch with Pat Werhane at the University of Virginia, because she's the kind of person who is really expert in business ethics that would be really useful. I think, as you said, there really seems to be a push in some quarters to make this is the new growth area.

YOUNGNER: Right.

SWAZEY: Where is bioethics going to be in 15 or 20 years? Is it still going to be around?

YOUNGNER: Oh yea. It seems that it's just captured a niche and the niche is going to grow. Renée and others have written about an issue that I think is part of why bioethics is accepted now in medicine in particular. Medicine has always had a kind of a recognition and guilt about its lack of humaneness.

So there are always complaints by patients, by people who watch and study medicine about its technical, cold, unholistic, insensitive, demeaning...all those things.

MESSIKOMER: Sounds wonderful! (Laughter)

YOUNGNER: And at least since the late 1950's and 1960's, there are people they call in to fix it. You know--psychiatry, sociology, bioethics, humanities. We're going to see that religion is going to come back in. And I know none of them are going to fix it. Nobody is going to fix this problem because it's inherent in the field, in the endeavor, in human nature. Patients want medicine that way to a certain degree, except when things get bad and then they don't want it. It's the nature, I believe, of practicing medicine. Most people who practice medicine can't do both things well. I know that if I was an oncologist or a surgeon, I would not be a humanistic person to my patients. I get to spend a lot of time with my patients. I'm not under pressure. I can be real nice to them and really think about them and listen to them. If I had all that responsibility and that many patients, that many decisions to make.... That's part of why I didn't go into pediatrics. I've seen people who can do both well but they're very exceptional, they're rare. And we're not going to change medicine to make them all that way, or most of them. It's just not going to happen. So this is always going to

be a problem. But I think bioethics, in part because it has incorporated all those other disciplines, maybe what we're going to call whatever it is that's supposed to fill that niche. It's also filling other niches that those groups didn't. The news media always seems to love to have a bioethicist commenting on things. And bioethics has, I think, done a very nice job of developing a taxonomy of problems that they're very good at sort of laying out in ways that people can talk about them. I think that's very useful and I don't think that any of the other fields have done that in the same way. So I think bioethics is going to be here. It's going to change. It may get more religion. It may get more sociology depending on the time, but I think it's going to stay. I don't know if that's good or bad.

MESSIKOMER: So you're saying that it helps to structure the discussion about these issues by providing the taxonomy in a language and also a forum in which they can be discussed?

YOUNGNER: Right. If you look at the bioethics commissions and what they've done, they've done that in a way that other people haven't. They lay out the problems and then give arguments on both sides and usually come up with recommendations that are within the moral framework that's existing at the time. I think that's been very useful. I don't think anybody else, as a profession, has done that kind of thing.

SWAZEY: Is it mainly because other groups haven't had that disciplinary mix that you believe makes bioethics not a profession?

YOUNGNER: Right.

MESSIKOMER: Maybe that's an argument for not having it as a separate profession.

YOUNGNER: Right.

SWAZEY: Is bioethics consultation going to stay?

YOUNGNER: Oh yea.

SWAZEY: Where do you think your colleagues are going to end up tomorrow on the PhD program?

YOUNGNER: They're going to want it.

SWAZEY: They are?

YOUNGNER: That's my prediction. They're going to want it because it will make money. It'll be fun. The masters program has been wonderful for the Center. It's brought the faculty together, it's a real focus. I've loved it. Those are cynical reasons but I think those reasons will predominate more than, say, "this is what the field really needs, even though we'll lose money and it's not that much fun." One of the things on the agenda that Tom wants to really talk about is whether this is something that's needed and is valuable.

MESSIKOMER: Needed by whom?

YOUNGNER: By the world.

MESSIKOMER: Oh, as opposed to...?

YOUNGNER: Us. We'll have that discussion too.

MESSIKOMER: What you need and what the world needs.

YOUNGNER: Right, and what you need usually has a big influence on what people's decisions will be.

SWAZEY: Have there been preliminary discussions in faculty meetings?

YOUNGNER: Not really, just very superficial.

MESSIKOMER: Has there been preliminary talk about it among those of you who participate? I mean have people put their views on the table so you know where they are kind of going in? No? Okay.

YOUNGNER: But I think the fact that it's on the agenda means that there are people who think it's a great idea. I guess Tom's one of them.

SWAZEY: Did he initiate the idea?

YOUNGNER: I don't know. But who else would've initiated it?

SWAZEY: Tom also told me to ask you, before we leave you in peace, why you guys didn't go ahead and choose Dr. Kevorkian when he applied for Tom's job?

YOUNGNER: I've always regretted that...always regretted that....(Laughter)

SWAZEY: A very different history for this Center, right? Tom said that he heard, I guess from you, that Kevorkian said he was a bioethicist.

YOUNGNER: The letter was lost.

SWAZEY: That's a shame!

YOUNGNER: But he wrote this letter that was most grandiose. Have you ever read one of his papers? You know he's published a few.

SWAZEY: Yes, I've read a couple of them. They're really scary.

YOUNGNER: They're also very verbose and use all kinds of words that I had to go look for in the dictionary and they're not even there. Well, he wrote a letter like that that was just this most flowery, convoluted prose about how, although he hadn't had training in bioethics, he was the world's greatest bioethicist, more or less. I knew who he was then because I'd read a couple of things that he'd written in forensic psychiatry books about capital punishment.

SWAZEY: His paintings are even scarier than his prose.

YOUNGNER: He has an overall philosophy that goes way beyond physician-assisted suicide. It's an extreme form of utilitarianism around death. He believes that death is bad, that if it happens we ought to make the best of it, so we ought to take the organs from people who die. We ought to do medical experiments on them. The whole idea is to create these obitoriums in cities where people can go to be euthanized, or commit suicide, or be killed by capital punishment, and as that's happening, or right before it

happens, both experiments are done on them and organs are taken. In his book, which I have, he talks with great relish about instances in history where this has happened. For instance in the French Revolution, how doctors were curious about when a head was detached from the body, how long a person was conscious. And how doctors at the guillotine, would run and pick up heads by the ears and look in the eyes and say, "Can you hear me? Can you hear me?"

SWAZEY: And now you've got Dr. White still in Cleveland! (Laughter)

YOUNGNER: He and Kevorkian, there's a certain something that they have in common. There are lots of details like this, and saying things like even if a person is captured by terrorists and is going to be assassinated, even though that's horrible, something good could come out of that. They could do experiments on the person before they die. It's a kind of extreme utilitarianism without any sensitivity to the moral and social context around it. Somebody could say, "Well, you're right but...Oh God! That's disgusting!" or, "That freaks me out!". He's sort of like Jeremy Bentham in a certain bizarre way, who had his own body preserved.

SWAZEY: Right, "Bentham in a box". They wheel him out at Oxbridge every year for high tea!

YOUNGNER: One of Bentham's reasons for doing that is that he didn't want them to

build statues to him and waste all the marble and wood in the world. That was kind of losing sight of the forest for the trees. Kevorkian's a very bizarre guy, but just think, if he'd come and been our director, we'd be in the news even more than we are! (Laughter)

SWAZEY: You'd outdo Art for sound bytes any day of the week!!

YOUNGNER: That's right!

SWAZEY: Carla, do have anything else you'd like to ask Stuart about at this juncture?

MESSIKOMER: Maybe in the future, Stuart, we will call you again.

YOUNGNER: Sure.

SWAZEY: It's been a wonderful interview!

YOUNGNER: Everybody is going to be very interested to read your book, in our both narcissistic and professional personas.

SWAZEY: Don't hold your breath, it's going to be a while!

END OF INTERVIEW