



## Beyond Good and Evil: Doing Ethics in the Clinic. A Lecture Celebrating 25 Years of the Philip Hallie Lecture, College of Letters, Wesleyan University, November 2, 2018

Joseph J. Fins<sup>1,2</sup>

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Phil Hallie was a reluctant narrator (Lorenz 1998). But he was one nonetheless. In *Tales of Good and Evil, Help and Harm*, he apologizes to his mother for telling her story and then goes on to write about her. He can't help himself. He writes:

Now here's a good way to do concrete ethics: Don't just tell stories interpreted in the old words of ethical theories. Show the intimate feelings of the storyteller, me!

After all, good and evil are as personal as love and hate. And that means bringing mama into it, her terror, the mortal fear that perhaps all Jews feel after what the Nazis did (Hallie 1997).

Hallie explains that his mother dreaded a planned trip to Germany, fearing for his safety, even in 1979. He quotes a letter to her "beloved and precious child" warning him of the peril. "Innocent blood was spilled there," she wrote. And it wouldn't matter, "because a hand-full of Christians helped some Jews, Jewish people are happy. Not so with God..."

Reflecting on those words, Hallie confesses, "I am horrified at this monster, myself" wondering "... if I had been making copy out of your feelings." He doesn't think so but is not totally sure: "I am *almost* certain that I have not been using you as a foil for my "concrete ethics..."

It is classic Hallie, probing his motivations and ambivalence through narrative.

As a medical ethicist, I too struggle with using cases as a foil for *my* concrete ethics. Yes, we have rules about confidentiality. It's not that. Instead it's the interplay of ethical choices and real people, like Phil Hallie and his mom.

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✉ Joseph J. Fins  
jjfins@med.cornell.edu

<sup>1</sup> The E. William Davis, M.D., Professor of Medical Ethics, Weill Cornell Medical College, New York, NY, USA

<sup>2</sup> Solomon Center Distinguished Scholar in Medicine, Bioethics and the Law, Yale Law School, New Haven, CT, USA

Tonight, we have been asked to talk about good and evil. In my work, it isn't so much evil but about the good. We reserve our discussions of evil for the perversion of medicine that occurred during the Holocaust or Tuskegee. In the clinical context, there is a presumption of beneficence, of the good. Our challenge is about defining the good and choosing among competing goods. And with the march of scientific progress, tracking the evolution of what we take as "the good" as medicine advances.

So, in the spirit of the College of Letters, I will *reframe the writing assignment* and consider how the good might change over time. In recasting the question, I recall the advice my Dad gave me before my comprehensive examinations in the College of Letters. He said if you don't know the answer to the question, question the question. It was good advice then, and it stands up now.

So, let me engage in some concrete ethics of my own and tell you about a case that still haunts me.<sup>1</sup> It involved a patient who had a severe brain injury whose family wanted to withhold life-sustaining therapy and let him die. They did not want to put in a feeding tube.

They were earnest and well intentioned, a cohesive family. A loving spouse and college age kids, who could have been from Wesleyan. I felt a personal kinship towards them. In other circumstances, we could have been friends.

But it was a tough call. He was conscious albeit, liminally so, and otherwise healthy. He was only in his late 50s and might have survived if given treatment. But it was a question of what kind of life? His wife—who was empowered to make these decisions—told us he wouldn't have wanted to live this way, disabled, and unable to communicate. They had had conversations, so it was more than inference. She knew his wishes. He had lived a vibrant life and valued the life of the mind.

We all struggled, deliberated, and eventually acceded to their wishes. He went home with hospice care and died in a matter of days, much more quickly than we had thought. I took some solace in the rapidity of his demise, feeling that we had made a good decision.

His wife was grateful. For several years, she would send purple and white orchids to my office. It made me feel good that I had been there for her and helped to orchestrate a compassionate death.

But that sense of satisfaction of having done good, lasted only for a while. Over the next two decades, I worked with patients with severe brain injury and seen the resilience of the injured brain firsthand (Fins 2015). We have developed better ways to peer into the injured brain and identified covert consciousness. We have also developed drugs and devices that can help prompt recovery.

I was part of a research team that first used a deep brain stimulator in the minimally conscious state (Schiff et al. 2007). A patient who could neither eat nor speak was, with the brain pacemaker, able to say six or seven word sentences, tell his mother he loved her, and say the first 16 words of the Pledge of Allegiance. He could also eat by mouth for the first time in 6 years.

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<sup>1</sup> Some of the details of the case have been altered to protect confidentiality.

