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It is Settled: The ‘Is’ Can (and Should) Inform the ‘Ought’!

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I read with great interest the plethora of commentaries in response to my target article. Many elaborated richly on several different topics providing excellent insights to further illuminate how we can design, interpret, and understand empirical research; others provided robust counter arguments to some of my claims; and a few raised interesting and important concerns in strong opposition to my work. This body of scholarship represents what I believe is one of the great strengths of bioethics: A multidisciplinary approach bringing together scholars with diverse backgrounds in arenas where we can openly share ideas that are made stronger through such collaborations. Sugarman, Kass, and Faden write: “Kon’s discussion... best evidences how the clinical context influences his analysis...” (Sugarman et al. 2009, 66), which is certainly true. Bringing together clinicians, philosophers, researchers, and others allows us to better understand the multifaceted nature of bioethical issues, and the lively discussion in this issue exemplifies why a multidisciplinary approach is essential. Due to the many ideas raised in the commentaries, I clearly cannot address all, or even most, in a brief response, therefore I will limit my remarks to only the issue that I believe is most important.

While the many scholars raised excellent points in their commentaries, rather than what was written, I was personally struck by what was NOT written. That is, in the 18 commentaries representing the combined wisdom of 27 experts, no author wrote: “The ‘is’ can never inform the ‘ought’!” The fact that no such claim was made leads me to believe that the debate is now over. The bioethics community (which I will choose not to define in the limited space I have here) has determined that indeed empirical research can, and dare I say should, inform normative ethics.

Several commentaries did address my handling of this issue, although none argued that the ‘is’ cannot inform the ‘ought’, and I would like to respond briefly to a few of the statements made. Professor Shelton seems not to object in principle but raises concerns that more work must be done to clarify when empirical work can inform and potentially alter our ethical norms versus when conclusions drawn from such work run counter to our moral precepts and therefore ought not change our ethical constructs (Shelton 2009). Similarly, Professor Kirkwood argues that we must develop a clearer understanding of what standard of evidential weight should be considered sufficient to modify normative standards (Kirkwood 2009). I could not agree more.

I doubt, however, that without significantly more work in this area we can clearly delineate criteria for making such judgment, and therefore at present (and I would venture for the foreseeable future) when data raise questions about ethical standards we will need robust discussions in order to determine whether such data should change our norms. For example, in a study on racial and ethnic disparities in healthcare we found that trauma patients of minority status were more likely to be tested for drugs and alcohol when presenting to U.S. emergency departments when compared to their Caucasian counterparts (Kon et al. 2004). In that study we also found that among those tested, patients identified as “Black” by healthcare providers

were more likely to have positive drug test results. Some have argued that our findings support racial profiling in emergency departments, arguing that physicians should use these data to target patients (based on skin color) who are more likely to test positive. In our report, we argued that this finding suggested that there may be social factors leading to the finding of higher rates of positive test results, and that we should consider developing social programs and other interventions to diminish this disparity. We argued that racial profiling, which clearly occurs in emergency departments, further undermines excellent care and fosters distrust among minority patients. While at this point I cannot offer a precise and coherent scheme to determine when data should alter norms and when they should not, I am confident that the bioethics community would agree that in this case our findings would not support racial profiling. Certainly, more work must be done to clarify how we can make such determinations in a clear and consistent manner.

Only one commentary seemed to suggest that perhaps the 'is' cannot inform the 'ought', however I believe that the authors' arguments are seriously flawed. Hoffmaster and Hooker state that my assertion that the international consensus statement advocates for a shared decision-making process is untrue (Hoffmaster and Hooker 2009). In their commentary, they suggest that their reading of the statement indicates that "Respect for patient autonomy does not seem to be on the wane in either North America or Europe" (sic). Unfortunately, their claim is simply inconsistent with the facts.

