Edmund G. Howe, "When Should Ethics Consultants Risk Giving their Personal Views?" *The Journal of Clinical Ethics* 16, no. 3 (Fall 2005): 183-92.

When Should Ethics Consultants Risk Giving their Personal Views?

Edmund G. Howe

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There is, perhaps, no scene more wrenching in all of literature than the last scene of Goethe's *Faust, Part One*. After Faust loves and leaves Gretchen, she loses her mind, and kills her mother and then the baby she has had by Faust. When Faust comes to her in prison, to free her, she asks,

> And do you know, my love,
> do you really know
> who it is you're setting free?[1]

In the special section included in this issue of *JCE,* six ethics consultants describe five cases that haunt them most. Of these, the one that haunts *me* most is Jeffrey Spike's "The Sound of Chains: A Tragedy."

In this case, Spike relates that a social worker called him for assistance on a case that every other consultant on the service had avoided: the staff did not want the mother of a shaken infant to be allowed to visit her baby. The baby had suffered brain damage so severe that he was ventilator-dependent, and most on the staff, although they doted on the beautiful baby, believed he would be better off dead. Even though the mother and her boyfriend were charged with the abuse, for some unknown reason the mother continued to be the baby's surrogate decision maker. The staff hoped that the mother would allow the ventilator to be removed — but, if the baby died, the mother might be charged with murder. Spike suggested that the mother should be allowed to visit.

Spike writes that this case haunts him because is it tragic; of the cases in this special section, it is the case that most haunts me, for that reason and for another: in making this suggestion, Spike put himself at risk. For example, the mother may have, on seeing her infant, picked him up and dashed him against a wall. Perhaps I was as affected as Spike was by this case because I have taken risks like this; unlike Spike, in one case I had the worst of outcomes: a child died as the result of parental neglect when I took a risk on them.

Whether Spike should have taken a risk is one of the questions he raises in his case. A broader question addressed in this column will be: What criteria should careproviders use when they decide to take a risk?[2]

Spike relates that his suggestion swayed other careproviders who disagreed with him about the mother's visit; he was surprised that it did. This leads to a second question: When (if ever) should ethics consultants

try to have their voice rule? And another question that is further to the point: Should ethics consultants attempt to increase the likelihood that their personal moral views will prevail?

Ethics consultants take a risk when they do this, because others — patients, family members, staff — may assume that ethics consultants have "special ethics expertise." They may assume that ethical expertise or ethical analysis can assist in deciding which of two reasonable but competing values should prevail. But this is erroneous: ethical analysis — and, therefore, ethics consultants — can't tell us which of two important and mutually exclusive values to choose; for example, it cannot tell us whether or not abortion is "right."

Given that their views may erroneously be seen as "more valid" than others', should ethics consultants even share their views? Of course, ethics consultants' views may be more valid because they are based on insights consultants possess that others may lack, but this validity does not depend on their being ethics consultants *per se*. Then again, if an ethics consultant has a special insight into a case and the others involved don't realize it, they may assume that the consultant has offered her or his view because the consultant thinks it is superior — for example, others may think that the consultant believes she or he is more compassionate than other people. If this is assumed, others involved in the case may feel offended and resolve to avoid ethics consultation in the future. As a consequence, other patients may be harmed. Given these various pitfalls, what are ethics consultants to do?

WAS SPIKE RIGHT?

In Spike's case, it is unclear why careproviders changed their minds after Spike suggested that the mother could visit her infant. When ethics consultants share their own moral views, their views are not devoid of clout; others may fear opposing them for a number of reasons:

- They may fear that later they may be at legal peril, because, if someone sues them, they may be more vulnerable if they have opposed an ethics consultant;[3]
- They may fear that opposing a consultant would be an unethical act;
- They may assume that they should afford the views of an *ethics* consultant greater moral weight.

