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Straining Their Brains: Why the Case
Against Enhancement is Not Persuasive.

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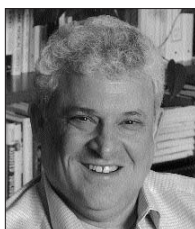
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ARTICLE

Shall We Enhance? A Debate

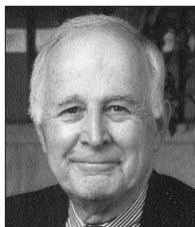
Arthur L. Caplan and Paul R. McHugh

Your kid's schoolwork not up to par? Looking for Mr. or Ms. Right? Any other problems caused by a mind's eye seemingly not quite on the ball? Answers might lie in a brain-enhancing pill. Some argue this is merely better living through chemistry and in line with humanity's self-improving actions throughout history, but others suggest that quick-fix medications could well distort the very things that make us human. Here a leading bioethicist squares off with a member of the President's Council on Bioethics on the controversy about pursuing better brains with a little help from biotechnology.



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by Arthur L. Caplan, Ph.D.,
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Shall We Enhance? A Debate

Just a few decades ago, “mind-expanding” drugs were the province of the avant garde, the rebellious, or the just plain irresponsible. Now, much as laser surgery enhances our eyesight, new drugs may enhance the power of the mind not only for the risk-taking few but for virtually any of us, on demand. While some observers argue that such innovations are only the latest in a long historical march toward human betterment and should be welcomed, others are more cautious. Tinkering with an otherwise healthy brain can be counter-productive, dissidents argue. Cerebrum invited Prof. Arthur L. Caplan, Director of the Center for Bioethics at the University of Pennsylvania, and Dr. Paul R. McHugh, a member of the President’s Council on Bioethics, to debate the “enhancement” issue from the sides that each of them favors. Prof. Caplan and Dr. McHugh first put forward their positions in written statements, which they then exchanged to write rejoinders. They used as the fulcrum of their debate the report of the President’s Council on Bioethics, Beyond Therapy: Biotechnology and the Pursuit of Happiness (from which a chapter on another topic, age retardation, is excerpted elsewhere in this issue).

Straining their Brains: Why the Case Against Enhancement Is Not Persuasive

By some estimates, nearly 1.5 million Americans have undergone laser surgery to improve their vision. The purveyors of this procedure often promise that those who have it will see better than they ever have before, even with the aid of glasses or contact lenses. Laser surgery sometimes can give eyes better than 20-20 vision.

So have those who have undergone this type of procedure and achieved enhanced vision done something immoral? If you were to read the recent report of the President's Council on Bioethics, entitled *Beyond Therapy: Biotechnology and the Pursuit of Happiness*,¹ or a recent article by a member of that council, Michael J. Sandel,² you might believe they had.

The arguments the Council and its members make against enhancement merit close scrutiny, not only because they have commanded much attention from policy makers and the media but because these arguments are mistaken. And as new knowledge about enhancing another part of the human nervous system—the brain—becomes available, it is all the more important that flawed moral reasoning does not hinder how this knowledge is used.

WISHING FOR BETTER BRAINS

Beyond Therapy is not mainly focused on new knowledge of the human eye or brain per se or how such knowledge might be used to enhance humanity. It is mostly concerned with efforts to improve children through genetic manipulation, gene therapy, and pharmacological agents, as well as with efforts to extend life and control aging through genetic engineering and other means. Nonetheless, it is easy to see that the kinds of concerns fueling the angst that so permeates this report are surely meant to generally rebuke efforts to improve mental performance as well.

For the most part, those who study the brain have very little interest in enhancing or optimizing anything. They seek to know how the brain works. Many scientists and physicians are also keenly interested in determining how, if possible, to repair the devastating impact of injury, disability, and disease that strike the brain.

But potential interest in brain enhancement is enormous. Already, a number of pharmaceutical and nutritional-supplement companies are interested in selling drugs that, like modafinil, allow individuals to go without sleep for longer

periods of time than they otherwise could or herbal substances that allegedly improve memory or sexual enjoyment. These are, arguably, enhancement drugs. And two things have not escaped some scientists' notice: that a drug capable of helping an Alzheimer's patient retain memory function might also provide some enhancement to those who simply have poor memory skills; and that the market possibilities for selling a drug such as a memory enhancer are huge.

