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*From Dr Keith J. Russell*

# On Being Politically Correct

Economists and Politicians agree on at least one thing—we are soon to enter 'The Pacific Century'. The booming economies of East Asia are soon, we are told, to overtake those of the tired engines of Europe and North America. We must look East if we are to understand the current world order.

So it was with relish that I recently spent a year teaching by invitation in one of China's largest Medical Schools. It was a welcome opportunity to help in the development of that ancient country. But with my medical background, it was also a chance to observe how this up-and-coming part of the world coped with the agonising issues in medical ethics exercising the minds of so many in the West.

How fascinating, then, to report that in this totalitarian society medical ethics has been absorbed by the politicians—as has almost everything else. What was right and true concerning human life and its values was learned from Marx or Mao. My students knew little about Western ethical concepts, nor the factors which had shaped Western medicine's distinctive, Hippocratic ethos. Instead, compulsory political meetings carried the ethical messages home for the Chinese doctor and beware anyone who questioned what he learned there. The Party could be trusted; don't bother to think too hard.

The subservience of medicine to political aims was most clearly seen in the maternity and gynaecological wards. With the rigid imposition of 'One couple—one child' policy Chinese married couples found themselves caught up involuntarily in a subtle eugenics policy. They might be put under pressure to abort the pregnancy if the quota of births in the work-unit had been exceeded that year. For some couples later on in a pregnancy, if an ultrasound examination revealed a deformed fetus, it was considered only right for the greater needs of Chinese society to abort it quickly. And even after birth the newborn was not safe from society's pressure to conform; some severely deformed or unwanted neonates were quietly sedated and left to die.

Shocking—yes. But unexpected—no. For Chinese doctors have found themselves pushed into an inevitable vortex of ethical confusion. Where there is no ultimate court of appeal in these enormously important matters, except the whims of the prevailing political dogma, then utilitarianism is king. Human lives are sacrificed on the altars of economics and the desperate extreme of the ultimate act of political correctness.

But we dare not smugly judge from a distance. There is no place for the curiously Western idea that we are above these things. China's dilemma is the same as ours in the post-Christian West. Both societies are groping to find answers to the momentous issues of life and death that our cultures have produced. And both parts of the world have found that those with the largest voices generally have their opinions heard. In China—these are the politicians who do so through a combination of fear they induce and brilliantly successful propaganda. In the West—a Christian minority has been effectively silenced by a talented secular majority.

So where do we go next? One observation in China gave me great hope. The Christian church in that country is booming. Many of my students were eager to explore the Faith. If this generation of talented people finds its mind renewed by the Christian gospel then surely it really will be 'The Pacific Century'. And not only economically.

*The Christian Life Commission of the Southern Baptist Convention, Nashville, Tennessee*

# The Struggle Against Abortion: Why the Use of Lethal Force is Not Morally Justifiable

## A Statement of Conscience

'The LORD examines the righteous, but the wicked and those who love violence his soul hates'
(Psalm 11:5 NIV)

September 1994

*Abstract*

*In July of this year, abortion doctor John Britton and his escort James Barrett were shot and killed. These vigilante murders have generated more rhetorical heat than light. The pro-choice and pro-abortion forces claim that such actions are the natural fruit of the conviction that human life begins at conception. The pro-life forces have objected strenuously, but have not fully justified their intuitive rejection of these murders. We hope that this statement, written from a Christian pro-life perspective will help to clarify the grounds for this rejection.*

*We maintain that:*

*1. The burden of proof is clearly upon those who would exercise deadly force. The Bible condemns murder in both the Old and New Testaments (Ex. 20:13; Matt. 5:21) and designates government as the proper agent for maintaining order within society (Rom. 13:4).*

*2. As appalling as the wanton taking of unborn human life may be, it is protected by recent court decisions in America, and so is currently legal. Thus, we must work to protect the unborn through the legal and democratic processes.*

*3. There are many praiseworthy and legal strategies to turn the tide of abortion, including abstinence-based sex education, ministry to women in crisis pregnancies, and a wide range of political and judicial efforts.*

*4. We affirm those physicians who refuse to perform abortions, recognizing that the vast majority of health care professionals abstain from this practice.*

*5. Since human law may be in conflict with God's law, nonviolent civil disobedience may be morally permissible, so long as the citizen willingly submits to the consequent penalties.*

*6. The unavoidable use of lethal force in an emergency to stop an assailant is quite different from the premeditated killing of enemies. Private citizens may be called upon to exercise the former, but not the latter. The premeditated use of deadly force is reserved to the government.*

*We contend that the killing of abortion doctors is not a morally justifiable or permissible Christian response to abortion. We completely reject such conduct and call upon all Christian people to join us in this rejection. We rebuke those who would seek to discredit the pro-life movement on the basis of the aberrant behaviour of a handful of violent extremists.*

*We reiterate our unshakable conviction that the life of each human being begins at conception, and we implore all Christians to oppose legalized abortion on demand and to work to reduce the number of abortions through legitimate means.*

## 1. Preamble

1.1 Acts of lethal violence have recently been used in an attempt to stop abortion doctors from performing abortions. Such violence has been perpetrated, in some cases, by those who seek to justify their acts on the basis of Christian moral principles. Dozens of violent incidents of other sorts have also occurred in and near abortion clinics over the past fifteen years.

1.2 The aftermath of these violent acts has made it clear that the views of the perpetrators are not merely idiosyncratic, but instead reflect the perspective of a small number of Americans, some of them Christians, who are strongly opposed to abortion.

1.3 Representatives of a wide range of 'pro-choice', 'pro-abortion', and 'pro-life' positions have offered public statements condemning such use of deadly force and the moral justification of such acts. It has been a rare instance of agreement. We join in condemning these killings.

1.4 However, the divergent reasons that pro-choice and pro-life groups have offered for their moral rejection of such acts as the Pensacola shootings, and of the moral claims that undergird such acts, bear witness to the continuing and seemingly unbridgeable gulf between these polarized parties to the abortion conflict.

We who offer this statement speak from a Christian pro-life perspective. Even though we share the moral condemnation of the killings that pro-choice groups and leaders have expressed, we have yet to read a statement from such persons that reflects our point of view concerning why such killings are not morally justifiable.

1.6 In particular, some claim that unborn life is not fully

human life, and thus that it is wrong to use lethal force in an attempt to prevent abortion. We strongly disagree with the claim that an unborn child is not fully human life, deserving of full protection. We will reject the killing of abortion doctors on other grounds.