These views may be mistaken. Ethics consultants' exceptional expertise is in knowing how ethical decisions should be made, not in which value or values should prevail. Since value errors are possible, however, consultants should have clear criteria for deciding when to share their personal views, before they go ahead and express them. What could these criteria be? To answer this, let's return to Spike's case and ask, using his case as a paradigm: What risks are worth taking? Why?

We want to trust all of our patients. We can be more helpful if we do. Most times, we choose to trust patients fully for this reason, even when we have reasons not to.[4] Thus, it is emotionally wrenching when we encounter a patient we can't or shouldn't trust. We aren't good (and perhaps it's good that we're not) at making the transition from trusting to distrusting, especially when we are face-to-face with a patient. The need to make such a shift is exemplified by Spike's situation, because the mother in this case could have responded by harming her infant. This possibility is the only valid reason to not allow her to see her baby. An inferior reason would be to punish her further. This so-called punitive basis for making decisions is ethically flawed, as will be discussed further below.

Why might the mother do such a thing — for example, as hard as it is to imagine, hurl her child against a wall? All ethics begins with accurate awareness. Those who do not work regularly in the area of criminal behavior may not have an accurate awareness of what some persons can do. Thus we should briefly consider this. There are actually several possible reasons (and this is not meant in any way to be all-inclusive):

- The mother may have an epileptic condition and do this involuntarily; the reaction could be triggered, for example, by intense emotion.[5]
- The mother may have used a drug in the past that can cause sudden violent behavior, such as PCP, and, out of the blue, have a flashback. This violence would also be involuntary.[6]
- Or she could suddenly react in this way due to an underlying psychosis; she could appear normal, but

without warning respond to a delusion in a violent way.[7]

- Much more likely is the possibility that the mother might do this voluntarily: she might have chosen to harm her infant out of rage and revenge against society in general — again, a possible human action that we don't like to consider. Yet some persons are motivated to seek revenge even when it is strongly against their best interest.[8]

My purpose here is not to indicate that any of these disorders are at all likely, but rather that it is possible that a woman could act this way. Knowing this, making a decision like Spike's may become even more difficult. Should Spike have done what he did?

I say, unequivocally, *Yes.* What is important here is the reason why, based on the ethical premise stated above. Ethics consultants should not share personal views when they are based only on personal preference; for example, based on their religion or what their parents taught them; rather, consultants should acknowledge these beliefs, but should make clear than they are not based on an exceptional skill at ethical reasoning. But consultants should share their personal views *when they think their views are based on an exceptional insight.* Further, they should share their insights even when others can't fathom what their insight is, or why the insight supports their personal views. As stated earlier, ethicists have skills that may enable them to sometimes see better ethical answers than others can.

Ethics consultants should share their own views because, if they don't, in the larger scheme of things, less good and/or greater harm (deontological and consequential) may result. To better understand what should "count" as an insight, let us imagine what skills may have allowed Spike to arrive at the conclusion he did. I can imagine, out of hand, three.

1. KNOWING EXCEPTIONS CAN BE MADE TO "THE RULES"

Spike may have recognized that, rather than responding reflexively to a rule such as "take no risks with possible criminals," in most cases, better ethical outcomes may be achieved by allowing exceptions to the rules. He and other ethics consultants may know that all rules, such as laws and codes, are very useful for many reasons, but are limited as ethical guidelines, because they don't — and can't — take into account all of the potentially relevant extenuating circumstances and situations. A paradigmatic example is the commandment "Thou shalt not kill." Many who believe in this commandment also believe that they would and should kill if an armed burglar in their house endangered them and their family.

Spike may know that it is sometimes ethically optimal to respond in a manner that is strictly "by the book," but that, at other times, this approach can be downright dangerous. He may have reasoned, applying these not-always-self-evident considerations, that it was a remote risk that the mother might harm her son, that she might have a seizure, a PCP flashback, a sudden psychotic break, or even willfully wreak revenge. When thinking this, Spike may have made a distinction between the magnitude of risk and its probability. Further, he may have imagined that, even if the magnitude of risk should be granted moral weight, the risk might not be too great, as, in some persons' view, the infant would be better off dead.[9] Spike may have been wrong. The mother might have killed her child. If she had, it would not mean that it was wrong for Spike to share his personal view.

