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Limiting Technology in the Process of Negotiating Death

Nancy Dubler, LL.B.


Death is a negotiated event; it happens by design. Whereas accident or negligence may occasionally intervene as an independent cause, 70% of the 1.3 million Americans who die in health care institutions do so after a decision has been made and implemented to forego some or all forms of medical treatment. One can only assume that this percentage has increased during the last decade as technological advances increasingly permit support of single organ function at the expense of integrated conscious existence.

Two powerful forces in health care evolved in the 1990s to affect the course and conduct of medicine at the end of life. Both are reflected, although not presented in sufficiently sharp focus, in the series of essays collected in the thoughtful volume, Managing Death in the Intensive Care Unit: The Transition from Cure to Comfort, edited by J. Randall Curtis and Gordon D. Rubenfeld. First, death has re-emerged as an acceptable outcome of medical practice, even in the intensive care unit, for patients whose prognosis is hopeless. Second, financial disincentives for long-term hospital stays must make us wary of determining the prognosis of hopelessness too easily. Capitated systems and prospective payment mechanisms provide incentives for shortened lengths of stay. This financial fact of life must not be permitted to contaminate decisions about death.

These evolutions, one clinical and one economic, have combined to force health care organizations and institutions to reevaluate their practices and protocols for managing patients at the end of life and especially in expensive intensive care units. In the aggregate, the results may be beneficial to patients and families as new perceptions and practices...

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limit the endless process of dying that had become the norm in many health care centers. But not surprisingly, dangers of discrimination, creation of levels of care linked to layered reimbursement, and unnecessarily hastened deaths lurk in newly found perceptions of palliative and hospice care.

Most of the chapters in this book are well conceptualized and clearly written, and some provide valuable tools for professionals seeking to offer appropriate and compassionate care to patients and their families. Both physicians and nurses provide data, algorithms, and scripts to assist intensive care unit (ICU) staff in providing compassionate care. Having recently attended a working group of clinicians and clergy where physicians were virtually begging for scripts to follow in the uncomfortable arena of spiritual values, I find that many chapters provide clearly useful and practical guidelines that address how to speak to, evaluate, and treat the dying patient in pain, and how to approach and support the family.

Nonetheless, there are certain micro- and macro-ethical themes addressed in the book that require more explicit development. If staff members are to be able to negotiate effectively between and among the parties who must cooperate in order to permit a “good” death, they must have the perceptions and skills to assess, evaluate, and manage conflict. Misunderstandings, disagreements, and disputes are inevitable in the context of life and death decisions when individual history and preference must combine with present prognosis according to principles of probability. Techniques of mediation and negotiation can facilitate a dynamic process that reflects, but is independent of, ethical principles of individual choice.

Nowhere is this point more evident than in the various discussions of the notion of “futility” that emerge in multiple chapters. As in many discussions, futility is conceptualized by all of the authors as a binary mode—either care is futile or non-futile. Yet, I would argue that except for those rare instances in which the cases reported in the medical literature demonstrate “no possible benefit,” the notion of futility exists somewhere on a sliding scale of benefit and burden. But what it more commonly reflects is the fact that communication between the surrogates and the physician has broken down. The term futility is a trump card played by the physician to deny requested care and to end the discussion. What is needed at that point is not the blunt instrument of physician-exercised power—the doctrine of futility—but rather a nuanced process to bring the family to recognize the scant possibility of benefit and burdens of continued care. In such circumstances, techniques of mediation that set the stage, level the playing field, invite discussion, identify positions, and
seek consensus among conflicting conceptions of a good care plan will be far more helpful than asserting and insisting on physician power to decide—the essence of the futility discussion. In pursuit of that consensus, time-limited trials and variations in ICU visitation rules may provide the redress of medical power that makes agreement possible. As death reflects more of a negotiated process rather than a discrete event, collaboration and negotiation will need to replace the raw exercise of power that appealing to “futility” represents.

When examining the likely effects of easier access to death for patients, families, medicine, and society, a microanalysis that focuses on forging a patient-care plan must be accompanied by a macroanalysis emphasizing more global themes. These themes include differential access to care, the problem of the uninsured and underinsured, the wise stewardship of scarce institutional resources, corporate contracting arrangements that search out cost-effective care, and the ever-present dangers of racism and discrimination in provision of services. This analysis should take place in the context of the principle that ICU care is, and should remain, a scarce resource whose use is restricted to those patients whose prior health status and level of function can be restored. This is so because limitation of health care expenditures is an ethical and not merely an economic issue. If we, as a society, are to have effective public education, infrastructure, cultural institutions, and other indicia of a good society, then we must limit the costs of medicine.

The assumption of the appropriateness of scarcity leads me to contest one of the premises of this volume, that it presents the “state of the art in caring for dying patients in the ICU.” It may be that determining when a patient is dying is an ICU function, but this is only valid as the precursor to transfer from the ICU to a more appropriate level of care. No rule is absolute, but if the ICU remains a limited resource it must be used wisely by admitting those who can benefit and denying admission or transfer to those who cannot. Intensive care units need to save the lives of salvageable patients but do not necessarily need to manage the resulting deaths. Other sites and staffs in the hospital may be better at, and more cost-effectively situated for, end-of-life care. Nonetheless, ICUs must be better prepared for the eventuality that some proportion of patients will die in the units.

I would also disagree that “good end-of-life care is like an art: it is difficult to define, but you know it when you see it.” This book belies the statement. A good professional knowledge base, quality communication skills (rated as high as clinical skills by family members), and a willingness to face the modest benefit that continued care will likely provide, combine...
to offer a basis for presentation of options and negotiation of a coordinated care plan. There are some artful elements, but many of the necessary techniques can be learned.

At the level of individual rights, a series of chapters in the book focus on the need for discussion with the patient, which is generally not possible when the person is in the ICU. As an alternative, the author discusses reliance on advance directives and family narratives. In these chapters, the author constructs pleas for a change in climate and perspective to emphasize truth telling. I would argue that if this is to occur, however, it must be accompanied by a new principle of "intellectual modesty." Often there is no truth to tell; the doctor can only relay past data and fashion a prognosis in light of published studies. When those studies offer dire predictions, respect for the patient, compassion for the family, and regard for the integrity of medicine should combine to offer a realistic prognosis. Clinical exposure and discussion of medical uncertainty is the only fair way to prepare family members for the death of the patient.

However, there is another perception about families that receives little attention in any of these essays. While the notion that families need support is addressed, their need for protection is equally important. It is commonplace for ICU clinical staff to reach the decision that a patient is dying and take appropriate steps to avoid prolonging the process. Decisions to permit death are part of the regular business of diagnosis and prognosis within the realm of illness and disease. But family members have no comparable intellectual framework and no matching emotional distance. For them, the death of the patient will leave an unfillable void. Compassion for family members requires that medical staff shoulder the responsibility for the decision to permit death without disempowering families’ rights to make decisions. This is no easy matter. The legal rules, ethical principles, and medical conventions of decision making by family members preclude the medical team from usurping the decision. But compassion requires that medical staff absorb the burden of the decision so that the family does not perceive itself as the cause of the patient’s death; this is the artful part of end-of-life care.

