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ETHICS & MEDICINE

An International Christian Perspective on Bioethics

Bioethics and the Challenge of the Post-Consensus Society <i>Nigel M. de S. Cameron</i>	1
Response to Nigel M. de S. Cameron's <i>Bioethics and the Challenge of the Post-Consensus Society</i> <i>David B. Fletcher</i>	7
Models of Nursing and Theories of Humanity: A Christian Perspective <i>Barbara Parfitt</i>	13
Consistent Bioethics and Christian Consistency <i>The Rev Stanley L. Jaki</i>	17
Major Conclusions and Recommendations from the Final Report of the NIH Human Embryo Research Panel	20
Book Reviews	23

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Bioethics and the Challenge of the Post-Consensus Society

The term 'bioethics' is still enough of a neologism to retain a foreign feel, as if we should place it in inverted commas or follow it with a vernacular gloss. That this should remain true among Christian scholars today is, perhaps, an index of the challenge we face; if, that is, the thesis of this paper as to its significance can be sustained. But we anticipate.

'Bioethics' is a neologism because, of course, bioethics is a novelty, the academic creature of our own generation. Sometime around 1970 a new discipline emerged, though its subject-matter, in large part, was hardly new. The relations of ethics and medicine and science and public policy go back a long way, at least as far (again, we anticipate) as Hippocrates of Cos and the medical deontology in the material associated with his name which—with an irony as delightful as it is unintended—goes by the name of the Hippocratic *corpus*.¹ The move from the merely descriptive term 'medical ethics',² though inspired by concern for appropriate denomination of a discipline which straddles but is not contained by medicine, is symbolic of the new chapter it has opened for public and professional reflection on values in the western tradition.

That is to say, it marks a point of radical discontinuity in the tradition of medical-ethical reflection, so radical, indeed, that once its significance has been grasped it takes our breath away. Its scope—aptly noted in the new name—is not simply professional and medical, though it is that; it is co-terminous with *bios*, life itself.³ From beginnings in the perplexities of moral flux which characterized the 1960s, its settled presupposition has come to take the form of a paradigmatic repudiation of the Christian-Hippocratic tradition as a context for discussion. For that reason, its project is nothing less than the re-construction of our culture's idea of what it is to be human. Though this discussion initially arose out of the special concerns of the medical community, its logic is irresistible. The questions being raised are increasingly to be found at points of contact between medical and associated scientific developments and issues of public policy. Each fresh technological possibility offers fresh opportunity for revision of the anthropology which underlies our community's judgments about its members. Bioethics offers a test-bed for the development of post-Christian views of who we are, as bioethicists lay claim to be the arbiters of human dignity. So we might speak of the 'leading role' of the bioethics community, in the post-Christian, post-consensus and therefore otherwise inchoate and leaderless society. As both harbinger and would-be arbiter of pluralism, bioethics is set fair to be *the* discipline of the future.

Though this might be considered a highly coloured account of the state and significance of bioethics—and, having offered our conclusions, or some of them, first, we turn below to discussion in support—it is nevertheless remarkable how little interest the evangelical community has shown in this discipline, whose burgeoning is widely recognized within academia. There is a particular reason why this is somewhat perplexing: evangelicals have hardly been disinterested in the bioethics agenda, having engaged wholeheartedly in political action on the most striking of all the revisionist elements in associated public policy. Opposition to abortion has become a key feature of the contemporary evangelical movement. Its indirect result in helping politicize a constituency long uninterested in public affairs has been striking. The final effect on the evangelical community of the seeming fruitlessness of twenty years of political engagement remains to be seen. It may lead to a maturing of political and social vision, or to a new phase of withdrawal from the public square, or—probably—to elements of both.

Yet it has been almost entirely unaccompanied by engagement in the general discussion of which the liberalization of abortion forms one component part. *Ad hoc* address of closely related issues such as fetal tissue transplantation and embryo research has not had the effect of stimulating a general interest in the field. While several individuals have been active, institutional engagement in bioethics has been extremely modest. Whether the sudden appearance of legalized euthanasia as a political possibility will catalyze such a broader response remains to be seen.

By contrast, the story of bioethics in the academy has been startling. Dozens of 'centres' and 'institutes' have sprouted in universities and other contexts, and some free-standing projects have managed to secure foundation funding for influential programmes.⁴ Some of these ventures are essentially letterhead exercises, some inter-departmental projects, building on available curriculum in law, philosophy, medicine, and other disciplines; others again have hired faculty and built a research and teaching team at arm's length from the traditional departments. At a time of general financial stringency such developments have been justified partly through their public relations advantage: a bioethics centre is a honey-pot to journalists. New journals are announced continually, and the *afficionado* could be occupied entirely in the succession of international conferences which have come to define the 'bioethics community' and prove the chief context of its development. Evangelicals who have participated in these gatherings could be counted on the

fingers of two hands.⁵ And in a discipline which is heavily journal-based, evangelicals have yet to found a technical journal.⁶

The rise of bioethics can be explained by the coincidence of two factors: the new technological developments which have come to characterize modern medical practice, and the break-up of the Christian value consensus in the west. This juxtaposition has proved fateful, the former serving as the occasion—and to a degree also as cover—for the piecemeal deconstruction of the latter within medicine. It is interesting to speculate on developments had the explosion in clinical technology taken place in a context of settled values, with the Christian-Hippocratic tradition intact. Its integrity would certainly have been tested, but the 'bioethics' which would have emerged as values broker would have been radically different; developing consensus values in the face of fresh challenges instead of abandoning both the tradition and the idea of consensus and moving toward a radically privatized and supposedly autonomy-based alternative. The challenges posed by technology and associated factors (such as scarcity) would still have been faced. But it would be naive to believe that the secularization of the ethical arena and the abandonment of the tradition have been somehow *required* by these challenges. The usefulness of the tradition would certainly have been tested; but it is in just such a context of challenge that its value would have been proved. In calling attention to the need and opportunity for wholehearted evangelical engagement in bioethics we are of course seeking the continuation of the tradition, and its application to the fresh questions which new clinical opportunities have posed. One reason it may be hard to understand how the tradition would have enabled the wider community to respond lies in the general failure of the Christian community to engage in serious discussion of bioethics. If Christians are the legatees of the Hippocratic centuries, how shall we maintain our position?

The Hippocratic Legacy

Part of the explanation of the crumbling of Hippocratism and the contributory failure of evangelicals to develop and argue a conscious alternative lies in a serious underestimation of the character and significance of this medical ethical tradition. The Hippocratic values, symbolized and summarized in the Hippocratic Oath, have been treated piecemeal. In the context of general ethical discussion this has resulted in an assumption that the values of the tradition can be abandoned piecemeal, without detriment to the professional character of medicine and to those other values which it is considered desirable to maintain. In the Christian context, a parallel result has been the tendency to focus on the piecemeal *defence* of the tradition: hence the focus on abortion as disease rather than symptom, an absorption with a presenting problem of the diseased culture of contemporary medicine with scant attention to the underlying value-shift of which it is one consequence among, potentially, very many. Yet the extraordinary survival of Hippocratism, under Christian patronage, down more than two millennia—to remain

almost intact in the final quarter of the twentieth century as the moral-professional base of western medical practice—suggests a value-system of great moral power. And on examination that is what it proves to be. In a remarkable testimony, Margaret Mead, *doyenne* of anthropologists, noted that the Oath marked one of the great turning-points in the history of the human race. 'For the first time in our tradition', she wrote, 'there was a complete separation between killing and curing . . . One profession . . . were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect—the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child. . .'.⁷

Just as the Hippocratic Oath is one of the best-known but least-read documents to come down to us from pagan antiquity, so Hippocrates, its supposed author, was 'the most famous of all physicians, of whom almost nothing is known'.⁸ A considerable literature has developed around Hippocrates of Cos and the obscure origins of the movement associated with his name, which burst out of late antiquity to become the mainstream tradition of not only Christian but also of Islamic medicine. He lived from 460–377 BC, or thereabouts, and bequeathed both the famous Oath and a substantial amount of other material. Some is said to date from before his day, much from after. As to the Oath itself there is uncertainty. We may find it hard to believe that it is entirely unconnected with the Hippocrates of history, perhaps in an earlier form. One clear scholarly conclusion has been to debunk the notion that all Greek doctors swore the Oath—that it represents mainstream Greek medicine. Whatever use was made of it, it was originally dissident in character; its adherents dissenting from many features of contemporary medical practice. Indeed, one attempt at identification⁹ took as its point of departure the assumption that whatever the Oath chose to condemn was likely to have been common practice in the medical culture of the day. So suicide-euthanasia and abortion, two practices specifically condemned, are known to have been common and widely—though not universally—approved. The physician who refused to procure termination of pregnancy or to cooperate in aid-in-dying was a physician with a difference. For that reason, in his influential discussion of the Oath (so influential that it was to be immortalized through citation in *Roe v. Wade*) Ludwig Edelstein, leading historian of medicine, could term the Oath a 'manifesto' for medical reform.

Three key aspects of the Oath should be underlined.¹⁰ First, it is an *oath*. This has been little noted; yet the theistic context which it offers for the ethical content of clinical practice and the vocation of the physician is highly distinctive—and helps explain the curiosity that it was to be adopted as the basis for *Christian* medicine. In striking contrast, the myriad statements of medical values which have been drafted and adopted by medical and other organizations in the twentieth century, all to some degree parasitic on the Oath, have severed themselves from this theistic context and are mere tables of rules.

Secondly, the Oath develops a model of medicine as a moral enterprise. We see an early statement of what it means to be a profession, something akin to what Christians mean by vocation. The 'life' and the 'art' of the

Hippocratic physician are one: medicine is a life-long exercise, at its outset and heart is the moral commitment of the Oath (one cannot even begin training without first accepting its binding authority), and its injunctions are underwritten with religious commitment.

Thirdly, the Oath is actually the meeting-place of three separate covenants. First there is the covenant between the physician and God. Then, secondly, there is the covenant between the physician and the profession. This again is central to the development of medicine as a profession, indeed to the very idea of a profession. The profession consists of those who have committed themselves by oath to a set of moral-religious concerns, and also to the mutually supportive relationships of pupil and teacher described. Thirdly, there is the covenant between physician and patient. These commitments are, indeed, well-known, and the idea of that relationship as covenantal continues to be much-discussed. The concept, of course, is rich. The commitment to help the sick, the doctrines of confidentiality and non-exploitation (focused in the refusal of sexual activity, even with the patient's slaves), the central commitment to the sanctity of life—all take the relation of physician and patient to a level above that of mere contract.

And it is in the mutually supportive relations of these two human horizontal covenants, held in place by the vertical covenant of the Oath itself, that Hippocrates medicine is to be practised. In this brief sketch we already begin to witness something of the remarkable moral power of Hippocratic medicine. Its integration of 'life' and 'art' in a life-long commitment to the good of the patient, its refusal to employ medical skills to do anything other than heal and help, and its grounding of these principles in covenantal obligations to God—these remarkable features of the Hippocratic enterprise help explain its mesmeric power, and distinguish it markedly from the contractual and merely horizontal project which modern medicine is fast becoming. We now turn to take some soundings in the contrasting characters of the old medicine and the emergent new. They are hardly exhaustive, and are intended above all to indicate something of the magnitude of the shift we are witnessing in medical values and, in the process (if indeed medicine is at root a moral exercise) in the nature of medicine itself; and to suggest the direction in which medicine is moving, so as we scan the horizon of the future we have some indication of where we are going.

Some Contrasts

1. Covenant and Contract

While some contemporary bioethical discussion has favoured the model of covenant in the understanding of the physician-patient relationship, the increasing tendency toward a contractual reduction of medicine is perhaps the most obvious of all shifts in its character. There is logic and perhaps inevitability in this move, since the abandonment of the idea of medicine as constituted by distinct moral commitments gives place, on the one hand, to notions of patient autonomy (to which we turn below),

and, on the other, to a reduction of medicine to the clinical and other skills of the physician. Medicine is conceived as the practice of those skills in the market place, a satisfaction of consumer wants. So social abortion, the marketing of cosmetic plastic surgery and banking of Nobel laureate sperm are proper professional services along with the healing of the sick and the provision of palliative care for those who are beyond healing.

At the same time, the separation of 'life' and 'art' undermines the professional-vocational idea: the physician's practice of medicine, cut free from intrinsic moral commitments, rediscovers itself as a (particularly skilled) service occupation among others. 'Free-for-service', honourably executed according to instructions received and employing the best of the physician's skills, becomes the pattern. While it may intersect at many points with the healing mission of Hippocratic philanthropism, this service-provision model is of another kind. Since medicine has normally been practised in such a way as to enable the physician to make a living from patient fees, there has generally been a contractual element in the professional relationship. What has changed is the significance which that element is coming to bear. While it has traditionally been subordinated to the covenantal structure of medicine practised out of moral commitment (such that, for example, *pro bono* work and sliding-scale fees have been seen as of the essence of the undertaking, and the physician refused to act to end life) the pattern is slowly breaking up, and a contractual reduction of the relationship taking its place.

2. Consensus and Autonomy

Hippocratic medicine in the western tradition had come down to us as a consensus practice. The medical profession embodied the values of the wider community; indeed, one of the characteristics of a profession, and part of the reason why professions are trusted by the community to discipline their own activities, is that the profession shares the community's own system of values and applies them in its special area of practice. Such an inherited understanding of the nature of medicine and its values has been challenged in two ways. First, it is suggested that there is no longer a consensus; that contemporary western society, however homogeneous it may once have been, is now characterized by a plurality of moral vision, such that it is no longer possible for social institutions to make anything other than prejudicial assumptions about the values of those whom they serve. Secondly, this state of affairs is welcomed, since it is maintained that only such a context of value pluralism is appropriate. The inherited notion that the physician's medical bag is already loaded with the distinct moral values which will inform clinical practice is rejected as 'paternalistic', a foisting of one person's values upon others with the assumption that the physician knows best.