1.7 At the same time, we find the response thus far from the pro-life community deserves more elaboration and depth. We are glad to see that all responsible pro-life groups and leaders have condemned such killings, as do we. But mere denunciation, however passionate it may be, is not enough. We believe that the point of view of persons advocating violence against abortion doctors requires serious moral reflection and engagement, more serious than has thus far publicly occurred. A number of profound questions of Christian morality and Christian citizenship are at stake.

1.8 As pro-life Christians, we are concerned about the possibility that some of our fellow pro-life Christian friends and colleagues will drift into an embrace of violence directed against abortion providers. Lack of serious engagement with the views of persons who advocate the use of violence will only increase the risk that this drift will occur. We are equally concerned that such violence will lead pro-life Christians to withdraw from morally legitimate forms of action to prevent abortion.

1.9 This statement, therefore, is intended as a moral analysis and rejection of the killing of abortion doctors, offered from a Christian pro-life perspective. It is at the same time intended as an urgent plea for intensified Christian involvement in all morally permissible forms of anti-abortion activities. We offer this statement in the name of Jesus Christ, our Saviour and Lord, to any who will listen, and especially to our fellow labourers in the protection of the unborn.

## 2. Murder in Christian Perspective

2.1 Murder, the culpable killing of a human being, is an extraordinarily grave offence against civil law as well as against the moral law of God (Ex. 20:13) on which all morally legitimate civil law is ultimately based.

2.2 The Bible teaches that each human life is sacred, for every human being is made in the image of God (Gen. 1:26–27). For this reason, each human life is of divinely granted and immeasurable value. Human beings are not free to take the lives of others, for those lives belong to God, their Creator. This is the meaning of the divine prohibition of murder in the Ten Commandments. 'Thou shalt not kill' means that God prohibits the unjustified taking, and mandates the protection, of human life.

2.3 In the Sermon on the Mount (Matt. 5:21f.), Jesus affirmed the prohibition against murder. Indeed, he warned of God's judgement even on intense expressions of anger and contempt for others, while calling his hearers to seek reconciliation with any persons from whom they might be estranged, even their enemies (Matt. 5:43–44). Jesus also proclaimed God's special favour upon those who make peace (Matt. 5:9). While wholeheartedly committed to the spread of the Kingdom of God (Matt. 6:10, 6:33), Jesus personally rejected the use of violence to accomplish even this holy aim.

2.4 The apostle Paul frequently affirmed the centrality of peacemaking and reconciliation, even describing God's saving act in Jesus Christ as an act of divine peacemaking between those who had once been enemies—an act that not only reconciled God to humanity but also reconciled estranged human beings to each other (Eph. 2:11–22).

2.5 Paul also argued that the governing authorities of this world have been established by God. Their mandate in a world deeply marred by sin is to serve God by deterring wrongdoing and bringing punishment on wrongdoers, thus protecting the innocent (Rom. 13:1–7). In this work, Paul writes, the authorities 'do not bear the sword in vain' (Rom. 13:4). Most Christians have understood this to be a divine authorization of the force by governing authorities, even deadly force at times, when such force is finally required to accomplish government's divinely mandated purposes. Through the centuries, strict criteria have been developed for the just employment of such force.

2.6 In Christian theology a historic split has existed between those who believe that the witness of Scripture prohibits any taking of human life under any circumstance by any person or institution, and those who believe that under the conditions of sin the taking of human life is in a very small number of tragic circumstances morally justifiable and thus morally permissible.

2.7 Those taking the former position could ground a rejection of the killing of abortion doctors in their uniform and absolute rejection of any killing of any human being under any circumstances by any person or institution. This point of view would be coherent and consistent, and no further argument would need to be made.

2.8 While respectful of this position, we believe that the overall witness of Scripture, including Romans 13, leads to the latter conclusion—that there are indeed a small number of tragic and exceptional circumstances in a fallen world in which the taking of human life can be morally justifiable.

2.9 However, from our perspective, the Bible establishes a profound presumption in favour of preserving life rather than ending it. God wills that human beings should make peace with each other, should be reconciled and should treat every life with the respect its divine origin and ownership demands. There is at the very least a *prima facie* moral obligation to refrain from killing. This means that an extraordinarily stringent burden of proof is imposed upon any who would seek to justify the taking of a human life.

2.10 To the extent that United States civil law reflects the divine moral law, it likewise is structured both to deter

and to punish severely the unjustifiable taking of a human life. Civil law does generally recognize that under certain unusual circumstances normally involving defence of self or third persons against deadly force, the taking of another human life by a private citizen might be justified. A stringent burden of proof in every case rests on those who would justify any taking of life.

2.11 United States civil law is also structured to recognize the broader mandate of government to use force and the threat of force, judiciously and carefully, to deter and punish evil and to protect the innocent from wrongdoing. The government protects its citizenry from domestic wrongdoers through the law enforcement and criminal justice systems, and from foreign wrongdoers through the armed forces. Private citizens rightly are barred from authorizing themselves to perform these functions.

2.12 Those advocating acts of lethal force against abortion doctors claim that such acts qualify as morally justifiable homicide, despite the current status of civil law in the United States.

2.13 This assertion requires Christian consideration of the moral and legal status of the act of elective abortion, as well as the moral obligations of Christians living in a democratic society that by statute permits elective abortion under most circumstances.

## 3. The Moral and Legal Status of the Act of Elective Abortion

3.1 Since 1973, the United States Supreme Court has interpreted the United States Constitution in such a way as to create a right of a woman to choose to secure the services of a physician who is paid to 'terminate her pregnancy'—that is, deliberately to end the existence of that life which is developing within her body. This state of affairs is justly called 'abortion on demand' in that abortion is permitted on the basis of no criteria other than a pregnant woman's demand for an abortion. The abortion workers who have been killed or injured have been relying on this decisional law to justify their conduct legally.

3.2 The moral status of the act of elective abortion is arguably the most bitterly contested moral and, consequently, legal, social, cultural, religious and political question of our time. This is not the place in which to offer a rehearsal of the arguments that pertain to this question. We will instead simply state our position in the following way.

3.3 As indicated above (2.2), we believe that each human life bears a divinely granted sacredness. We believe that its sacredness begins at conception, when biological life begins. We believe that gestational life—life in the womb from conception to birth—must be understood as human life in its earliest stages rather than as pre-human, non-human, potential, or any other less-than-fully-sacred kind of human life. We know that, if allowed to continue developing without hindrance through a normal pregnancy, a gestating human life becomes a newborn baby. Thus, we are compelled to consider elective abortion the killing of a human being.

3.4 We have already argued that, given the sacredness of human life, the burden of proof is on any who would morally justify its deliberate extinguishing. The terrible flaw at the heart of federal abortion law is that abortions are currently permitted *while requiring a woman to meet only a minimal burden of proof which may be imposed by state laws.* In terms of gestational life, the federal government has wrongfully abdicated its responsibility to protect the innocent and to establish and enforce stringent criteria for the justifiable taking of human life.