One of the negative consequences of medical decision making in this litigious era is the insistence that if the patient or family have the right to decide, then they must shoulder the burden of the decision. This theme is evident in the risk-management notions of informed consent that emphasize the litany of risks over the balance of risks and benefits. In order to protect against the later possibility of legal liability, the locus of decision must be clearly separated from the medical professionals involved in care. That is a foolish consequence of our tort system and the litigious
society it encourages, and it is also a terrible basis for allocating the components of the decision-making process at the end-of-life. If institutions want to focus on liability for end-of-life care, they should be concerned about the fact that physicians who are not specialists in intensive care have half the success of intensivists in treating very sick patients. This provides powerful support for specially trained intensive care staff and a warning to institutions that permit community-based physicians to supervise the care of imperiled patients. 13

But this sea change in medical perspective and the goals of physician communication will require a robust discussion within society, rather than a debate cloaked in the framework of court cases whose fact patterns often distort the discussion to force the narrative to conform to preexisting common law principles. This re-conceptualization of the debate began with the emergence of palliative care as a separate consulting discipline. The public discussion in the media of a “good” death has also contributed to this change. Reconstructing the grim reaper not as the enemy, but as a welcome friend, will take time and require reframing the goals of medicine. 14 But it will require changes in “hospital culture, physician practices, and societal expectations” to really move practice. 15

This book is another entry into the expanding discussion of end-of-life care. It applies to the ICU, but even more so to other medical staff who treat dying patients and support their families. It reflects the reality that medicine is adjusting its Olympian stance to the realities of chronic disease and the aging of the population. Patients and families have noticed that the SUPPORT study revealed that over 50% of patients die in moderate to severe pain, and that endless days in the ICU may extend dying, but may not reverse a declining quality of life. 16 Medicine has acted as prince of the realm of death for the last fifty years. It has ushered in new techniques for treating illness. It must now learn to ease death as it previously enhanced life.
References


9. Curtis & Patrick, supra note 4, at 85.


15. Kollef, supra note 7, at 44.

Gostin on Public Health Law

David P. Fidler, J.D., M.Phil.*


When I was invited to review Professor Larry Gostin’s new book, Public Health Law: Power, Duty, Restraint, I immediately said yes despite the fact that my schedule could scarcely bear another deadline. I had the privilege in May 1999 to read and comment on some early chapters of Gostin’s book for the Milbank Memorial Fund, which is a co-publisher of the book. Those early chapters whet my appetite for the completed book, which has now been published.

Before I had read a single word of the final product, I was primed to consume what promised to be an outstanding contribution to understanding the complex relationship between public health and law. Gostin’s earlier scholarship on public health law has proved important to my efforts to address the neglected relationship between international law and public health. I could not pass up the opportunity to devour and digest Gostin’s book and do my part to disseminate the learning it contains.

The book’s publication coincides well with this Journal’s debut. The Journal is a unique product of the collaborative energies of faculty and students from medicine, public health, and law—all disciplines for which Gostin has been a teacher and colleague. Gostin intends for his book to speak to the many disciplines affected by, and struggling to contribute to, the pursuit of healthier human populations. And when Gostin speaks, people listen.

Gostin’s book further arrives at a timely moment because concern about the status of public health in the United States seems to be increasing. Concern about emerging and re-emerging infectious diseases, the growing threat of antimicrobial resistance, the implications of the West Nile virus outbreak in the Northeast, and fears about bio-terrorism have all concentrated attention in recent years on the fragmented and under-funded condition of public health in the United States. While public

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health officials have been sounding warnings for years, others, such as journalist Laurie Garrett, have now picked up the message of alarm, and are making the case for public health to a larger audience in order to stimulate remedial action.

In this time of ferment and concern for public health in the United States, Public Health Law makes a seminal contribution that, I predict, will dominate for the foreseeable future how students and scholars from multiple disciplines approach the role of law in American public health.

I. LAW AND THE PUBLIC’S HEALTH IN THE UNITED STATES

The basic message of Public Health Law is that “law is essential for creating the conditions for people to lead healthier lives.” Many people, including health-care professionals, often view medicine and law as antagonistic disciplines. But this popular perception confuses health care and public health. In his Preface, Gostin points out that the contemporary study of the relationship between law and health is dominated by “medicine and personal health care services—clinical decision-making, delivery, organization, and finance.” Gostin argues that the population-health perspective provided by public health has been missing in the work done on health care law or health law. Gostin designed his book to address this neglect.

Curiously, although Gostin states that public health law has been “perennially neglected” as a field of study, he does not explain why such neglect occurred and what the consequences are for public health. One could read the book and conclude that law as an instrument of public health has not been neglected but has instead been used extensively for decades at all levels of government in a wide variety of contexts to promote and protect the public’s health. After all, Gostin identifies an impressive collection of legal issues in public health that governments and courts have been addressing for a long period of time. In fact, such a book could not have been written if there was not already a large body of law in existence. What, then, does Gostin mean when he says that public health law has been neglected?

The reader must discern the reasons why public health law has been neglected from the structure and argument of the book: Public health law has been neglected because of its broad, diffuse scope and immense complexity; and this neglect has produced law that compromises the ability of the United States to balance properly public health objectives and individual rights and liberties. The neglect that public health generally has endured for the past few decades may also contribute to the neglect of public health law, but Gostin does not explore this important factor.
When Gostin refers to the perennial neglect of public health law, he also means that neither legal nor public health scholars or practitioners have ever really conceived of “public health law” as a distinct field of inquiry. In American democratic society, law and legal frameworks shape every endeavor. Public health is no different. But, while many areas of social action have attracted significant conceptual and practical legal attention from scholars and practitioners, public health has largely been ignored as a field of legal analysis. The neglect is primarily intellectual rather than practical because governments and public health agencies have continued to rely on and add to public health law in their everyday activities.

But, when we realize how much law shapes public health as a social value and determines governmental activity in this area, the intellectual neglect of public health law means that we lack a framework to understand how and why law is critical to the objective of public health. We see the individual trees but not the forest—the larger ecosystem in which law and the protection of population health intertwine in ways that we should understand given the importance of the values of the rule of law and public health. While I would have liked Gostin to explore why public health law has been neglected, this desire does not detract from his correct identification of the problem and his ambitious attempt to organize, explain, analyze, and seek to improve how the public health law ecosystem functions.

It is important to emphasize the enormity of the task Gostin set himself in addressing the lack of interest in public health law in the United States. The first challenge relates to the concept of “public health,” which public health practitioners define very broadly. Gostin cites the Institute of Medicine’s definition of “public health” as “what we, as a society, do collectively to assure the conditions for people to be healthy.” This definition reveals that public health cannot be narrowly viewed as, for example, merely the low prevalence of infectious diseases in society. Public health is concerned with the whole panoply of possible threats to human health, which gives public health law an enormous scope.