While there has certainly been—and still is—a tradition of paternalism in medical practice, in which treatment decisions are taken by physicians and other healthcare

workers without adequate consultation with the patient, this is to be distinguished from Hippocratic 'paternalism', in which the basic moral framework of medical practice is accepted by the physician (not in fact devised by him: he is committed to it by the Oath) and determines the limits of his patient care. The Hippocratic refusal to aid in suicide by giving poison even 'though asked to do so' underlines the moral character of medicine while spelling out one crucial particular in which the options open to the patient were to be limited.

However, what we know of Hippocratic beginnings suggests that Hippocratic medicine was originally not consensus medicine at all. It was a minority protest both against specific evils (such as aiding patient suicide) and more generally against a model of medicine without intrinsic moral values. We shall comment later on the significance for us, in the twilight of Hippocratism, of this facet of its first dawning. For the present we may note that, plainly, for the practice of value-laden medicine in a free society there must be those within that society who are prepared to accept the values. They may not be their own, although—perhaps because they share some of them, or desire the clinical excellence with which they are packaged—they are content to receive medical treatment in accordance with them. We must conjecture some such context for the first rise of Hippocratism.

By contrast, the abandonment of the idea of value-laden medicine, in a society whose general values are in flux, directs our attention and the moral focus of medical practice away from the physician and towards the values of the patient. In ideas of patient 'autonomy' we have the fresh centre of gravity of the medical enterprise. No longer does the tradition have authority; the physician is cut off from the profession and its history. Moral responsibility for medicine moves decisively from physician to patient: the obverse of the fee-for-service role in which the contractual reduction of medical practice has cast the doctor. In an important sense, this is the end of 'medical ethics', as a substantive moral exercise: the 'ethics' no longer inheres in the actions of the physician but in the desires of the patient. We do not have doctors' ethics but, as it were, patient ethics. The physician has been reduced to a cipher, save in one regard: medicine must be practised in such a way as will maximize patient choice, and enable and empower the patient to determine the physician-patient relationship. That is to say, the substance of 'medical ethics' has become merely procedural. In less than a generation, medical ethics, having long been confined to medical etiquette within a settled tradition, has now once more settled into an exercise in etiquette—the definition of the protocols of pluralism, in which the only good has become that of choice.

The attraction of this understanding of values and medicine is obvious. The albatross of Hippocratism can be cast off and need not be replaced: medicine no longer needs substantive, consensus values—these or

any others. Virtue is made of seeming necessity in the lauding of autonomy as the only final good. Yet were it not for seeming necessity, such a model of medical values would surely have been doomed simply by a recognition of its inherent practical difficulties. For it requires nothing less than that each patient should be his or her own Hippocrates.

As it happens, medical ethics has generally been particularly concerned for the validity and integrity of patient choices. The notion of 'informed consent' has developed, underlining the significance of acts of patient consent such that a mere formal act of assent is not adequate to bear the moral (and legal) responsibility needed—whether for treatment, for organ and other donation, experimental participation, and other exigencies of the interface of patient and physician. For consent to be *informed* it must, of course, be *sufficiently* informed; sufficient to make the transfer of moral (and legal) responsibility between physician and patient something other than a convenient fiction. Yet it is here that we find the Achilles' heel of the post-consensus model of medicine. Were the support of what we have termed 'seeming necessity' not so strong (and, in truth, how else *could* a post-consensus medicine justify itself?) it is hard to understand how a serious defence could be mounted of this transfer of responsibility for ethics in medical decision-making from the medical profession to the individual patient. For in so many situations—and especially the most serious—the typical patient is about as far removed as could be imagined from the well-informed semi-detachment which might be held to be necessary for a morally serious, adequately weight-bearing choice to be made.

It is worth exploration of what this might mean in what at present appears the most pressing case in which an autonomous patient choice is necessary. The pressure toward some form of euthanasia in the United States is strong. Ballot defeats in two states (Washington and California) were close, and it is plain that there is sufficient anxiety about terminal and chronic care (in areas such as pain control and overtreatment) that it is unlikely, if not inevitable, that some states at least will follow the Netherlands and opt for a formal permission of (active) euthanasia.¹¹ The Dutch example is instructive: after ten years of liberal euthanasia practice, permitted by the courts and the medical authorities although actually illegal, legislators have (1993) finally decided to buttress this practice with the force of law, creating the first euthanasia jurisdiction (Nazi Germany apart) in the modern world. Several thousand deaths a year result from physicians killing patients; in a disturbing minority of cases without even the flimsy safeguards which the courts and medical authorities have devised.¹² A major practical concern is financial: certainly the pressure behind the federal Patient Self-Determination Act of 1991 was that of cost-saving, on the assumption that 'living wills' would tend to limit treatment. In the context of spiralling health-care costs the combination of an appeal to patient choice and the

prospect of substantial savings might be thought to be unstoppable.

Consider the candidate for 'voluntary' euthanasia. By definition (according to the voluntary euthanasia proposals which various groups have been touting) the candidate must be sick; typically, terminally ill, perhaps chronically with a poor prognosis and much discomfort—some kind of menu of 'life-not-worth-living' clinical options, so as to exclude young mothers with post-natal depression and jilted teens and others for whom general encouragement to suicide might be thought unhelpful. But insofar as any decision for self-destruction can be reasonable (whether the means is self-applied, with 'physician assistance', or an act of killing for which consent has been given) the pressures operating in the typical case might be thought to preclude any possibility of a decision sufficiently free and sufficiently informed to bear the kind of moral weight which is required—to distinguish such acts from other acts of killing. A host of clinical and social features is commonly associated with patients in such a situation: a tendency toward depression (which often passes, particularly if treated), especially shortly after diagnosis; a sense of worthlessness, with anxiety about family commitments—and especially about money—mingled with a feeling that (whatever they might say to the contrary) relatives would be better off with them dead. Anyone with experience of elderly relatives knows something of the challenge of convincing them they are loved and valued. Add to such a situation the context provided by a law permitting euthanasia and a medical community practising it, and the pressure would be great.

The point is this: the chief argument in favour of legalizing euthanasia/physician-assisted-suicide is that from patient autonomy. Yet in the typical clinical scenario any exercise of patient choice would be severely circumscribed. So when such choices are, *prima facie*, being made, what is actually happening?

3. Power and Service

That takes us to the heart of our critique of the possibility of post-consensus medicine, in which radical value pluralism is contained within a common system of medical education and practice by the operation of a values market, with patient autonomy the alleged engine of clinical moral choices. This is the vision of the new medical ethics, in which the repudiation of the substantive values of Hippocratism has gone hand-in-hand with a welcome for pluralism-and-autonomy and a lack of interest in the possibility of forging fresh consensus. The example of 'voluntary' euthanasia is striking, not least because in a case where the ultimate weight of life and death hangs on a choice, that choice is peculiarly liable to be made in circumstances which are flawed—even on the (questionable) assumption that a decision for self-destruction by a patient is of rational accounting. But, of course, the same is true, *mutatis mutandis*, of every exercise of patient

choice. The signing of consent forms, a traditional legal indicator of the acceptance of treatment, has been turned by the break-up of consensus in medicine into a procedure which must bear the entire moral weight of an increasingly uncertain decision-making process. If it cannot actually bear that weight, then—in a medical culture of which it is an increasingly central feature—what alternative account may be offered?

The answer is hardly profound. In reaction to the perceived 'paternalism' of the earlier situation, in which there was actually a substantial ethical consensus, the rhetoric of autonomy is now serving within a fragmental medical culture as cover for the exercise of power. If the idea of patient autonomy offers an inadequate account of the relations surrounding the ethical component in clinical decision-making, power over the patient is being exercised by someone else. In place of the candid ethics of Hippocratism, which bound doctor and patient alike in a covenantal commitment with its final justification in pagan, and then Christian, religion, we have an appeal to patient autonomy which overlays a covert system of power relations in which—now that there is consensus no more—the interests of other parties are brokered. That is to say, the role of the rhetoric of autonomy has become that of a smokescreen, blinding not only patients and ethicists but even those parties who, wittingly or not, are playing their part in taking the clinical-ethical decisions.

In an egregious case, in which relatives are applying pressure to persuade a patient to die sooner rather than later (perhaps to save them money), this is plain and should be sufficiently evident to care providers and others responsible for the interpretation of patients' wishes. In a disturbing report from the Netherlands, one of the architects of the euthanasia regime accepted that even in such a situation he would be prepared to proceed and kill the patient.¹² But more typically the pressures are less evident and, on examination, they are invariably highly complex—in so far as they can be disentangled. What, for example, is the role of public policy in limiting and weighting patient options? We have already commented on the Patient Self-Determination Act, which in the guise of an encouragement to patients to make their own choices has had the effect of pressuring patients to make the particular set of choices implied in signing a living will, and was intended to cut healthcare costs. What about *Roe v. Wade*, as a judicial declaration of public policy? What of the major role of individual doctors and nurses in influencing patient choices? What of the subtleties of family decision-making, second-guessing, gentle pressures—especially where money is concerned? And what about third-party payers, whose plain interest is in minimizing costs by limiting treatment, ideally with the patient taking responsibility for the decision? Take a case of AIDS, or some other costly chronic/terminal condition in which there may be a lengthy period of sickness before death. Were some form of euthanasia to be law, the interest of an insurer in encouraging it upon diagnosis or

as soon thereafter as possible would be immense. Since much of the cost of treating such patients falls on government, the public policy implications could be very serious.

The point of this extended discussion of euthanasia is partly to show how that case in which patient autonomy is most heralded is itself one in which such an alternative to consensus medicine proves deeply problematic, as its language becomes a cover for the power-play of interested parties. It is partly also to show how in every other clinical situation, as moral choices are made, the patient is under complex pressures. Abortion is of course another striking case in which the language of choice is made a cover for the operation of influences of different kinds. The Pandora's Box being opened by the Human Genome Project, with its endless opportunities for the manipulation of humankind, will offer another stage in this development, as individuals are faced with choices and are not sufficiently informed nor sufficiently free to make them; such that others make their choices on their behalf, yet without candour and therefore without responsibility.

The Hippocratic medical culture was a culture of service. The healing of the patient was the physician's goal; and if he could not heal, he would do no harm. His values were openly held, and his single-hearted devotion was to the restoration of health. In its place another culture is in the making. It claims to have no substantive values to put in the place of those of the tradition, save that of autonomy: the patient must supply the values, the physician the skill. Yet the culture of service is giving place to a culture of power, as covert manipulation in the interests of other parties takes the place of the candid commitments of the old consensus.

And despite the protestations of bioethicists that they have no new consensus to set in place of the old, behind the smokescreen of autonomy and pluralism there emerges the outline of a new understanding of human nature. The general acceptance which has been found in the bioethics community for liberal abortion, for moves toward euthanasia, for the manipulative technology of *in vitro* fertilization and the options opened for gene therapy, for deleterious human embryo research—the vivisection of our own kind: the flavour and the direction of bioethics is distinctive and combines a depressing disinclination to value human life above some ultimately subjective calculus of its quality, and an openness to manipulation of those on the margins of the human race. The bioethics community is serving as a test-bed for post-Christian views not only of medicine but of human nature itself. It is that which gives to these discussions their fateful significance. For bioethics is a discipline which, even in comparison with the general moral drift in western society, is peculiarly secularized and owes little to our tradition. It is bioethicists who more than anyone else have looked to the future, and taken on the mantle of responsibility for fashioning its values.

If this analysis is only partly justified, the challenge to Christians is complex and considerable. At one level we

have to unscramble twenty years of studied lack of interest in a set of discussions which have seemed to us overshadowed by the practice of liberal abortion. If that symptom was all that troubled us we face a rude awakening as the nature and extent of the disease becomes evident. If Christians are to begin to challenge what we have called the 'leading role' of the bioethics community in mapping tomorrow's values in science, medicine, and public policy, then we have much to make good.

And we must do so without expectations of easy success. The notions of human value being tested in bioethical discussion are designed for the post-Christian society; they have a special congruence with its concerns. As we develop our own institutions—centres, journals, conferences—both to nurture the believing community and to provide a base from which to venture out into the mainstream, we do so believing above all that this is where Christian lifestyle distinctives and the most characteristic Christian apologetic and witness will be located. Yet we may also choose to recall that the first Hippocratics were dissidents, a minority intent on the reform of their medical culture at a time when, as Margaret Mead noted, 'killing' and 'curing' were alike components in the medical enterprise. They set out with their manifesto of reform, practising a distinctive medicine which refused some services but offered patients, instead, a healing covenant which was grounded in the physician's covenant with his God. And to prospective colleagues they offered a distinctive preparation, contingent upon acceptance of their own covenantal commitment. The lesson is not hard to draw, and if we seek an example we can hardly do worse, as Christians—physicians, nurses, educators—than look back on these pagans; on their commitment, and on their final achievements.

1. Loeb edition in 4 volumes, translated by W.H.S. Jones, vols. 1,2,4; by E.T. Withington, vol. 3, 1957–59.

2. 'Medical ethics' remains the commoner term in Europe, as for example in the 'European Association of Centres of Medical Ethics'.

3. There is a sense, of course, in which the prefix *bio-* is therefore redundant, and as the far-reaching implications of the post-Christian view of human nature are explored by 'bioethicists' this will become plain. The role of medicine in bioethics will finally be seen to have been almost accidental; but it has served to provide unwitting professional cover for the development of a project which would otherwise be regarded as deeply subversive of the culture. It has also enabled bioethicists to commend themselves to patients as those who stand for us against the otherwise all-powerful doctor; bioethics as the alternative to paternalism. The fact that, as we shall later argue, patient autonomy is finally meaningless, since it depends crucially on the myth of informed consent, is difficult to demonstrate to patients who have been warned off medical paternalism with the compelling illogic of 'When did you stop beating your wife?' arguments.

