Genetic Testing and Traditional Values

There seems to be a minor blindspot in Strong's article,[1] published in the November 1993 issue of the ARCHIVES, discussing the ethics of whether or not to do prenatal testing for and/or abort fetuses because they have minor medical problems, are of the wrong sex, or have the wrong body habitus.

His problem is that the entire discussion assumes that all of our patients and society as a whole accept the basic assumptions of modern medical ethics, ie, a utilitarian ethic in which there is no ultimate meaning of life except what we, as individuals, make as the meaning.

Utilitarianism uses as its highest "value" or "good" material criteria, for example, as measured by health, wealth, and independence. There is, however, no assumption that life has an intrinsic good in itself, nor does utilitarianism claim that any deed can be intrinsically right or wrong.

As a result, some ethicists argue that since suffering is a worse form of evil than death or nonexistence, then it is ethical to euthanize, abort, or allow one to die rather than to allow suffering[1]; indeed, most of Strong's discussion is about where we, as a society, should draw the line for our unborn offspring. Such a philosophy is politically correct in academic circles, but not everyone agrees with this basic assumption.

For example, the majority of Americans think that abortion is *not* a value-free choice to be made for any reason, but see it as a form of killing that should be done for only the most serious circumstances. A significant minority of the population thinks that life begins at conception and should never be destroyed.[2]

I guess it comes down to the primary question: What is the meaning of life? Are we completely in charge of our own lives, permitted to "do our own thing," or are we responsible to a higher power? Is imperfect human life, our own or that of others, something to be destroyed out of compassion, for convenience, or because society wants to balance the budget, or is every life sacred from conception to natural death, because every person is loved by a deity who knows the number of hairs on our heads and who calls us by our names?

Some have stated that religious discussions have no place in secular societal decisions. Others ridicule any attempt to include such discussions as being a product of the "fundamentalist religious right."

Such narrowness might be justified in academia. However, it does a disservice to those of us who treat patients who make ethical judgments based on a more conservative and/or traditional religious ethic.

Nancy K. O'Connor, MD
Private Practice
Nanty Glo, Pa

1. Strong C. Tomorrow's prenatal genetic testing: should we test for 'minor' diseases? *Arch Fam Med.* 1993;2:1187-1193.
2. Fletcher J. Ethics and euthanasia. In: Horan D, Mall D, eds. *Death, Dying and Euthanasia.* Frederick, Md: University Publications of America Inc; 1980:229-304.
3. Dionne EJ Jr. *Why Americans Hate Politics.* New York, NY: Simon & Schuster; 1991:341-342.

In reply

Although O'Connor raises an important issue, her description of contemporary medical ethics is inaccurate. She points out some of the problems of utilitarianism, but it has many other difficulties that have been widely recognized for years. Some die-hard utilitarian ethicists remain, but they are a small minority, and O'Connor misinforms us when she says that utilitarianism is "politically correct." Medical ethics today is more accurately described as pluralistic in that there are many conflicting nonreligious and religious viewpoints. I have explained elsewhere why I oppose utilitarianism,[1] and I do not make the implausible assumption, as O'Connor states, that most people are utilitarians.

O'Connor implies that I, and ethicists generally, hold that there is no place for religious discussions in medical ethics, and I wish to make it clear that this innuendo is false. Even more disturbing, the tone of O'Connor's letter implies that to discuss the abortion issue from a secular perspective, as I do, is somehow inappropriate. However, there are several reasons why secular discussions should be part of the dialogue. First, many disagreements exist both within and among various theological traditions, and therefore they have been unable to agree on a single perspective for settling the abortion issue. Second, given the plurality of views, we need to seek approaches that are "secular" in the sense of taking into account and accommodating the variety of personal views that are held. This is one of the things that contemporary medical ethics attempts to do.