2. APPLYING A NARRATIVE APPROACH

Spike might have known how to use a narrative approach or a thick description of a particular patient; that is, he may have known that although, statistically, a suspected criminal may be more likely to commit a crime to be vengeful, a thicker description of the person may strongly suggest that this is highly unlikely. Thus, it might be a sound bet that the mother would be an exception to the rule, and letting her see her baby would not create a risk. Spike knew that, if the mother did kill her baby, it would increase the seriousness of her crime to murder. Still, she could have acted out of revenge. Spike observed the mother closely as she visited her baby; this was another way to reduce possible risk. He noticed her tears as she spoke to her baby.

3. CONTEMPT FOR THE MORAL WEIGHT GIVEN TO THE DESIRE TO PUNISH

More than others involved in the case, Spike may have eschewed and felt contempt for any moral weight others might have wanted to give to their desire to punish the mother. He may have recognized that punishing her involved the presupposition that she deserved this response.[10] Such a claim would be depend strongly on a supposition that the mother deserved punishment because she started on an equal genetic and social footing with the rest of us. Spike may have felt: There, but for the grace of God, go I.

This response indicates the kind of awareness recommended by many who write about ethics, such as John Rawls.[11] We may choose to see others as being culpable in ways that we are not, to heighten our own sense of self-regard. We may want to see ourselves as being superior and unlike others, because we don't commit criminal acts, as they do. We may, however — even if we have the luck of good genes and a wholesome upbringing — be more vulnerable to heinous acts than we would like to admit.

The insights that we have attributed to Jeff Spike may or may not be those he actually had, although I presume that he had them and many more in this case. The few listed here are intended to convey what I mean by exceptional insight. I hope they illustrate what I mean when I write that, if ethics consultants do not express their insights, greater wrong may be done. In Spike's case, all of the staff were content to remain passive. If Spike had remained silent, all would have allowed harm to the mother, who would have lost what may have been her last opportunity to be with her baby.

The ethical rationale for consultants to always speak up when they have an exceptional insight is nowhere better expressed than by Elie Wiesel, who, when in his teens, was deported from his home in Hungary to the Nazi camp at Auschwitz. Wiesel's father, mother, and younger sister who were with him died. He has spent his life trying to teach others what he feels he learned from this horrific experience. He says, "Indifference reduces the other to an abstraction . . . to be indifferent [to the suffering of others] is what makes the human being inhuman."[12] Aren't most of us susceptible to being indifferent? Couldn't something like this happen on a ward, where staff care for patients? Spike's experience would suggest a painful answer.

We may have already known this answer, or should know it from well-known events, the most famous of which may be what happened to a woman named Kitty Genovese, who was stabbed to death, over time, in public, while many watched and listened, but did not respond to her cries for help, although even an anonymously placed phone call to the police would have saved her.[13] Lauren Slater, a psychologist, reviewed this event and the scientific studies related to it, and came to this conclusion: the more people who witness an event, the less responsible any one individual feels. Diffusion of responsibility is compounded by a social etiquette so strong that it overrides even life-and-death situations.[14]

If Slater is right, we have a possible reason why no one spoke up for the mother until Spike did. We can imagine, also, that, rather than seeing the mother as different and wholly unlike us, we could see her as more like us than we would like to admit. But is there scientific data to support this? Slater reports on a study conducted by John M. Darley and Bibb Latané, in which the researchers mimicked and studied the Genovese murder. In their study, an actor, pretending to have a seizure, cried out for help from another room, saying he was choking and dying. Subjects in the study could confer with each other and could have easily sought help at no risk to themselves, but most did not.[15] Further, if the subjects didn't act immediately, Darley and Latané found, they were unlikely to act later. And the greater the number of persons in the group, the less likely people were to act. Slater notes that Darley and Latané's experiment contradicts the evolutionary adage that there is safety in numbers.[16] Thus, there are empirical as well as ethical grounds for consultants' speaking out when they believe their views are based in insight — regardless of the risk.