4. The Hastings Centre, with its informative *Report*, is based at Hasting-on-Hudson, NY, and is the most active and influential of these projects. We are in dire need of an equally well-resourced Christian equivalent.

5. Among the 300+ present at the founding congress of the International Association of Bioethics in Amsterdam, Holland, in October 1992, the present writer discovered two other evangelicals. It is worth noting that this organization has been established at the initiative of Peter Singer, the Australian philosopher who is located in a relatively extreme position, even for a bioethicist; yet he managed to secure the sponsorship of both the Dutch ministry of health (which, given the euthanasia culture in Holland, may be not entirely surprising) and that of the European Commission (the executive body of the European Community).

6. There are, of course, excellent all-purpose magazines put out by

organizations of evangelical physicians; and there is *Ethics and Medicine*, a middle-level journal with which this writer is associated.

7. From a personal communication, 1961, cited in Maurice Levine, *Psychiatry and Ethics*, George Braziller, New York, 1972, pp. 324f.

8. *New Oxford English Dictionary*, Oxford, 1978.

9. That of Ludwig Edelstein, *The Hippocratic Oath. Text, Translation and Interpretation*, Johns Hopkins Press, Baltimore, 1943.

10. The text of the Oath reads as follows:

The Covenant

I swear by Apollo Physician, by Hygeia, by Panacea, and by all the gods and goddesses, making them witnesses, that I will carry out, according to my ability and judgment, this oath and indenture:

Duties to Teacher

To regard my teacher in this art as equal to my parents, to make him partner in my livelihood, and when he is in need of money to share mine with him; to consider his offspring equal to my brothers; to teach them this art, if they require to learn it, without fee or indenture; and to impart precept, oral instruction, and all the other learning, to my sons, to the sons of my teacher, and to pupils who have signed the indenture and sworn obedience to the physicians' Law, but to none other.

Duties to Patients

I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them.

I will not give poison to anyone though asked to do so, nor will I suggest such a plan. Similarly, I will not give a pessary to a woman to cause abortion. But in purity and in holiness I will guard my life and my art.

I will not use the knife either on sufferers from stone, but will place to such as are craftsmen therein.

Into whatsoever house I enter, I will do so to help the sick, keeping myself from all intentional wrong-doing and harm, especially from fornication with woman or man, bond or free.

Whatsoever in the course of practice I see or hear (or even outside my practice in social intercourse) that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets.

The Sanction

Now if I keep this oath and break it not, may I enjoy honour, in my life and art, among all men for all time; but if I transgress and forswear myself, may the opposite befall me.

This translation by W.H.S. Jones in *The Doctor's Oath*, Cambridge University Press, 1924, with headings added and Jones' translations of Hygeia and Panacea as Health and Heal-all replaced.

11. There is some confusion over terminology. 'Passive euthanasia' is best taken to mean deliberately bringing about a patient's death through a planned omission or course of omissions. 'Active euthanasia' is killing the patient with a poison or some other means. To call the withholding or withdrawing of treatment at the end of life—when it has been judged no longer beneficial to the patient—'euthanasia', as some euthanasia advocates are prone to do, is deliberately to confuse the discussion. The withholding or withdrawing of treatment judged no longer beneficial is simply good traditional medical practice.

12. See, for example, John Keown, in *Ethics and Medicine* 8:2.

13. Cited, *ibid*.

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Response to Nigel M. de S. Cameron's *Bioethics and the Challenge of the Post-Consensus Society*

In his writing, journal editing, and teaching, Nigel Cameron has emerged as one of the preeminent voices in the emerging community of evangelical scholars working in bioethics. He has been sounding an alarm to the Christian community based on his interpretation of the present state of bioethics and the role of that discipline in society. Dr Cameron believes that the secular bioethics establishment is at the leading edge of movements within medicine, movements which themselves are signalling a sea-change in Western values. He sees 'bioethics' as more than a new discipline, but as a travelling entourage of scholars moving internationally from conference to conference, living on the resources of various funding agencies, and leaving in its wake a spate of institutes and a river of published materials. He sees irony in that this field, which historically had been the province of the

physicians most directly involved with the issues, today is dominated by academic philosophy.

Most central to his concern is that whatever their intramural disputes, secular bioethicists as a group are characterized by a rejection of traditional Christian and Hippocratic values. The movement's ambition is shown by the replacement of the proprietary term 'medical ethics' with the more expansive 'bioethics', showing its concern with all of life and its desire to reconstruct 'our culture's idea of what it is to be human'.¹ With its post-Christian agenda, the secular bioethics establishment threatens to shape the values of pluralistic society at large in ways that threaten to unseat traditional values. In view of these developments, Dr Cameron has called on the evangelical community to awaken to their responsibility to understand and dialogue with bioethics at the level of

its guiding assumptions, and not merely to respond to the particular issues that attract attention at the moment.

In this article, Dr Cameron continues this prophetic project with a critique of the role of bioethics in 'post-consensus medicine.' Post-consensus medicine has rejected its status as a profession guided by shared values rooted in Hippocratism and becomes a vendor of skills to be used according to client desires. These desires are themselves ungrounded and adrift in society's 'radical value pluralism.' He regards 'the new medical ethics' not as a guiding set of commitments and covenants but merely as a discipline for adjudicating decisions. In doing this, it relies heavily on the intrinsically unsuitable mechanism of 'patient autonomy,' which he calls 'the alleged engine of clinical moral choices'.

Dr Cameron has given us a provocative and insightful view of the 'big picture' of the present state of biomedical ethics. But how satisfactory is his diagnosis of medicine as having fallen from a state of Hippocratic grace into the sinister hands of bioethicists? Certainly he has correctly characterized certain tendencies and strands within the bioethics community. Cultural conservatives of every colour, and evangelicals in particular, need to become alert to the extent to which major sectors of the intellectual community repudiate basic value commitments. Nonetheless, his account of contemporary bioethics needs to be examined. In particular, I will dialogue with his depiction of bioethics community, raise questions about his account of the decline of Hippocratism and contemporary moral chaos in medicine, and discuss his treatment of consent.

I

Dr Cameron sees something rather ominous in the choice of the broad term 'bioethics' to refer to the concerns of these scholars and seems to protest at the expansion of the discussions of those concerns to those who are not healing professionals. On the first point, it is noteworthy that the term was introduced in 1971 by Van Rensselaer Potter, who had in mind the variety of issues raised by biological science, especially those related to the environment.² The term seems to have been appropriated by those interested in medical ethics because it reflected the broadened scope of the range of topics with which this new discipline would be concerned as compared to those that usually arise in clinical practice. Bioethics would be concerned with issues of human subject research, assisted reproduction, and recombinant DNA, for example, which would touch the practice of most clinicians only tangentially. Whether it is the case that some contemporary bioethicists now see themselves engaged in a project to reconstruct our 'image of the human,' the use of the term itself seems to connote no such concern.

'Bioethics' also better conveys the sense that these issues are issues not merely of professional ethics but of social ethics, of concern to the broader society. But how appropriate is it for scholars in other fields to intrude into medical territory? This is a complex issue, because it is true both that physicians have a distinctive ethical perspective in their dealings with their patients, and their actions need to be defensible in terms of general, publically

debatable principles.³ In a very thoughtful article, Grant Gillett notes a 'curious tension between the intuitions of doctors, which are almost always against active voluntary euthanasia, and the arguments of philosophers which are almost universally for it'.⁴ Gillett attributes physicians' reluctance to countenance euthanasia to 'a crucial element in the moral competence of a doctor,' which he identifies as 'a tendency to hesitate, have misgivings or feel a "pause" about certain principled medical decisions involving life and death'. The doctor who deals with medical cases has insights that are not available to the nonphysician ethicist, insights which might for example cause him to pause to reconsider his previously considered decision not to treat a severely abnormal baby upon hearing it cry. Reflecting on such a case, Gillett 'will argue that his momentary pause was morally significant rather than being the result of an irrational and distracting emotional reaction which should be put to one side in moral reasoning'. A doctor who failed to feel the pause at this cry 'betrays a moral insensitivity which calls into question his grasp of the moral content normally present in the relevant principles'.

Gillett calls attention to the respects in which medical ethics, to be done well, requires respect for clinical wisdom. Yet it should be urged that biomedical ethics must draw upon the wisdom of the broader community, upon philosophical and theological reflection. Conservative Christian ethicist Paul Ramsey has asserted that

the problems of medical ethics . . . are especially urgent in the present day. These are by no means technical problems on which only the expert (in this case the physician) can have an opinion. They are rather the problems of human beings in situations in which medical care is needed. Birth and death, illness and injury are not simply events the doctor attends. They are moments in every human life.⁵

We need not choose between the perspectives of Gillett, who upholds a particular professional ethic, and Ramsey, who argues for a universal one. Both must be kept in balance by the careful ethicist.

Dr Cameron seems to see the community of bioethics scholars as united in its relentless assault on traditional values, but is it indeed a powerful and unified bloc? First, how influential is academic bioethics, with its distinctive methodology, canonical texts, and leading personalities? While bioethics, like applied ethics in general, has had a great influence in the academy, it is not so clear that academic bioethics has a dominant effect on the values of medicine and of society.⁶ The role of bioethicists in medical practice has always been and continues to be limited and controversial, and it has seemingly little direct influence on the way the public frames its debates about moral issues. It is true that bioethicists tend to control the teaching of ethics courses in medical schools, although it is far from clear that overall they exert a great influence in the way young doctors learn their ethics. While only some medical students take ethics courses, all doctors learn medical morality by studying their mentors in clinical education. Philosophical and theological bioethicists have always been seen somewhat as intruders in clinical decision making, and many of the best ones

have admitted to 'temerity' in undertaking to speak to such issues and to the need to inform themselves of the way such issues are discussed in the communities of biomedical professionals.⁷ A noteworthy trend in the contemporary intellectual scene is to disparage those specialists who presume that their academic ethics preparation qualifies them to speak to the clinical or any other practical situation.⁸

Philosophical bioethics has even less influence in the discussion of bioethical issues in popular culture, notwithstanding the tendency of the media to consult bioethicists for reactions to bioethical news stories. While some bioethicists are known to the public, the distinctive careful methodology by which they come to their conclusions is hardly familiar to the public. In the abortion discussion, for example, as it is carried on in middle- and high-brow publications, one rarely finds the pro-choice position backed up by reference to the works of Judith Thomson, Mary Anne Warren, or Michael Tooley. The moral status of the fetus is perhaps the most heavily discussed aspect of the abortion debate in philosophical circles, yet it is hardly referred to in media discussions. Reference is made instead to such concerns as the putative need for women to have control over their own reproductive lives in order to enjoy professional and economic liberty.

It is also evident, and of paramount significance to an evaluation of the bioethics movement, that bioethicists are much more diverse than Cameron believes. While many bioethicists argue for a strikingly liberal agenda, such as the above mentioned three thinkers along with Peter Singer, Helga Kuhse, and James Rachels, more cautious voices abound, including Willard Gaylin, Leon Kass, Mark Siegler, Alexander Morgan Capron, Paul Ramsey, and a host of others. Insofar as I discern a pattern in the thought of the most respected members of the bioethical mainstream, I see it as more conservative than that of the public.

If contemporary bioethics is indeed moving away from its moral moorings, we may question precisely what is causing this shift. Cameron attributes this drift to the dominance of ethicists who argue on the basis of philosophical ethical principles towards conclusions that are incompatible with traditional medical and Christian values. Another possible explanation is that relativism and postmodernism are intruding into medical ethics. Most bioethicists are committed to principles, believe that there is objective moral truth, and accept rational argument as a way of resolving philosophical disputes. Argument can fruitfully be carried on with these more traditional bioethicists. Postmodern bioethicists, on the other hand, would not only favour a radical agenda, but would hold a position on truth and rational argument that would make impossible corrective discussion.

Edmund Pellegrino, MD, of the Center for the Advanced Study of Ethics at Georgetown University Medical Center believes like Cameron that the 'ancient ethical framework' of medicine 'is under the severest strain in its long history,' and that 'every one of (the) tenets' of medical ethics is being seriously questioned and is likely to be reformulated.' He argues that 'traditional moral supports have been weakened and precepts disassembled. Just what medical ethics will look like even a decade from now is highly

problematic.'⁹ Pellegrino parts company from Cameron, however, in his diagnosis of this problem. Although he agrees with Cameron that the problem is traceable to the involvement of philosophy in bioethics, it is the relativism, nihilism, and scepticism popular in philosophy today, not the principle approach, that contributes to a 'crisis' in the future of medical ethics.

According to Pellegrino, there have been four periods in the history of medical ethics. The first is the long period of Hippocratic traditionalism that existed until the mid-1960s, when the second step of 'principle-based moral theories began to reshape the Hippocratic ethic'. The third, rather brief, period, now coming to an end, is one of 'antiprinciplism, in which competing moral theories are challenging the primacy of principles.' He seems to have in mind the revival of casuistical, case-based ethical reasoning, and the virtue approach.¹⁰ The fourth period, the era that causes Pellegrino alarm, is the 'crisis' of postmodern, neo-Nietzschean philosophy with its undermining of any claims to objective moral truth. Pellegrino would say that Cameron has incorrectly identified today's problem with the second, principled, step, when in fact it is in the fourth, post modern period that bioethics is losing its footing in traditional morality.

What is the dispute between Cameron and Pellegrino, and what is at stake? They agree that bioethics is moving into some very undesirable directions, and they both attribute this in part to the severing of Hippocratic bonds and the role of philosophy. For Pellegrino, Cameron is misreading the history of bioethics and thus misinterpreting the contemporary situation. Would that it were the case that, as Cameron believes, philosophers still argued in terms of principles, Pellegrino would lament. The coming dark ages of bioethics will be a time in which will be allowed no claims to objective moral facts or to means by which they can be known.