The second challenge arises in explaining how the American legal system—a very complicated, sophisticated, textured machine—works in the context of public health. The machinery defies simplification, even before one considers sorting out how the machinery operates in the vast terrain of public health. Thus, the ambition in Gostin’s book is quite breathtaking.

I stress the enormity of the task because some people, both in public health and law, may find that Gostin does not analyze with sufficient depth many of the public health and legal issues, principles, and problems the
book addresses. Lawyers may find themselves hungry for more detailed legal analysis, while public health experts may find that the law overshadows public health concepts and principles. These understandable reactions should be tempered with an appreciation of Gostin's attempt to conceptualize public health law as a discrete field valuable to both the legal and public health professions.

Gostin defines "public health law" as follows:

Public health law is the study of the legal powers and duties of the state to assure the conditions for the people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, liberty, proprietary, or other legally protected interests of individuals for the protection or promotion of community health.¹¹

Chapter 1 of the book explores this definition to delineate the conceptual boundaries of the role of law in public health—or what Gostin calls the theory of public health law. This theory identifies five essential features of public health law: (1) the special responsibility of the government for public health activities; (2) the focus on the health of populations; (3) the relationship between the state and the population or between the state and individuals or private enterprises that place the greater community at risk; (4) the provision by the government of population-based services grounded in the scientific methodologies of public health; and (5) the power of the government to coerce individuals and private enterprises in order to protect the larger community from health risks.¹²

One of the great strengths of the book is that it grounds the study of public health law in the larger framework of the rule of law in the United States. As Gostin argues:

Public health law should not be seen as an arcane, indecipherable set of technical rules buried deep within state health codes. Rather, public health law should be seen as broadly as the authority and responsibility of the government to assure the conditions for the population's health. As such, public health law has transcending importance in how we think about government, politics, and policy in America.¹³

Gostin successfully demonstrates the fundamental duty governments have at the local, state, and federal levels to protect and promote the public's health and how central law is to the fulfillment of this governmental duty. The book serves not only as an overview of the role of law in public health but also as an exploration of the rule of law's
importance to the American way of government.

Readers who are knowledgeable about the current crisis in American public health might, however, scratch their heads when Gostin argues that public health law has transcending importance in U.S. politics and governance. The gradual crumbling of the U.S. public health system provides weak evidence that anything connected to public health is transcendent in the United States. Clearly Gostin’s argument is normative not descriptive, but these observations suggest that Gostin could have given a more contemporary public health context to support his aspiration “to create a record of the field of public health law at the turn of the millennium.”

Also missing from the book’s theory of American public health law is any perspective that public health in the United States is connected to international and global issues and forces, actors, and rules that complicate the use of law to promote and protect public health. In a time when local, national, and international public health officials and experts are struggling to come to grips with what has been called the globalization of public health, it was strange to see no discussion in Public Health Law of matters beyond American shores. For example, Gostin argues that constitutional, statutory, administrative, and tort law represent the “analytical methods and tools of public health law.” Conspicuously absent from the methods and tools of American public health law is international law. The United States is a party to many treaties that directly and indirectly relate to public health, including the Constitution of the World Health Organization (WHO), the International Health Regulations, the World Trade Organization, North American Free Trade Agreement, and international legal agreements on environmental protection. The United States is also a key player in the development of new international law, such as WHO’s proposed framework convention on tobacco control. Why is international law not part of the theory and practice of American public health law?

In some respects, Gostin’s decision not to include international and global issues was refreshing because it communicated the continuing importance of local, state, and national efforts on public health and did not treat the globalization phenomenon in public health through the repetition of shallow globo-rhetoric. Still, Gostin’s approach treats public health law in the United States as if America is isolated and unaffected by the public health problems in, and threats from, other countries. It does not seem prudent to me “to provide an honest account of the doctrine and the controversies facing the field [of public health law] in the year 2000” without including any analysis of international legal issues directly relevant.
II. THE STRUCTURE AND DYNAMICS OF AMERICAN PUBLIC HEALTH LAW

Part One of *Public Health Law* analyzes the conceptual foundations of American public health law. After the definition and theory of public health law are provided in Chapter 1, Gostin gives an overview of the structure and dynamics of the American system of public health law. Chapter 2 (Public Health in Constitutional Design) and Chapter 3 (Constitutional Limits on the Exercise of Public Health Powers: Safeguarding Individual Rights and Freedoms) explore the structure of American public health law through the governing framework established by the U.S. Constitution. The key structural elements Gostin examines in Chapters 2 and 3 are federalism, the separation of powers, and notions of limited government to protect individual liberties.

Grounding public health law in the American constitutional system is critical because the governmental duties to assure the conditions necessary for a healthy population are divided, distributed, and disciplined by the Constitution. Gostin effectively communicates the complicated constitutional principles that guide the pursuit of public health. If I have any quarrel with the way Gostin structures his analysis of federalism, it is with his treatment of state public health powers after his analysis of the federal role in public health. Under the Constitution, direct public health powers belong to state governments, not the federal government; most public health policy, law, and expenditures originate, as a result of the constitutional design, at the state level. Gostin’s analysis in Chapter 2 gives pride of place to the federal government’s public health powers and role. Gostin does, however, discuss the conflicts that federalism creates in public health between the federal government and state governments by analyzing the *Lochner* era through to the Supreme Court’s more recent decisions (*Lopez*, *New York*, and *Seminole Tribe*) that contain a “new federalism” that limits more the power of the federal government to regulate intrastate activities.

Gostin’s analysis of the federal government’s powers in the public health context focuses on the constitutional authorities to tax, spend, and regulate interstate commerce. The federal government’s powers to regulate commerce with foreign nations, make treaties with foreign nations, and conduct the nation’s foreign policy are important powers in the public health context that Gostin does not mention. It is these federal powers that have sustained the United State’s involvement in international public health efforts since the nineteenth century, including U.S. leadership and participation in the creation and operation of the Pan
American Sanitary Bureau, Office International d’Hygiène Publique, and the WHO. Gostin’s failure to mention these federal powers in the constitutional design reflects the book’s lack of an international perspective on American public health law.

Chapter 3 expands on the notion of limited government by analyzing the constraints the Constitution places on government power in order to protect individual rights, and how these limits affect the pursuit of public health. The tension between the government’s power to act on behalf of the public’s health and the constitutional protection of individual rights dominate Public Health Law. Not only does Gostin explore this tension conceptually in Chapter 3, but he also focuses on this issue in Part Two of the book, which contains six chapters. He also raises this theme in other chapters. More than half of Public Health Law is, thus, devoted to the public health-individual rights tension.

In the Preface, Gostin questions “the primacy of individual freedom (and its associated concepts—autonomy, privacy, and liberty) as the prevailing social norm.” He also questions the assertion associated with the late Jonathan Mann that respect for human rights and public health are synergistic. While Gostin admits that there is validity in the Mannesque position, he asserts that public health and individual rights “sometimes cannot coexist.” I return to this issue in my discussion of Part Two of the book below.