Slater describes another study that found that people may change when they can see the dangers of passivity. In one study, Arthur Beaman showed participants films of the study by Darley and Latané described above, and explained five stage that persons go through to act responsibly:

1. Notice what is happening.
2. Interpret the event as one in which help is needed.
3. Assume personal responsibility.

4. Decide what action to take.
5. Take action.[17]

After this instruction, participants were found to be twice as likely to take helpful initiatives as the control subjects were. Still, when I think of Kitty Genovese, read about these studies, and read Spike's case, I have increased appreciation for all ethics consultants who act as Spike did. Which leads to the next question: When should we act this way?

OTHER EXAMPLES OF EXCEPTIONAL INSIGHT

The sole criterion we should use to decide to share personal views is this: when we genuinely believe that we have an insight that others may lack. We have considered the kinds of insights that Jeff Spike may have had. The five other ethics consultants who present cases in the special section in this issue also offer superlative examples.

Denise M. Dudzinski presents the case of a 50-year-old woman who had severe chronic pain in her arm, who wanted to have it amputated not only because of the pain, also but because it smelled badly and frightened her young grandson. Her doctors wouldn't amputate because they thought that, even with surgery, the woman would likely still have phantom pain. Dudzinski became involved not because she was formally consulted, but because she took the initiative to do so when she first heard about this patient. She tries to become involved in cases, she says, *before* they become dilemmas. "Wow!" as John Fletcher used to say. This proactive initiative exemplifies the caring that Elie Wiesel, in condemning indifference, espoused.

As Dudzinski points out, the unusual and bizarre nature of the patient's request led some of her careproviders to question her competency. Dudzinski supported the patient in her request. What insight may have prompted this? It may have been that, over time, as the patient remained in pain and continued to request surgery, the merits of not honoring her wishes progressively decreased. This moral view is based on the deontological value given to respecting patients' dignity by giving them autonomy. The moral weight accorded to most patients' wishes should, accordingly, increase over time. This principle is based on essentially the same values as "sliding scales" that are used to determine patients' capacity to make decisions. With the passage of time, if there is relatively less we can offer a patient, the more we should respect her or his autonomy. Respecting patients' autonomy to a greater extent is something that we can offer as their range of treatment options decreases.

Dudzinski presents her insight this way: "At most, an amputation would have been a zero-sum game, leaving the patient in the same pain, but without an arm." Dudzinski did not believe that the patient's decision-making capacity was too badly compromised because a psychiatric assessment confirmed her decision-making capacity.

There is an additional instructive and slightly sad aspect to this case. Dudzinski relates that a student later brought her attention to a patient who had been admitted with apotemnophilia, an illness that caused the patient to want his arm to be amputated, even though it was healthy and he was not in pain. Dudzinski says that she really wanted to speak with the patient, but did not. This is sad because I have no doubt that she could have helped; I wonder if the stress of interacting with the surgeons in the earlier case took a toll.

Doing what Spike, Dudzinski, and the other authors of cases in this special section did is likely to exact an emotional toll. Dudzinski and Paul J. Ford say in the introduction to the special section that it is easy to feel isolated when we have few colleagues with whom to confer or debrief in a confidential manner; to which I say: Hear, hear! This is particularly the case when ethics consultants intervene by sharing views that "go against the grain." The study by Darley and Latané, cited earlier, indicates how important peer support is.