Cameron takes evangelicals to task for their lack of interest in the ongoing debates of bioethics, and in that he is surely correct and is sounding a trumpet that all evangelicals should hear. Relatively few evangelicals indeed have distinguished themselves by their contributions to the bioethics debate, although fine work is being done by conservative scholars such as Richard Mouw, John Kilner, Stanley Hauerwas, Allen Verhey, and Dr Cameron himself, among many others.¹¹ If serious, pioneering work in bioethics is lacking in bioethical circles, much of the blame must lie with the evangelical community that has failed to nurture and encourage such scholarship. In this light, we might point a finger at those elements of the evangelical community that went to such lengths as to pressure a major evangelical publisher to withdraw a book that might have stimulated major debate, response, and eventually progress. For an account of this debacle, see D. Gareth Jones, 'Preface to the Revised Edition,' in his *Brave New People: Ethical Issues at the Commencement of Life*, in the revised Eerdman's edition.¹² If his views were unacceptable from a Christian standpoint, all of us were owed a clearly reasoned repudiation, rather than a silencing of his viewpoint. Clearly an environment in which bioethical issues are so settled in advance that cautious explanation is sought out and severely punished is not yet mature enough to sustain serious scholarship.

Even apart from the work of evangelical scholars, evangelical concerns are not unheard since they are often shared by the Roman Catholic and mainline Protestant theorists who have always been prominent in the field. In fact, there is evidence of a growing influence of the religious perspectives in ethics, including that of evangelicals. The work of the Park Ridge Center in Chicago, and its journal *Second Opinion*, is one example of an increasing interest in a religious voice in bioethics. Religious concerns still receive a hearing in bioethics.¹³

II

Central to Dr Cameron's argument is the thesis, developed in more detail in his book, *The New Medicine*,¹⁴ of the demise of Hippocratism and the baleful consequences of this demise for the profession of medicine. Hippocratism, a professional ethic originating in a minority of Greek physicians and cultivated by the Christian west, provided a covenantal basis for medicine. Such medicine was to be practised in relation to God (that is the significance of having it sworn as an oath) and in fidelity to the profession and the patient. Only such a commitment is capable of raising the practice of medicine above the merely 'contractual' and 'horizontal,' to which we are rapidly heading. Cameron sees the repudiation of the Oath as connected with the tolerance of abortion and the growing acceptance of euthanasia, both explicitly repudiated in the Hippocratic Oath, as well as in cosmetic plastic surgery and Nobel Laureate sperm banking, in which medicine markets responses to marketplace wants. Hippocratism, the watershed of humane values in medicine, is in decline, according to Cameron. With that decline, we might say that medical ethics becomes a sort of business ethics, seeking to enforce free business contracts.

While medicine must be based on a commitment to shared professional values rather than on the understanding of oneself as a vendor of service, will the Oath suffice for us today? Any attempt to make the Hippocratic Oath, either in the original pagan version or in the Christian version, *The Oath According to Hippocrates In So Far as a Christian May Swear It*, the normative basis for medicine will necessarily be fraught with difficulty, I believe. First, the Oath's crucial function of rooting medicine in a relationship between the professional and God encounters difficulties. As the text of the Oath itself reveals, the author or authors were polytheists, and for them to invoke the gods of ancient Greece is a different matter than for us to invoke the one God as the source of all Being and of all norms. The Christian version of the Oath, entitled *The Oath According to Hippocrates In So Far as a Christian May Swear It*, remedies this ill of pagan Hippocratism but at a price. As the property of only one of the faith traditions of modern society, it cannot claim the allegiance of non-Christians, and thus cannot bind the profession as such. I suspect that as Christians we could not endorse a generic Absolute Power that could appeal to the lowest common denominator of theistic belief.

Second, when we look into the religious and philosophical context of Hippocratism, we see more that gives

us pause even about their reasons for happily repudiating abortion and euthanasia. Hippocrates and his group were probably Pythagoreans, members of an Ionian sect who lived in a strictly regulated colony regulated by abstinence, silence, and probably secrecy about their doctrines and cult practices, who were known for their interest in health, mathematics, and philosophy, and their belief in reincarnation. Their opposition to abortion seems to have roots in old Pythagorean doctrines rather than in beliefs that are congenial to Christianity, including their repudiation of intercourse as a 'necessary evil' for procreation, and their physiological speculations on the composition of fetus as vapours from which soul and sensation emerge. Similarly, their prohibition of assisting suicide is based not on a Christian commitment to life as stewardship, but from the belief that embodiment is a divine punishment that one is not to attempt to escape.¹⁵

Third, the Oath in its original version would have to be reinterpreted to be applicable to modern physicians. While its prohibition of revealing confidences and refraining from sexual exploitation will have lasting significance, the prohibition of surgery and the restriction of the teaching of medicine only to males do not. On what basis are we to retain the more welcome aspects of the code while jettisoning the others?

While I endorse a covenantal model of the physician's responsibilities such as Dr Cameron upholds, I suspect that the reaffirmation of this covenant and of its duties today requires serious bioethical reflection rather than the reintroduction of an ancient code.

III

Much of Dr Cameron's criticism of the contemporary state of biomedical ethics is levelled at the contemporary use of the concepts of patient autonomy and informed consent. Cameron's attack on the consent requirement is theoretical as well as practical; theoretically, the requirement represents an abdication of physicians' ethics, and practically it is unworkable in ways that would be obvious if bioethicists didn't need it so much.

The current role given to these concepts represents 'a transfer of responsibility for ethics in medical decision making from the medical profession to the individual patient.' According to Cameron, bioethicists' concern for patient autonomy is simply a way of abandoning the enterprise of *medical* ethics and replacing it with 'as it were, patient ethics'. The shift to patient ethics allows physicians to countenance doing things previously rejected out of hand as inconsistent with the Hippocratic Oath; as Cameron correctly notes, a 'chief argument in favour of legalizing euthanasia/physician assisted suicide is that from patient autonomy.' He attacks autonomy, charging that 'the role of the rhetoric of autonomy has become that of a smokescreen, blinding not only patients and ethicists but even those parties who, wittingly or not, are playing their part in making the clinical-ethical decisions.'

Despite the heavy weight that consent is made to bear, Cameron notes that 'in so many situations—and especially the most serious—the typical patient is about as far removed as could be imagined from the well-informed

semi-detachment which might be held to be necessary for a morally serious, adequately weight-bearing choice to be made.' In his discussion of euthanasia, he notes that 'in the typical clinical scenario any exercise of patient choice will be severely circumscribed. So when such choices are, *prima facie*, being made, what is actually happening?' Bioethics has placed all of its eggs in an unsuitable basket.

It is unclear to me whether Dr Cameron rejects outright the concepts of autonomy and consent, or merely considers them to be overemphasized in contemporary bioethics. In any case, I believe that these concepts deserve and require a far more sympathetic reading than he gives them. While they may be beset by well-known difficulties, they remain indispensable if we are to do justice to human liberty and dignity.¹⁶ I would recommend that we retain the noble tradition of giving a primary role to patient autonomy and to the informed consent requirement that both expresses and safeguards it.

Thoughtful exponents of autonomy and consent have never seen it as an abdication of physician responsibility, but as an inclusion of the patient as a partner or co-labourer in the tasks of medicine. In an early classic of medical ethics, *The Patient as Person*, Paul Ramsey calls consent 'a chief canon of loyalty' between physicians and patients, and refers to it as a 'deontological dimension or test' which 'holds chief place in medical ethics.' Ramsey says that 'in this requirement, faithfulness among men—the faithfulness that is normative for all the covenants or moral bonds of life with life—gains specification for the primary relations peculiar to medical practice.'¹⁷

A theologically derived defence of consent is found in the recent book approaching bioethical issues from a Christian perspective by Hessel Bouma III and his associates. Loving other persons as images of God provides 'a strong and distinctly Christian rationale for obtaining the informed consent of patients . . . (a rationale) congenial with secular arguments for respecting a patient's autonomy rather than simply doing what is perceived as being in the patient's best interest'.¹⁸

The principle of autonomy and the associated consent requirement are rooted in the Hebrew Christian ethical tradition, with its affirmation of the dignity and liberty of every person. They have the advantage of a great deal of classical and contemporary support among philosophers, providing ample common ground on which to do bioethical work with nonbelievers. Autonomy has been given support by John Stuart Mill and Immanuel Kant. It is enshrined in the Nuremberg Code, enacted to provide protection of individuals from abuse at the hands of biomedicine such as was experienced in the Nazi regime, and is found in other major ethical codes. In law, it has a very important status and protects individuals from coercion, deception, harmful interventions, and slavery. Justice Cardozo said, 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body'.¹⁹

There is no inconsistency in being committed to honour the principle of autonomy and informed consent, while at the same time retaining an appropriate sense of the physician's professional responsibility. Paul Ramsey puts it well when he says that in gaining the patient's consent, we enlist him or her as a 'joint adventurer in a common

cause,' and it establishes not a 'contract' but a 'partnership' between them.

The difficulties of autonomy and consent are well known, but I will briefly review some of them here. Autonomy itself is criticized for its individualism by a variety of critics, including those associated with communitarianism such as Robert N. Bellah and his collaborators in *Habits of the Heart: Individualism and Commitment in American Life* and *The Good Society*.²⁰ There is, for example, an increased understanding of the role of family and an affirmation of the legitimacy of involving them in medical decisions.²¹ In an important article, Daniel Callahan has decried 'minimalist ethics' for much the same reason that Cameron does, for its reduction of all of ethics to mere respect for autonomy.²²

Consent has been long and widely attacked on practical grounds. The information that patients must assimilate, the degree of voluntary control they must enjoy over their actions, the absence of coercive influence by physicians and others, have all been held to be problematic for normal patients, and even more so for the dying, those in long term care, children, prisoners, and others. Franz Ingelfinger believes that the process of obtaining consent is little more than 'an elaborate ritual,' because patients and research subjects can hardly be expected to understand medical information, a view agreed to by Louis Lasagna.²³ Scepticism about the possibility of consent soon leads to laxity in requiring it. Ingelfinger believes that the only real protection of individuals is the responsible physician, while Lasagna believes that the best interest of society should override individual rights.

Against such dangerous scepticism, Tom L. Beauchamp and James F. Childress require of those who would consent to only what normal choosers, rather than what ideal choosers, bring to their decisions: the capacity to act intentionally, with understanding, and without controlling influences that determine the action. The authors 'only require a substantial satisfaction of these conditions . . . A person's appreciation of information and independence from controlling influences in the health-care setting need not exceed a person's information and independence in making a financial investment, hiring a new employee, or attending a particular college. The goal, realistically, is only that such consequential decisions be substantially autonomously.'²⁴ Ramsey too was alive to these problems, and called for 'reasonably free and adequately informed consent'.²⁵

Such reasonable specifications for fulfilling the consent requirement answer the problems raised by Dr Cameron. In cases in which consent cannot be obtained, various mechanisms have been introduced such as proxy consent, a durable power of attorney empowering another to make decisions as one would wish, and advance directives. These seem to address the most pressing concerns about those unable to give adequate consent on their own.

In conclusion, it is no exaggeration to say that the bioethics world has never been more in need of the principled, well-informed perspectives that evangelicals and other Christians can contribute. Evangelicals who would participate in these discussions must deal with distrust by some in their own camp and a secular bioethics environment which will continue to have greater difficulty

with claims to absolute truth. We will welcome any allies we can find, anyone who is willing to countenance the possibility of objective moral truth that can be known by human beings. As we uncertainly approach the turn of the century, I predict a greater need for the leadership of perceptive and committed Christian thinkers like Dr Nigel Cameron.

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Models of Nursing and Theories of Humanity: A Christian Perspective

The use of theories and models for nursing practice raises for Christian nurses a number of key questions. These questions are not so much related to the actual practice of nursing but rather they are questions about the philosophical assumptions which nurses make when adopting a given theory or model for practice. Many of the assumptions from which models and theories of nursing are developed are from a perspective that is contrary to those of a Christian nurse. Christian nurses themselves are often unaware of these assumptions or the implications

of using a model which reflects a different set of values and beliefs to which they adhere.

In order to help Christian nurses understand more clearly the implications in practice of their value and belief system a workshop for Christian nurses from Europe was convened and aspects of a Christian understanding of Humanity were discussed. The discussions of that group are presented in this paper.

The paper aims to reflect critically and constructively on assumptions that underlie various models and theories

of nursing and the grounds that theorists offer for adopting a set of values.

Introduction

The move towards the conceptualization of nursing practice has resulted in the development of many different nursing models and theories. These make explicit or implicit assumptions about the nature of human beings and the values that influence their world views. Models typically aim to reflect and to influence practice. In either case there are, of course, dangers. For example Walker and Avant (1984) suggest that nurses should be developing their own models for practice as a reflection of the clinical situation. If a model is constructed in this way, it runs the risk of being a simplistic representation of practice which is unable to direct or initiate change. The traditional medical model is therefore perpetuated as many nurses are currently most comfortable working within its framework. Models must review as well as analyze and conceptualize practice. On the other hand this may lead to a model being wrongly forced on a situation, leading to disillusionment on the part of the practitioners in addition to a sense of failure on the part of theorists or students.

Undoubtedly, the underlying values and assumptions of models influence the nature and aims of nursing and the roles of the patient/client and the nurse. These need to be identified. For nurses who hold religious beliefs these values and beliefs may present a conflict with those arising from a theological world view.

Within this paper no major distinction is drawn between theories and models of nursing and no attempt is made to distinguish them. Generally speaking, theoretical frameworks take various forms of which the model is one. Models include theoretical constructs. The word 'model' as used in this paper, encompasses theory and model.

