Welcome to the bioethics issue of Health Policy & News for Students. As Director, Co-director, and Director of Programs for the Columbia University Center for Bioethics, we are happy to support this unique issue of Health P&S as a means to alert and encourage you to take advantage of the many opportunities for involvement in the field of bioethics as part of your P & S education. The Center for Bioethics’ mission is to provide an interdisciplinary, inter-professional, and inter-campus forum to advance both scholarly work on and public understanding of contemporary issues.

The interface between science and ethics is a notoriously gray area where intended and unintended consequences surface, and unique and unexpected outcomes emerge. Given the rapid and unrelenting advances in biotechnology and medicine, it is imperative to consider their ethical, legal, social, and policy implications. Examples of ethical perplexities confronting us include: Do parents have the right to authorize the use of their baby for the treatment of other family members? Should pharmacists be allowed to refuse to fill prescriptions for the morning after pill? Finally, with our ability to create transgenic animals (e.g., goats encoded with the spider gene that produces silk in their milk), should we...
continue to create new species before we know and understand the interactions between the transgenic animals and other species? Is there a boundary across which responsible researchers should not cross? These are but a few of the sensational yet troubling innovations lurking to confront us.

The Center explores and explicates these often perplexing issues by promoting research, offering educational programs, and providing service to our diverse communities. We offer monthly seminars and other opportunities for the Columbia community and beyond. Our Ethics for Lunch series, supported by a generous grant from the Gold Foundation, is offered three times a year and provides lunch and lively discussion of challenging clinical cases confronted by the New York-Presbyterian Hospital Ethics Committee. We also offer a Bioethics Elective for Fourth Year students (PSN08P). Along with an eclectic faculty from varied backgrounds, we grapple with the most compelling topics in the field including reproductive technologies, end-of-life and transplantation issues, patient autonomy, stem cells and cloning, genetics, racial disparities in illness and health care, and clinical trials and pharmaceutical promotion. Two of the articles in this issue are products from this year’s talented group of students. A Sugar Pill for Your Headache, by Amy Cram, discusses the ethics of using a placebo as an intervention. And in the Dangers of Preconception Sex Selection, Divya K. Shah pits the principle of procreative liberty against the resulting negative externalities for the child-to-be, family unit, and broader society. This class is a great way for students to become immersed in the most contentious issues confronting physicians and society.

We are celebrating the 3rd anniversary of the Center for Bioethics May 20, 2005, with a presentation on Neuroscience, National Security, and Human Research Ethics featuring one of the nation’s outstanding bioethicists, Jonathan Moreno, PhD, who directs the Center for Biomedical Ethics at the University of Virginia. All are welcome to attend this event. Contact Scott Reiners at sjr2118@columbia.edu to register. For more information about our events, visit our Web site at www.bioethicscolumbia.org.

Bioethicists urge us to consider the implications of our burgeoning technology and to keep in mind the bioethical mantra — it is not what you can do, rather, it is what you should do.

This is one of the most exciting times to be in medicine. We at the Center for Bioethics feel privileged to be able to share these times with you, the future leaders of medicine and research.

Ruth L. Fischbach, PhD, MPE,  
Director of the Center for Bioethics  
Robert L. Klitzman, MD, Co-director  
Joyce Plaza, MS, MBe, Director of  
Programs and Development
“We will have to repent in this generation not merely for the hateful words and actions of the bad people but for the appalling silence of the good people.”
Dr. Martin Luther King, Jr., From "Letter from Birmingham Jail," April 16, 1963

When we think of medical ethics, what comes to mind? For me, it is often complicated medical issues that apply to relatively few individuals – organ transplantation policy, stem cell research, and end-of-life issues for people in vegetative states. The people involved in debates are often part of relatively privileged sub-groups; members of societies with the luxury of time, energy, and resources to ponder the most essential issues surrounding life, death, and medical care. Nuanced discussions ensue, often rife with controversy, involving religion, philosophy, the most sophisticated medical technology, and the latest scientific discoveries. In a world where advances in medical care often outpace the laws and health systems that govern and administer them, such careful thought is essential. And as technological capabilities give us increasing control over the course of our lives, it is important that we take the time to reconnect with the organic and often chaotic nature of our humanity. However, often missing from the dominant ethics discourse are issues related to basic human rights and social justice. While the literature of bioethics contains much discussion of these issues, they are not as political or “newsy” and thus do not receive much popular press or public debate.