A second example of exceptional insight is offered in a case written by Paul J. Ford in the special section. Like most ethics consultants, he has greater insight regarding the importance of deontological values. In the case he describes, he attempted to assist a family who did not think that sustaining their loved one's life was futile, as they struggled through the repeated discharges and readmissions of a cognitively impaired patient

who was experiencing multiple-organ failure. Ford says, "I empathized with the family's frustration. . . . Each new medical team believed that the family must not 'understand' the situation: elsewise the family would withdraw all therapy." The insight that different views may be equally valid is related to the notion (also held more commonly by ethicists than others) that respecting a person's dignity may mean not only respecting rational thoughts, but respecting, to some degree, desires that are irrational.[18] I think in this regard of a family who had called an ambulance long after a loved one had stopped breathing. In this instance, which occurred long ago, there were clear signs that the family member had been dead for some time, and that cardiopulmonary resuscitation (CPR) couldn't possibly succeed. The ambulance staff wanted simply to take this deceased person away. The family was, however, irate: they strongly wanted the drivers to attempt CPR. So they did. They tried and failed. The family felt much relieved.

Ford also writes about the importance of follow up in ethics consultation: "I am haunted by the thought," he says, "that a careful, consistent follow up of the original consultation could have bettered the overall situation." The ethics consultation process, he laments, is often reactive, rather than proactive. To this, I would add: "Me, too." I think here of the case that most haunts me, in which I consulted with a patient who wanted to die. We were able to begin a very positive relationship, and together formed a plan for treatment. As per our plan, I left the task of following through on the plan to others. But they didn't follow through, and neither did I. In short order, the patient returned to her former state, and she died as she initially intended, by refusing interventions that could have kept her alive for many years, with a life that she agreed would be a good one.

Ethicists may also tend to have exceptional insight in regard to feelings. This is demonstrated in the case discussed by Joy D. Skeel and Kristi S. Williams in the special section, who were treating a 36-year-old man with a diagnosis of borderline personality disorder. He was admitted to the hospital repeatedly after having swallowed rat poison and other poison many times, which caused his careproviders a great deal of anguish — and anger. Skeel and Williams recognized the importance of the staff's anger, and identified how the needs of the staff and the patient collided. They saw how the staff's anger affected their behavior — which the staff themselves couldn't see. Emotions can be contagious, and, as Darley and Latané report, it is extremely important for persons to agree with others. This is another example of an instance in which ethics consultants should speak out.

Ethics consultants may be more able to feel, and bear, what patients and their families truly experience.[19] This is exemplified by Richard M. Zaner, who writes in the special section about how he sat with a couple, bearing their pain and uncertainty as they tried to understand an early prenatal diagnosis of serious disability. "I was left with a strong sense of my own vulnerability in the face of such uncertainty," Zaner reports. He identified with the parents' frustration that they must decide, even though they were uncertain. Reading this, I think of the rare patients one sees in psychiatry who have suicidal feelings that are not severe enough that they need or are willing to be hospitalized. Yet they say honestly that they can't be sure that their feelings could not suddenly become stronger and overwhelm them, so that they end their life. They report that they fear this greatly. The only and best option may be to merely be with them and share their fear. This is an awareness that Zaner clearly had; there is no doubt that, because of this, the couple he sat with were grateful to him.

ERRORS ETHICS CONSULTANTS MAY BE MORE LIKELY TO MAKE

Ethics consultants may be more vulnerable than others to certain risks; they may, for instance, not have become hardened, and so may underestimate some risks. Wanting to trust and help, they may inappropriately try to rescue.

A cognitive error to which ethics consultants may be especially prone is to become caught up in theory. Trained to think in the abstract, they may become overly rigid, placing undue importance on a principle when nuances should be taken more into account.[20] I think here of a not-uncommon example: ethics consultants sometimes insist that the precise wording on an advance directive be interpreted and acted on literally,

when it would be better to try to imagine what the patient would have wanted if he or she had been able to more accurately anticipate future events.