1. Critical Questions:

i) Terminological issues

Many nurses are unclear about the meaning of terms. This may have to do more with factors external to the models than the models themselves. Nurses often encounter a term in practice or in a secondary source without reading the original work, which leads to lack of clarity in understanding and lack of precision in use. There are familiar difficulties with translation, including cross-cultural translation of terms within the same language, e.g. between the United States and the United Kingdom. Some difficulties are attributable to the models themselves. Different models employ some terms differently. For example Orem (1985) uses the idea of self care in a relatively sophisticated way: it is a learned activity that 'purposely regulates human structural integrity, functioning and human development' (Orem 1985) but it is often interpreted as meaning a more general type of independence such as is described in the Roper, Logan and Tierney Activities of Living model (1980). It is also true that concepts used in particular models may be interpreted in terms that reflect a particular cultural framework. For example, assumptions about the

meaning of self care may not reflect the positive focus intended by the author on individual attainment which is so valued in North America; in Europe that notion may be taken as meaning something different, perhaps less desirable. The overall implications of a model cannot always be gauged.

ii) Grounds for adopting a set of values

Models may omit a statement of the grounds for adopting a set of values. It is recognized that some models have limited objectives, are devised for a restricted context and clearly set out both their purposes and the values that underpin those purposes. If there is a call for values to be grounded, then clearly the proposed scope of the models must be taken into account. Where however the purposes are broad and contain fundamental perspectives on humanity and human values, two requirements are in order which are often not met. The first is a *statement* of the grounds on which certain values are adopted. The second is the *justification* of the view of humanity taken when such values are proposed. Proposals about health or nursing typically presuppose a view of what it is to be a person, of what counts as human flourishing, well being or fulfilment, and of what counts as the social good. That is, there is a world-view. An ethical standpoint is undergirded by values; values are undergirded by anthropological convictions, anthropological convictions assume some ontological account of human being, ontology meaning a description of the nature of reality.

It may be objected to this that models cannot be reasonably expected to offer the comprehensive account that is envisaged. However broad the model, no one can expect an entire world view to be described and defended in the context of nursing purposes. As regards a comprehensive account, this objection seems fair. But it remains the case that models contain or operate on certain assumptions. If they are proposed for the benefit of the whole nursing community, those assumptions and their grounds should at least be indicated which frequently does not happen. For example Neuman (1982) refers to gestalt and field theories along with the ideas of Teilhard de Chardin and Sartre, but she nowhere explicates these ideas nor specifies their relation to the model. In the case of Leininger (1978) there is a failure to acknowledge in many instances the anthropological roots from which many of her ideas have developed. On the other hand Benner and Wrubel (1989) give us an example of an approach to nursing in which such grounds are made relatively explicit. They base their ideas on the phenomenological aspects of Martin Heidegger's thought and the teachings of H. L. Dreyfus and R. S. Lazarus. The relation of practice to theory is Heideggerian also in the work of Taylor (1962, 1982) (1985) and MacIntyre (1981). So 'primacy of caring' has an existential basis where 'care' is situated within a view of being in the world, as Heidegger interprets it. The compatibility of Heideggerian and theistic frameworks is doubtless a complex enough question. But Christian nurses must be aware of possible incompatibilities. Models have occasionally been grounded in Christian theological convictions. Caring is central to Erickson's (1991) development of caring science where the ontology of caring science is presented as an auton-

omous discipline. Humans have a spiritual dimension such that to be human is to be basically religious. Of course this is not universally accepted. Because humans are held in this model to be religious there is no harm in thinking of caring autonomously as though religion could be left out of it, for a proper caring science would take into account the religious nature of human beings. Erickson (1991) uses terms such as the 'caring theology' to advertise a holistic view of the human being. Both the origin and the explanation of her concept of caring is theological.

iii) *Psychological and religious needs*

Models typically do not relate the psychological and religious needs of patients satisfactorily. Most models try to address needs that are simply present in the culture and this includes religious needs although they may not make specific reference to them. The religious needs of patients or clients are often viewed as just a species of psychological or cultural need. Psychological and cultural need may be regarded in general terms just as human existential needs, or more specifically as human spiritual needs. The concept of a specifically religious need may itself be a very general concept. There are different religions and it would be unrealistic to require of a model that it cater for all these needs in their specificity. But it may be necessary to talk specifically of religious needs, embracing different forms of religion. Models should have reference to religious needs. Of course it may be said that to call a human need 'religious' is to offer an interpretation, one that may be challenged. Whatever religious people think, their needs may not be genuinely religious: e.g., they may think that they need God, but they really do not. Whether or not this is the case, the fact is that religion has been historically and culturally crucial in human formation everywhere over the centuries. Humanity has been shaped by *perceived* religious needs, whether or not there are correspondent religious realities. A model of nursing which fails to take this into account is surely defective. The importance of people's beliefs and religion has been shown in the WHO (Euro) nursing study (1987) which found that 57% of the 1154 subjects studied affirmed the importance or centrality of their religious beliefs.

2. A Theistic dimension

This paper now moves towards an increasing specificity identifying the lack of a *theistic* dimension in models. The theistic dimension is narrower than a religious dimension, for it takes in just one form of religion, that which characterizes Judaic, Christian and Muslim and occasionally Hindu belief in God. Belief in one God, theism, or monotheism distinguishes those religions from most oriental philosophies and Western phenomena like the New Age religion. Within theistic perspective, belief in God shapes the view of humanity and ethical values. Why should models take into account such perspectives? Even if the need to take religion into account is granted, is not the theistic requirement intolerably narrow? Why cater for a particular, presumably minority religious group? Attitudes towards theism implied in the models affect their acceptability or effectiveness for theists. If values are

not explicitly or implicitly grounded in the nature of God, the models that espouse them cannot be expected to be regarded as universally valid. If models exhibit the ground of their views, they will stand in some relation, positive or negative to theism, hence the lack of positive or negative reference to theism constitutes a weakness.

In brief, our religion and its beliefs affect our perceptions of humanity and so make a significant difference to our understanding of nursing theory and consequently to nursing practice.

3. Assumptions made within models and theories

There are assumptions made in most models about harmony, human agency and the relation of humanity to the cosmos which Christians may wish to challenge.

i) *Harmony*

Many models seem to operate on the assumption that values in life can be integrated in a harmonious whole, life's parts fitting together smoothly. Yet of the 23 or so models compared by Fitzpatrick and Whall (1989), only Watson (1985) gives an explicit definition of health in terms of harmony.

Watson views health as a harmony of mind, body and soul. This entails the congruency of the self as perceived from without and the self as experienced from within. The goal of nursing is to help people gain a higher degree of harmony. This goal is pursued through the mutual caring process and the inter-human transactions that relate to the inner world of the individual so that the nurse helps that individual find meaning in his or her existence. Where suffering, turmoil and thus disharmony reign the nurse promotes self control, self determination and choice. As Watson puts it '... Care and love are the most universal, the most tremendous and the most mysterious of cosmic forces: they comprise the primal and universal psychic energy.' Watson here refers to Teilhard de Chardin, a Jesuit thinker who held God to be the source of this love (although the model does not make this point and is open to interpretation in a non theistic way). It is not that Watson denies disharmony as a phenomenon to be coped with but the goal is to move people towards harmony. There is a wider context for this conviction, as we find when movements for global peace and prosperity are reflected in statements such as the WHO understanding of health as a 'state of complete physical and mental and social well being and not merely the absence of disease and infirmity.' (WHO 1946) These sentiments have been widely criticized as unrealistic but appear to exemplify an ideal many think we should pursue. It is necessary to be critical of the unrealism which is rooted in false perceptions of human reality and human destiny. It is true that humans long for and in their constitution are geared towards some form of harmony. More: harmony and integrity can in a measure be realized. However there are two difficulties. Firstly, it is maintained that harmony is attainable in the present. On what basis? Secondly, it is maintained that harmony so attained is attainable as a purely human project. On what grounds? In relation to the first point if harmony of body, mind and spirit is available (typically in the context of cosmic

harmony) the paradoxes and rough edges of human reality and experience are subjected to gratuitous and artificial schematization. In relation to the second point Christians hold that if harmony is understood in purely human terms, as a purely human project without reference to God, then an unrealistic view of human powers and potentialities is present.

ii) Human agency

The question of the nature of personhood is fundamental. In some instances human beings are viewed too passively in models with human activity wrongly conceptualized. A kind of determinism can prevail that reduces the role of human initiative and activity. Adaptation models are an example of a tendency to imply that human beings merely respond to stimuli arising out of the environment or to the internal stimuli over which they have no control. The greater difficulty for Christians however lies with the prevalence of the opposite extreme in thinking: over emphasis on human activity in the form of self-determination and the potential for self improvement. Self determination can itself take at least two forms. Firstly there is a view of human autonomy which is a kind of utilitarian individualism. Health becomes a virtually unqualified achievement of personal goals. Secondly, there is a kind of expressive individualism. Here individualism is located in the context of attaining social and even cosmic identity. It is individualism, because there are alternative and optional identities, but the nature of that identity is not merely personal.

In general two difficulties arise from an over emphasis on self determination. In the first place, one may over estimate the degree to which humans can determine themselves. In the second place, one may neglect those persons whose condition makes them more receptive than active as agents, whose position requires that we think of them in terms of love and compassion.

Some models allow for this even if they may be misapplied. Sometimes the problem lies in the model and not the application. Orem's may be an example of the former (1985) though on a common (but not necessary) interpretation, its utilitarian aspects intrinsically over emphasize self determination. An example can also be given from the 'expressive' aspect of Rogers' model, with its emphasis on the realization of potential.

iii) Humanity and the Cosmos

According to one view of humanity in its relation to the cosmos, there is a bond whereby humans are integrated in their essential being into a cosmic whole. In this view, God, humanity and the world constitute a cosmic unity. This standpoint is often connected today with the New Age ideas and is further associated with particular techniques, for example meditative techniques which are designed to realize this unity. This is a position as Christians we should reject. While one may believe that humans may be brought into a deep kind of unity with God and hope ultimately for a perfect integration of humanity and world order, there is a theistic distinction between God, humanity and the world. A model of nursing offered by Christians would not only avoid elements of an understanding of humanity which under-

mine the beliefs and values of Christians but would also need to emphasize those elements which are relevant to the theory and practice of nursing for a Christian nurse.

Positive elements for incorporation into a Christian model of Nursing practice

The following nine points do not constitute a model for nursing, but they do affirm its theory. They set out a perspective on human beings which informs our assessment of models and state the requirements of theories.

1. Christians view humanity as created, fallen and redeemed. Humanity thus is constituted by a law that is not of its own making. To fulfil the purpose of the creator and attain a destiny that is beyond this world, God has reclaimed and redeemed human creatures. Such is the broad Christian perspective which is the bedrock of Christian belief.

2. A Christian world view is not essentially the product of a reason which surveys worldly reality and definitively interprets it from its own resources. But the theological explanation is offered as the most plausible interpretation of an order we all encounter, as an example of the interplay between peculiarly religious conviction and the broader possibilities or reason we take as human beings. It is difficult to explain moral experience if humans are the product of purely accidental evolution of systems (biological naturalism) and not of a purposeful creator. Those who argue for compassion and kindness as things that are right and good while callousness and cruelty are wrong and bad typically affirm some objectivity for their moral beliefs. If these beliefs were merely human artifacts, no one could quarrel morally with those who held that we should treat people in a cruel and callous fashion or who held compassion to be morally optional and not objectively good. If these beliefs are not merely artifacts, they have an objective validity relatively independent of human beings. Christians hold that this is the case and that objective values are best explicable on the basis of belief in God, their ground and source. There is no attempt here to offer proof of this outlook. It is philosophically debatable. The point is to indicate how a belief based in Scripture nevertheless may function to explain and interpret the world of common human experience.

3. A Christian perspective on humanity makes an important difference to nursing in at least two respects. Firstly it accords humans a distinctive direction. If one asks: 'what is the goal of self improvement?' or 'in what direction should we strive for self actualisation?' a distinctive answer is given, irreducibly in terms of God. Secondly, it has a distinctive view of the source of spiritual power. God, as a power external to us, offers us his transforming power within us. This has immediate implications for notions such as 'self repair'. It is important to speak of divine power or the impression will be given that theistic belief is simply assent to proposition: the proposition that God exists.

4. If humans are compounded of a law of creation and a flaw of constitution, disharmony is essential to the human condition as we know it. Medicine has for years empha-

sized dimensions of psychosomatic unity and Christians concur in this emphasis in as much as disharmony affects both body and spirit. Redemption achieving spiritual and bodily wholeness and harmony with the created order, is a divine promise and so the object of hope dependent on God. ('Harmony' may not be a natural word to express this conviction theologically, but it is consistent with the scriptural notion of a peace that will be all encompassing and destined to banish bodily and spiritual disease). The crucial point is that perfect harmony is a future hope, not a present prospect. There is, of course, a reconciliation with God which brings spiritual peace and integration in the present even when growth is necessary. But while spirit can be healed at deepest level, the body always remains subject to fundamental frailty. This is not to deny, obviously, the possibilities of a considerable measure of healing in which nurses play an important part.

5. Emphasis on the future does not deter from caring for the body in the present. On the contrary, where hopes are pinned on present improvement of the bodily condition there is liable to be disappointment. A hope of future wholeness, sustains efforts in the midst of disappointment. Christianity is a religion of love and not just of hope. This love is directed towards every aspect of the being of others. Love is an infinite passion directed towards finite beings so it is concerned for bodily needs in the present. But creaturely finitude must be emphasized. Finitude distinguishes the creature from the creator, it is not itself the cause or source of disharmony. It is the conflict of elements within our finite condition, not our very finitude that creates problems. That is the conflict of life subject to the law of creation and life subject to disorder, traditionally described in terms of sin and its consequences.

6. Human love must be related to belief in God as love. While God is not merely love, he is in his very identity love. Love is likewise at the heart of human reality. For humans are created in the image of God. According to St Paul, faith, hope and love are three cardinal virtues, but none is greater than love (1 Cor. 13:13). Love is supreme because it is divine. Faith and hope are not naturally ascribed to God. But God is love, reconciliation with God through Christ is communion with the God of love through grace. The love of God thus comes to form the life and being of the believer. Although this does not mean an abolition of the distinction between divine and human, infinite and finite, it does mean a form of union between infinite deity and finite humanity.