The final chapter of Part One—Chapter 4 (Public Health Regulation: A Systematic Evaluation)—provides an overview of the dynamics of public health law in the United States. While Chapters 2 and 3 were mainly descriptive, Chapter 4’s focus on public health regulation is prescriptive because Gostin develops criteria to guide policymakers and courts in their respective considerations of public health law. Because public health regulation involves trade-offs between public goods and private interests, governments must justify intervention to promote population health. Gostin identifies three classical justifications for public health intervention: (1) the harm principle—competent adults have freedom of action unless they pose a risk to others; (2) the protection of incompetent persons, such as children or the mentally ill, to ensure their health and safety; and (3) the regulation of self-regarding behavior, or paternalism.

Gostin argues that the state bears the burden of justification and has to demonstrate the existence of significant risk to the public health in order to intervene. He explores risk analysis in public health law by presenting four factors to consider: the nature of the risk, its duration, the probability of harm, and the severity of harm. While these factors closely align with science, Gostin properly cautions that social values also play a role in risk
But the government's job is not finished when it has identified a significant health risk because it must also show that (1) the intervention has a good chance of being effective because the means and ends are reasonably related; (2) the public health benefits are proportional to the economic and other costs; and (3) the intervention produces a fair distribution of benefits, costs, and burdens in society.

Gostin acknowledges that this framework for making public health decisions does "not invariably lead to the best policy because any analysis is fraught with judgments about politics and values and is confounded by scientific uncertainty." Gostin hopes, however, that his systematic analysis provides a structure that will help public health authorities and politicians craft and apply consistent standards when making policy and law.

III. BALANCING CIVIL LIBERTIES AND PUBLIC HEALTH OBJECTIVES IN AMERICAN PUBLIC HEALTH LAW

Part Two of Public Health Law contains five chapters, each of which analyzes what Gostin believes is a conflict between the enjoyment of civil liberties and the effective pursuit of public health. See Table 1 for an overview of Part Two.

It would be foolhardy and impossible for me to try to comment in detail about the massive amount of public health and legal materials Gostin expertly organizes and analyzes in these chapters. He succeeds in covering very complicated legal areas comprehensively yet concisely, as well as always tying his discussion firmly to the objectives of public health. Gostin combines analysis of the background legal principles and frameworks with exploration of current hot topics in public health law, such as health information privacy, HIV screening of pregnant women and infants, and litigation against the tobacco and firearms industries.

My concerns with Part Two are, on the whole, minor. The sections in Chapter 9 on public health and the rise of the administrative state and the regulatory tools of public health agencies struck me as information the reader needed in Part One of the book when Gostin was laying down the basics of public health law. Chapter 10's focus on tort law seemed somewhat out of place in the part of the book dealing with the conflict between civil liberties and government regulation for public health purposes, but I could not identify a better place to put this material given the structure of the book. Gostin could also have grappled more with the problem many people see in the tort litigation on tobacco and firearms: The courts are effectively being asked and allowed to make public health
### Table 1. Summary of Part Two of *Public Health Law*

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<tr>
<th>Chapter</th>
<th>Topic</th>
<th>Examples of Issues Analyzed</th>
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<tbody>
<tr>
<td>Chapter 5</td>
<td>Personal Privacy</td>
<td>- Public health surveillance&lt;br&gt; - Mandatory disease reporting&lt;br&gt; - Partner notification&lt;br&gt; - Population-based research&lt;br&gt; - Ethical underpinnings and legal status of health informational privacy&lt;br&gt; - Confidentiality&lt;br&gt; - Model public health information privacy law</td>
</tr>
<tr>
<td>Chapter 6</td>
<td>Freedom of Expression</td>
<td>- Theories of health communication&lt;br&gt; - Public health communications&lt;br&gt; - Commercial speech and public health&lt;br&gt; - Compelled commercial speech&lt;br&gt; - Regulation of cigarette advertising (case study)</td>
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<tr>
<td>Chapter 7</td>
<td>Bodily Integrity</td>
<td>- Compulsory vaccination&lt;br&gt; - Testing and screening&lt;br&gt; - Compulsory screening and unreasonable search and seizure&lt;br&gt; - Compulsory screening and disability discrimination&lt;br&gt; - HIV screening or pregnant women and infants (case study)</td>
</tr>
<tr>
<td>Chapter 8</td>
<td>Autonomy and Liberty</td>
<td>- History of personal control measures&lt;br&gt; - Isolation, quarantine, and compulsory hospitalization&lt;br&gt; - Compulsory physical examination and medical treatment&lt;br&gt; - Criminal law and knowing or willful exposure to infection</td>
</tr>
<tr>
<td>Chapter 9</td>
<td>Regulation of Economic Behavior</td>
<td>- History of commercial regulation&lt;br&gt; - Public health and the rise of the administrative state&lt;br&gt; - Regulatory tools of public health agencies&lt;br&gt; - Economic liberty and public health—contracts, property uses, and “takings”</td>
</tr>
<tr>
<td>Chapter 10</td>
<td>Tort Law and Public Health</td>
<td>- Theories of tort liability&lt;br&gt; - Mass tort litigation and epidemiology in the courtroom&lt;br&gt; - Public health value of tort litigation&lt;br&gt; - The “tobacco wars” (case study)&lt;br&gt; - Tort litigation and firearms (case study)&lt;br&gt; - Limitations of tort law for public health</td>
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Policy where legislatures have failed to take action. Finally, I could not help but think of all the parallels between Gostin’s analysis in Part Two on civil liberties and the discourse in international human rights law about public health actions by governments. Gostin has previously applied his approach to individual rights in the public health context in the context of international law, and Part Two easily lent itself to mentioning the similarities in approach in domestic law and international law concerning the tension between individual rights and the pursuit of public health.

One of the greatest strengths of Part Two of *Public Health Law* is that Gostin provides ways to make the conflict between civil liberties and public health regulation more palatable by laying out substantive and procedural
principles that can help ensure that infringement of individual rights for public health reasons are scientifically justified, non-discriminatory, and the least restrictive measures possible. In Gostin’s hands, the inevitable conflicts between civil rights and public health law are principled, constrained conflicts that demonstrate continuing respect for individual rights and commitment to protecting the public’s health. Such an approach supports powerfully the contribution that respect for individual rights can make to general public health.

IV. THE FUTURE OF AMERICAN PUBLIC HEALTH LAW

Part Three of Public Health Law focuses on the future of public health law in the United States. Chapter 11 analyzes the need for public health law reform and provides principles to guide such reform. Gostin argues that his final chapter answers the critique of American public health law issued by the Institute of Medicine (IOM) in 1988. The IOM called for reform of public health law to clarify the authority and responsibility of public health agencies and to empower them to deal effectively with contemporary public health threats. Gostin takes up the IOM’s challenge by: (1) outlining the inherent problems of public health; (2) setting out three conceptual principles that each public health statute should contain; and (3) laying out the guidelines for public health law reform (table 2).