Maybe it is because issues of basic human rights and social justice are not seen as controversial, the way stem cell research and prenatal screening are for so many people. After all, there is little controversy over whether all people should receive adequate food, water, and medical care. Genocide is clearly unethical. Human rights debates tend to involve more the practical political and economic concerns around how to address the problems. However, upon closer inspection, it becomes clear that health as a basic human right is not taken for granted in the United States. In fact, the United States was the only country to vote against a recent United Nations Human Rights Commission resolution declaring health and health care as a fundamental human right.

Health as a basic human right is not taken for granted in the United States. In fact, the United States was the only country to vote against a recent United Nations Human Rights Commission resolution declaring health and health care as a fundamental human right.

According to U. N. representative David Hohman, “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health” is “not an immediate entitlement to a citizen.” Who is countering this opinion in the United States?

continued on following page
It seems that physicians should be at the fore of this debate. As physicians, are we not ethically bound to grapple with the issues most essential to health, quality of life, and human suffering? Given the versatile skill set and uniquely keen perspective that our training provides, should we not be primary advocates for people with grave concerns related to inequality, health, and abuse? Must our profession limit us to the subtleties of medical therapy and complexities of biotechnology?

I argue that it is time for physicians to take a more prominent voice in addressing the difficult human rights concerns of our time. I am not advocating for an abandonment of the more “traditional” medical ethical issues, but for a broadening of the framework with which we approach ethical debates. Physicians should seek to address the health needs and concerns of all people, including disadvantaged individuals both in the United States and around the globe. I offer as an example the human rights abuses of juveniles involved in the criminal justice system within the United States.

The juvenile justice system began in the United States with the Illinois Juvenile Court Act of 1899, which created a system for dealing with criminally-involved youths separate from the adult criminal courts. Such laws soon spread through all 50 states, creating a national juvenile justice system. Though the system was extremely fragmented from its inception, it was universally based in civil rather than criminal courts, and was mandated to “care for” and rehabilitate troubled youths. It was never intended to be a system of punishment. Although most state laws and administrative structures still maintain an intention to serve the best interests of court-involved youths, the current system is grossly inadequate in fulfilling its original mandate of care and rehabilitation. Instead, many youths—and especially those with prior mental health concerns—rapidly deteriorate in juvenile facilities. As a result, the juvenile justice system violates the human rights of young people, and fails society by releasing mentally disturbed and un-rehabilitated adults, who are likely to commit further and more serious crimes. The specific problems with the system are complex and multi-fold. In fact, I am dubious to refer to the state-by-state array of juvenile courts, holding facilities, and detention centers as a single juvenile justice “system.” However, three broad areas of critique are almost ubiquitous: the inadequacy of mental health care in the juvenile justice system, the transfer of youths to the adult criminal justice system, and the over-representation of Black and Hispanic youths in the juvenile justice system. While all three concerns lead to serious abuse and inequality, the scope of this article only allows me to focus on mental health services within juvenile facilities.

Late last year, a number of stories about suicides and suicide attempts among minors involved in New Jersey’s juvenile correction holding facilities hit the news. On March 1 of this year, the New York Times reported on abuses and neglect in the juvenile justice system in the city. Of the 500 or so 7-to-16-year-olds held in juvenile facilities on any given day in New York City, some have committed serious crimes, while others have simply been turned away by their families and have nowhere else to go; almost all of them have some sort of diagnosable mental disorder. Prison Health, the lucrative company charged with overseeing health care in New York City’s criminal justice system, employs only one doctor to oversee health care for the 5,000 or so youths who pass through the system each year. His staff of part-time nurses and social workers is unable to handle the overwhelming health care needs of court-involved youths. As a result, mentally disturbed youths go unmonitored, warning signs are missed or ignored, necessary care is not given, and young people suffer.