3.5 We recognize that for a woman (or, for a couple) an unwanted pregnancy may well be a crisis pregnancy. We acknowledge that women seek abortions for a wide range of reasons. Tragically, these range from the most serious and justifiable (i.e., a threat to the physical life of the mother) to the least serious and justifiable (i.e., gender preference, interruption of vacation plans, and so on). The effect of current abortion law is that any reason for an abortion, or no particular reason, is as good as any other. The great majority of abortions in the United States are performed for what can best be described as reasons of convenience.

3.6 We recall the biblical principle that it is morally forbidden for a private citizen to end a human life except in the act of self-defence. Only in cases when gestational life poses a serious threat to the physical life of the mother, in our view, does elective abortion clearly meet this self-defence criterion. A significant number of pro-life Christians are willing to grant the possibility that abortion in the cases of rape, incest, and/or radical fetal deformity also ought to be included among those exceptions to the general prohibition of abortion that should be recognized by law. We disagree. But we recognize that rewritten abortion laws framed along those lines would still disallow all but a very small percentage of abortions in this country.

3.7 Instead, our nation continues to operate under a law that requires no significant burden of proof for abortion. This represents a fundamental assault on the sanctity of human life. Human beings are not at liberty to lower the threshold for the taking of human life, but that is precisely what abortion laws have done. Lowering that threshold is one of humanity's greatest temptations, one to which human beings have succumbed all too frequently, especially in our own century of world war and genocide.

3.8 But we need to look elsewhere for examples. Our own violence-wracked nation bears witness each day to the devastating consequences of disrespect for the sacredness of human life. Truly the blood of the murdered cries out from the ground (Gen. 4:10; Lev. 18:28). We believe that abortion on demand is the leading, but not the only, example of a broader national moral and social crisis of disrespect for human life.

3.9 From our perspective, then, the overwhelming majority of abortions represent a morally unjustifiable form of killing. It is a unique form of killing, involving several parties. An abortion is undertaken by a physician who performs abortions, at the request of an unborn child's mother. Often, a woman is pressured by the child's father to have an abortion. Pressure may also come from family members, friends, and others. Her decision is then permitted by the civil law of the United States. Each participant in this act of unjustifiable killing, including the government of the United States (and ultimately 'we the people,' who are the sovereign of this government and have elected its officials), bears a share of the responsibility.

3.10 For twenty-one years, since the 1973 *Roe v. Wade* and *Doe v. Bolton* Supreme Court decisions, abortion on demand has been the controlling interpretation of the Constitution in the United States. In that time over thirty million abortions have been performed in this country. We believe that this state of affairs can only be called a moral outrage.

3.11 We share the intense frustration of tens of millions of this nation's citizens who grieve over each of the lives lost, the futures never realized, the human beings who unjustly have been prevented from ever 'seeing the light of day' (Job 3:16). We also grieve for the many mothers and fathers who spend much of their lives profoundly regretting their choice to have an abortion, mourning the children they never had the chance to love and enjoy.

## 4. Legitimate Forms of Christian Response

4.1 Most Christians who believe, as we do, that the overwhelming majority of abortions are morally unjustifiable acts of killing, rightly feel the need to offer significant moral response. Indeed, millions of American Christians even today are engaged in activities that constitute such a response; most of these activities, in our view, are fully and morally justifiable and quite constructive. They are aimed at saving lives, and are directed at each of the participants in the abortion decision.

4.2 For example, many Christians are involved in supporting abstinence- and values-based sex education programmes in schools, civic institutions, and churches. The Southern Baptist Convention's 'True Love Waits' programme is an effective example. Such programmes are rooted in the biblical moral norm that sexual intimacy is designed by God to be reserved for marriage (1 Cor. 6:9–20; 7:9; etc.). It is obvious, but important to point out nonetheless, that the demand for abortion would decrease radically if God's intentions for sexuality were heeded. Abortions happen because unwanted pregnancies happen; unwanted pregnancies happen, most of the time, because of sexual activity outside of marriage. It is important to note again that it takes both a man and a woman to engage in such sexual activity, and both are responsible for the consequences.

4.3 Christians are also involved in helping pregnant women 'choose life,' that they and their children 'may live' (Deut. 30:19). Christians have led the way in establishing crisis pregnancy centres and maternity homes. In such places pregnant women are cared for and prepared either to raise their children themselves or to give their children to others who can do so via adoption. This is a noble form of Christian ministry to women and their children. We give thanks to God for those women who avail themselves of these ministries and thus save their children's lives.

4.4 Pro-life Christians, especially those in the health care professions, are also on the front lines in the struggle over abortion as an aspect of medical practice. Such health care professionals bear witness to their convictions by refusing to 'regularize' abortion as an aspect of medical care. They remind fellow health care providers of the 'first, do no harm' provision of the Hippocratic Oath. This kind of witness—a witness of winsome moral persuasion and example, rather than invective and violence—is an important and appropriate part of the struggle against abortion. It is one of the reasons why very few physicians are willing to perform elective abortions.

4.5 Abortion on demand became law in our democratic society by the decisions of persons who attained their office by legitimate processes, and remains lawful through the same processes. Christians, anguished at this state of affairs, are rightfully involved in the wide-ranging kinds of political engagement afforded us within the democratic process.

4.6 Such involvement includes voting, lobbying, campaigning for pro-life candidates, drafting legislation, writing letters to government officials, getting involved in political party platform drafting, running for office, initiating boycotts, and so on. We believe that there is no doubt whatsoever that such activity is our right as citizens and our obligation as Christians.

4.7 Some pro-life Christians are involved in lawful public witness in the vicinity of abortion clinics, such as the handing out of printed materials and the organizing of prayer vigils. We believe that public witness of this type is morally justifiable.

4.8 Some Christians have engaged in various forms of nonviolent, public, civil disobedience in the vicinity of abortion clinics as an aspect of their protest against legal abortion on demand. This kind of activity has been a matter of considerable debate in pro-life circles and concern in the broader society.

4.9 From a biblical perspective, Christians clearly are required to submit to and obey the governing authorities of the lands in which they live. This responsibility flows from the divinely authorized nature of these governing authorities (see 2.5).

4.10 Scripture does recognize, however, that governments sometimes violate their God-given purposes, even

to the extent of enacting laws and policies that are in direct and specific conflict with the divine moral law. History bears frequent tragic witness to the same reality. The Bible teaches that Christians are morally permitted, and sometimes even obligated, to violate a civil law that is in direct, specific conflict with the law of God (cf. Ex. 1:16–2:10; Dan. 6; Acts 4:1–31, 5:12–42).