Many students, for example, are keenly interested in any drug that might improve their ability on tests or in musical, dramatic, or athletic performances by allowing for

Each argument carries some emotive force but is not a sound basis for rejecting choices that individuals might make to improve or optimize themselves or their children.

increased short-term memory, greater attention span, or reduced anxiety. The military has an interest in seeing mental performance improved so as to increase the combat effectiveness of individuals and units. And not a few of us drink coffee, tea, colas, and other stimulants to try to enhance our cognitive performance. Many people take various drugs, foods, and herbs, or utilize technology such as virtual reality, to try to enhance their mood, emotional state, sexual enjoyment, or range of sensory experience.

While these activities can be, and sometimes are, abused, it would hardly seem morally objectionable to try to improve one's mental abilities. Surely it is the critics of efforts to improve the brain that bear the burden of showing why this is wrong.

GOING BAD BY DOING BETTER

So what are the Council's and Professor Sandel's moral concerns about efforts to improve, enhance, or optimize our brains, vision, or any other human organ or trait? Their objections seem to be that:

1. The happiness or satisfaction achieved through engineering is seductive and will lead to a deformation of our character and spirit;
2. Engineered improvements in performance are not authentic, not earned, and therefore not morally commendable;
3. To accept enhancement for our children will undermine and deform the role of the parent.

None of these arguments provides a sufficient reason to oppose enhancement or optimization, be it of our vision or our brains, our own or our children's. Each argument carries some emotive force but is not a sound basis for rejecting choices that individuals might make to improve or optimize themselves or their children. This is not to say that every choice for enhancement or optimization is beyond moral criticism or even morally valid. But it is to say that those who would have us turn away in principle from all forms of enhancement or optimization have not made a convincing case.

Consider this question from the President's Council, which suggests that all efforts at enhancement will distort or deform our character:

Indeed, why would one need to discipline one's passions, refine one's sentiments, and cultivate one's virtues—in short, to organize one's soul for action in the world—when one's aspiration to happiness could be satisfied by drugs in a quick, consistent, and cost-effective manner?

The concern expressed here is that if we enhanced ourselves and our achievements and enjoyments came easy, why would we continue striving to be good and virtuous people?

THE WRONG CULPRIT

The problem with this argument is that many people who do not now strive to be good and virtuous are neither enhanced nor optimized in any way. Laying the blame for vice at the foot of enhancement ignores the inconvenient fact that the desires for quick returns, easy money, and instant gratification have nothing at all to do with enhancement. They are traits of many, if not most, human beings. The notion of character development implicit in this account has deeper roots in fictionalized accounts of young men at boarding schools than in anything that accurately describes how human beings actually evolve the character traits that they manifest.

Still, the council broods in *Beyond Therapy*, easy pleasures and cheap thrills will make us weak and spineless. There is nothing like misery to make us stronger. Sorrow, courageously confronted, can make us wiser

and more compassionate. By the same kind of logic, the selective serotonin reuptake inhibitor (SSRI) antidepressants, when used to reduce our sorrows, would endanger this aspect of affective life. Because they dull our capacity to feel psychic pain, they would render us less capable of experiencing and learning from misfortune or tragedy or empathizing with the miseries of others. If some virtues can be taught only through

Putting aside the fact that sorrow can also drive some to suicide and bring others to dysfunction and despair, is it really true that improvement and virtue cannot co-exist?

very trying circumstances, those virtues might be lost or at least less developed. Putting aside the fact that sorrow can also drive some to suicide and bring others to dysfunction and despair, is it really true that improvement and virtue cannot co-exist? The Council's argument is a bit like those who worried what the military airplane would do to the virtues of the ground combat soldier—that the improved technology would make obsolete the kind of courage needed for a frontal assault. Oh really? Tell that to the fighter pilot who needs to evade ground-to-air missiles or to the helicopter pilot evacuating a wounded soldier under a barrage of ground fire.

Improving performance is not necessarily toxic to virtue. It simply shifts how virtue is manifest. It is highly unlikely that those with enhanced vision or muscles or brains would lack for challenges in the real world.