According to the Surgeon General, between 50% and 75% of children and adolescents in the juvenile justice system have at least one mental health disorder.
Such stories brought attention in the tri-state area to problems related to the paucity of basic mental health services in juvenile facilities. Across the nation, hundreds of thousands of youths are “warehoused” in dangerous and overcrowded detention centers every year. The conditions in these facilities lead to violence and social stress, escalating the mental illnesses with which many youths enter. According to the Surgeon General, between 50% and 75% of children and adolescents in the juvenile justice system have at least one mental health disorder, but the facilities rarely have the resources to adequately assess, monitor, and treat these youths. As a result, around 2,000 youths are injured and almost 1,000 youths commit suicidal acts each month, according to Physicians for Human Rights.

Juvenile facilities are generally split into two types: pre-adjudication and post-adjudication facilities. Pre-adjudication facilities – the type most recently cited in the New Jersey scandals – range from small to large facilities where court-involved youths await their hearings. Conditions in these facilities are notorious, and are especially dangerous for young people with mental health concerns. There are currently few resources in these facilities to assess and treat youths for mental disorders, putting thousands at risk of injury or death. Post-adjudication confinement facilities are where young people go after they are sentenced. These facilities vary widely. Some youth-only facilities provide psychiatric care, educational programs, and emphasize rehabilitation. Others mix adults and youths, and focus on punishment. Both because they mix adults with children and because they emphasize punitive concerns over rehabilitation, these confinement facilities are particularly damaging to youths.

Girls in the system are particularly vulnerable, and the number of girls entering the system has been increasing dramatically in recent years. Research shows that 92% of girls entering the juvenile justice system have been subject to one or more forms of emotional, sexual, or physical abuse. Forty percent of these young women have been raped. This prior trauma would clearly create grave psychological needs that should be addressed immediately upon entry into any facility. However, youths are often left to deteriorate once they enter the system. On March 1, 2005, the New York Times told the story of one young woman neglected by the city’s system. Tiffany was removed from her parents’ home at a young age, due to their drug abuse. She was sent to her grandparents’, but eventually ran away after her brother was sexually abused there. She was beaten on the streets, and soon began to hear voices. After a minor non-violent offense at the age of 13, she was placed under the control of the juvenile justice system. But first, she was sent to a psychiatric hospital where she was diagnosed with bipolar disorder and put on strong medications. After her hallucinations subsided, she was sent to a juvenile holding facility where she was re-evaluated by the Prison Health doctor. He concluded that she was only hyperactive, and switched her to cheaper medications. Her hallucinations returned and she felt constantly frightened, but the prison staff rarely checked on her. Eventually, after she threatened to kill herself, she was sent back to the psychiatric hospital and placed on the previous strong medications.

Stories like Tiffany’s exist throughout the nation’s juvenile justice system. It is clear that the system is failing our youths. The solutions to the problems, however, are less clear. With only about 6,300 child and adolescent psychiatrists in the entire United States, it would be impossible to provide adequately trained health professionals in every juvenile facility in the country. Instead, it is necessary to create systems through which youths can be evaluated, monitored, and treated and to employ well-trained staff to carry out these tasks.

continued on page 10
"Joshua Inman is a 47-year-old man who has been complaining of chronic back pain for more than six months. He has had physical therapy, chiropractic manipulations, acupuncture, and a range of narcotic and anti-inflammatory treatments. Dr. Walters has had success in similar cases earlier in her career using a combination of a placebo and powerful suggestion. Dr. Walters tells him that she now feels it is time to treat his problem more aggressively. As she prepares an injection of vitamin B12, she tells him: “There is a new and powerful medication that has recently been approved for cases like this. We don’t like to use it early in the treatment because it is very powerful and supplies are limited.”

Dr. Walters supplements the shot by providing him with a bottle of anti-inflammatories, which, she informs him, are the same medicine in pill form. Upon his return, Mr. Inman says that his back is better for the first time in months (1)."