Ethics consultants, and careproviders, may not respond optimally to patients they aren't sure they can trust, such as parents who bring their child to the emergency room when the child's problem may have been caused by abuse. The following case is an example of this general difficulty. Staff suspected the parents of a hospitalized child of abuse when the toddler was found to have calcium deposits on his head, which were consistent with multiple beatings. In fact, the child's chart documented that this had been caused by spontaneous bleeding a few years before, but those notes were not noticed until later. The staff told the parents an outright lie: that they had to stay in the hospital overnight, while the staff performed a brain scan, because their child might stop breathing and die. In fact, the staff wanted to keep the parents at the hospital in case the scan gave them a better indication that the child had been abused. The parents were petrified with fear at this, and also because they knew the staff suspected them of abuse, and might try to take their child away from them. The parents were left alone for six hours, feeling isolated, frightened, and paranoid. They still feel dread when they have to bring their now-teenaged son to the hospital, because staff inevitably notice and comment on the concern about abuse that is documented in the young man's medical record.

While this case is an outlier, it echoes Spike's experience. Surely, all careproviders can do better. We pay too little attention to how we can, and should, most respectfully change from a trusting to a less-trusting role. Even in situations like these, careproviders should visit parents who are isolated and fearful, at frequent intervals, and should attempt to empathize with them. We can say something like, "I'm sorry. This must be excruciating. As I hope you know, we don't have any other choice. If there is one, I wish we knew of it. I hope you can understand."

CONCLUSION

It is essential that ethics consultants express their views when they have insights others may lack. They should do this even when they fear they may be wrong. Doing anything else smacks of indifference. Further, all persons, including careproviders, are highly susceptible to the influence of others, and so may remain passive as long as others present respond in the same way. It may be that the only way that right will be done in these situations is for ethics consultants to speak out.

Six authors in this special section describe cases that haunt them. All give different reasons, but all had to stand, in one way or the other, "against the crowd." It is possible that the stress from doing this is part of what haunts the authors. In any event, this is a price of expressing one's views when others disagree.

Spike, more than anything else, perhaps, allowed himself to respond on the basis of his human feelings. The mother may remember and cherish this last memory of holding her baby, regardless of where she spends the rest of her life. I think of a mother who felt this way after giving birth to a 19-week-old fetus who died. Her memory of the joy of briefly holding him was the only positive memory she had of the otherwise excruciating experience — but the joy of that moment has never gone away.

The pain of patients like the mother in Spike's case, who remain in touch with their dreadful reality, can only be imagined. Although Gretchen in *Faust* is a fictitious character, her story may provide a window through which the pain of patients like Spike's can be better understood. Gretchen drowned her baby and then went mad. In her dungeon cell, she begs Faust,

> Grab it! Hurry!
> It's trying to rise! Kicking!
> Save it! Save it!

Frantic with grief and remorse, she says to him,

> I am in your hands now, at your mercy.
> But first let me nurse my baby.[21]

NOTES

1. J. W. von Goethe, *Faust, Part One*, trans. C.R. Mueller (Hanover, N.H.: Smith and Kraus, 2004), 193.

2. G. Adshead, "Evidence-Based Medicine and Medicine-Based Evidence: The Expert Witness in Cases of Factitious Disorder by Proxy," *Journal of the American Academy of Psychiatry and the Law* 33, no. 1 (2005): 99-105; H. Schreier, "Munchausen Syndrome by Proxy," *Pediatrics* 110, no. 5 (November 2002): 985-8.

Pate v. Threlkel, 661 So. 278 (Fla. 1995). In this case a patient had thyroid cancer, a "genetically transferable disease." When her adult daughter acquired the cancer, the daughter and her husband sued the mother's physicians, claiming that if they had warned the mother that she was at risk and if the daughter were tested, "more likely than not, the daughter's disease would have been detected while it as still curable." The court concluded that when such an outcome is foreseeable, physicians have a duty to warn the parents. C. Kachigian and A.R. Felthous, "Court Responses to *Tarasoff* Statutes," *Journal of the American Academy of Psychiatry and Law* 32 (2004): 263-73, and B. Ginsberg, "*Tarasoff* at Thirty: Victim's Knowledge Shrinks the Psychotherapist's Duty to Warn and Protect," *Journal of Contemporary Health Law and Policy* 21, no. 1 (Winter 2004): 1-35.