SATISFACTION NOT GUARANTEED

So the case is not made that improving our brains will destroy our character. What then? The Council wrings its collective hands at the prospect that enhancement of the brain or optimization of brain performance will cheapen the value of our experiences:

But seldom do those who win by cheating or who love by deceiving cease to long for the joy and fulfillment that come from winning fair and square or being loved for who one truly is. Many stoop to fraud to obtain happiness, but none want their feeling of flourishing itself to be fraudulent. Yet a fraudulent happiness is just what the pharmacological management of our mental lives threatens to confer upon us.

Translation: If you don't really earn your performance, if you do not sweat and toil at it, then it will not be authentic, and it will ultimately prove unsatisfying. One is tempted to ask who is writing this stuff—is the Council somehow psychically channeling our Puritan Protestant ancestors?

Life is full of many pleasures that are not earned by testing our limits but that are fully and thoroughly enjoyed.

Certainly it is exciting to achieve satisfaction by testing our limits, by seeing what we can achieve by striving, struggling, and working to overcome innate boundaries. But it is also very satisfying to have benefits that simply come from out of the blue or through good fortune. No people with enhanced vision that I have ever

encountered feel the least bit of guilt, shame, or doubt that the improved vision they enjoy is fraudulent because they did nothing to deserve or earn it except pay their money and let a laser do its thing. Life is full of many pleasures that are not earned by testing our limits but that are fully and thoroughly enjoyed. Think of the pleasure in winning the lottery; or in being reassured that your friends like you even though you cheat at cards, cannot stop smoking, eat too much, or are sometimes boring; or in solving problems using computers and any other form of technological assistance you can muster to aid your fallible brain.

We do not always have to “earn” our happiness to be really and truly happy. Nor do we reject as fraudulent those things that make us happy that we have done little or nothing to earn. An enhanced brain or improved cognitive functioning would not in principle undermine the ethos of authenticity that undergirds human satisfaction because that infrastructure is not as the Council depicts it. Authentic happiness sometimes results from success in the battle against limits, but authentic happiness can also result from luck, happenstance, serendipity, gifts, indulgence, whimsy, and, although the Council seems unable to fathom the possibility, even vice.

IMPROVING CHILDREN

Lastly, consider the concerns of the Council's Sandel writing in *The Atlantic*. He is worried that if we seek to perfect our children—to enhance and optimize them—we will no longer see them as “gifts”:

In a social world that prizes mastery and control, parenthood is a school for humility. That we care deeply about our children and yet cannot choose the kind we want teaches parents to be open to the unbidden. Such openness is a disposition worth affirming ... it invites us to abide the unexpected, to live with dissonance, to rein in the impulse to control.

Put aside the irony of the author, a professor at a school (Harvard University) that inspires parents to devote enormous resources to enhance their children's abilities so that they may enter there, extolling the idea of accepting your kids as they "are."

Is there value to be found in accepting the random draw of the genetic lottery with respect to one's children?

Ignore the fact that the vision of parenting put forward seems unduly bound by an upper-class American vision of what makes for desirable parenthood—no collective parenting or parent-child estrangement cloud Sandel's vision. Is there value to be found in accepting the random draw of the genetic lottery with respect to one's children? Should a random point mutation that produces a slight change in a trait, or a spontaneous recombination of genetic material, really be seen as the source of value in creating the unexpected in our offspring?

It seems to me that much of what parents traditionally do is try to shape and control their children. Would changing what the accidents of nature produce really result in a child that is any less the object

of parental design? And would such change lessen parental affection for the child? It is not self-evident that this must be so. One can accept a gift, embellish, tweak, noodle, and modify it in order to improve it, and still cherish what was given as a gift.

The case against all enhancements is not made. Which, again, is not to say that all enhancements are, of necessity, good or desirable. But it is to say that "in-principle" objections to enhancement should not deter those who seek to improve their own minds or those of their children. ■

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No Veterinarian to “The Naked Ape” I

As I recount to colleagues our debate within the President’s Council on Bioethics leading to the publication of the book *Beyond Therapy: Biotechnology and the Pursuit of Happiness*, many ask, “Why are you guys worrying about the off-label use of medications” such as growth hormones, steroids, stimulants, and antidepressants? By “off-label” they mean the use of these drugs and hormones not, as originally intended, to cure people of conditions such as depression, infection, or hormone deficiency but to enable the healthy to become stronger, quicker, or taller than they would naturally. “After all,” they note, “who’s to say where sickness ends and health begins—and anyway, why can’t folks try stuff as long as it doesn’t hurt them?”