I would hope that most in the medical community would find Dr. Walters’ “powerful suggestion” to be unsettling if not unethical. But is there something we could learn from her use of a placebo to treat her patient’s pain that, until this time, had been unresponsive to a whole range of therapeutic interventions? What if your doctor offered you pain medication with no known side effects?

Here is another possible scenario: You are an orthopedic surgeon and are referred a patient, Mr. Inman. Mr. Inman is a 68 year-old retired teacher with osteoarthritis of the left knee. Over the past few years his pain has increased to the point where it interferes with his quality of life. Your friend, his PMD, has already tried him on anti-inflammatories but medical therapy has failed him. He currently complains of not being able to play with his grandchildren secondary to increasing pain. He is referred to you to discuss surgical options. You offer him three choices which have been shown in randomized controlled studies to be equally effective in decreasing pain per patient report (2). Two involve general anesthesia and intubation, the other sedation and analgesia in which the patient breathes spontaneously. Now what if the one involving sedation, but not general anesthesia, is “placebo surgery” in which incisions are made and the patient is made to think he has had orthopedic surgery when he hasn’t?

The placebo effect is thought of as any effect that seems to be the consequence of an inert treatment. A broader definition proposed by Kaptchuk suggests the placebo effect represents “not only the narrow effect of a dummy intervention but also the broad array of nonspecific effects in the patient-physician relationship, including attention; compassionate care; and the modulation of expectations, anxiety, self-awareness” (3). Whichever definition you subscribe to, it involves a “dummy intervention’s” effect on the patient.

It first gained widespread attention in Beecher’s 1955 article “The Powerful Placebo” which concluded: “It is evident that placebos have a high degree of therapeutic effectiveness in treating subjective responses, decided improvement, interpreted under the unknowns technique as a real therapeutic effect, being produced in 35.2+/-2.2% of cases” (4). Since the publication of his article, it has been generally accepted by the medical community that placebos may relieve symptoms and improve quality of life.

So if we are to accept that there is a placebo effect, then what are the ethical issues involved in the placebo as medical or surgical treatment? What are our obligations to our patients? When is it ethical to use a placebo intervention? According to University of Washington Professor Clarence Braddock III, “In general, the deceptive use of placebos is not ethically justifiable. Specific exceptions should be rare and only considered if the following conditions are present: the condition is known to have a high placebo response rate, the alternatives are ineffective and/or risky, the patient has a strong need for some prescription” (7).

Once you have decided your patient would benefit from the placebo and has fulfilled the criteria above the question is: what do we tell our patients about the placebo? We are taught the basic tenants of bioethics are beneficence, non-maleficence, autonomy, and justice. In the case of Dr. Walters and her patient, Mr. Inman, does beneficence (treating his pain) trump autonomy (his right to make an informed decision about his own treatment)? I don’t believe it is ever ethical to deceive a patient—not only does it undermine a patient’s autonomy but if revealed, it threatens, if not destroys, the patient-doctor relationship and society’s relationship and view of the medical field. continued on page 10
In 1902, John Beard of the University of Jena declared, “any interference with or alteration of the determination of sex is absolutely beyond human power.” Only seventy years later, a variety of preconception, preimplantation, and prenatal techniques enable parents to determine their child’s gender at an early developmental stage.

Preimplantation genetic diagnosis (PGD) was developed in the early 1990s in order to screen embryos for X-linked genetic disease, but its use has been extended to include screening for chromosomal aneuploidy, detection of mono- genetic diseases, and nonmedical gender selection. The procedure begins with ovarian hyperstimulation, followed by in vitro fertilization (IVF). The fertilized embryos are biopsied, and only embryos with the desired genotype are transferred back into the mother’s uterus. The procedure is available at over 50 centers worldwide, but is costly – approximately $3000 for PGD and upwards of $20,000 for the requisite IVF cycles. Since validity of PGD in screening for embryos with congenital or X-linked genetic disorders is rarely questioned, the ethical dilemma in the United States primarily concerns its use for ‘nonmedical’ purposes.