7. This does not pose problems for understanding how those who are not Christians, including nurses, have the capacity to love. On the contrary it explains it. Christians hold that God is not just present in or to believers. God is present in or to believers only because he is first present as the ground of all reality. God is the only source of goodness. Christians do not just acknowledge, they rejoice in evidence of goodness outside of Christianity. For any goodness is from God. Nevertheless if that is the case it is clear that humans flourish effectively, receive secure direction or experience sufficient power, only when God is known. Hence the difference made by a Christian perspective.

8. Christianity does not provide prescriptive detailed answers for all dilemmas in nursing, more than in other spheres. It provides principles but not detailed regulations governing every situation. So two things are safeguarded. The first is the genuine difference between individuals. Humans are not one unvaried entity. The second is the genuine place of creativity in the discernment and application of principles. Humans are not purely passive. A lot of things go into judgement: principles, value, understanding of people, professional knowledge, and sheer experience. Love matters here for the reason that lack of love clouds judgement whereas love clarifies it.

9. Finally, is the emphasis on love unrealistic? No, it is not. Rather models often contain tacit explanations of nurses that could not be realistically fulfilled without love. Love governs a diverse set of operations. For example; love bestows on people a sense of self worth and personal identity. Our identity as persons is grounded in God's decision to create and redeem us in love. Love is at this point indiscriminating for one person is not intrinsically more worthy of love than another and we should seek to care as deeply for the one as the other. But the unifying aspects of love go along with its sensitivity to diversity. Obviously there are diverse kinds of caring. There is such a thing too as natural preference in human relationships. If this were not so, natural friendships and marriages could not be formed. Temperament and temperamental differences are part of the natural constitution of humanity. What love does here is to prevent natural preference from collapsing into active dislike for someone. Jesus is the model for Christian love, and it is not possible for us to think of him in terms of active dislike. Love here enjoins us in the discipline of overcoming natural dislike, expressed as it can be in impatience and unconcern. So love transforms dislike first into acceptance and even into positive liking though natural differences in likes remain. The appeal to love, then in relation to nursing, is an appeal to a distinctive direction and power in service.

The concluding reflections on love invited a concluding caution in relation to models of nursing. It is accepted that there is a need for models, the importance of professionalization and the role of proper academic enquiry into the principles and practices of nursing. But we need also to retain a dimension prominent prior to contemporary moves in the professionalization of nursing. Traditionally, nursing has had a vocational sense attached to it with simple but deep love motivating the care. The language of 'vocation' may be controversial; but theory, model and professionalization must not be allowed to stifle love or eclipse its nursing importance. Human relationships are rooted in human contact and only love makes a proper channel of healing.

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Consistent Bioethics and Christian Consistency

The joining of the words, bios and ethics, into bioethics may seem superfluous. Can there be, one may ask, an ethics which is not about life or bios? Bioethics is on its way to be a kind of ethics which is more about success in manipulating life than about life itself. In the process, bioethics compromises its claim to being a science, that is, a consistent reasoning.

The process is already parading on the front page of major newspapers. A case in point is the triple headline in the November 26, 1992, issue of the *New York Times*. The first headline was about 'success in using fetal tissue to repair a brain' impaired by Alzheimer's, Parkinson's and Huntington's disease. The second was about 'hopeful breakthrough'. The words 'success' and 'hopeful breakthrough' served to mollify those relatively few who may have had ethical reservations about success as an ethical justification. Indeed the third headline claimed that the technique could benefit those with degenerative diseases and alter ethical debate'.

Throughout the report, which covered more than half a page, the word ethical has not occurred even once. But there was no shortage of references to scientists who described the technique as 'feasible' and the results as 'spectacular' or 'dramatic' that fulfill an 'almost excessive promise'. This repeated emphasis on success was to oppose doubts that might arise about the ethical character of the procedure. Everything was done to de-emphasize the cost, about thirty thousand dollars per patient, of the successful operation. The smallest factor in that cost was the price of embryos. Fetal tissues are very cheap in a land where over two million or more abortions have been performed every year for the last thirty or so years.

Still, as little as possible was to be said about the fact that in each case one needed 'multiple abortions to be scheduled within hours of the five-hour fetal implant operation'. Dwelling on this and similar details of the procedure might have, of course, increased the number

of those relatively few who on grounds other than religious oppose abortion. In Western democracies by far the largest number of those who oppose abortion or hold the sanctity of human life as a basic bioethical principle come from religious groups—non-liberal Christians and orthodox Jews. But they are not supposed to speak of their religious reasons in public and in legislative debates. The assumption is that such reasons are not rational.

This separation of the religious from the rational, or in our case, the religious from the ethical, has many illustrations. A most interesting example was provided by Eunice Kennedy Shriver, sister of the late John F. Kennedy. She protested against those who referred to her brother as one who would have opposed the anti-abortion stance of Catholic bishops in the United States. She insisted that her brother firmly endorsed the right of anyone to free speech. She also claimed that her brother had a positive and comprehensive view on human life and fetuses and that this interest reflected his moral values.

Without specifying what that comprehensive view and those moral values were, or what was their source, Eunice Kennedy Shriver held them to be different from her brother's religious views and values. She asked in the same breath: 'Do we not understand that religious beliefs and moral values are not the same?' A fearsome question, hiding a fearful misunderstanding. In Eunice Kennedy Shriver's case that misunderstanding produced the statement that while respect for human life from its inception is a moral value, it is 'not a religious doctrine like belief in the virgin birth, or even the sacredness of Jesus'. (Letter to the editor, *New York Times*, May 13, 1990, p. 18). She obviously thought that only those propositions are religious that one can know only through revelation.

She seemed to forget that in the context of biblical revelation not a few propositions are offered that can also be known by mere reason. There is no need for revelation to know that killing is a seriously immoral act. Does this

mean that the fifth commandment is merely an ethical truth and not also a religious truth? The same could be said about theft and lies.

In modern democracies the separation between religious beliefs and moral values is now being pushed to the extreme. In the process, morality, or ethics, is becoming a mere cover-up for something else. That something else is the taking of statistical patterns of behaviour for ethical norms. But when any such pattern is allowed to parade as a norm, no norms will be left. The result is a march into the marshlands of ethical relativism. There bioethics ceases to be a science, that is, a consistent discourse about ethics.

The relativistic view of ethics has received a notable endorsement in a recent book by Laurence H. Tribe, professor of constitutional law at Harvard University. Already, the title of his book, *The Clash of Absolutes*, indicates this relativist approach. It is, of course, true that both the pro-abortionist and the anti-abortionist sides hold their respective positions as absolute truths. Professor Tribe, a staunch advocate of the right to abortion, resolved this conflict by redefining the absolute: 'Absolutes themselves may be contingent; they arise out of particular social contexts, problems, and concerns that change as society changes.'

The claim that 'absolutes may be contingent' is a perfect case of what George Orwell called 'doublespeak'. We know whom he had in mind. Their Hungarian victims would, however, be wrong in thinking that their now liberated language is always on high moral ground. About many a statement concerning bioethics, now current in Hungary, one could say what George Orwell said in 1947 in an essay about 'Politics and the English Language': 'One ought to recognize that the present political chaos is connected with the decay of language . . . Political language—and this is true of all political parties, from Conservatives to Anarchists—is designed to make lies sound truthful, and murder respectable, and to give an appearance of solidity to pure wind.'

This is what has been happening for some time in secularist bioethics. It is ruled by the consideration that the majority is morally right, which, of course, is no more than to claim that statistics is the supreme moral principle. Proponents of that bioethics also hold as supreme principle the quality of life, without ever giving a specific definition of what is meant by that quality. Clearly, it cannot mean a perfectly or even essentially healthy life. In that case most of mankind would lose its right to live.

If absolutes are contingent, it makes no sense to think about bioethics as a consistent field of inquiry. In other words, any society which lives by the rule that it is free to change its moral philosophy, has no right to a bioethics based on unchangeable propositions. Therefore modern democratic society will have to settle with a bioethics that can be rewritten, at least in part, with every new progress in scientific success. Legalization of success will then be a routine matter for a new parliament or for another referendum. Such a society can claim consistency only by being consistent in not claiming it.

Bioethics as a truly consistent science can be had only on two conditions: one is the stating of a set of propositions that are absolutely valid. Such are propositions that

cannot be reduced to any other propositions. Among such principles are the sanctity of the human individual and that such an individual is not emerging slowly from embryonic development but is present there from the very start of that development. Scientific arguments, taken from genetics, may help in this respect, but they will not clinch the argument.

It should be enough to think of most specialists of Hox genes. In the report about their recent biennial meeting none of them was quoted as seeing a proof of the sanctity of the individual in the marvellous effectiveness of those genes in the earliest phases of human embryonic development. Yet some of them saw in the operation of the Hox genes a replica of the old Aristotelian theory that the male sperm carries within it a homunculus, a miniature but fully formed man, only to grow to full size in the womb. In fact some of them even saw a strange parallel between the Hox genes and the homunculus Jesus often drawn within the light beam that carries, in Renaissance paintings of the Annunciation, the message from the Archangel Gabriel to Mary. (See report in *New York Times*, Feb. 23, 1993, pp. C1 and C9).

This, of course, may lead immediately to the second part of the title of this presentation, Christian consistency. Such a consistency has something to do with Christ, to say the least. He indeed laid down some very stark principles of consistency for his followers. Suffice it to think of his words about the impossibility of serving two masters. Or his warning that anyone who had already put his hand on the plough must not look backward. Or his comparison of the Kingdom of God with the precious pearl for which one had to sell all that one possessed. Or his request that one should part with one's own eyes and hands if they prevented one from entering the Kingdom of God. Or his warning that his followers should be consistent to the point of being ready to take up their cross every day. And by that cross he did not mean some little daily inconvenience but the most cruel form of execution ever devised by man.

There should be much food for thought in these statements of Christ for Christians who think that while moral compromise is not possible in general, it is possible in some bioethical matters. Christ was certainly most compassionate but never to the point of compromising, that is, to being inconsistent with any principle laid down by him. He did not hint that some lasting profit still could accrue to the one who gained the whole world but in the process lost his very soul. Unless one takes these words at face value, one will side with those who have been conducting a campaign of vituperation against John Paul II, following the release of his letter to the Catholic archbishop of Sarajevo, dated February 2, 1993. The Polish pope urged that victims of rape who are about to give birth to unwanted babies be supported with full Christian love. Indirectly the pope voiced a consistent view of the unconditional moral evil of abortion.

The charge against the pope is that he has no compassion. But once compassion is set as a supreme standard one is left speechless in reference to that mother, daughter, and their doctor in America—all Christians of Polish descent—who were the first to carry out a new experiment in bioethics. It consisted in implanting the married daugh-

ter's fertilized ovum in her mother's womb so that the daughter, with a defective uterus, might have the fulfillment of becoming a mother. Together with their doctor, they invoked the principle of Christian compassion.

False appeal to Christian compassion can be made not only by individuals but also by large Christian denominations. A case in point is the decision made in early September 1991 by the General Assembly of the Evangelical Lutheran Church of America, with more than five million members. Its monumental exercise in inconsistency took place in reference to abortion, an exercise approved by 905 of the delegates as against 70. On the one hand, the General Assembly declared that 'Human life in all phases of its development is God-given and, therefore, has intrinsic value'. But the Assembly also endorsed abortion 'as an option of last resort'. To tie these two irreconcilable statements together the Assembly had to resort to an ambiguous use of the word 'presumption'. According to the same declaration 'the strong Christian presumption is to preserve and protect life'. But do we, Christians, have a Christ-given freedom to barter principles for presumptions, and lose consistency in the process? Would not this be the worst kind of presumption to be made by a Christian?

This dawned on a doctor who became a pastor in a fundamentalist Christian Church, again in America. All of a sudden he stopped performing abortions. Then he was approached by a woman with circulatory problems who had already had one stillbirth, but gave up the use of contraceptive drugs and became pregnant again. She now asked the doctor to perform an abortion. He refused. He said that before he had become a pastor, he might have done it. 'My circumstances have changed and I have tremendous responsibility in the church . . . Saying "no" was very difficult in some sense. But in another sense, it was easier because my decision was made for me.' (*New York Times*, Sept. 8, 1991). He obviously meant that Christ has already decided for him. It was another matter whether the doctor's endorsement of contraceptive practice as a 'conscientious use of birth control' was consistent with that decision of Christ and with the sign in the doctor's office that Life Is Sacred.

All this illustrated that even within Christian ranks there is still an awful lot to do toward a consistent bioethics. Outside Christian ranks bioethics is already governed by opportunism. Every new offering is convenient. Such a bioethics is a caterer to expediency. To make matters worse, the legislative implementation of that ethical meandering will be taken for ethics. Only a few realize that a chasm has, for some time, been opening up between legality and morality.

What about a country like Hungary? It is a traditionally Christian country, it still counts many Christians, though not as many as we would like to think. And it counts many others as well. In such a country, which is a typical Western country, bioethics will be formulated in various ways. Far from all of them will be in compliance with Christian principles, let alone in a consistently principled way which is Christian. There will be a variety of bioethics. Obviously the one which will be legislated and re-legislated will fall short of the Christian ideal.

The question is how short. The answer to this depends

partly on the number of Christians and on the measure in which they are consistent with their Christianity. First, Christians must not forget that democracy, like any political system, is merely the art of the possible. And as long as Christians keep in mind that they live in a fallen world, they will not look even on democracy as the art of the impossible. Democracy is not a mechanism that assures justice, but rather a framework that gives anyone the right to struggle for justice as he or she sees it. The point was succinctly made by Masaryk around 1922 when Hungarians in the newly formed Czechoslovakia asked him how many rights they would have. As much, Masaryk replied, as they will struggle to acquire for themselves.