These natural questions are relatively easy to answer, as they all in some way turn on concerns over the risks involved in taking medications. But I remind my interlocutors that people do certainly sense other problems in “off-label” medications and express their concerns. Witness the recent outcry in the newspapers, picked up and amplified by the president’s State of the Union address, over major league baseball players who increased their strength—and disrupted the credibility of their records—by using muscle-enhancing

steroids and growth hormones on the advice of their trainers and physicians.

Some critics of this practice were concerned over the risks to health these professional athletes were prepared (or pressured) to accept. Indeed, these risks are not trivial. But many more were troubled by what biologic enhancements implied about the meaning of achievement in sport and the values expressed in athletic competition.

A QUESTION OF PURPOSE

Several of my questioners did identify this challenging question from the controversy over sports by asking: “Just what are you trying to preserve or defend when you debate the use of medications to enhance some trait, rather than treat an illness?”

I hold that answering this question of purpose is central not only to the sports issue but also to the mission of the Council itself. Therefore, I begin by noting how this Council was charged by the president to spur public discussion on bioethics in a fashion that would get beyond some simple calculus of risks and benefits to consider what challenges to human values and moral purpose the new discoveries in biomedicine could bring to us as people. Sport is one arena where such challenges would emerge, but hardly the only one.

Specifically, in working with our chairman, Leon Kass, to produce *Beyond Therapy*, we Council members explored how medications with effects on mood and cognition, so useful in treating certain mental disorders, might alter a doctor's practice with people seeking to enhance desirable traits.

Doctors, after all, do not see themselves as veterinarians to Desmond Morris's *Naked Ape*—workers who tinker with the bodily structure and function of a human as if they were simply beefing up a biologic machine. They hold that, as advisors and teachers, they treat people who need more than technological know-how in order to thrive, who need help to understand what goes into a good human life and how it can go awry. However, as information spreads about medications, some patients—perhaps better called “clients”—are turning up asking for and expecting novel pharmacologic services from their doctors, services that may not extend the patients' best interests. *Beyond Therapy* intends to spur the public to think about these matters.

Case examples help make these ideas about apt and inapt use of medications—especially the newly discovered medications—clear. Here are three, chosen because each depicts a particular aspect of contemporary life in a psychiatric practice and represents a situation where human hopes and fears are in play. In each, medications are an issue even though a “quick fix” with some medication not only would have fallen short of a solution but might well have distracted everyone from the central and deeply human issues at the heart of the problem.

A FRUSTRATED YOUNG MAN

To begin: at least once a year, I am asked to see some young man (seldom a young woman) whose parents worry about his school performance and are wondering whether some medications—either sedatives for his mild test anxiety or stimulants for his mild distractibility—might enhance it. The parents are gifted professionals with long records of academic success and honors (valedictorians, Phi Beta Kappa election, etc.). They worry that their son's present school record and lack of scholastic achievements matching theirs indicate either that something is wrong with him that I might fix with one of these new medications they have read about, or that he has some unapparent psychological conflict that I might resolve for him.

My task in this situation is to get the parents to forget about adjusting him to their aims with medications or anything else. I want them to appreciate what he brings to them and to all of us in life-affirming ways.

The truth is that the son does not have the superior IQ of his parents. The statistical “reversion to the mean” inherent in the genetic roulette of a polygenic feature such as IQ has brought him a somewhat lower capacity than his gifted parents. But often he, and subjects like him, more than balance this aspect of their makeup by displaying—and in fact surpassing

their parents in—several other fine human characteristics. He may be handsome, charming, athletic, graceful. These traits are visible and acknowledged by all, even though, on the day I see him, his most prominent feature is his frustration over disappointing his parents.