Many arguments for permitting preconception sex selection center around satisfying the desire of couples who have strong preferences regarding the gender of their offspring. These preferences may stem from a desire to raise a child of the culturally preferred gender, to parent a child of one’s own gender, or to achieve gender balance in a family. Ironically, few policy makers argue openly in favor of sex selection on the basis of parental preference. Instead, they reach for the principle of procreative liberty, arguing that unless substantial harm to others results from a reproductive practice, couples should be able to act on their preferences for children of a particular gender. In a 2001 report from the Ethics committee of the American Society of Reproductive Medicine (ASRM), chairman John Robertson supports this view, “if methods of preconception gender selection are found to be safe and effective, there would be no compelling reason to ban or restrict their nonmedical use.”

The public outcry that followed the ASRM’s initial acceptance of preconception sex selection for family balancing illustrates the ferocity of the ethical debate. While the arguments against sex selection are varied, they can essentially be divided into those that inherently oppose the concept of parental control over the sex of one’s offspring and those that warn against the potential individual, familial, and societal consequences should this control be permitted.

The argument that preconception gender selection represents an inappropriate level of control over non-essential characteristics of children is rooted in the philosophical conception of procreation and parenting. The President’s Council on Bioethics maintains that sex selection “treats the child as an artifact and the reproductive process as a chance to design and produce human beings according to parental standards of excellence.” Proponents argue that preconception sex selection places excessive concern on minor genetic characteristics rather than the inherent, worth of one’s offspring. While many find this argument instinctually compelling, its intersection with morality and religion make it difficult to apply in a broad secular context. In the public sphere, far stronger arguments against sex selection are based on the consequences to the individual, the family unit, and the broader society.

Arguments against gender selection can be well contextualized - to borrow the language of economists - in terms of the ‘negative externalities’ that they impose. An externality is defined as any effect, positive or negative, on a third party to a transaction. The question of whether sex selection is included among the ‘procreative liberties’ that are enjoyed in the United States is perhaps best addressed in these terms. continued on page 11
Terri Schiavo’s family focused the nation on the ethics of medical decision-making in patients unable to make decisions for themselves. Some even suggested encouraging Americans as young as 16 to write advance directives—when they earn driver’s licenses.

The issue of when advance directives should be created brings us to another group of patients unable to make decisions for themselves: children and infants. Pediatric patients rely on adults—parents, physicians, social workers, judges—to make their medical decisions. And these patients can provide no clues from past statements to guide their proxies, making the decisions even more ethically complex.

Nationwide, public discourse about the ethics of limiting medical treatment in children began in 1982 with the “Baby Doe” case. “Baby Doe” was born with Down’s syndrome and a tracho-esophageal fistula, which would prove fatal if not surgically corrected. His parents and his obstetrician decided to withhold treatment. A judge agreed that his parents had the right to make this decision.

The federal government, then under the Reagan administration, immediately stepped in to argue that withholding treatment constituted discrimination against handicapped infants. However, the Supreme Court disagreed. Since doctors cannot treat infants without the consent of parents, the Court ruled, parents retained the right to withhold treatment.

In 1984, Congress reframed the issue from one of discrimination against the infant to one of medical neglect. They added language to the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978 (CAPTA) that frames the withholding of medically-indicated care from handicapped infants as illegal neglect. The law includes exceptions, in which withholding of care is acceptable if the child is irreversibly comatose or if “treatment would (i) merely prolong dying; (ii) not be effective in ameliorating or correcting all of the infant’s life-threatening conditions; or (iii) otherwise be futile in terms of the survival of the infant.”

Interestingly, this law applies only to infants under the age of one year. Parents have much greater leeway in making medical decisions—including to withhold treatment—for children older than one year. This “loophole” seems to be intended to allow parents more control over their child’s healthcare after they have spent at least one year developing parent-child bonds. It implicitly encourages parents to appreciate the “sanctity of life” per se before bringing “quality of life” concerns into treatment decisions.

New York has more explicit laws than many states about who can make medical decisions for children. In New York, parents are allowed to establish advance directives for their children. New York Do-Not-Resuscitate (DNR) laws also allow, in certain cases of “medical futility,” for physicians to make a patient DNR in spite of a family wishing otherwise.