Gostin’s analysis in Chapter 11 remains at a general level, and he does not apply his reform principles to specific public health problems facing the United States today. I understand why Gostin chose this approach,

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<tr>
<th>Inherent Problems of Public Health</th>
<th>Politics, money, leadership, jurisdiction, legitimacy, and trust</th>
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<tr>
<td>Principles All Public Health Statutes Should Have</td>
<td>The law should empower public health agencies to regulate individuals and businesses for the public’s health.</td>
</tr>
<tr>
<td></td>
<td>The law should restrain government in its exercise of power to achieve the benefits of liberty and freedom.</td>
</tr>
<tr>
<td></td>
<td>The law should impose duties on government to promote the public’s health.</td>
</tr>
<tr>
<td>Guidelines for Public Health Law Reform</td>
<td>Create modern, consistent, and uniform public health laws.</td>
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<td>Define a mission and essential functions for public health agencies.</td>
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<td>Provide a full range of public health powers.</td>
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<td>Impose substantive limits on the exercise of public health powers.</td>
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<td>Impose procedural requirements on the exercise of public health powers.</td>
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<td>Provide strong protection against discrimination.</td>
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<td>Provide strong protection for privacy and security of public health information.</td>
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Table 2. Problems, Principles, and Guidelines: Reform of Public Health Law in the United States
but I found myself wanting to know what Gostin thinks are the priorities for public health law reform in the United States today. While Gostin mentions perennial difficulties that confront public health, he does not discuss the depth of the problems now confronting American public health. Public health literature, especially in connection with infectious diseases, contains a great deal of hand-wringing and teeth-gnashing about eroding public health capabilities in the United States. Gostin’s argument for public health law reform has an abstract, detached feel to it because the general American political, economic, and social commitment to public health as an endeavor is weak, and has been so for many years. The political resurrection of public health seems a precondition for plans to reform public health law.

Gostin mentions the conceptual and practical obstacles public health faces, and he argues that it “needs opportunities to draw attention to its resource requirements and achievements, and to develop constituencies for programs.” He claims that the “lawmaking process provides just such an opportunity,” and that the law reform process can rebuild support and commitment for public health. If antimicrobial resistance cannot get the attention of legislators and politicians in the United States, then I have a hard time believing that advocating general legal reform efforts will stimulate and sustain a public health renaissance in the United States. Legal reform efforts, I imagine, need to be parasitic on specific efforts to deal with public health threats. Interesting legal reform efforts have, for example, taken place in at least one state trying to cope with threats of possible pandemic influenza and bio-terrorism.

In Chapter 11, Gostin does not focus on any specific public health threats facing the United States. In other writings, Gostin and colleagues made specific arguments and recommendations about public health law reform with respect to the problem of infectious diseases. Gostin was also involved in promoting model principles for health information privacy. It was easier to grasp those recommendations because they flowed from an analysis of specific, contemporary problems in American public health. But Gostin does not connect his general ideas on public health law reform to the concrete challenges confronting American public health today and in the foreseeable future. In other chapters, Gostin provided case studies of current public health problems to illustrate the application of general legal principles, rules, and precedents. Chapter 11 perhaps needed some application of the general law reform guidelines to actual public health problems.

For example, many experts believe that the general aging of the U.S. population will present public health challenges, the likes of which
American public health has not previously confronted. How should public health law be reformed, if at all, in the face of the public health concerns created by the aging of the population? Antimicrobial resistance is another growing crisis in American public health that relates to infectious diseases. How should Gostin’s law reform guidelines be applied to the problem of antimicrobial resistance, and what would be the scope and shape of the resulting legal reform?36

Another reason I yearned for some discussion of specific public health threats in Chapter 11 is that such discourse might have revealed Gostin’s priorities for public health law reform. As Part One demonstrated, public health law is a massive field. In Chapter 11, Gostin does not indicate whether he thinks public health law reform is needed more urgently in, say, infectious diseases than in environmental protection. Where should public health law reform realistically be targeted first? Is there one area of public health law (e.g., infectious diseases) that provides the most fertile opportunity to apply all or most of Gostin’s law reform guidelines?

Gostin’s approach to public health law reform does have the advantage of not being linked to specific public health problems that may not be perceived as urgent in five or ten years time. His general approach might not, therefore, become outdated, giving his ideas on public health law reform longevity and permanence. My concern is, however, that by not identifying specific public health problems and the lack of priorities for legal reform, Gostin’s arguments may lack immediacy and impact. Instead of supporting the normative goal of making public health law transcendent in American society and governance, Gostin’s approach in Chapter 11 may unintentionally invite further neglect.

My concern will be proved baseless if the readers of Public Health Law understand and then apply Gostin’s ideas on legal reform to specific areas that require attention. Previously, reform of public health law was a problem in search of principles. Gostin has now provided the principles with which to approach the problem both generally, and in connection with any specific public health threat facing the United States. Despite my concerns about Chapter 11, this is a seminal and noble achievement.

CONCLUSION

Public Health Law will quickly become the leading intellectual and practical guide to American public health law. In the United States, the study of law is populated by works of enduring significance whose authors became synonymous with a field of law: Corbin on Contracts, Prosser on Torts, etc. Now, both the public health and legal disciplines have Gostin on Public Health Law. Let neither my praise nor my criticism herein deflect
the readers of this *Journal* from appreciating the accomplishment and contribution Gostin’s book represents for all those interested in the future of public health in the United States.
References

1. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2000) [hereinafter PUBLIC HEALTH LAW]. Gostin has also produced a reader in public health, law, and ethics that is designed to be used with PUBLIC HEALTH LAW in schools of law, public health, medicine, health administration, and other fields. LAWRENCE O. GOSTIN, PUBLIC HEALTH, LAW, AND ETHICS: A READER (forthcoming 2002). The reader is not reviewed herein.

2. Memorandum from David P. Fidler to Daniel M. Fox, Milbank Memorial Fund, and Lynne Withey, University of California Press, providing comments on draft chapters of PUBLIC HEALTH LAW (May 19, 1999) (on file with author).


5. PUBLIC HEALTH LAW, supra note 1, at 309.

6. Id. at xvii.


8. The neglect of law by public health, and the neglect of public health by law, is also apparent at the international level. In the 1990s, the neglect of the relationship between international law and public health became the source of a growing body of scholarship, to which Gostin contributed. See LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC (1997).

9. PUBLIC HEALTH LAW, supra note 1, at 327.

10. Id. at 13.

11. Id. at 4. The subtitle of the book—Power, Duty, Restraint—summarizes the key attributes in Gostin’s definition of public health law.

12. Id.

13. Id. at 327.

14. Id. at xxi.

15. I identified only two moments in the book when the analysis drew in things international. The first involved a brief description of the controversies that arose around clinical trials in developing countries of anti-HIV drugs. Id. at 124. The second contained an even shorter mention of international law on quarantine matters. Id. at 206.