It was against this backdrop of progress that I saw the patient's wife about 5 years ago at the hospital. She had grown old and seemed to have become sick as well. But we immediately recognized each other. We embraced. Her eyes still beamed with gratitude for what we had done for her husband years ago.

But I wasn't so sure. As we exchanged pleasantries, my mind was somewhere else, wondering if we made the wrong decision. We had made so much progress over the past years. Might he have done well? Or well enough? My inner monologue was a tortured one. Should I bring this up? Did I have an obligation to disclose my second guessing? Wasn't disclosure a good? Should I tell her that if the same case were to present itself tomorrow I would frame it differently? Was it a question of being transparent, or simply unburdening myself?

More to my core, I've spent the last couple of decades advocating for the needs of patients with brain injury (Fins 2015; Wright and Fins 2016; Fins 2017; Fins and Wright 2018). Would I be a hypocrite if I didn't say something?

Very quickly, I decided that I could say none of this. It wasn't about doing good, it was about not inflicting a harm. After all, what *good would it do* to share my doubts? It could only be cruel and thus incompatible with my obligations as a healer. I thought of what Hallie wrote about cruelty (Hallie 1995). Reflecting on the goodness that he found in Le Chambon (and recounted in *Lest Innocent Blood Be Shed*) (Hallie 1979) he observed that:

... the opposite of cruelty is not simply freedom from the cruel relationship; it is hospitality. It lies not only in something negative, an absence of cruelty or imbalance; it lies in unsentimental efficacious love... No, the opposite of cruelty was not the liberation of the camps, not freedom; it was the hospitality of the people of Chambon...The opposite of cruelty was the kind of goodness that happened in Chambon (Hallie 1995).

Simply put it would have been *inhospitable* at that time, and in that place—a *hospital which should be a sheltering place of hospitality*—to share my concerns with this still grieving wife, herself in need of healing (Fins 1996). And that was the guidance supplied by Hallie's scholarly legacy, one of practical wisdom, of concrete ethics.

But Phil would not have been satisfied if we had stopped there. That I did not confess my doubts neither absolved me of them, nor answered the deeper question of how what appeared to be good at one time might fall short years later.

These were more fundamental questions. Is the good static, or does it evolve as our scientific knowledge deepens? It seems that the good must certainly change, or at least change the way in which it expresses itself over time. And as it morphs it leaves us adrift.

And there's the paradox. We often think that knowledge is empowering, that more scientific facts will direct us to a proper course of action. The irony is that as we have learnt more about brain resilience, we are *less certain about what constitutes the good, or what the right thing to do is*.

One thing is clear: simple categoricals no longer apply. Numbers can't point us to our values and science cannot answer these questions in isolation. We have

to engage in ethical deliberations that place the humanities in dialogue with the sciences, as exemplified by Phil Hallie's concrete ethics. Nothing less will suffice.

Each generation needs to learn how to engage in this most worthy and important conversation. And *this is why* we should be grateful for Wesleyan, the College of Letters, and Phil's shining example.

## References

- Fins, J. J. (1996). From indifference to goodness. *Journal of Religion and Health*, 35(3), 245–254.
- Fins, J. J. (2015). *Rights come to mind: Brain injury, ethics and the struggle for consciousness*. New York: Cambridge University Press.
- Fins, J. J. (2017). Brain injury and the civil right we don't think about. *The New York Times*. <https://www.nytimes.com/2017/08/24/opinion/minimally-conscious-brain-civil-rights.html>. Accessed 30 Jan 2019.
- Fins, J. J., & Wright, M. S. (2018). Rights language and disorders of consciousness: A call for advocacy. *Brain Injury*, 32(5), 670–674.
- Hallie, P. (1979). *Lest innocent blood be shed*. New York: Harper and Row.
- Hallie, P. (1995). Camus's hug. *The American Scholar*, 64(3), 428–435.
- Hallie, P. (1997). *Tales of good and evil, help and harm*. New York: HarperCollins.
- Lorenz, C. (1998). Can histories be true? Narrativism, positivism, and the "metaphorical turn". *History and Theory*, 37(3), 309–329.
- Schiff, N. D., Giacino, J. T., Kalmar, K., Victor, J. D., Baker, K., Gerber, M., et al. (2007). Behavioral improvements with thalamic stimulation after severe traumatic brain injury. *Nature*, 448(7153), 600–603.
- Wright, M. S., & Fins, J. J. (2016). Rehabilitation, education, and the integration of individuals with severe brain injury into civil society: Towards an expanded rights agenda in response to new insights from translational neuroethics and neuroscience. *Yale Journal of Health Policy, Law, and Ethics*, 16(2), 233–288.

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