My task in this situation is to get the parents to forget about adjusting him to their aims with medications or anything else. I want them to appreciate what he brings to them and to all of us in life-affirming ways. I point out that no one can “major in IQ” in life, but anyone can use a whole variety of assets to make life work for him or her. These parents need to understand the young man for what he is and use their talents—and social connections if need be—to guide him toward enterprises that will employ his particular talents and skills to build a life and a career. They should emphasize his strengths, stop trying to make him more like themselves, and give up their notion (common, I’ve discovered, among the gifted) that the only path to success in life is the one they followed.

I do not immediately succeed in this process with some of these parents, primarily because at the start they assume that my job is to do their bidding and “fix” the young man rather than reinterpret their situation for them. But with time I can usually win them over, thanks mainly to the natural affection all parents have for their offspring, but also because I, an outsider, embarrassed them into thinking about the gifts of life by emphasizing what is attractive about their son.

RIGHT FEELINGS, WRONG OBJECTS

Here is a second prototypic example of how assumptions about life can, in the present era, prompt a search for enhancement medications that misses the point. A young woman arrives in my office depressed and concerned about what she imagines to be some flaw in her psychological makeup that renders her unattractive to others. Her concerns, it turns out, have emerged from several failed romances. Each seems to have followed the same course: she meets an attractive young man and develops a relationship that rather promptly—as is customary with young people now—becomes an intimate one. After some months, and just as she has begun to hope they will marry and start a family together, he tells her he is “not ready” for such a serious commitment and its attendant responsibilities. She concludes he is not sufficiently interested in her, and soon they part.

The repetitiveness of this experience—right down to the stock expression “I’m not ready”—leads her to believe that something about her is to blame. She wonders, as she reflects on her feelings and her behavior, if she’s “too intense,” “too possessive,” or “too needy.” She’s certainly disheartened and demoralized, and she asks me for medication for her mood and perhaps some other medications that would reduce her anxiety around men—making her perhaps more “relaxed” about these matters.

I notice how she is distressed and concerned about male withdrawal but seeks to explain it as a result of her shortcomings. With these ideas in my mind, I try to show

her that, in expecting intimacy to lead to commitment, she is the one who is acting in a natural way, and her boyfriends are not. I tell her that she needs neither a sedative for her thoughts nor an antidepressant to rid her of her low mood but a better assessment of the situation she faces.

When I eventually point out how contemporary sexual mores, supported by easy contraception, tend to emphasize what one receives from an intimate relationship rather than what one brings to it—i.e. taking something from one another rather than making something together—she may wonder, primarily because she has never heard such ideas from a doctor, whether she has come to the right office. Only after

She came with the belief that her moods and distress represented some set of pathologic features in herself. I try to help her appreciate that she has been cooperating with a cultural system that permits males to remain perpetual adolescents.

figuratively catching her breath does she ask exactly what I think she should do in these situations. I respond to this question by saying she will need some coaching or “cognitive-behavioral” psychotherapy as she approaches affectionate relationships in the future. I suggest several therapists—usually female—who have helped other young women I referred.

She came with the belief that her moods and distress represented some set

of pathologic features in herself. I try to help her appreciate that she has been cooperating with a cultural system that permits males to remain perpetual adolescents (and even offers them a standard excuse line, “I’m not ready”), postponing indefinitely their transition into responsible—read “stand-up”—men. Her goal should be to figure out how to stop cooperating with this system and its misuse of her.

TEMPTING THOUGHTS

As a final example of the temptation to use pharmacologic tools for enhancement, I offer an experience and thought experiment from my personal, rather than professional, life. I enjoy periodic, several-day visits from my 8-year-old grandson. We do many things together, but one that we enjoy is playing chess and analyzing situations on the board. He’s pretty good for a youngster, and for a period of about half to three-quarters of an hour, we can concentrate together on these problems.

But as the time passes I sense his attention waning and eventually—sooner than I do—he wearies of these “if the opponent makes that move then we should follow with this response” analyses. I’ve learned to offer him something else to do with me then—best something more physical such as running or throwing a ball—all with the tacit agreement that “maybe later” we could return to chess.

The thought experiment, though, comes as I realize how, with a medication such as Ritalin, I could hold him longer at the chessboard, enjoy the interplay with him for a greater stretch of time, and even, so I might rationalize, make him a better player.