In addition to these legal limitations, the American Academy of Pediatrics (AAP) has published ethical recommendations about medical decision-making for children. They encourage physicians to discuss the risks and benefits of each option with parents and to provide recommendations about what they believe are the best options for the patient at hand. They do advise physicians, however, that the family should make the final decisions. The AAP also specifically discourages defining a child’s “quality of life” by their potential “social worth;” they instead encourage judgments about quality of life to focus on the experience of life as viewed by the patient, the child in question.

Unlike in adult populations, discussions about treatment preferences and limitations need not be initiated with all families. But they are appropriate—and important—in families with seriously ill or impaired children.
Want more bioethics? The following is a short list of some reliable and reputable bioethics related Web sites. Although not a comprehensive list, these are great resources for bioethics information.

**bioethics.net:** The Web site for the American Journal of Bioethics (AJOB) provides featured articles from AJOB; a Bioethics Portal including sections for Bioterrorism, Cloning, Bioethics Jobs, Upcoming Events related to bioethics, and bioethics related news items.

**blog.bioethics.net:** A bioethics blog from the editors of the American Journal of Bioethics.

**bioethicscolumbia.org:** Columbia University Center for Bioethics Web site. Contains information on Center’s mission, faculty, projects, activities and events, as well as links to other resources in bioethics. Has a useful Calendar that includes bioethics events in the New York region.

**georgetown.edu/research/nrcbl:** National Reference Center for Bioethics Literature at the Kennedy Institute of Ethics, Georgetown University. Provides the ETHX database, the Genetics and Ethics database, helpful bibliographies called Bioethics QuickBibs, (found at georgetown.edu/research/nrcbl/quickbib.htm). Check out their publications and their contact information found at www.georgetown.edu/research/nrcbl/publications.

**Pubmed.gov:** Limit by the “Bioethics Subset” to restrict your search to bioethics articles and publications.

**nih.gov/sigs/bioethics:** Bioethics Resources on the Web-National Institutes of Health.

**asbh.org:** The American Society for Bioethics and Humanities (ASBH) is a professional society of more than 1,500 individuals, organizations, and institutions interested in bioethics and humanities. This site is a source of information for members, prospective members and anyone interested in bioethics and humanities.

**bioethics.union.edu:** Online MA program sponsored by Albany Medical College and Union College.

**mcw.edu/bioethics:** Medical College of Wisconsin. The Master of Arts in Bioethics can be completed through either a traditional, campus-based curriculum or through an innovative web-based curriculum. The Center also offers a dual degree programs in medicine and bioethics and a dual degree program in law and bioethics. The Certificate Program in Clinical Bioethics, which provides a basic introduction to the philosophical, legal, and clinical foundations of health care ethics, is designed to enhance the clinical practice of health care professionals or to provide a foundation for further study.

Interested in pursuing graduate studies in bioethics? Note that the Resources link on the ASBH website contains information on Academic Centers and Programs (asbh.org/resources/links/academic.htm) and Bioethics and Humanities Education links (asbh.org/resources/links/bioethics.htm).

It is also possible to get a degree in bioethics completely online:

**bioethics.lumc.edu:** Online MA Program in Bioethics & Health Policy from Loyola University Chicago Stritch School of Medicine.

**bioethics.union.edu:** Online MA program sponsored by Albany Medical College and Union College.

This program is available entirely online but has optional on-campus, short course components. It is operated by the Neiswanger Institute for Bioethics & Health Policy at Loyola’s Stritch School of Medicine but also features faculty from other departments of the university. This website also contains resources related to the teaching of professionalism and cultural competence, and ethical issues related to disability.

(Prof Plaza, Director of Programs and Development for the Columbia University Center for Bioethics has a Master of Science degree in Library and Information Science and a Master of Bioethics degree. You can contact her at jp2199@columbia.edu)
Juvenile Justice, From Page 5

A report released on October of 2001 by the American Academy of Child and Adolescent Psychiatry Task Force on Juvenile Justice Reform found that a strikingly low proportion of juvenile facility staff are knowledgeable about child and adolescent health issues, and that there is no unified national system to assess and accredit juvenile facilities. In addition, too many facilities focus on punishment over rehabilitation. Health professionals can use their credibility and knowledge base to speak out against the unnecessary suffering and health damage taking place within the juvenile justice system. Physicians can advocate for adequate mental health care in juvenile facilities, and for the expansion of programs to shift the focus of the juvenile justice system back toward rehabilitation, education, and health.