Approaches that are secular in this sense are not antireligious; rather, they seek consensual norms that can be accepted by all, regardless of faith. One way to seek con-

sensus is to invoke the "conscience clause," as I did in my article. I stated the following:

An additional concern is that some geneticists would conscientiously object to performing prenatal testing for disease susceptibilities, late-onset diseases, and relatively minor conditions, and some primary care physicians would conscientiously object to referring patients for such tests. Such conscientious objections might be based on the degree of risk to the fetus in performing such tests. Even if this concern is removed by the development of noninvasive testing, conscientious objections might still be based on the degree of respect the physician believes should be given to fetal life. In reply, the view in question would honor conscientious objections by physicians.[2]

Moreover, religious traditions are a main source of influence in the formation of private conscience. Thus, it is inaccurate to suggest, as O'Connor does, that my approach excludes religious views. I invite O'Connor to take a step back and ask herself, "What approaches to the professional ethics of prenatal genetic testing would be acceptable, given the wide range of personal views among physicians?" This question poses the framework, I suggest, from which my article should be evaluated.

Carson Strong, PhD
University of Tennessee College of Medicine
Memphis

1. Strong C. Justification in ethics. In: Brody BA, ed. *Moral Theory and Moral Judgments in Medical Ethics*. Dordrecht, Holland: Kluwer Academic Publishers; 1988:193-211.
2. Strong C. Tomorrow's prenatal genetic testing: should we test for 'minor' diseases? *Arch Fam Med*. 1993;2:1187-1193.

Factors Affecting Access to Medical Care

I enjoyed the article by Cykert and Layson,[1] published in the November 1993 issue of the ARCHIVES. I do agree with the authors' hypothesis that universal health insurance will not assure universal access. However, I disagree with the "Materials and Methods" section of the article. First, the authors chose a small southern town that may not be representative of the general population. The reader was not given any demographic information, such as the mean age of the population, minority status, or percentage of the population that received Medicaid or Medicare vs private insurance. I believe this information is important because if the majority of the population had private insurance, physicians would be less inclined to accept Medicaid or Medicare.

Second, because such large differences were found between rural and urban physicians, perhaps rural physicians should not have been used in the study. To determine why rural practices were different from urban practices, it might have been interesting to find out if rural areas had recruited young physicians to the area by subsidizing their medical education or helping them start a practice.

The authors postulate that physicians cannot afford to accept Medicaid or Medicare because of "high overhead costs, and personal, practice-, and medical school–related debt." This statement seems to put money over patient care. Most physicians I know did not go into medicine "for the money." I can understand, however, that the large debt that one accrues during medical education may be a significant factor. Current efforts to expand national health service corporations may provide some relief in this regard.

Sondi Moore-Waters, MD
Morehouse School of Medicine
Atlanta, Ga

1. Cykert S, Layson RT. Will universal health insurance assure universal access to ongoing primary care for adults? *Arch Fam Med*. 1993;2:1153-1155.

In reply

Moore-Waters appropriately points out that many factors influence physicians' willingness to accept publicly insured patients. Regarding his specific comments, our survey was centered in Greensboro, NC, and its surrounding counties. The city itself has a population of 185 000, and when the surrounding communities are added, the overall population of the survey area is roughly 600 000. Approximately 12% of patients are insured by Medicaid, 13% by Medicare, and 60% by private insurance. Fifteen percent are currently uninsured. These data are not significantly different from data pertaining to cities of similar size and surroundings. This study was indeed local and in a sense does lack generalizability; however, there is no reason to think that these patient acceptance trends based on insurance status do not exist elsewhere.

We disagree with Moore-Waters' assertion that because of the greater willingness of rural physicians to accept publicly insured patients that these data should have been excluded from our report. The reasons given for this difference are plausible and it would be extremely important to ascertain physician and environmental characteristics that contribute to these more generous acceptance policies. Our data do not support the idea that recruitment of young physicians is the driving force behind enhanced patient acceptance in rural areas since there was no significant difference in duration of practice between the rural and nonrural groups.

Finally, we believe, as Moore-Waters does, that physicians in general do not go into medicine "for the money." However, given that the mean debt of medical students is now estimated at $55 000 and that students endure a minimum of 7 years of intense training with minimal pay, it is