P.S. Appelbaum and T.J. Rudegeair, "On the Duty to Protect: An Evolutionary Perspective," *Bulletin of the American Academy of Psychiatry and Law* 20, no. 4 (1992): 419-26. These authors asset that the Tarasoff holding that therapists should protect unknown victims over known patients violated predispositions to those for whom we feel closest acquired through evolution.

3. For this reason, the oft-cited belief that ethics consultants and committees can merely make recommendations may be misleading — and an understatement.

4. The conflict between choosing to trust patients or their family members and "sleuthing" arises most commonly when careproviders distrust the motivations of surrogate decision makers, such as when they stand to inherit parents' wealth. Careproviders cannot, however, "have it both ways." If they choose to trust, to be as supportive of the family as they can, they have to give up sleuthing; or, they can sleuth more, but at the price of losing their capacity to give the family optimal support.

5. This possibility is further complicated because persons may have psychomotor seizures that are neurologically generated or pseudoseizures that are "psychological." They also may have dissociative responses. D.M. Treiman, "Violence and the Epilepsy Defense," *Neurologic Clinics* 17, no. 2 (May 1999): 245-55; N.C. Thompson, I. Osorio, and E.E. Hunter, "Nonepileptic Seizures: Reframing the Diagnosis," *Perspectives in Psychiatric Care* 41, no. 2 (April -June 2005): 71-8; J.G. Akyuz et al., "Dissociation and Childhood Abuse History in Epileptic and Pseudoseizure Patients," *Epileptic Disorders* 6, no. 3 (September 2004): 187-92. In this last study, female patients with pseudoseizures showed higher levels of dissociation.

6. P.N. Hoaken and S.H. Stewart, "Drugs of Abuse and the Elicitation of Human Aggressive Behavior," *Addictive Behaviors* 28, no. 9 (December 2003): 1533-54. J.B. Leikin et al., "Clinical Features and Management of Intoxication Due to Hallucinogenic Drugs," *Medical Toxicology and Adverse Drug Experience* 4, no. 5 (September - October 1989): 324-50, pp. 331-3.

7. M. Oberman, "Mothers Who Kill: Cross-Cultural Patterns in and Perspectives on Contemporary Maternal Filicide," *International Journal of Law and Psychiatry* 26, no. 5 (September -October 2003): 493-514; M.G. Spinelli, "Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives," *American Journal of Psychiatry* 161, no. 9 (September 2004): 1548-57. In animals, a chemical deficiency has been identified that may cause infanticide in male mice. T. Matsumoto, S. Honda, and N. Harada, "Neurological Effects of Aromatase Deficiency in the Mouse," *Journal of Steroid Biochemistry and Molecular Biology* 86, no. 3-5 (Sep 2003): 357-65.

8. From the earliest times, stories of revenge have been told in which persons seek revenge, notwithstanding the cost to themselves. The stories have existed from Homer's first epic and the plays of the Greek playwrights in ancient times to *Madame Bovary* in modern times. K. Yamamoto, "The Ethical Structure of Homeric Society," *Collegium Antropologicum* 26, no. 2 (December 2002): 695-709; R.M. Gottlieb, "Refus-

ing the Cure: Sophocles's Philocetes and the Clinical Problems of Self-Injurious Spite, Shame and Forgiveness," *International Journal of Psychoanalysis* 85, part 3 (June 2004): 669-89; J.A. Arlow and F.D. Baudry, "Flaubert's Madame Bovary: A Study in Envy and Revenge," *Psychoanalytic Quarterly* 71, no. 2 (April 2002): 213-33.

Neuroscientific studies have revealed most recently that the response of seeking revenge can take place in humans when certain neural pathways are more active in the brain. Evolutionary theorists even argue that such an "eye-for -an-eye" strategies makes sense, as they may preventing future damage to one's kin. B. Knutson, "Sweet Revenge?" *Science* 305, no. 5688 (Aug 2004): 1246-7.