The thought is enough to identify the injustice. To use my medical skills to draw something I want from him rather than to accept and support the break from effort his nature seeks is to deny, indeed belittle, his boyhood. “More recess, less Ritalin” I regularly prescribe to people worried about how boys tend to be restless in class. I’m even more confident of the wisdom in that prescription after spending time so happily with a first-rate example of the group.

CHEATING VICTORY OF ITS MEANING

With these case examples in mind, let us now return to the sports problem that may be the greatest source of public interest and disquiet over pharmacologic enhancements today. I hold that the expressions of concern brought out in those discussions resemble in many ways the concerns raised in my clinical examples. I also believe that some aspects of the solutions likely to be effective for these athletes will apply to practice with patients such as I’ve described. Much will depend on attitudes in the community about what is to be admired and what is to be scorned, about what advances and what retards our human pursuits.

William James referred to organized sports as “the moral equivalent of war.” And for most of us that’s just why we are drawn to the games, as both players and spectators. Nowhere else can we see human beings struggling to be their best, displaying the strenuous, dare one say manly, virtues of courage, tenacity, and self-sacrifice for some collective victory in an arena where blood is not shed and lives are not lost. At its best, organized sport works as a tangible

and direct moral educator to us all, by identifying people who have honed wonderful physical gifts and, often, demonstrating how adversity and stress can be overcome through persistence and bravery put into play with a sense of purpose.

Major League Baseball should free itself from the misuse of steroids and other drugs not just by appropriate supervision, rules, and stiff fines but as well by ridicule, contempt, and moral reprobation of the offending athletes by their peers and by the supporters of the game. This reproofing stance derives from rejecting the “anything goes” view of athletic competitions and is inspired by respect for the opportunity in sport to witness remarkable combinations of human gifts and virtues, played out in a framework of conventions that give those gifts and virtues a stage. Artificially altering the players—distorting their bodies and making them somehow chemically different from the rest of us—debases this opportunity.

Most of us can see these points immediately and appreciate that unnatural procedures, by severing performance from effort, cheat victory of its meaning. In the same way, I try to encourage my patients to see the real goals embedded in their pursuit of happiness. Thus I do not aim to cover over a painful but natural response to life circumstances or tone up some cosmetic flaw. Rather I seek to help a person find coherence and direction in his or her life so as to resolve some of the difficulties prompting the trip to a psychiatrist. “Man does not live on pharmaceuticals alone,” we might say today in updating the Gospels. I apply that lesson repeatedly in my office.

Each person in my case examples needed help to recognize just how, like the use of steroids by baseball players, the pharmacologic interventions they wanted would be wrong. Here medicating might not be against some formal rule, but it would in important ways distort the goal of treatment and often turn attention away from the real nature of the situation. In all three cases this goal was to recognize the challenging realities built into human life and how best to meet them. The first case illustrated how one should recognize and honor the diversity of excellence to be found among people, the second how to recognize and honor the natural assumptions of human affection, and the last how to recognize and honor psychological characteristics built into and appropriate for the different stages of human development. To intervene with medications in any of these examples might have helped achieve some narrow aim but would have done so at the price of loss of reverence for the good things that life, outside our command, brings to us and prompts us to fulfill.

THE MORAL BOTTOM LINE

As anyone who reads *Beyond Therapy* will quickly appreciate, the Council was not calling for laws to deal with these issues of “off-label” treatments. We thought and wrote differently here than we would about matters where life and death—or even physical well-being—are involved. Different members brought different experiences with biologic enhancements to this discussion. All, though, wanted to help the public to appreciate both what great goods

these new medicines bring to our treatment of the mentally ill and the many aspects of human life at stake as our knowledge in psychopharmacology expands.

In particular, I wanted to emphasize what psychiatric practice taught me about what to behold, identify, and admire in individual lives. I’ve learned that, when no psychiatric illness disrupts the picture and calls for medical relief with these new medications, these assets usually offset the challenging blemishes that remain for each of us to overcome. People triumph over these milder handicaps when they are helped to make sense of their circumstances, live up to their gifts, and cultivate those strenuous virtues of self-sufficiency, energy, loyalty, and independence of mind that grow with practice over time.