In March of this year, the Supreme Court struck down the death penalty for juveniles. Citing the 8th amendment to the U. S. Constitution, which bars cruel and unusual punishment, this decision was a triumph for the human rights of court-involved youths. Prior to this decision, the United States led the world in the juvenile death penalty, executing more youths than the rest of the world combined. Texas alone accounted for more than half of these executions. The juvenile death penalty was banned under the international covenant on civil and political rights (ICCPR), a treaty to which the U. S. was party but repeatedly violated. Now, only Iran and the Congo continue to allow the juvenile death penalty. The success of the campaign to end the juvenile death penalty in the United States depended largely on the voices and support of many physicians. Many experts in child development argued that differences in cognitive and brain development make children and adolescents more impulsive and less culpable for their actions. The Nobel Peace Prize-winning organization, Physicians for Human Rights, put forth the Health Professionals’ Call to Abolish the Execution of Juvenile Offenders in the United States. It was endorsed by over 400 health professionals and experts, including former U. S. Surgeon Generals C. Everett Koop, David Satcher, and Julius Richmond. The juvenile death penalty offers an example of how physicians can be effective and powerful advocates for human rights concerns in the United States. However, the way in which we handle youthful offenders in this country is still tainted by gross injustices and human rights violations. While youths who commit crimes and harm society must face the consequences of their actions, we must hold human rights and potential rehabilitation as top priorities. It is part of the essential tenants of the healing profession to advocate for the health needs of the most vulnerable members of our population, and our ethical discussions should thus more readily incorporate issues related to human rights, social justice, and health.

If people were to think that deception and maltreatment were common, there would be no trust of health care professionals just as we still see mistrust of the health care system by minorities from their past experiences with it (eg. Tuskegee, etc.). If it is ever acceptable to tell a patient a placebo is anything more than it is, an inert substance, what should be said? I propose disclosure. But just as we don’t tell a patient about to start a medication, “Motrin has been shown to be 50% effective in relieving headaches,” we don’t need to tell our patients response rates. A provider could say something to the effect of: “Studies have shown that patients find this treatment effective in relieving pain although there is no known physiologic effect. I will follow up with you in a few weeks and see how you are doing.”

That being said, it has been found that physicians who are enthusiastic and optimistic toward the drug or placebo have been found to be more effective (3). Another study found that a strong endorsement of a drug substantially reduced the patients’ self-reported pain as compared to a weak endorsement (8). A doctor like Dr. Walters may get such good results from shots of vitamin B and sugar pills in part because she uses such enthusiastic language.

A less significant placebo response may be the sacrifice necessary to preserve patient autonomy and avoid deceiving a patient and risking the patient-doctor relationship. Or is there another solution? If patients respond to a physician’s attitude towards their condition and treatment as in the studies above, are words enough? Moerman and Jonas suggest just this in their paper. “Placebos are inert. You can’t do anything about them. For human beings, meaning is everything that placebos are not, richly alive and powerful.…. We constantly have to address the moral and ethical issues of prescribing inert treatments, of lying and the like.” It seems possible to evade the entire issue by simply avoiding placebos… eliciting the meaning response requires remarkably little effort (You will be fine, Mr. Smith”). So why doesn’t this happen all the time? And why can’t you do it yourself? (8).

Indeed, why can’t we?

sex selection from page 7

While American society deeply cherishes individual liberty, it is not without limit – our personal liberties are inherently restricted by the negative externalities that we impose on other individuals. This line of reasoning naturally begs the question – what negative externalities are imposed by sex selection and on whom are they imposed? The obvious and perhaps consequential externalities are those that impact the society as a whole: the reinforcement of societal gender bias and the potential for creating imbalance in the sex ratio.