4.11 The burden of proof for justifying civil disobedience rests with those considering it. Besides being intended as a challenge to a morally illegitimate law or policy, such nonviolent civil disobedience should follow the failure of a range of other, less radical forms of action; should have some likelihood of effectiveness; and should have positive consequences that are likely to outweigh negative consequence.

4.12 Christians living in a democratic society who make the grave judgment to engage in public, nonviolent, civil disobedience must willingly submit to the consequences of their actions. Thus, Christians involved in civil disobedience related to abortion should expect to be prosecuted. To break a morally illegitimate law, and to submit willingly to the consequences of doing so, is in fact an attempt to change civil law via moral witness—and thus, to affirm all morally legitimate civil law.

4.13 We believe that laws concerning access to abortion clinics and protests around abortion clinics function as a fence around the immoral law that permits legalized abortion on demand. Because the abortion law is a permission for private citizens to have and to perform abortions, rather than a mandate requiring behaviour of one type or another, it is impossible to perform direct civil disobedience in the matter of legalized abortion on demand. This means that nonviolent civil disobedience, if it occurs, can be directed only at subsidiary laws.

4.14 We have outlined several lawful ways in which Christians can offer constructive moral response to the morally illegitimate law permitting abortion on demand. These can by no means be described as having been exhausted. There is much more to be done. This raises the question of whether nonviolent civil disobedience is justified.

4.15 On balance, we believe that acts of *nonviolent* civil disobedience related to abortion, though not morally *obligatory* for Christians, may be seen as morally *permissible*. This is ultimately a matter of individual conscience before God.

4.16 Legalized abortion on demand has become deeply entrenched in our society. What many Christians once hoped would be a temporary aberration has become an institutionalized reality. We must acknowledge that this has occurred because significant portions of our society have wanted it to occur. The tragic and abhorrent legal reality reflects an equally tragic and abhorrent social, cultural, and moral reality.

4.17 Pro-life Christians should work to change these social, cultural, and moral realities in which legalized abortion on demand is rooted. It is a heart-by-heart, home-by-home, city-by-city, state-by-state struggle. We must greatly intensify our efforts in the morally justifiable anti-abortion activities described above. It is our moral obligation.

## 5. Why Lethal Force is Not Morally Justified

5.1 The killing of abortion doctors by private citizens raises the important question of whether such an action is a morally legitimate Christian response to legalized abortion on demand. We strongly contend that killing abortion doctors is not a moral option for Christians, and respond to the various arguments as follows:

5.2 First, we reject the argument some have made that such killings are valid as an act of defending the innocent from harm. We reply that according to both civil law and divine moral law private citizens are permitted to use lethal force against another human being only if this occurs as an unintended effect of the act of defending oneself or another against an assailant's unjust attack. Private citizens are not allowed to *intend* to kill another human being and are not allowed to engage in *premeditated* acts of deadly force in order to accomplish what they intend. In other words, a private citizen can intend to stop, but not to kill, an assailant regardless of the final result. Attacks on abortion doctors fail this test.

5.3 Furthermore, an act of homicide is unjustifiable if the attacker's victim could have been adequately defended in any way other than causing the attacker's death. We believe that the many pro-life measures outlined in section 4 do offer a range of constructive (even if not fully adequate) forms of defence of the lives of the unborn, and thus, the killing of abortion doctors is unjustifiable.

5.4 We believe, further, that the killing of an abortion doctor in actuality does not constitute a meaningful defence of unborn life. This is the case because an abortion doctor is only one of the participants in the act of elective abortion, and not the most important one. It is the woman seeking an abortion who drives the process. The killing of an abortion doctor does nothing in itself to diminish a woman's demand for an abortion. If abortion is legal, and she perceives no alternatives to abortion, she will find another abortion provider. As long as abortion is legal, if we wish to save the lives of unborn children we must influence the actions of women who are considering abortion. The best and most Christ-like way to do is lovingly to provide her with viable alternatives to abortion. This does not absolve others, especially the baby's father, who may be exerting enormous pressure on the child's mother.

5.5 Second, we reject the argument that the killing of an abortion doctor is justifiable as a form of capital punishment. We reply that the moral legitimacy of capital punishment in contemporary American society is a point of dispute among pro-life Christians. More germane to

the argument is the fact that whatever right there may be to execute a criminal is reserved exclusively to governing authorities, and is never the prerogative of a private citizen. A peaceful and orderly society can have no place for self-appointed executioners.

5.6 Third, we reject the argument that killing an abortion doctor is an act of violent civil disobedience made necessary by the gravity of the moral evil of abortion on demand. It is our conviction that no act of lethal force can be properly ascribed to the rubric of civil disobedience. Moreover, the contradiction between the use of lethal force and civil disobedience is especially glaring in a democracy, in which so many alternative forms of activism for social and legal change are permitted. We contend that such an act is better described as an act of revolution rather than an act of civil disobedience intended to accomplish reform.

5.7 Fourth, we reject the argument that a government that allows legalized abortion on demand has of necessity lost its legitimacy, and that in such a circumstance private citizens are free to resist it 'by any means necessary'.

5.8 To this we reply that we accept the legitimacy of the government of the United States, despite its failure to protect the lives of the unborn and its sanction of access to abortion on demand. It is the people of the United States who have, in fair and free elections, selected the leaders of our government, and it is these duly elected leaders who have appointed judges to the Supreme Court and other federal courts. The actions and inactions of persons in all three branches of the federal government over more than twenty years are responsible for legalized abortion on demand. In turn, their decisions have reflected the pressures brought to bear on them by citizens of the United States, functioning through the democractic process.

5.9 From this we conclude that it is the people of the United States, acting through legitimate governmental institutions, who are responsible and ultimately accountable for immoral laws permitting and protecting the taking of unborn human lives. We do not believe that laws permitting abortion on demand remove the legitimacy of our government. Rather, the authority of our legitimate government has been perverted to allow and protect abortion on demand.

5.10 To us, legalized abortion on demand is the single gravest failure of American democracy in our generation. But we recognize it as a failure of a legitimate democracy rather than as the imposition or decree of an illegitimate regime. For this reason, we reject what can only be described as *the logic of revolution* that some have articulated. Instead, among our other pro-life efforts, we pledge intensified commitment to change the law through the democratic processes of the United States of America.

5.11 Fifth, we reject the claim that private individuals have a right to circumvent the processes of democratic government by using deadly force where the law sanctions abortion on demand. We realize that what is legal and what is moral are not always identical. Where they diverge, Christians bear a dual responsibility, first to act in accordance with the moral law, and second to respect and obey the legitimate authority of government. So long as a government retains legitimacy, and so long as opportunities for reform remain, individuals and groups must work within the democratic process and must resist the temptation to take the law into their own hands.