16. Id. at xviii.

17. In reading Public Health Law, I sensed Gostin’s desire to lay out the “concept” of public health law. I recalled the effort of the great English scholar of jurisprudence, H.L.A. Hart, to capture what he called the “concept of law.” H.L.A. HART, THE CONCEPT OF LAW (1961). In explaining the concept of law, Hart attempted to deal with international law because he apparently believed that he could not ignore this realm of law. Id. at
208-31. With Hart in mind, I wondered why Gostin chose not to include international law in his “concept of public health law.”

18. PUBLIC HEALTH LAW, supra note 1, at xxii.

19. In the Preface, Gostin explains this approach by stating that he “felt it important to develop a common understanding of the constitutional basis for the exercise of public health powers and the limits on those powers.” Id. at xxiii. Thus, Gostin “decided not to examine the rich constitutional history and structures at the state level, which are equally important to the field of public health but whose inclusion would have made the book too diverse and detailed.” Id.


23. See, for example, Gostin’s discussion of “The Synergy Between Human Rights and Public Health” in Chapter 4. PUBLIC HEALTH LAW, supra note 1, at 107-109.

24. Id. at xxii.

25. Id. at xx (stating that "My friend, the late Jonathan Mann, was particularly eloquent in urging the conclusion that public health and human rights are synergistic; preserving and promoting individual rights most often advances human well-being.").

26. Id. at 109.

27. Id. at 107.

28. Perhaps Chapters 9 and 10 could have been combined into a separate part focused on public health and the direct and indirect regulation of economic behavior. Whether this alternative structure would have really improved the book is very questionable because the substance of Gostin’s analysis in these chapters is excellent.

29. See GOSTIN & LAZZARINI, supra note 8.

30. PUBLIC HEALTH LAW, supra note 1, at 310 (“It is important to emphasize that no single model of law reform is likely to fit the entire spectrum of public health ranging from the regulation of food, drugs, and water supply to the workplace, environment, and infectious diseases. The proposed guidelines, therefore, represent general themes important to good governance of public health agencies engaged in a variety of public health activities.”).

31. Id. at 326.

32. Id. at 327.


36. Gostin discusses the problem of drug resistance in Chapter 8 and mentions...
possible policy options for addressing it—government incentives for, or regulation of, physician prescribing; government provision of compliance-enhancing services for vulnerable patients; compulsory measures to ensure antibiotics and antiretrovirals are not misused, ranging from civil commitment to the less restrictive approach of directly observed therapy. \textit{Public Health Law, supra} note 1, at 221-23.
Of Cloned Embryos, Humans, and Posthumans

Evelyne Shuster, Ph.D.*


Since Ian Wilmut’s report in Nature that he had cloned an adult sheep by transferring the nuclei of its somatic cells into an enucleated egg, two other announcements in Britain and the United States have renewed the debate on human embryo research and increased speculation about the prospect of human cloning. In the summer of 2000, a panel of scientists in Britain recommended that Parliament permit research on stem cells derived from human embryos created by somatic cell nuclear transfer, a technique used to produce “Dolly,” the cloned sheep. British scientists emphasized in their proposal that cloning techniques would be applied only to produce stem cells for treatment purposes (therapeutic cloning), and that under no circumstances would they contemplate approving somatic cell nuclear replacement to produce a child (reproductive cloning). Nonetheless, critics and the public fear that, in the absence of an enforceable global treaty to ban the practice, cloning techniques developed and perfected in Britain will inevitably be applied elsewhere to produce human clones.

A week after the British proposal, the U.S. National Institutes of Health (NIH) issued new guidelines to permit federally funded scientists to conduct research on human embryonic pluripotent stem cells, so long as these stem cells are derived by private parties from unused frozen embryos created for infertility treatment in private clinics (spare embryo research). The strong support of celebrities like Christopher Reeve and Michael J. Fox, as well as the millions of people and their families whose lives may be improved by stem cell research, may help assure that these regulations remain in effect during George W. Bush’s presidency. While people in the United States and abroad generally approve the creation and destruction of human embryos for stem cell research, there is virtually no

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support for creating children by cloning or for attempting to genetically engineer embryos to make “better babies.”

Reproductive cloning has raised near unanimous public condemnation and has spurred a flurry of laws and legislative proposals to outlaw cloning humans. Opponents have argued that reproductive cloning robs children of their right to personal identity and commodifies them by treating children as interchangeable, thereby devaluing human life and threatening human rights and dignity. Cloning proponents argue that reproductive cloning is no different from currently used methods of assisted reproduction, and that cloning would offer infertile couples just another way to have genetically related children, with the added bonus of almost absolute genetic control over their offspring.

The new proposals that favor research into therapeutic cloning to broaden our understanding of, and hopefully to find new treatments for, diseases have tamed the public outcry at doing research on a slippery slope that could lead to human reproductive cloning. But no responsible scientist or physician currently suggests attempting to help create a child by cloning because it is not safe. Questions of safety and efficiency are legitimate concerns and may eventually be answered, at least partially, by stem cell research. Once therapeutic cloning research begins, there may be no sufficient safeguards to prevent sliding down a slippery slope from therapeutic to reproductive cloning, and then to genetic engineering. The ethical issues surrounding human embryo research (including the ethics of human cloning) are thus even more relevant today than they were at Dolly’s birth in 1997.

Philosopher Paul Lauritzen, the editor of the series of essays that make up Cloning and the Future of Human Embryo Research, is on the right track in wanting to put Dolly’s birth in the context of embryo research. As Lauritzen explains in his introduction: “cloning is an outgrowth of IVF [in vitro fertilization] technology, and we are unlikely to formulate an adequate view of cloning unless we take this fact into account.” We thus need to see the birth of the cloned sheep, “as an intermediate step—perhaps the penultimate step—leading from the birth of the first IVF baby, Louise Brown, toward the birth of the first cloned human baby.”

Framing reproductive cloning within the realm of embryo research is defensible; but broadening the frame to place cloning within the realm of human reproduction is much more problematic. Nonetheless, Lauritzen takes human reproduction as the focal point of this work, following the lead of the 1994 report of the NIH Human Embryo Research Panel (HERP), and the President’s National Bioethics Advisory Commission (NBAC) Report on human cloning.
Lauritzen correctly notes that when NBAC decided to avoid the issues related to embryo research (to sidestep the pitfalls of abortion politics that mired HERP), it created two additional problems. First, it allowed NBAC to proceed as if the status of the preimplantation embryo, and thus of embryo research, had already been resolved, which is simply not the case. Second, it gave the impression that the cloning issues identified by NBAC were unrelated to the status of embryo. Thus, "[o]nce we recognize the continuity between cloning and human embryo research, we are also in a position to see that there are two obvious points of departure for this volume."