Preconception gender selection promotes sexism by reinforcing the current societal gender bias. This can occur by allowing more children of one gender to be produced or by identifying gender as a reason to value one child over another. Altering the sex ratio between the two genders has serious consequences. The standard sex ratio is 105 boys born for every 100 girls. To give a global context, note the following examples of imbalanced sex ratios (number of boys born per 100 girls) from selected countries (data recent as of 2001): Venezuela 107.5, Yugoslavia 108.6, India 117, China 117, Cuba 118, Azerbaijan, Armenia, & Georgia 120. The gender ratio in the United States has been stable at 104.8. National gender imbalances often result in a variety of ills – from difficulty in finding a mate to an increase in gender related crimes such as rape and sex trafficking.

Using gender as a reason to value one child over another is equally dangerous. Women have been subject to disadvantage and discrimination solely because of their gender. Even if one’s intention in using preconception gender selection is not to denigrate women, acting on the basis of gender preference for offspring lends credence to socially constructed stereotypes of what it means to be a man or a woman. As long as society maintains its gender bias, permitting couples to control the sex of their children will only reinforce it.

Some may also argue that the United States is a culture that does not “have a preference for a particular sex.” Aside from discounting the clear gender bias inherent in our society, this comment overlooks the diversity of ‘American’ culture. It is of note that certain American ethnic groups have seen statistically significant increase in their sex ratios between 1984 and 2000. The ratio for Chinese Americans rose from 104.6 to 107.7, for Japanese Americans 102.6 to 106.4. This trend has not been overlooked by private clinics that offer gender selection. In August 2001, soon after the ASRM ethics committee condoned the use of gender selection for ‘family variety’, The New York Times reported an onslaught of advertisements for sex selection targeted towards Indian expatriates, one of the country’s fastest-growing ethnic groups. “Desire a Son?” asked one ad in India Abroad, a weekly newspaper for Indian expatriates in the United States and Canada. Similar niche marketing has been emerging in media targeting East Asian immigrants. In order to retain its image as a society built on a foundation of equality, the United States is advised to learn from the experiences of other nations and limit the practice of sex control.

While it is important to consider the negative externalities that preconception gender selection imposes upon a society, it is equally vital to explore the impact on the psychology of individual children and families. The primary argument against gender selection in this regard is that in choosing one sex over another, parents are necessarily making a statement about what they expect of that child, based on his or her gender. This is likely to lead to disappointment for parent and child alike should the personality of a child, irrespective of gender, fall short of expectations.

The negative externalities imposed by preconception sex selection impact the child-to-be, the family, a society, and a nation. Unfortunately, the general public condemnation of sex selection has not been mirrored by firm public policy regarding the process. The United States stands alone as the only Western nation able to offer preconception gender selection while lacking a uniform and comprehensive system by which to regulate it. Thus far this country has favored “the protection of individual choice and the autonomy of parents, even when we disagree with their course of action.” This policy must be reversed, to protect the interests of this generation as well as the next.


Pediatrics, from page 8

Some hospitals have developed documentation to help physicians and families confront these difficult issues. For instance, the Children’s Hospital of Wisconsin created a standardized form that parents of critically or terminally ill children can use to document their advance directives. The hospital supplies the form to physicians, who fill them out with families. Copies are kept by the family and in the hospital’s emergency department.
Help the Center for Bioethics  
Help P&S Students!

The Center for Bioethics plays an increasingly crucial role in the education of P & S students. We offer seminars, courses, advice, and support for student activities. Your support is needed to help the Center fulfill its mission. Your contributions are welcome—no matter how large or small. There are various ways you may contribute to the Center’s efforts which are vital to both medical education and medical care.

You can access [http://www.bioethicscolumbia.org/giving.html](http://www.bioethicscolumbia.org/giving.html) or contact Joyce Plaza, Director of Programs & Development
Phone: (212) 342-0442 or Fax: (212)342-0451
Email: jp2199@columbia.edu
Credit card donations can be made by mail or fax. Planned giving opportunities are also available.

Columbia University in the City of New York  
Center for Bioethics  
College of Physicians and Surgeons  
Mail Code 161  
630 West 168th Street  
New York, NY 10032