5.12 We believe that a government may lose its legitimacy as it sets itself against divine law and loses the popular support of its people. Should such circumstances arise, and should that government preclude all opportunities for reform, then Christians, for sake of conscience, may be forced to consider more drastic measures. We deny that our nation is nearing or has reached such a crisis. Our goal must be reform, not revolution.

5.13 We understand that no government can allow laws against the taking of human life to become a matter of private interpretation without placing its own existence and legitimacy in jeopardy. A private citizen who makes the decision to use lethal force against human life contrary to established law is not merely breaking the law against murder, he or she is also assaulting and undermining the authority of the government itself. Thus, any private decision to break the law against murder—even where there is an intention to do good—is an act of rebellion that threatens the existing governing authority, contrary to the will of God (Rom. 13:2). It is not simply an act of civil disobedience. It is certainly not an act of legal reform.

5.14 The distinction between nonviolent civil disobedience and the private use of lethal force can be illustrated from American history. Many Christians felt compelled during the 1850s to violate the fugitive slave laws by participating in the Underground Railroad, which illegally assisted slaves in escaping to freedom. That was nonviolent civil disobedience. On the other hand, John Brown and his supporters fomented slave insurrection and rebellion against the state by lethal force. That was the advocacy and exercise of lethal force by private citizens and is beyond the prerogative of individuals, Christian or non-Christian.

5.15 We wish to call attention to the fundamental difference between nonviolent and violent forms of action for social and legal change. We believe that the witness both of Scripture and of history affirms that a social movement's crossing over from nonviolence to violence is a most perilous, and almost always unjustifiable, step. One consequence of such a transition is that resistance to certain *deeds*, such as abortion, is often transformed into attacks on certain *persons*, such as those who perform abortions.

5.16 When the distinction between the wrong and the wrongdoer is obliterated, social change or resistance movements tend to focus on doing away with the wrongdoer rather than taking concrete steps against the wrong. The morally worthy original goal of the movement is replaced by one that is new and unworthy. Any possibility of reconciliation with the wrongdoer, of conversion of that wrongdoer, and of peacemaking, possibilities at the heart of the life and ministry of Jesus, is eviscerated. Instead, efforts focus on how to kill rather than how to make change occur. The people who are the intended recipients of this violence respond in kind. The devastating cycle of violence is intensified.

5.17 Once the bloodshed escalates, social movements embracing violence tend to slide rapidly along the continuum from violent resistance limited to specified targets toward unlimited violence directed at an even wider range of persons (are judges and politicians going to be the next targeted?). Even at the first stage, innocent bystanders often are injured. One reason God wisely prohibits murder is precisely because of the incendiary effect of bloodshed on the minds and hearts of sinful human beings.

## 6. Conclusion

6.1 Our conclusion is that the killing of abortion doctors is not a morally justifiable or permissible Christian response to abortion. We utterly reject such conduct as inconsistent with Scripture and call on all Christian people to join us in this stance.

6.2 We believe that Christians are, nevertheless, morally obligated to oppose legalized abortion on demand and to reduce the number of abortions through other, morally legitimate, channels. We must do so more actively and faithfully than ever before.

6.3 Pro-life Christians must act quickly and vigorously to prevent a small but vocal band of militant activists from destroying the credibility, effectiveness, and witness of the mainstream Christian pro-life movement. We pray earnestly that God will bless the efforts of all who employ morally legitimate means in order to save the lives of the most vulnerable among us, the unborn children. We are persuaded that this refects the mind of Christ.

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*The Centre For Bioethics and Public Policy*

# Response to the Human Fertilisation and Embryology Authority's Consultation Document on Research and Fertility Treatment Using Human Ova and Ovarian Tissue Obtained From Live Women, Cadavers or Fetuses

The Centre for Bioethics and Public Policy is a Centre for the pursuit of research in the field of bioethics in the centre of the Judeo-Christian tradition.

The CBPP welcomes the opportunity to comment on the important issues raised in the HFEA's consultation document *On Donated Ovarian Tissue in Embryo Research and Assisted Conception*.

## Basic Principles of Human Justice

The CBPP's response is based on the understanding, fundamental to the Christian tradition, that life is a gift from God. This understanding is inextricably linked to two principles of the utmost importance in relation to the questions raised in the consultation document: the principle of the sanctity of human life and the principle of the inviolability and integrity of the family.

The first principle enjoins us to respect and protect human life at all stages from beginning to end, that is to say, from the first moments of its beginning in the womb. Our understanding that human life begins in the womb is based not only on religious conviction but also on modern embryology, which testifies to the fact that from conception onwards the neo-conceptus has within itself the power to grow into a mature person, provided its development is not hampered by accident, illness or intentional destruction. It follows that we cannot accept any medical procedures involving the deliberate destruction of human life at any stage from the time of conception.

Seen as a gift, the child is to be cherished, nurtured and protected and looked after in the best possible way; and this means within a family held together by the bonds of marriage. Marriage may not be an absolute guarantee of a safe haven for the child to grow up in, but it is and remains the best foundation for a sound and stable home. Built on the corner stone of that mutual love that brought the man and the woman together, the family is the most basic unit of society; and sealed by the conjugal oath, marriage entails a commitment not only to stay together but also to treat each other as unique and irreplaceable within the conjugal union. And the child, viewed in the light of the two goods of marriage, the relational one and the procreation of children, is seen as the fruit and crown of the conjugal love.

Even when gametal donation involves no physical act of marital infidelity, it nevertheless can be seen as a violation of the marital vow inasmuch as it substitutes one of the spouses for a third party in the intimate matter of procreation. The child conceived as the result of gametal donation is not the fruit of marriage or conjugal love.

This does not mean that such a child may not be loved as much as other children, nor that it might love its parents less than it would have done if it had been born the true genetic child of its rearing parents. Also, all children irrespective of how they have been conceived deserve to be welcomed on equal terms into the human family and society at large.

But the child is not an object and should not be viewed as a possession, and so having a child is not something to which adults have a right. As a human being and equal in human dignity to his or her parents, the child deserves

the respect due to a human person. However, the introduction of a third party, the donor, into the midst of the intimacy of procreation adds an element of manipulation that is demeaning to the dignity of the child as a person. And this is true even if the child is not conceived in a test-tube or Petri dish as the result of laboratory procedures—though such procedures further reduce the child towards the status of an artefact.