As a doctor, the moral “bottom line” for me in the use of all medications (not just the new ones) is: Turn to a medication only after you have thought carefully about the patient’s symptoms and complaints and decided these issues represent or express some disruption of brain function or structure in need of medical management. Otherwise, help those who consult you to see what they can do to make better sense of their situations and deal more effectively with them. If this method of assessment is followed, then the new discoveries in pharmacology will work as they were designed and a coherent, effective practice of psychiatry will proceed for the benefit of all. ■

Important Treatment, Wrong Diagnosis: Enhancement is not to blame for the abuse of autonomy

Every so often a physician will complain to me that it is impossible to get families to consent to the cessation of life-extending medical treatments for their terminally ill loved ones. These doctors are not talking about borderline cases; they are talking about situations in which a patient is in the final throes of cancer, the last stages of AIDS, or at the brink of expiring from congestive heart failure. But, still, the family insists that everything be done.

My response is to ask why the doctors are listing options and alternatives. When they look at me with an expression of confusion, I elaborate: Why are they not presenting their recommendation about what they believe is *the appropriate thing to do*—in these particular situations, to shift from therapeutic interventions to palliation. The physicians sometimes angrily retort that as someone in the field of bioethics I should realize that their role is not to tell people what to do (as these professionals' role models and mentors once did) but to give patients and families choices consistent with the doctrine of informed consent that bioethicists have supposedly drummed into their heads as key to the moral practice of medicine. This line of argument does not

move me, I respond, as informed consent is not simply giving people options and alternatives. It is also sharing with them the wisdom of experience and judgment about what option is the best one to pursue.

Dr. McHugh's comments on his experiences with patients and families who turn to the field of medicine for pills and nostrums to fix the everyday woes of life put me in mind of these conversations. He correctly points out that the right thing to do when confronted with parents who want a pill to make their child smarter or patients requesting a drug to calm their anxieties about an unsatisfactory love life is to offer counsel about the acceptance of limits or the need to learn to cope with the challenges of disrespectful, outlandish, or crude behavior. Not every insult, slight, failure, disappointment, and challenge in life merits the prescription of a pill.

Doctors are not waiters; they do not simply respond to the orders and preferences of their patients. If bioethicists have given medicine the idea that this is what informed consent means, whether in the ICU or in the practice of psychiatry, then bioethics is wrong.

That said, the fact that medicine has become beguiled by respect for patient autonomy does not mean Dr. McHugh is right to commingle concerns about enhancement with concerns about an undue obeisance to patient preferences and demands. While he is on the right path in terms of providing sounder alternatives to patients' requests for "quick fixes" and in not yielding to their anger when he offers direction rather than drugs, the source of the more general problem is the medical community's overindulgence of patients' demands—not the fact that they sometimes demand enhancement.

The dislike of steroids is the dislike of a dangerous drug. But it may or may not extend to the professional baseball player who has had laser surgery to improve his vision.

Nor does the example of steroid use in baseball take Dr. McHugh exactly where he wants to go in cautioning about the destructive influence of enhancement. True, some forms of enhancement seem to undermine fair play in sports. But not all.

I am reminded of a conversation I had with an Olympic official who pointed out that the pleasure Americans and Europeans take in beating basketball teams from Africa is in no way diminished by the fact that the African teams are undernourished, poorly coached, and have almost no access to training facilities. We are so used to these forms of enhancement in our sports that

not only do we not protest them, we are downright angry if our favorite athletes do not have access to the best dietitians, masseuses, sports psychologists, sports physiologists, and strength coaches.

The dislike of steroids is the dislike of a dangerous drug. But it may or may not extend to the professional baseball player who has had laser surgery to improve his vision or who pitches even better after reconstructive surgery than he did before.

It is hard to draw the line when it comes to enhancement. Surely medicine should not simply prostitute itself to the whims of its patients. The need to rein in autonomy-run-amok in doctor-patient encounters is real. However, the patient who seeks improvement may, even post-counseling, continue to seek it. The point is not that all enhancement is bad, but that it is bad medicine to assume that if a patient wants the enhancement then it must be bad. ■

Where's the Wisdom?