This selection of essays is a direct result of choosing an embryo/reproduction framework. The book is composed of three parts: Part 1, "Moral Status of the Preimplantation Embryo;" Part 2, "Debates Surrounding Cloning and Embryo Research;" and Part 3, "Public Policy Issues." There are three appendices reproducing the Executive Summaries of the HERP report and the NBAC report, including excerpts from Chapter 2 of the NBAC report entitled, "The Science and Application of Cloning." The fourteen contributors to the twelve chapters are drawn mainly from the field of philosophy and religion (only three authors are from the legal profession). To me this is most welcome in an era where philosophy and religion have ceased to strongly offer their critiques in terms of majesty and sanctity, respectively. Six of the fourteen contributors were either members of HERP, NBAC, or both, and for the most part, their chapters offer little new. Nonetheless, the chapters read as if they were written for the book, and the knitting together of ideas that intertwine them is a credit to the book's editor.

Specifically, the first four of the five chapters in Part I of the book are well argued and sufficiently open-ended for legitimate metaphysical discussion of the moral status of the embryo. These chapters provide excellent information, particularly with regard to the meaning of the phrase "respect for embryos."9 As Bonnie Steinbock accurately observes in the first chapter, "giving meaning to this concept of 'special respect' or 'serious moral consideration,' however, remains problematic."10 She takes the position that human embryos have interests rather than rights because they lack sentience, consciousness, or even simple awareness of any kind. Thus, she argues, neither embryos nor gametes are harmed, wronged, or deprived of anything by being used in research or destroyed. She nonetheless insists that respect for human embryos can still be a meaningful concept regardless of the way embryos are disposed of so long as they are used to generate worthwhile benefits for humankind.11 Steinbock adopts a version of utilitarian philosophy according to which the
right act is a function of the good it generates. The obvious difficulty is determining what counts as a good and what counts as a harm, and how to measure them to determine the right balance between the good of scientific progress and the harm society could incur in terms of less respect for human life by using embryos instrumentally.

Courtney Campbell responds to Steinbock in the book’s second chapter (Source or Resource? Human Embryo Research as an Ethics Issue). Campbell laments the pervasive influence of scientific reductionism that causes us to view embryos as consumer products like a box of Cheerios. He asks “whether the embryo is a source of life or a re-source of science.” Would it be too much to ask to show regret, anguish, or some form of verbal expression of how unfortunate it is to perform research on embryos? He believes that the moral consideration of respect for embryos as illustrated by HERP and Steinbock is “merely a political facade used to disguise and make publicly palatable scientific interests in having access to embryos for research.” But Campbell stops short of saying that if respect for human embryos is to have any meaning at all, destructive embryo research should not be done.

The third and fourth chapters, by Maura Ryan (Creating Embryos for Research: On Weighing Symbolic Costs) and James Keenan (Casuistry, Virtue, and the Slippery Slope: Major Problems with Producing Human Embryonic Life For Research Purposes) focus on whether there is any justification for creating human embryos for research. Keenan, for example, stresses that the way we view embryos determines how we use them. And thus, “our willingness to manipulate the embryo determines our understanding of the nature of the human embryo.” Rather than trying to settle the issue of the nature of embryos (on which people may never agree), we should speak about what it is that humans do when we produce human embryos for research. How does this affect the way we are as humans qua humans, and our human dignity? This is a fair question since, as Richard McCormick has observed, what we do to embryos we do to ourselves, and this affects who we are and the way we view each other as human beings.

The fifth chapter, by Alta Charo (Every Cell is Sacred: Logical Consequences of the Argument from Potential in the Age of Cloning), provides a bridge to the second part of this volume. She rightly points to the problems (if not the absurdity) that logically follow from the argument that we ought to respect embryos because of their potential to become human beings. This argument, she contends, would have us granting similar respect to sperm and eggs because both are necessary to produce embryos, and also to any somatic cell, each of which cloning techniques
can use to produce a human embryo (of course with a human egg).

The second part of the book includes three essays, two of which are authored by Dan Brock and Ronald Green, and are very supportive of human cloning. The other essay by Laurie Zoloth (Born Again: Faith and Yearning in the Cloning Controversy), is the strongest and most original in the collection. Zoloth, a Jewish scholar, properly labels cloning to produce a child “replication” rather than reproduction, and insightfully speculates that replication cloning is intriguing “because it offers an answer to the inevitability of alterity, estrangement, and death.” Zoloth argues that cloning represents the human desire for immortality, and points to our fear of death and our longing for eternal return even if this is only by way of genetic recycling. To her, cloning is neither about infertility (which can be more easily managed with other means), nor about children. Cloning is about self-absorption and narcissistic dreams (or nightmares).

Zoloth rightly maintains, for example, that “if cloning were about children, we would need to be thinking about the 100,000 children in foster care in America,” (and I would add, the ten million AIDS orphans in Africa) “and the way that race, illness, or oddity makes children unadoptable, untakeable.” Zoloth muses that genetic replication cloning is an answer to our deepest, “staggering mesmerizing panic at our own mortality,” and “reflects the deepest of yearnings: for redemption and resurrection into a better, purer, and transformed self, a self given a second chance at an embodied human journey.” This is why the “cloning controversy reaches so deeply into the popular imagination.” Her excellent essay makes for valued reflection that is likely to lead us to the heart of the human soul, desire, and human frailty, and to the fundamental question of why we contemplate human cloning. But because it is so ambitious, it seems out of place in this part of the book.

The third and final part of the book includes four essays on public policy issues, and illustrates the complexities and pitfalls at the intersection of ethics and public policy, as well as the difficulties of achieving consensus in bioethics. Carol Tauer, for example, points to “the current impasse in public policy and the impasse in moral debate on human embryo research, showing that the moral debate flounders because of different views as to where the burden of proof lies.” She properly asks: “Do those who defend embryo research have to show why it is morally justifiable, or do those who oppose it have to show why it is morally wrong?”

The last essay in the book, by Heidi Forster and Emily Ramsey (The Law Meets Reproductive Technology: The Prospect of Human Cloning), highlights the limits of legislative proposals on cloning in the United States and abroad. Regarding the United States, the authors raise the question of
whether there is a fundamental constitutional right to clone. In their
answer, they cite the argument that “opponents of human cloning assert
that cloning does not fall within our previously recognized constitutional
liberties because cloning is distinguishable from currently practiced
reproductive technologies.” In this view, they quote Steinbock with
approval: “cloning correlates with ‘replication’ not ‘reproduction,’ and is
not constitutionally protected.” The point should not be lost; if the
“opponents” are right, those who seek constitutional protection for
cloning as just another method of reproduction will be disappointed, just
as those bioethicists who recently sought constitutional protection for
physician-assisted suicide as a form of autonomy were disappointed.

This category point, i.e., cloning is genetic replication, not human
reproduction, also made by Zoloth, is at the heart of the cloning debate,
and has not been resolved. Ignoring or marginalizing it does not resolve or
even move the debate along. If raised at the outset of the book, rather than
at the end of the book, this category controversy would have had the
potential to shatter the entire book’s framework. It would have rendered
irrelevant the familiar landmarks of embryo research and human
reproduction (exemplified by the HERP and NBAC reports) that bear the
stamp of time, geography, and culture, and with which we have become
accustomed to seeing cloning’s supporters use to try to tame the creative
and wild profusion of ideas about cloning.