A new diagnosis as been suggested to incorportate this possibility: M. Linden, "Posttraumatic Embitterment Disorder," *Psychotherapy and Psychosomatics* 72, no. 4 (July -August 2003): 195-202.

9. Obviously, some persons would disagree, believing that this infant, or perhaps all infants, would always be better off alive.

10. Persons may or may not be "geared" to be caring, rather than punitive. Meissner, a psychoanalyst, does not assume that we can take persons' caring for granted. "It has been argued, since Darwin [1872]," he states, "that man is by nature disposed to altruism, that is, he is naturally attuned to group loyalty and sensitive and responsive to the social expectations and needs of his fellowmen." W.W. Meissner, *The Ethical Dimension of Psychoanalysis* (New York, N.Y.: State University of New York Press, 2003), 311. See, related to this, P.S. Appelbaum and T.J. Rudegeair, note 2 above.

11. J. Rawls, *A Theory of Justice* (New York, N.Y.: Oxford University Press, 1971).

12. E. Wiesel, "The Perils of Indifference," speech given at the White House as part of the Millennium Lecture series, hosted by President Bill Clinton and First Lady Hillary Rodham Clinton, 12 April 1999, *www.history plce.com/speeches/weisel.htm,* p. 3. Wiesel, with his father, mother, and sisters, was deported to Auschwitz in the summer of 1944. He was liberated from Buchenwald, where his father, mother, and a younger sister died in April 1945.

13. A.M. Rosenthal, *Thirty-Eight Witnesses: The Kitty Genovese Case* (Berkeley, Calif.: University of California Press, 1999).

14. L. Slater, *Opening Skinner's Box* (New York: W.W. Norton, 2004), 102.

15. J.M. Darley and B. Latané, "Bystander Intervention in Emergencies: Diffusion of Responsibility," *Journal of Personality and Social Psychology* 8, no. 4 (1968): 377-83.

16. Slater, see note 14 above.

17. A. Beaman et al., "Increasing Helping Rates through Information Dissemination: Teaching Pays," *Personality and Social Psychology Bulletin* 4 (1979): 406-411, discussed and cited in L. Slater, see note 14 above, pp. 108-110 and 258.

18. For a study suggesting that irrationality is caused by having suboptimal strategies present and is elicited by state-dependent decisions, see C. Schuck-Paim, L. Pomilio, and A. Kacelnik, "State-Dependent Decisions Cause Violations of Rationality in Animal Choice," *PLoS Biology* 2, no. 12 (December 2004): e402, E-pub, 23 November 2004, *www.pubmedcentral.gov/articlerender .fcgi?tool+pubmed &pubmedid+15-550984.*

19. M. Sandelowski and J. Barroso, "The Travesty of Choosing after Positive Prenatal Diagnosis," *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 34, no. 3 (May - June 2005): 307-18; M.L. Moutard, "Prenatal Diagnosis of Cerebral Malformation with an Uncertain Prognosis: A Study Concerning Couple's Information and Consequences on Pregnancy," *Annales de Genetique* 47, no. 1 (January - March 2004): 41-51.

20. G. Gillett, "Reasoning in Bioethics," *Bioethics* 17, no. 3 (June 2003): 243-61. A. Bradshaw, "Yes! There Is an Ethics of Care: An Answer for Peter Allmark," *Journal of Medical Ethics* 22, no. 1 (February 1996): 8-12.

21. See note 1 above.

Goethe's awe for the nursing mother may have affected his choice of delusion. He states, "In the Palazzo Tanari there hangs a famous picture by Guido of Mary suckling her child. . . . Her expression, as she looks

down on her child and her breast, is one of speechless and utter submission, as if it were not a child of love and joy to which she is giving her breast, but a heavenly changeling; she cannot do otherwise and, in deep humility, cannot understand why this should have happened to her." J.W. von Goethe, "Italian Journey (1786-1787)," in *Selected Works*, trans. W.H. Auden and E. Mayer (New York: Knopf, 2000), 283.