The same answer is true of Christians within the mechanism of modern democracy. They will have to struggle and do so consistently. They should also know that Christ would never reconsider his statements that his followers will forever be under pressure in this world. Christian consistency is not so much a question of arguments as of persuasion, or prayer, and of heroism, if necessary. In a growing number of cases secularism is acting—through its universities, academies, television, radio, publishing houses, news media and political mechanisms—in a dictatorial way within an allegedly democratic context.

The following may indeed take place in the not too distant future. It is a scenario written in 1981 by one of the great 20th-century American writers, and certainly the greatest American Catholic writer of our times, Walker Percy, a doctor turned novelist. In a letter which he wrote to the *New York Times* (published in its June 11, 1981, issue) Percy noted the irony that in supporting pro-abortion legislation, the secularists, usually swearing by science, now try to ignore an elementary scientific fact. It is the fact that the life which begins from the moment of the fertilization of the ovum is a human life and nothing but human. Then Percy conjured up a court case with a biology teacher in the dock. He is told by the judge that it is merely a personal opinion that a fertilized human ovum is an individual human life. He is also told by the judge that in public schools no one has the right to propagate private opinions. The biology teacher, Percy continues, caves in and, like a modern Galileo, submits. But in turning away he is heard to murmur: and yet it moves, it's alive.

Such a confrontation is now appearing on the horizon in America, the leader of world democracy with an ever heavier touch of secularist totalitarianism. A proof of this is the latest American legislative programme, called FOCA (Freedom of Choice Act). If enacted, any doctor can be thrown into prison if he or she refuses to perform abortion and other new-fangled bioethical acts. If FOCA becomes law, Catholic hospitals, which in the United States form 15 percent of all hospitals and last year alone cared for 56 million patients, can be penalized for not allowing abortion and similar medical acts of bioethical 'success' which are and remain radically immoral from the Christian viewpoint.

Christians will be under pressure, but pressure alone will assure their sameness as Christians as time goes on. For as long as Christians are under pressure, they can be sure that they are the followers of Christ, the pledge of

consistency or sameness. It is about him, and him alone, that could be stated that he is the same—yesterday, today, and forever.

The author, born in Hungary, is the 1987 winner of the Templeton Prize. He is Distinguished University Professor at Seton Hall University. This paper was presented at the 1993 Budapest Conference in Bioethics.

Major Conclusions and Recommendations from the Final Report of the NIH Human Embryo Research Panel

September 27, 1994

Guiding Considerations

The Panel concluded that certain areas of research involving the preimplantation human embryo are acceptable for Federal funding within a framework of stringent guidelines. Three overarching considerations led the Panel to this conclusion:

- the promise of the human benefit from the research is significant;
- the preimplantation human embryo warrants serious moral consideration as a developing form of human life, but it does not have the same moral status as infants and children because of the absence of developmental individuation, the lack of even the possibility of sentience and most other qualities considered relevant to the moral status of persons, and the very high rate of natural mortality at this stage; and,
- Federal funding of such research would provide consistent ethical and scientific review at the national level to an area of research that has been ongoing in the private sector without such review and public scrutiny.

Definition

'Preimplantation human embryo' is defined by the Panel as a fertilized ovum in vitro that has never been transferred to or implanted in a uterus. This includes a fertilized ovum that has been flushed from a woman before implantation in the uterus. This procedure, which is both infrequent and poses special risks, is included because it is one potential source of embryos.

General Principles

The following general principles should govern Federally

funded research involving the preimplantation human embryo:

- The research must be conducted by scientifically qualified individuals in an appropriate research setting.
- The research must consist of a valid research design and promise significant scientific or clinical benefit.
- The research goals cannot be otherwise accomplished by using animals or unfertilized gametes. In addition, where applicable, adequate prior animal studies must have been conducted.
- The number of embryos required for the research must be kept to the minimum consistent with scientific criteria for validity.
- Donors of gametes or embryos must have given informed consent with regard to the nature and purpose of the specific research being undertaken.
- There must be no purchase or sale of gametes or embryos used in research. Reasonable compensation in clinical studies should be permissible to defray a subject's expenses, over and above the costs of drugs and procedures required for standard treatment, provided that no compensation or financial inducements of any sort are offered in exchange for the donation of gametes or embryos, and so long as the level of compensation is in accordance with Federal regulations governing human subjects research and that it is consistent with general compensation practice for other federally-funded experimental protocols.
- Research protocols and consent forms must be reviewed and approved by an appropriate Institutional Review Board, and for the immediate future an ad hoc review process which extends beyond the existing review process to be established by the NIH and operated for a period of at least three years.
- There must be equitable selection of donors of gametes and embryos and efforts must be made to ensure that benefits and risks are fairly distributed among subgroups of the population.

- Out of respect for the special character of the preimplantation human embryo, research involving preimplantation embryos should be limited to the shortest time period consistent with the goals of each research proposal, and for the present, research involving human embryos should not be permitted beyond the time of the usual appearance of the primitive streak in vivo (14 days). An exception to this is made for research protocols with the goal of reliably identifying in the laboratory the appearance of the primitive streak.

Fertilization of Oocytes for Research

With regard to the difficult issue of whether it is ethically acceptable to fertilize oocytes expressly for research purposes, the Panel concluded that studies that require the fertilization of oocytes are needed to answer crucial questions in reproductive medicine and that it would therefore be unwise to prohibit the fertilization and study of oocytes for research purposes altogether. However, because the preimplantation human embryo merits respect as a developing form of human life, the Panel recommends that the deliberate fertilization for research purposes be allowed only under two conditions (examples of research that might meet these two conditions are provided in the Panel report). Those conditions are:

- when the research by its very nature cannot otherwise be validly conducted.
- when a compelling case can be made that this is necessary for the validity of a study that is potentially of outstanding scientific and therapeutic value. Because of their concern that attempts might be made to create embryos for reasons that relate solely to the scarcity of embryos remaining from infertility programmes and because of their interest in preventing the creation of embryos for any but the most compelling reasons, Panel members believe that special scrutiny during the review process is warranted for research that may meet the second condition.

Parthogenesis

The Panel was asked to consider the acceptability of Federal funding of research involving the parthogenesis, the activation of eggs to begin cleavage and development without fertilization (activated eggs are called parthenotes). Human parthenotes are not developmentally viable, and they do *not* represent a form of asexual reproduction. Because research on parthenotes might provide information on the specific role of the egg mechanisms in activating and sustaining early development, without generating a human embryo, as well as shed light on problems arising during oocyte development that promote a type of ovarian tumor formation, the Panel recommends that research proposals involving parthogenesis be considered ethically acceptable on condition that they adhere to the general principles and that under no circumstances is transfer of parthenogenetically activated oocytes permitted.

Sources of Gametes and Embryos

With regard to sources of gametes and embryos—which could include women in IVF programmes, healthy volunteers, women undergoing pelvic surgery, women and girls who have died, and aborted fetuses—the Panel concluded that the following were acceptable sources of gametes and/or embryos provided all other conditions regarding consent, risk/benefit, and limits on commercialization are met:

- Women/couples in IVF programmes. Great care must be taken to ensure that there is no undue, or even subtle, pressure to donate. The voluntary nature of such donations is essential, and under no circumstances should individuals who do not wish to donate their gametes ever feel pressured to do so.
- Women undergoing scheduled pelvic surgery, as long as no additional risks are imposed. Researchers must explain any changes from standard surgical procedures and, if hormonal stimulation is used, the risks of such drugs.
- Women who are not scheduled to undergo a surgical procedure, but only for research that involves transfer of the resulting embryo for the purpose of establishing a pregnancy.
- Women who have died, but only for research that does not involve transfer and as long as the woman had not expressly objected to such use of her oocytes and that appropriate consent is obtained. Consenting donors, or next of kin proxy, should be clearly and specifically aware that the organ being donated is the ovary and that it might be used in research that could involve the fertilization of any oocytes derived from it.

The Panel concluded that the following sources were unacceptable for Federally funded research:

- Women who are not scheduled to undergo a surgical procedure, unless the research is for the purpose of establishing a pregnancy.
- Oocytes obtained from aborted fetuses for research that involves transfer. The use of fetal oocytes in research that does not involve transfer also should not be supported until the ethical implications are more fully explored and addressed.

Review and Oversight

Because of the sensitive nature of research involving the preimplantation human embryo, all such research proposals submitted to the NIH for funding or that are proposed for conduct in the NIH intramural research program should be subject for a period of at least three years to an additional review at the national level by an ad hoc body created with discretionary authority of the Director of NIH. When the ad hoc review body ceases to exist, all such research proposals should continue to be specially monitored by the NIH councils and the NIH Office for Protection from Research Risks. This monitoring would include a commitment by the councils to pay particular attention to the protocols as they are presented

for approval, in order to ensure that the local Institutional Review Board and NIH study section have correctly applied the guidelines adopted by the Director of NIH.

Categories of Research

Consistent with its mandate, the Panel considered specific areas of research in terms of acceptability for Federal funding. The Panel was charged to classify types of embryo research into three categories: (1) acceptable for federal funding; (2) warranting additional review; and (3) unacceptable for federal funding.

Acceptable for Federal Funding

A research proposal is presumed acceptable if it is in accordance with the general and specific guidelines recommended by the Panel and unless it has been placed in the warranting additional review or unacceptable categories. Examples of acceptable research include, but are not limited to, the following:

- Studies aimed at improving the likelihood of a successful outcome for a pregnancy.
- Research on the process of fertilization.
- Studies on egg activation and the relative role of paternally-derived and maternally-derived genetic material in embryo development (parthenogenesis without transfer).
- Studies in oocyte maturation or freezing followed by fertilization to determine developmental and chromosomal normality.
- Research involving preimplantation genetic diagnosis, with and without transfer.
- Research involving the development of embryonic stem cells but only with embryos resulting from IVF treatment or clinical research that have been donated with the consent of the progenitors.
- Nuclear transplantation into an enucleated, fertilized or unfertilized (but activated) egg, without transfer, for research that aims to circumvent or correct an inherited cytoplasmic defect. [A narrow majority of the Panel believed such research should be acceptable for Federal funding. Nearly as many thought that the ethical implications of research involving the transplantation of a nucleus, whether transfer was contemplated or not, needed further study before the research could be considered acceptable for Federal funding.]
- Research involving the use of existing embryos where one of the progenitors was an anonymous gamete source who received monetary compensation. In order to determine whether the exception might apply, special attention must be given during the review process to ensure that payment has not been provided for the embryo itself and that all other proposed guidelines are met. (This exception would apply only to embryos already in existence at the time at which this report is accepted by the Advisory Committee to the Director, NIH, should such acceptance occur.)
- A request to fertilize ova when a compelling case can be made that this is needed for the validity of a study

that is potentially of outstanding scientific and therapeutic value. Special attention is warranted for such research because of concern that attempts might be made to create embryos for reasons that relate solely to the scarcity of embryos remaining from infertility programmes and because of the Panel's interest in preventing the creation of embryos for any but the most compelling reasons.

Warrants Additional Review

Research in this category is of a particularly sensitive nature. The Panel did not make a determination for the acceptability of these proposals and recommends that there be a presumption against funding such research for the foreseeable future. This presumption could be overcome only by an extraordinary showing of scientific or therapeutic merit together with explicit consideration of the ethical issues and social consequences. The Panel recommends that such research proposals be funded only after review by a broad-based ad hoc body created at the discretion of the Director, NIH, or by some other formal review process.

- Research between the appearance of the primitive streak and the beginning of neural tube closure.
- Cloning by blastomere separation or blastocyst splitting without transfer.
- Nuclear transplantation into an enucleated, fertilized or unfertilized (but activated) egg, with transfer, with the aim of circumventing or correcting an inherited cytoplasmic defect.
- Research involving the development of embryonic stem cells from embryos fertilized expressly for this purpose. [Decided by a narrow majority of members. A number of members felt that the research was acceptable for Federal funding and some believed that such research should be considered unacceptable for Federal funding.]
- Research that uses fetal oocytes for fertilization without transfer. [Decided by a narrow majority of members. A number of members believed that such research should be placed in the unacceptable category.]

Unacceptable for Federal Funding

The Panel was guided by four ethical considerations in determining the types of research that should be unacceptable for Federal funding: the potential adverse consequences of the research for live-born children, women, and men; the respect due the preimplantation embryo; concern for public sensitivities on highly controversial research proposals; and, concern for the meaning of humanness, parenthood, and the succession of generations. Throughout its report the Panel balanced these concerns against the scientific promise and the clinical and therapeutic value of proposed research, particularly as it might contribute to the well-being of women, children, and men. For the types of research considered unacceptable, the Panel determined that the scientific and therapeutic value was low or questionable, or that animal studies did not warrant progressing to human research. Even if claims were made for their scientific or therapeutic value, the Panel believed that serious ethical concerns

would counsel against Federal funding of such research. Such unacceptable research includes:

- Cloning of human preimplantation embryos by separating blastomeres or dividing blastocysts (induced twinning), followed by transfer in utero.
- Studies designed to transplant embryonic or adult nuclei into an enucleated egg, including nuclear cloning, in order to duplicate a genome or to increase the number of embryos with the same genotype, with transfer.
- Research beyond the onset of closure of the neural tube.
- Research involving the fertilization of fetal oocytes with transfer.
- Preimplantation genetic diagnosis for sex selection except for sex-linked genetic diseases.
- Development of human-nonhuman and human-human chimeras with or without transfer.
- Cross-species fertilization except for clinical tests of the ability of sperm to penetrate eggs.
- Attempted transfer of parthenogenetically activated human eggs.
- Attempted transfer of human embryos into nonhuman animals for gestation.
- Transfer of human embryos for extrauterine or abdominal pregnancy.

