What Happens Next – Sunday February 28, 2021
Bioethics, US-Israel Relations, Selling the Museum's Art, and Who is White?
Jonathan Moreno

Larry:
Before we go to questions, we're going to have our second panelist speak, and that is Jonathan Moreno. Jonathan is a professor of medical ethics and a history of science at the University of Pennsylvania. Go ahead, Jonathan.

Jonathan Moreno:
Thanks, Larry, and thanks for including me. My comments are going to work beautifully with Jacob's. What I'm going to try to do is provide a wider historical lens for the field that Jacob and I both work in, which is often called bioethics, but actually has ancient roots in medical ethics. The Hippocratic Oath, if you look at it, has an interesting void with respect to doctor-patient relations. It says nothing about what we would today call informed consent or patient self-determination or truth-telling. By the way, it also doesn't say, "Do no harm," which is a common misunderstanding. That happens somewhere else in the Hippocratic Corpus.

So why do we now call this field bioethics? The reason is mainly because something happened in the 1960s, the late 60s, the early 70s that did introduce the patient's voice in a way that wasn't the case in traditional medical ethics, which is very doctor-oriented. If you look at the Hippocratic Oath, it has a lot to say about the fraternity, the guild of medicine, but it doesn't have really anything to say about how much patients should be told.

People started rebelling against that for a lot of reasons in the 60s and 70s, so now we have consent forums, which, more often they're written by lawyers than they are by ethicists. But that is a problem between the institution and the patient, and that is an issue we can talk about. So, what happened in the late 60s, early 70s, I think brought us into two distinct fields that were related. One is clinical ethics, ethical issues about death and dying, and about the beginning of life. These issues continue today. Also, we got involved in issues around human subject experiments, so a lot of the conversation these days about how appropriately to do experiments concerning the vaccines relate to longstanding conversations about how much people need to know, how much they're informed. You don't have to necessarily be told that you're getting a placebo, but you have to be told you might be getting a placebo, right? We think about the way that these vaccines have been developed recently.

A couple of big events in the 60s and 70s that really pushed these conversations forward. In clinical ethics, the famous case of Karen Ann Quinlan in New Jersey in the mid-1970s, a woman who was in a vegetative state, whose parents went to court to get the right to speak for her

about what she would have wanted. She lived for nearly nine and a half more years in a vegetative state with excellent nursing care. And of course, just a couple of years before the Quinlan case, in the early 70s, the revelations of the Syphilis Study, which took us into human research ethics, as well as scandals in the late 1960s about human experiments. But the Syphilis Study, again, hangs over us like a shadow today because so many people of color remember the Syphilis Study, know something about it, and that's part of the reluctance, the vaccine resistance that many people have. I'd love to talk with Jacob during the conversation about what his perception is of that in his own hospital, particularly among the support staff.

So the field of bioethics had these two areas, clinical ethics, ethics of human experiments, and then I think, especially in the 90s, you have the emergence of what I call the ethics of basic science. A lot of that is around the Human Genome Project, which was the first big physics project invested in by the US Government, billions of dollars to create what its promoters like to call the blueprint of what it is to be a human being.

And that, of course, has led to tremendous science, including the development of CRISPR-CAS9 nine, which we're aware of, that was applied unethically to those three embryos in China a few years ago. That was the big topic before the pandemic. But also, not only issues in genetics. The ethics of basic science have also come to include the ethics of brain science, an area I'm particularly interested in and have written a lot about. For example, we have repeated conversations about whether it's appropriate to put human neural cells into animals. This actually started during the stem cell and cloning arguments earlier in the 2000s. They're continuing today. There's a lot we don't know, in particular about mental illness. There are some mental illnesses that do not have adequate animal models, and really, we're not doing it all well with therapies for many mental illnesses, particularly schizophrenia, depression. So, if you could put these human-neural-based cells into rodents, you could learn a lot, but how far do you go with that? That's an ongoing discussion and controversy in the ethics of basic science.

And finally, to talk about public health ethics, in my view, my field, bioethics, the literature is pretty thin on the ethics of public health. I think we are going to confront, in our field, a kind of bioethics reckoning about public health. Jacob actually mentioned a couple of the problems that we really have left largely unresolved, and I'll just mention a few more to wrap up.

If you look at textbooks in bioethics, there's a moral principle that is virtually absent. It's the principle of reciprocity. How much do we owe each other? Bioethics has largely been dominated by ideas about self-determination, autonomy, informed consent. And that's fine; those standards are very important. At the same time, what we've seen in the last year is that we really don't have a wide and deep appreciation for reciprocity in our relations with each other. And I think that's something that we really have to talk about, as a field and as a society.

The way that we have prioritized, and this goes to Jacob's point, the categories for therapies and for vaccination, obviously, the implementation, as Jacob says, has been at best a patchwork, and not one that inspires a lot of confidence in the system. We really need to take another look at that, and particularly how we can begin to understand the role of structural inequalities in that prioritization. The relationship between public health measures, like masking and distancing, and commercial activity, we really need to address this notion that there is an irreconcilable conflict between commerce and public health.

Historically, that is not at all true. If you look at the history of medicine, the growth of global GDP in the last 250 years has come right along with the growth of understanding of terrible infectious diseases, like cholera and smallpox. There's not an inherent contradiction between commerce and public health, but acutely, there has been one in the way some countries, including the US, have dealt with this crisis.

And then finally, how can we have a better understanding of the role of our obligations to people who have mental illness? We have really not done well with public health in general in this country. We especially have not done well with public mental health. Nobody goes to a city who doesn't see the fact that too many of our streets are like wards in mental hospitals were 30 years ago. This is not acceptable in a civilized society. We need to take another look at the ethics of public mental health and our obligations to people who cannot take care of themselves. I'll stop there and look forward to the conversation.