If cloning is not reproduction, then it represents a discontinuity with
current reproductive techniques, and thus there can be no similarities
between them: they are different in kind rather than degree. I think this
view is correct, and that the cleavage between cloning and reproduction
makes the concept of reproductive cloning itself an oxymoron.
Reproduction is sexual; cloning is asexual and produces a child without
the genetic input of two members of the opposite sex. Asexual cloning is
genetic replication because the child so conceived has only a copy of an
already existing genome that has been replicated. Of course we can try to
make genetic relationships “fit” into our current mold, but it is not easy. In
asexual genetic replication, the clone child will be the twin sister or
brother of his or her genetic “original.” But the genetic original will also
fill the social role of parent. But this is neither an unproblematic twin
relationship nor an unproblematic parent-child relationship. Unlike
“natural” identical twins, created by sexual reproduction, the cloned child
is a “delayed twin,” born after (usually long after) the birth of her genetic
twin original. This “delayed twin” condition is unique to cloning, and
creates intractable problems of filiation.

The central ethical issue is not the status of the human embryo created
by the Dolly technique, but the liberty of the resulting child. In delayed
genetic replication, the child must be compared to his or her “original,”
almost necessarily in a lopsided fashion. Vital restraints are likely to be
imposed on that child to follow in the wake of its genetic original, or to
avoid the “mistakes” made by the original. As Hans Jonas insightfully
argued more than twenty-five years ago, genetic replication robs the
resulting child of his or her right to an open future, a crime Jonas believed
should not be committed even once. Of course, genes do not exclusively
determine who we are. Environment matters mightily. But this statement
does not change the intent or content of cloning, which must exclusively
be to make a genetic duplicate. That is all cloning is, and that is all cloning
can do. The prevailing international view is that creating a genetic replica
of an existing person is degrading to children by limiting their liberty and
thereby violating fundamental principles of human rights and human
dignity.

Moreover, far from being a treatment for infertility (as Green argues),
cloning abolishes the very concept of infertility itself. This is because in
asexual replication it would no longer matter for the purposes of having a
genetically related child whether the would-be parents are gametically
fertile or not. Each of our somatic cells can be used for replication cloning,
and thus everyone is able to self-replicate (assuming eggs are available and
women are willing to gestate the resulting embryos). If replication cloning
is equated with reproduction, to speak of cloning as treatment for
infertility is meaningless.

The unique characteristic of cloning demonstrates that it introduces a
fundamental difference in producing a child. One cannot simply assume
continuity between cloning and other methods of assisted reproduction.
The difference in kind in producing a child by cloning requires an analysis
of the threshold above which there are differences, and below which there
are similarities. Such analysis is indispensable for the establishment of even
the simple form of ordering such as the one adopted in this volume.
Failure to recognize this, is the book’s most substantive weakness.

I recently read a piece by New York Times columnist, George Johnson
that caused me profound uneasiness and prompted me to reflect on how a
culture experiences the proximity of things, establishes support of things
we apprehend in one great leap, and determines the order by which these
things must be considered. In this piece, Johnson shows how “it has
become natural to think of [the Internet] biologically” and quotes
scientists who say they have found a universal law, “a power law,” that
supports a number of listed things ranging from cells to the Internet. Included in this list are: (1) a flourishing ecosystem of computers, (2) a
sprawling brain of Pentium-powered neurons, (3) the networks of molecules in a cell, (4) the networks of species in an ecosystem, (5) the networks of people in a social group, (6) the Internet, and (7) the metabolic networks of life-sustaining chemical reactions inside cells. Johnson thus asks: How does this kind of ordering arise? In what kind of structure do these seemingly diverse categories exist?

French philosopher Michel Foucault raises similar questions in his book, *The Order of Things*, when he asks: What do we do when we classify? What is the ground for establishing the validity of classification? On what support and according to what grid of identities, similarities, and analogies have we become accustomed to sort out so many different and similar things? Foucault observes (in the context of a simple kind of enumeration) that while each of the things listed can be assigned a precise meaning and a demonstrable content, there is a “monstrous quality” in the enumeration that destroys the common ground on which the meeting of each of these things is possible. In his words: “Absurdity destroys the and of the enumeration by making impossible the in where the things enumerated would be divided up.”

The category into which we “fit” human cloning constitutes the common ground that links similar and different things, and each thing to all the others. If, for example, we add cloning to the list of assisted reproductive technologies, which includes *in vitro* fertilization, artificial insemination, embryo splitting, embryo manipulation, infertility, etc., then cloning will take on the quality of the things enumerated in that category. Likewise, if we add cloning to the list of species alteration, which includes asexual replication, egg manipulation, germline modification, etc., then cloning will take on a much more sinister aspect.

“Fitting” cloning into the species alteration category is consistent with what Ian Wilmut himself has said about his project to improve animals in the context of animal cloning:

> We do not seek simply to clone animal—to produce facsimiles of existing creatures. This was never our agenda; it is just what other people thought was important. *Cloning for us is and always has been an exercise in science finding out how cells work and a technology that enables the genetic transformation of animals.*

As Wilmut explains, somatic cell nuclear transfer was not even invented for genetic replication but rather primarily to be used for germline genetic modification to “improve” or “genetically enhance” embryos that would produce animals with altogether new characteristics (like the ability to produce specific proteins useful in the production of...
human drugs). This category point makes the possible application of somatic cell nuclear transfer cloning to humans much more troublesome. It is fair to say that it would have made for a much more up-to-date book had a discussion of human genetic enhancement through embryo manipulation been included.

The pairing of somatic cell nuclear transfer cloning and genetic enhancement is powerful because it makes genetic replication (of embryos) a means to the end of genetic transformation of the human species. Genetic engineering through new or improved genes that can be added to somatic cells (later used as the nuclei of embryos) to produce “smarter” people, people with enhanced memory, and people resistant to diseases and environmental insult, may be much more appealing to most people than simple genetic replication. And if we want to try to stop the eugenic project of genetically enhancing embryos to improve the “quality” of our children, to the extent that human cloning techniques are necessary to make genetic enhancement efficient, outlawing human replication cloning will effectively outlaw human genetic enhancement as well.

We must think globally and at the species level about proposed interventions that threaten to change the inherent characteristics of what it means to be human. For this we need a mechanism to protect the integrity of the human species, and a way to shift the burden of proof to those who would change it, rather than to those who would protect it. But American bioethicists are ill-equipped to provide a valuable contribution because of their almost exclusive focus on the patient-physician relationship. This focus gives American bioethicists a lot to say about reproductive treatment for individuals and couples, but almost nothing to say about species integrity or alteration. The lack of any species-level debate or global vision is reflected in this book, and means that this selection of essays can provide only a limited introduction to human cloning, and even less about the more challenging question of human species alteration by genetic manipulation of which human cloning is the harbinger.
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11. Id. at 30.


13. Id. at 40.


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18. Id. at 134.

19. Id. at 133.

20. Id. at 134.


22. Id.


24. Id. at 216.


28. Id. at xvii.


30. Id.