Throughout the consensus statement the authors support a shared decisions-making process as evidenced by such statements as: "The jury of the Consensus Conference advocates a 'shared' approach to end-of-life decision-making. The jury sees this as a dynamic process with responsibility for the decision being shared between the caregiver team and patient surrogates" (Carlet et al. 2004). Indeed, even in the case where the patient retains capacity, the critical care community has moved to a shared decision-making standard: "[D]ecision making in the intensive care unit (ICU) should follow a model of 'shared decision making' including clinicians, patients (when they can participate), and the patient's family" (White and Curtis 2006). Citing the consensus statement, Dr. Mitchell Levy, the current president of the Society of Critical Care Medicine (SCCM), has written in strong support of a shared decision-making model in cases of both competent and incompetent patients in the ICU (Levy 2004), and has included such statements in addresses at the Society's annual meetings. Indeed, the official recommendation of the American College of Critical Care is that all decisions in the ICU for both competent and incapacitated patients employ a shared decision-making model (Davidson et al. 2007), and those guidelines specifically cite the consensus statement in support of this change. Finally, at every annual meeting of the SCCM since the consensus conference, there have been sessions where clinicians are educated on how they can employ shared decision-making in their own practice. It is therefore clear that the shared decision-making model has replaced the autonomy-driven model in the care of critically ill patients in the United States. As such, I believe that Hoffmaster and Hooker's arguments lack foundation.

As an aside, I would also like to respond briefly to criticisms raised in two commentaries (Holm 2009, Sugarman, et al. 2009). These authors note their own work, and the work of others, that has been published regarding classification and the role of empirical research in bioethics and suggest that I should have included a discussion of this previous work in my paper. As most AJOB readers know, there has been some excellent work done in this area previously, and I would doubt that not including such a discussion caused readers to believe that my work is the first attempt in this field. It would seem that one option would have been to provide a detailed description of all of the previous work in this area followed by fully developed arguments as to why I believe that these previous systems were insufficient. Such a discussion would likely take more space than the entire paper as written, therefore a complete and nuanced account would have engulfed the work. Alternatively, I could have provided, as these

commentators did, a brief overview of previous work without much detail and then briefly explained why I believe each is insufficient. I fail to see how such a thumbnail sketch would adequately inform the reader, and I would venture that my brief presentation of other scholars' work would have been met with criticisms that my simplistic renditions failed to adequately represent the sophisticated and nuanced schemes developed by these noted academicians. As such, it seemed appropriate to focus on what I wanted to say, say it as clearly and concisely as I could, and allow others to consider and comment. I am confident that many readers were already aware of this previous work, and those that were not and found this topic interesting likely decided to learn more about the topic and have already found the works cited along with others that impact this area. If not including the work of some scholars led to any sense that I failed to appreciate the importance of their work, that was certainly not my intention.

I would have enjoyed considering individually the many excellent and profound ideas raised by those who wrote commentaries, however doing so would require far more than 1500 words. I will therefore end my response quoting Professor Kirkwood: "[This] is but one good step, but more steps are needed before we can see where we are going" (Kirkwood 2009, 91). Let us hope that the conversation, debate, and inquiry continue.

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References

- Carlet, J.; Thijs, LG.; Antonelli, M., et al. Challenges in end-of-life care in the ICU. *Intensive Care Medicine*; Statement of the 5th International Consensus Conference in Critical Care: Brussels; Belgium. April 2003; 2004. p. 770-784.
- Davidson JE, Powers K, Hedayat KM, et al. Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004–2005. *Critical Care Medicine* 2007;35(2):605–622. [PubMed: 17205007]
- Hoffmaster B, Hooker C. What empirical research can do for bioethics. *American Journal of Bioethics* 2009;9(6–7):72–74. [PubMed: 19998125]
- Holm S. Kon's reinvention of the empirical bioethics wheel. *American Journal of Bioethics* 2009;9(6–7):69–70. [PubMed: 19998123]
- Kirkwood K. Empiricism, values and bioethics. *American Journal of Bioethics* 2009;9(6–7):91–92. [PubMed: 19998134]
- Kon AA, Pretzlaff RK, Marcin JP. The association of race and ethnicity with rates of drug and alcohol testing among US trauma patients. *Health Policy* 2004;69(2):159–167. [PubMed: 15212863]
- Levy MM. Shared decision-making in the ICU: entering a new era. *Critical Care Medicine* 2004;32(9):1966–1968. [PubMed: 15343031]
- Shelton W. Empirical bioethics: Present and future possibilities. *American Journal of Bioethics* 2009;9(6–7):74–75. [PubMed: 19998126]
- Sugarman J, Kass N, Faden R. Categorizing empirical research in Bioethics: Why count the ways? *American Journal of Bioethics* 2009;9(6–7):66–67. [PubMed: 19998121]
- White DB, Curtis JR. Establishing an evidence base for physician-family communication and shared decision making in the intensive care unit. *Critical Care Medicine* 2006;34(9):2500–1. [PubMed: 16921327]