In addition, by separating gestational from genetic motherhood, the parties involved not only violate the natural order but undermine the trust children hitherto have always had in their kinship ties with their gestational mother. A child not conceived as the fruit of marriage will lack that full sense of kinship identity which anchors a person in the present and provides knowledge about his roots in the past. It is in search of their kinship identity that many adopted people try so hard to find their genetic parents. All human beings desire to know who they are and from where they came.

For all these reasons, we find techniques of assisted conception involving gametal donation socially and morally unacceptable (even though Parliament has sanctioned it).

We recognize, however, the great pain caused by childlessness and support the view that there should be a greater emphasis on research into the causes of infertility (provided such research is pursued in ways consistent with respect for human life from the time of conception) and on prevention of infertility.

## Egg donation

**[a]** ***Should ways be sought of increasing the supply of eggs for use in research and infertility treatment? If so, what ways can be suggested?***

Objecting to all forms of egg donation, we can see no acceptable grounds for seeking to increase the supply of human eggs unless there is a shortage of eggs for morally justifiable and desirable research purposes. But we know of no evidence for a need to increase the supply for these purposes. (Regarding the justifiability of research, see [b], [c] and [d].)

Since both ovarian hyperstimulation and the harvesting of eggs as procedures involve considerable health risks to the woman, we consider it improper to encourage women to undergo either procedure. In particular, it is indefensible, in our view, to subject women undergoing hysterectomy to the danger of ovarian stimulation or to allow women to come forward and subject themselves to this hormone regime for the sole purpose of donating ova. Neither a doctor's good intentions nor even the goodwill of the donor herself could justify taking this risk.

Women undergoing IVF constitute a limited source of eggs for research or infertility treatment purposes, especially since many of them are unwilling to donate their eggs or ovaries, even though they are taking no extra risk in donating spare unfertilised ova. And given the demand for human eggs, we are concerned that fertility treatment in some cases is offered free of charge to a woman in return for eggs. This makes for duress and a particularly distasteful form of exploitation of a woman's natural desire for a child.

Egg or ovarian tissue harvested from a dead woman could possibly be justifiably used for research purposes, if the donor had given her informed and specific consent to this use (see below at [c]). On the other hand, the use of eggs or ovarian tissue from spontaneously aborted female fetuses for research or in infertility treatment may be impractical. This is not only because the tissue deteriorates fast but also because many such fetuses would suffer from chromosomal or other abnormalities. Regarding the harvesting of eggs or ovarian tissue obtained from aborted fetuses, we fear this would inevitably involve close cooperation between the abortion team and the researchers or infertility-treatment team in order to coordinate the timing of the abortion and the harvesting procedures. Such cooperation would be morally unacceptable as well as incompatible with the recommendations of the Polkinghorne Committee.

## Research

**[b]** ***Should ovarian tissue from live donors be used in research?***

**[c]** ***Should eggs or ovarian tissue from cadavers be used in research?***

We recognize that, in limited circumstances, some types of research (for example into the causes of genetic disease) involving the use of human ovarian tissue and/or unfertilised human eggs could be justified, provided it does not involve the creation and destruction of embryos and provided the donor is exposed to no undue risks (see above [a]) and her free, informed and specific consent has been obtained (see below at [h]).

**[d]** ***Should eggs or ovarian tissue from dead fetuses be used in research?***

Insisting on the principle of the sanctity of human life at all stages from the time of conception, we object to gestation and termination of pregnancy for the sake of obtaining fetal tissue suitable for research and consider it morally unacceptable to create embryos for research-purposes. But provided the use of human eggs or ovarian tissue does not involve the creation of embryos, and provided that, in accordance with the Polkinghorne-recommendations, only tissue from dead fetuses be used, we do not object to a limited use for research purposes of egg or ovarian tissue obtained from fetuses spontaneously aborted. In regard to fetal material obtained in connection with abortion procedures, we reiterate our fears concerning the practical necessity to coordinate the performance of the abortion and the harvesting of the eggs or ovarian tissue (see above [a]).

## Treatment

**[e]** ***Should ovarian tissue from live donors be used in treatment?***

We have already stated our general objections to ovum donation, pointing to the social and moral implications for the child and the family, and emphasising the threats posed by the practice both to the parent-child relationship and spousal one. We have also pointed to the medical dangers involved in ovum donation.

Ovarian tissue donation raises the same social and moral issues as donation of individual eggs. Moreover, the potential to produce thousands of eggs from such tissue calls for special caution not only in order to ensure a limited number of offspring from the same donor (the HFEA Code of Practice, para. 7.18, limits the permissible number of offspring from one donor to 10) but also to make sure that the procedure does not by-pass the restriction that no eggs from girls under 18 be used for donation purposes (HFEA Code of Practice 3.35).

**[f]** ***Should eggs or ovarian tissue from cadavers be used in treatment?***

For the same reasons as we object to egg or ovarian tissue donation from live donors and also out of repugnance at the thought that the dead should be having children, we object to the use of eggs or ovarian tissue obtained from cadavers. In addition, we wish to emphasize that although a dead donor can be exposed to no medical risks, the respect due to human body does not cease after death, even if it may be attenuated.

As to the child, there may be unknown risks involved in using eggs from dead women for the purpose of procreation. We have already expressed fears about the psychological impact ovum donation may have on children born as a result of the procedure. The fact that the child's genetic mother was dead by the time the child was conceived could be a further cause of worry, if the child (or later the grown-up adult) were to find out about the circumstances of its conception.

**[g]** ***Should eggs or ovarian tissue from fetuses be used in treatment?***

The suggestion that fetal eggs or ovarian tissue be used in fertility treatment has been met with widespread revulsion both among the general public and within the House of Commons. Earlier this year Dame Jill Knight DBE, MP, proposed an amendment to the Criminal Justice and Public Order Bill, which banned the use of fetal eggs or ovarian tissue to treat infertile women. The amendment was passed in the House of Commons and is expected to do the same in the House of Lords. This almost certainly preempts the issue.

We wish nevertheles to make a few comments on the suggested procedure. From a medical point of view, we agree with the fears expressed in the Consulation Document, para. 22, regarding the risk of chromosomal or other abnormality in spontaneously aborted fetuses. We also agree with the fears, expressed in para. 21, concerning the medical risks involved in using ovarian tissue or eggs obtained after induced abortion. Ovarian tissue or eggs have not undergone the normal process of 'natural selection' which takes place in women allowed to reach adulthood. Fetal ovaries contain several million eggs, but only a few hundred of these will mature naturally in the woman's adulthood and be available for fertilisation. In availing of fetal eggs, there is thus a serious risk of using eggs which, in normal circumstances, would have been spontaneously weeded out because of abnormality.