Book Reviews

Health Care Reform: A Human Rights Approach

Edited by Audrey R. Chapman

Georgetown University Press, Washington, D.C., 1994. Cloth ISBN 0-87840-554-2, \$37.50, Paper ISBN 0-87840-555-0, \$14.95

This book is a collection of essays which, at the time of the writing of this review, explores issues as fresh as the morning newspaper. The book is the result of four widely interdisciplinary consultations initiated by the Science and Human Rights Program of the American Association for the Advancement of Science with the assistance of the Robert Wood Johnson Foundation. This project's stated objective was to explore a human rights approach to health care reform in the United States. The project's participants particularly sought to translate an abstract right to health care into a specific set of obligations and commitments commensurate with available resources. In the end, this group wished to create some concrete criteria whereby public policy responses to the fundamental human right to health care may be judged.

Realizing the volatile nature of any discussion of human rights entitlements, the project group insisted that its presentation of health care as a human right be framed in the context of the social good it produces rather than the private benefit it provides. For instance, any emphasis on universal coverage should not major on percentages of coverage but rather on the social harm that occurs if all people do not have access to decent affordable health care.

The book is organized into four parts. Of these, the second and third parts are probably of most interest to those who wish to see an organized presentation of the right to health care as well as a preliminary attempt to define a basic standard of health care. The essays in the first part examine the evolution of the American medical system and the concomitant debate about a right to health care. In her essay, Janet O'Keeffe gives a historical overview of how insurance companies have gained such a large influence in both health care delivery and costs. She declares that this historical influence is a large part of the reason why the social debate over health care is couched in economic rather than human rights terms. In his essay, Dan W. Brock, a member in the early 1980s of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, describes and criticizes the political pressure which forced the Commission to describe health care not as a moral or human right but as a societal obligation to ensure health care for all. Brock contends that framing health care as a social obligation takes the pressure of responsibility off

the individual and puts it nebulously on society at large with the federal government as a safety net for the poor and indigent. In other words, he believes that what is everybody's business is nobody's business.

Contributors to the second part 'Health Care as a Human Right' conceptualize the content and limitations of a right to health care. Several themes recur throughout the essays in this section. One prominent theme is that for health care to be a meaningful right, its boundaries must be exactly defined. Larry R. Churchill in his paper admits that a system of health care which entitles all citizens to all possible services is financially infeasible. He, along with practically all the other essay authors, quite freely confesses that health care rationing is an economic necessity. Virginia A. Leary in her essay expresses admiration for how the Canadian health care system has successfully contained costs while giving patients choice of physicians in a system based on equality and non-discrimination rather than on economic means. Robert M. Veatch sounds another theme in his insistence on egalitarian justice as the basis for defining a basic standard of health care benefits for all. His egalitarianism pursues equality of well-being for all and not necessarily sameness of treatment for all. This allows some room for public policy manoeuvring in forming treatment programmes which will be both effective and cost-efficient. Another theme touched on by several essayists is the extent to which America is out of touch with the international community in its commitment to universal coverage of all its citizens. The reader is repeatedly reminded that the United States and South Africa are the only industrialized nations which do not provide a basic health care standard of treatment for all its citizens apart from their ability to pay. Audrey Chapman in the final paper of the second part details very well the requirements of a human rights approach to health care.

The third section 'Defining a Basic Standard of Health Care' provides answers to an essential question of health care reform: what level of care should be guaranteed to all citizens? Of particular interest are such essays as the ones by James Lindemann Nelson and Michael J. Garland. Nelson asserts that any adequate standard of health care must come from public participation informed by public forums. The community defines the 'good' to be achieved and the health care system is then structured with available resources to achieve that good while also allowing for period review and alteration on the basis of changed economic and medical advancements. Garland's essay is important because he provides an apologetic for the Oregon plan as a rational means to achieve universal coverage. This paper is even more helpful when viewed alongside several of the other essays in

this book which sharply criticize the Oregon plan as equitable in principle but uneven in practice due to the small input the poor had in the final compiled list of covered illnesses.

The final section includes essays whose authors wage a frontal assault on the notion of managed competition as an effective framework for health care reform. Audrey Chapman concludes the volume by offering a rather forceful criticism of the Clinton Health Security Plan while at the same time constructing her own platform for an egalitarian approach to universal coverage implemented by a government operated single payer system.

A strength of the book is its interdisciplinary approach to the health care discussion. The authors of the various essays concur that a right to health care is different from a right to free speech because of the expense involved in providing health care for all. Excessive expenditures on health care will endanger other entitlements for the poor because of the limited pool of economic resources. Therefore, health care is a right with limits, the boundaries of which must be drawn by public consensus with public commitment to share equally in providing affordable irrevocable health care for every American (and even illegal aliens). The interdisciplinary nature of this publication explores the interrelated social impact of health care from the perspective of such disciplines as economics, sociology, and philosophy.

A noticeable weakness of the book is its omission of any discussion of welfare reform in relationship to health care reform. How can these two huge entitlements be merged in a way that will not break the back of American taxpayers while also discouraging the kind of fraud which has long been a part of the welfare system? Furthermore, may we expect a single payer health care system to be any more efficient or less expensive than the current entitlement programmes in place?

In reading this work, a Christian will be impressed with the depth of the authors' compassion in attending to the health care need of all Americans. But it is a compassion which is willing to forego certain freedoms in order to provide for the common good. To what extent will the American people tolerate this compassion if it is a forced charity enacted through the governmental redistribution of wealth? This is one of the crucial questions of health care reform.

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On the New Frontiers of Genetics and Religion

J. Robert Nelson

William B. Eerdmans publishing company, Grand Rapids, Michigan, 1994. \$12.99, paperback, ISBN 0-8028-9741. 224 pages.

'An expanding knowledge and understanding of human life is the primary purpose of both genetic science and religious thought', according to J. R. Nelson, senior research fellow of the Institute of Religion, Texas Medical Centre, and the Adjunct Professor of Medicine and Medical Ethics at Baylor College of Medicine. He goes on to state that 'The geneticist and theologian both have high stakes in the search for knowledge . . . One is ancient and perennial; the other modern and just emerging'. In his book, 'On the New Frontiers of Genetics and Religion', Nelson attempts to address the religious and ethical issues which arise from genetic science.

The book is full of interesting anecdotes, although the overall impression is that the subject area is simply too vast, and this makes the choice of information presented seem rather random. Perhaps this can be explained by the origin of the book, which apparently grew out of two 'Genetics, Religion and Ethics' conferences held at the Texas Medical Center, Houston, in 1990 and 1992. Given the vast nature of both 'genetics' and 'religion' it

may be informative to summarize the nature of these conferences.

The first conference was funded by the trustee of the Institute of Religion, which is an institute independent of any Christian denomination or other faith. The second conference was funded by HGP grant from the DOE and NIH. Participation was officially endorsed by many Christian denominations (Greek Orthodox, Episcopalian, Methodists, Lutherans) and representatives of other Christian denominations and other religions also took part (Roman Catholics, Jews, Muslims, and Hindus). In all, 260 people took part representing 8 countries. Nevertheless, the emphasis in the book is on Judaeo-Christian approaches to genetics, and I felt the title 'On the New Frontiers of Genetics and Religion' was a little misleading. For example, in the section entitled 'The Frontier of Religion' there is brief mention of the Jewish theology and ethics, followed by 11 pages on various Christian approaches, but no mention of other religions, and the chapter on 'Official Religious Position' (Chapter 6) is entirely based on Christian viewpoints.

Likewise, although eight countries were officially represented at the conferences, the book is entirely based on the scene in the United States. This is apparent in the discussion on the origins and funding of the Human Genome Project (the author acknowledges only funding via the NIH and DOE by 'the Government'), in the discussion on history of patenting modified organisms (with no acknowledgment of the different pace of patenting legislation in Europe or the rest of the world), and in the section on access and cost of pre-natal diagnosis.

'On the New Frontiers of Genetics and Religion' is generally fairly accessible to both non-scientists and non-theologians, and provides some fascinating insights into many different and diverse areas. The first chapter elaborates on the history of the two frontiers which form the basis of the book. The history of genetics is described briefly, and there are some interesting details about the background and management of the human genome project. The frontier of genetics is elaborated on in Chapter 2 (Genetic Advances in Medicine) which contains up-to-date examples of gene therapy, and in Chapter 3 (Genome and some social issues). There are some inaccuracies and oversimplifications in the descriptions of genetic science, for example, the author states that 'testing of modified plants in open environment has been shown to be harmless when carefully monitored'. This statement implies a lack of appreciation of possible long term risks to the environment, which cannot be and have not been dismissed completely, even if they may be considered negligible.

The Frontier of Religion section is expanded in chapter 5 'Personal Religious Positions Individually Expressed' which contains personal testimonies of Jews, Roman Catholics, Eastern Orthodox Christians, Protestants, Muslims, and chapter 6 'Official Religious Positions'. Again, these chapter make interesting reading, although it would have been preferable if the author had either clarified his focus on Judaeo-Christian religions, or provided a more comprehensive review of other religions.

The most intriguing chapter of all, 'Concepts of Human Nature' (Chapter 4), comes between the Frontiers of Genetics section and the Frontiers of Religion chapters. Most of the discussion of the religious and ethical issues arising from genetic science takes place here, providing both fascinating and frustrating reading, since the author raises interesting points in a rather haphazard fashion, and seems to move on to the next point as soon as he has expounded the essence of an issue. The author starts the chapter by questioning what we mean by human nature, and suggests that the findings of genetics open up new ways of analysing this question. There follows an analysis of change, and various problems humans have had accepting sudden changes in the past, such as findings in geology, evolutionary science, psychology and computing. Nelson places the challenge of adapting to possibilities of

molecular genetics in the context of the response of religious communities to these other momentous breakthroughs. He now returns to the question of what is meant by human life, and outlines the conflict between the materialistic and spiritual/idealistic view of humanity. Via an analogy with quantum theory (that physical systems can be described in terms of energy as well as matter) he concludes that human life is an inseparable mixture of material and spiritual—which he calls psychosomatic. These are interesting ideas, but the author does not do justice to them with a brief mention and no further expansion. Moreover, anyone interested in pursuing these thoughts is given very little guidance for further reading, since referencing is sparse and sporadic.

There follows an examination of the relationships between the physical body (including the brain), the mind, and the soul; the existence of evil, disease, susceptibility to disease, and abnormalities of behaviour. Nelson refutes the sociobiologist E. O. Wilson's theory that all human behaviour is determined by genes, although he does believe that morally pathological behaviour can have some genetic basis. There is an extensive section on whether humans should be seen as 'co-creators' with God, or as 'stewards' of the earth's resources, with the conclusion that the term stewardship avoids the ambiguity of the term co-creator while preserving the need for responsible action in communion with the Creator. Unfortunately, the practice relevance of the difference in terminology is not explained, and one is left wondering why such a large section was devoted to this semantic point. Finally, he returns to what must be the basic question in this chapter. 'Can we alter our humanness by this kind of manipulation?', a question which he unfortunately does not address adequately.

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The Genetic Revolution

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In 1953 Watson and Crick elucidated the molecular structure of DNA and this Nobel prize winning research ushered in what has come to be termed the *new genetics*. Subsequent development in the field of genetics has been rapid. The purpose of Dr Dixon's book is to provide a basic introduction to recent developments. This is to provide his readers with a more enlightened point of view from which to face the many challenges emanating from the ongoing advances in recombinant DNA techniques. Dixon did not set himself an easy task. He covers a wide range of areas, as diverse as agriculture to medicine, where modern genetics is playing a significant role in current advances. The number of references, over four hundred, is evidence enough of vast labour.

The issues of human cloning and AIDS are discussed at some length, even if neither is closely linked to genetics. The issue of embryo cloning is mainly of concern for those engaged in

fertility research. On the other hand, there is often inadequate discussion of some of the more immediately relevant developments. For example, although he deals with the subject of gene therapy, the author never really explains the distinction between somatic gene therapy and germ-line gene therapy. He never confuses the two; but he fails to discuss the radical differences. He also fails to present clear distinctions between the various types of genetic diseases.

Many commentators, the author included, hold that the *new genetics* may lead to a rebirth of eugenics. But while positive eugenics receives a brief discussion, issues relating to negative eugenics seem to be ignored. Yet the spectre of past eugenic movements should serve as a warning in the present day to guard civil liberties in order to avoid a rebirth of notions specifying what types of human being are suitable to inhabit the world. Unfortunately, the author provides no guidance on these issues.

The author makes no effort to hide his own personal Christian perspective, but it remains unclear exactly what bearing his own beliefs have on the issues raised in the text. It is perplexing to hear him speak of *playing God* in the context of a chapter explaining, on the whole, successfully, the underlying molecular biology of recent developments in genetics. But, somehow *playing God* seems to be the theme of the book, a central question being whether any human interference with the genetic make-up of an organism in some way conflicts with divine reason, a question which may reflect a certain fundamentalist attachment.

The author maintains that issues of right and wrong are complex, yet vitally important; he also thinks that the issues involved in the new genetic technologies will make us question the value and definition of humanity itself. But is it not true that if, as Christians, we accept that humans demand respect and justice from the time of their first origins to their natural end, then it becomes clearer what constitutes pursuing good and avoiding evil? Acknowledging that we live in a pluralist world, Dr Dixon seems to suggest that the concepts of good and bad rest on how *you* as an individual feel. But emotion cannot be a foundation of morality; if it were, there could be no objective moral order. We might reflect upon the history of Nazi Germany and the consequences that may follow if an individual enforces his or her own 'moral' standards.

There is nothing wrong in genetic research *per se*. Developments in genetics are valuable when placed at the service of mankind, when they promote and protect its integral dignity. But there is need for tight control and regulation of genetic research. Some researchers do pursue research irrespective of statutory regulations, often under the guise of *you cannot stop science*. Dixon is right in remarking that regulations are one thing, persuading every scientist to abide by them another.

Within the next fifteen years we should know the entire sequence of the human genome. Truly, as the author indicates, we are living in the era of the gene, a time when every aspect of human living will be affected as our understanding of the genetic basis of living organisms is furthered.

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