The book *Beyond Therapy* here under discussion is a product of the President's Council on Bioethics. That preposition, "on," gets little attention but this debate demands that we note what it implies. The Council is not a crew of bioethics experts presenting its judgments to the world. It is an assembly of scientists, physicians, and humanists deliberating on the mandate and portfolio of bioethics itself. By discussing vexatious biomedical matters and publishing treatises drawing from these open discussions, we are ultimately trying to discern whether the relatively new discipline of bioethics is entitled to special standing or authority as a body of organized thought enriching the alliance

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between physicians and the public. Specifically, does it improve upon the physician's traditional ethics of recognizing good practice in enterprises that function (to quote the Hippocratic Oath) for "the benefit of the sick"?

Professor Caplan, an academic and highly regarded bioethicist, is a spokesman of this new discipline, and thus I'm deeply disappointed that his views on the matters dealt with in *Beyond Therapy* are so dismissive. We have heard rumblings of dissatisfaction with our Council's thought and leadership from him, so I was eager to see a thoughtful recasting of the specific issues we raised that might amplify our efforts or display alternative ways to come at them. Rather, Professor Caplan disparages the whole enterprise to consider and debate potentially deleterious sides to the promiscuous use—"beyond therapy"—of pharmacological treatments.

The Council members certainly knew the value of these medications for the sick but thought it wise to consider how they might be used—or requested—when no sickness was involved. Call our endeavor a needed break in the headlong rush toward nonmedical exploitation of biotechnology, a pause to consider any Huxleyan brave new world implications that might rest within the marvelous medical advances provided by modern drugs that affect the mind and brain.

Beyond Therapy boils down to the following questions: Are there any serious problems to discuss here? Do, as Professor Caplan claims, only Rugby-School-cold-shower folk worry about biotechnology just as they abjure all creature comforts? Are there things about human nature that

we want to preserve when thinking about prescribing these new medicines?

Professor Caplan treats all these questions off-handedly—likening, I have to suppose, any concern for the huge increase in Ritalin prescriptions for children to worries over the American appetite for Starbucks coffee. Not only is his response to the book a rebuke to the Council’s effort, his answer to any concern expressed by the Council is to tell us to get with the program of modernity and stop bothering everybody with trivia.

But he often seems to miss the point. For example, he sees us as worrying that “seductive” promises of bioengineering “deform the role of parent.” We do have concerns over “seduction” but not because these promises “undermine...the parent.” Rather, they distort everyone’s—parent and child’s—attitude towards childhood in exactly the way pushing kids to attend Harvard, a practice apparently deplored by Professor Caplan, does.

I spoke as a practicing psychiatrist about my worries with some of the empty promises carried by the new pharmacology in case examples I won’t repeat here. But I’d like to mention something other than the flippancy of Professor Caplan’s exercise.

I detect no sense of direction in his commentary. As we doctors strive to help patients separate the real from the false, we can hope that bioethics, for which Professor Caplan speaks, might one day come up with better insights than suggesting we meet all demands for therapy, especially novel ones, by going with the tide. My cautions about enhancement are no resistance to change

but recognition of how, for doctors, going with the tide may mean forsaking the responsibility—and opportunity—to consider new technologies in the light of wisdom derived from living and sympathetic contact with real people. Proposing the treatment that best allows a patient to flourish is seldom simple, especially when many treatment programs are available and each carries its own complications. Surely physicians can reasonably expect their professional ethics to offer some principled inclination or direction for their practices, given the weight of responsibilities they carry.

Without thoughts that provide a sense of direction—such as emerges from the reflections in the Hippocratic tradition about the nature of “benefit” and “harm” in their dealings with patients—physicians are at the mercy of technologic illusions and detachments. These tend to promote actions at costs they don’t anticipate and exact a penalty, in loss of trust, that they are called to pay when damage cannot be repaired.

Our Council published *Beyond Therapy* not to worry the public or to legislate practices but to spur discussion about often unseen features of the new biotherapies. Bioethics was spawned from the philosophical faculties but is now being tied more and more into medical discourse. If Professor Caplan’s unconcerned response is representative of expert opinion from the new world of “official” bioethics, the public will be disappointed by the contributions from that quarter and may wonder about the value of that new enterprise in thought. ■