Regarding the social and moral questions, we repeat our view that the unborn child is nobody's property but possesses the same human dignity as more mature human beings and, therefore, deserves the same respect and protection as a child already born. Some advocates of the use of fetal ovarian tissue or eggs for infertilty treatment (and/or research) claim they find abortion regrettable, but argue that, if others may benefit, it could be seen as a positive aspect of what might otherwise be described as an unrelieved tragedy. This is no more than a sly argument seeking to justify abortion by providing a 'good motive' for it.

While objecting to all forms of gamental donation, we find fetal ovum donation particularly disturbing. Like adult ovum donation it severs the kinship chain and all contact between genetic mother and child. In addition, it skips a whole generation and so makes a farce of motherhood. To become a mother without having been born is against nature. And being born under such circumstances may not only confuse the child about the proper role of parenthood but also cause concern about the value adults attach to children born and unborn. Were the child to find out how it was conceived, it may sense a certain inconsistency in the fact that it has been conceived, nurtured and cherished, while its genetic mother was treated as no more than disposable material and a source of 'spare parts'. Fetal ovum donation, if allowed, would send children 'mixed messages' about the attitudes of parents to their young. Not only may such 'mixed messages' cause distress but they could even have repercussions for the subsequent generation; children learn to be good and caring parents by being responsibly and lovingly reared.

## Consent

**[h]** ***If you think that eggs or ovarian tissue from any of these sources should be allowed to be used in treatment or research, whose consent should be required, when should it be given, and in what form? Should there be any difference in the consent required for eggs or tissue used for research, and eggs or tissue used for treatment?***

We accept that certain limited forms of research using ovarian tissue or eggs (but not involving fertilisation) may be justified, if informed consent to this specific use has been obtained from the donor, and provided the donor was not emotionally exploited or exposed to undue risks.

That is to say, we accept limited use for research purposes of eggs or ovarian tissue obtained from live donors or cadavers (who consented to this use of such tissue before their death). But, in view of the serious nature of the psychological, social and moral issues involved, we would not consider it proper to approach children under 18 for consent to the use of their ovaries or eggs for research purposes. Nor would we consider it appropriate for parents to give consent to such procedures on behalf of a daughter under 18.

The HFE Act makes no specific provision for the use of eggs or ovarian tissue from a fetus. It does, however, state that specific consent is required of the donor in order to use his or her gametes to make test-tube embryos (HFE Act Schedule 3, para. 6 (1)). Since no consent can be obtained from a fetus, this effectively rules out the use of fetal eggs or ovarian tissue for research involving the creation of embryos!

However, neither the HFE Act nor the Polkinghorne Report has made any specific recommendations in respect of any other kind of use in research of fetal eggs or ovarian tissue. But provided the fetus is without any doubt dead (and we are aware there are special difficulties in diagnosing the death of a fetus), we could accept the occasional use of fetal eggs or ovarian tissue for certain limited research purposes not associated with fertility treatment or embryo research. We reiterate, however, our concern regarding morally unacceptable collaboration between the researchers and those involved in induced abortion.

Our objections to the use of donated ova to treat infertile women remain, but, if such treatment is undertaken, we insist that the donor, be she alive or dead, should have given prior fully informed, free and specific consent to the procedure. As in the case of research no one under the age of 18 should be allowed to consent to ovarian tissue or egg donation for treatment purposes; nor should anyone be allowed to give such consent on behalf of a girl under 18.

As to the use of fetal ova or tissue for treatment of infertile women, we refer to the HFE Code of Practice which says: 'Gametes should not be taken for treatment of others from anyone under the age of 18' (HFA Code of Practice 3.35). This rules out any use of fetal eggs or ovarian tissue in infertility treatment!

Normally, when parents have a recognized right to consent to medical procedures on behalf of their children, this is on the assumption that they act as guardians of their childrens' best interests. When a mother decides to abort and destroy her child, she effectively abdicates her duty as the guardian of her offspring and, hence, also her right to consent to any procedures involving the use of her child's body. In particular, she can claim no right to authorize the creation of (her) grand-children by cannibalising the body of her unborn daughter.

We also wish to point out that while the Consulation Document refers to the Polkinghorne Report when considering the rights of the father of an IVF embryo, it omits mention of the HFE Act which states that: 'An embryo the creation of which was brought about *in vitro* must not be used for any purpose unless there is effective consent by each person whose gametes were used to bring about the creation of the embryo to the use of that purpose . . .' (HFE Act, Schedule 3, para. 6 (3)). Notwithstanding our objections to the use of donated gametes in fertility treatment, we endorse the view that, when such procedures are undertaken, the father's consent must be sought.

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# Liver Transplantation and Alcoholic Patients: When is it Justified to Just Say No?

## State of the Issue

A series of unique questions may be engaged in the context of liver transplantation. To begin, is it appropriate to give a second liver to someone who has destroyed his or her first liver through alcohol abuse? If the answer to the initial question is affirmative, further necessary inquiries will arise as a result. Should the alcoholic person in question then be allowed equal or unequal access to organs vis-a-vis patients who have not 'caused' their liver disease? Does access require a verifiable period of abstinence? These three interrelated questions, which at first glance seem deceptively straightforward, have been argued both pro and con from a plurality of worldview perspectives since at least 1983.[1] The difficulty surrounding this discussion may relate to the fact that in some ways the subject itself is sui generis. For example, since 50% or more of end-stage liver disease (ESLD) is primarily alcohol-mediated and donor livers are scarce, alcoholic patients could theoretically utilize all the livers donated for transplantation leaving none for all the other varieties of ESLD. This intense level of utilization by a single group is without precedent in other transplant endeavors. A discussion of transplant organ allocation in this context may serve as a paradigm of justice with potential application to other areas allocating scarce resources.

## Framing the Question: Pertinent Statistics

A discussion of alcoholic patients' potential access to organs reflects the dramatic human and financial toll intrinsic to liver and other single organ transplantation. Factoring such persons into the transplant equation will amplify substantive issues essential to the ethical conduct of transplant organ allocation.

Despite the overwhelming success of solid organ transplantation during the last decade, the technique itself is beset with an Achilles heel. In the United States, the waiting list for all available organs peaked at an astounding 34,000 people in March, 1994[2], up yet again from 30,000 in 1993.[3] More disturbing is the statistic revealing that 6–7 of these patients die per day during a futile wait for organs never donated.[4] The prohibitive mortality invariably afflicts the group with single organ failure (e.g. heart or liver), a group uniquely dependent on successful transplantation for survival. An exacerbation of the great need highlighted by these statistics, as well as a severe stress placed on an already scarce supply of donor livers, would occur solely through the unhindered addition of alcoholic patients to liver transplant waiting lists.

In 1984, a total of 63,730 people in the United States died from all varieties of liver disease.[5] Approximately 36,000 of these deaths were attributed to alcohol-induced liver injury. Even more telling, only 1,000 liver transplants were performed during the same year. The percentages have not changed significantly, in that more than 50% of ESLD in contemporary society continues to be primarily alcohol-related and such liver injury would conservatively add another 30,000 potential candidates to the annual waiting lists. Unfortunately, during the next decade, the total number of liver donations has at least doubled, at most tripled to approximately 3,000 per year. The mortality of non-alcoholic cirrhotics already on the waiting list would increase immeasurably and would be the first contingent of waiting list expansion with alcoholic patients. Since it is presumed that others with cirrhosis have not 'caused' their morbidity, do those with alcohol-related liver injury deserve equal consideration for scarce transplantable livers?

The financial impact of an expanded liver transplantation waiting list requires scrutiny as well. The cost range for liver transplants is anywhere from $135,000 to $250,000.[6] This large price discrepancy is a direct result of the variable degree of illness present in individual cirrhotics prior to transplantation, and as a corollary, their variable need for inpatient hospital care prior to liver transplant surgery. End-stage kidney patients may be medically stabilized with any of a variety of outpatient dialysis modalities while awaiting transplantation. However, there is no such organ-specific support for the potential liver transplant patient who may often spend weeks in intensive care units—possibly ventilator dependent—at a significant expense awaiting the first available organ. Since a significant proportion of ESLD in alcoholic persons affects lower socioeconomic strata, the question may be raised as to who would underwrite the additional expense incurred by a waiting list expansion contingent on alcohol-mediated liver injury.[7]

Moss and Siegler have interpreted the pertinent statistics in an innovative manner in a further attempt to underscore the unique aspects of liver transplantation.[8] In so doing, the authors have identified the transplantable liver as a nonrenewable, *absolutely* scarce resource. Indeed this was amply corroborated by the statistics cited earlier and may be restated similarly for other single organs. But one must inquire further as to why the liver as a transplantable single organ is so different from other single donated organs such as the heart. Cardiac failure leading to heart transplantation has multiple etiologies, but no one group within the heart failure category itself comprises 50% of those in need of organs as do alcoholic persons requiring liver grafts. In fact, a history of alcoholism per se is considered a contraindication to cardiac transplantation. So despite important similarities between and among different transplantation modalities, the ethical issue of allotment with liver transplantation engages a unique set of circumstances. One group of patients with a homogenous pathology—alcoholic persons with ESLD—and an etiology associated with presumed 'unvirtuous' behaviour requires an expensive, rare and timely resource to survive. The resultant dilemma succinctly stated: if they freely receive it, many others will die as a result.

## Confusion Engendered: Begging a Question in Historical Perspective

The persistent historical impact of the aforementioned NIH consensus panel (1983—impact ca. 1990) is important enough to warrant a more detailed discussion. Its determination—viz. that ESLD from alcohol should be an indication for liver transplantation in 'only a small number of cases'—became an essential early doctrine of the liver transplant enterprise. The potential human fallout of enforcing the panel's policy became only too apparent through a 1986 court case in the state of Michigan.[9] A Medicaid patient with ESLD incurred through alcoholism was deemed ineligible for liver transplantation since Michigan policy required two years of abstinence from alcohol prior to active waiting list placement. The patient, abstinent for six months, appealed to the court who ruled that he should be placed on a waiting list immediately. Unfortunately, the patient expired prior to the availability of a donor organ. The refusal of transplant access to him is representative of similar responses to innumerable other patients with alcoholic cirrhosis during the ensuing decade.

The rationale for the panel statement concerning access to liver transplantation for alcoholic persons is instructive and was based on the dismal early statistics of liver transplantation in patients with alcohol-mediated ESLD —a period of less than ideal outcomes with transplanted livers in general. It is important to realize at this juncture that ethical discourse on this topic has occurred in the backdrop of two very different medical eras: an early one (ca. 1963–ca. 1985) with poorer results followed by a time (1985–present) with markedly improved outcomes after liver transplantation as a treatment for alcohol-mediated ESLD. Twenty-five of the earliest liver transplants for alcohol-mediated ESLD led to a disturbing one-year

survival of only 20%.[10] This statistic ostensibly demonstrated an unequivocal lack of medical benefit in alcoholic persons and led to blanket refusals of alcoholic patients' candidacy for liver transplantation—whether abstaining or not. Exclusion was then apparently validated by an empirically-tested ethical criterion, i.e. the lack of a medical benefit. This facile exclusion of alcoholic patients, however, did not bear up to further scrutiny. The same review of liver transplantation results in 1984 was applied to another group with ESLD, patients with sclerosing cholangitis. This latter group demonstrated only a 20.2% one year survival post liver transplant. It appears that this disparate application of a medical benefit criterion represented nothing more than a blind prejudice against alcoholic patients. Patients with sclerosing cholangitis were allowed to compete equally for liver transplantation despite a similar lack of medical benefit.

Over the last five years, a disingenuous evolution has occurred through the continuous application of medical benefit criteria to liver transplant recipients with a history of alcohol abuse. Outcomes with liver transplantation overall, and more specifically for alcoholic patients, have improved dramatically during the early 1990s. In fact, more recent studies addressing survival of alcoholic persons with ESLD strongly suggest that they as a group do just as well with and after liver transplantation as any patient population with cirrhosis.[11] In some instances, alcoholic patients with ESLD may actually do better than other higher risk populations with liver failure.[12]

In light of this empiric data, one must address both what recent transplant success itself says—as well as what it does ***not*** say relative to contemporary ethical discourse. What has become abundantly clear is that improvements in transplantation technique and overall medical care (e.g. cyclosporin) have greatly improved the survival of transplanted alcoholic patients with ESLD. The application of medical benefit criteria alone to the determination of whether alcoholic patients should receive livers, however, has confused contemporary decision-making. In fact, misapplication of such data is a prime example of 'begging the question'. Though improved survival statistics post transplant negate the conclusion of 1983 NIH panel, in no way do they address the more fundamental ethical questions of whether alcoholic ESLD *should* be transplanted and whether the access of this particular group should be *equal*. Utilization of medical benefit criteria alone as unequivocal evidence for transplantability is representative of medicine as technique and as such medicine detached from essential ethical boundaries. Success in technique alone does not permit a firm ethical conclusion to be drawn concerning transplantability.

One further digression in the context of medical benefit criteria must be addressed. Despite the drawbacks inherent in the misapplication of medical benefit criteria, there are just ways remaining to apply the same criteria in select circumstances and as a result to exclude certain alcoholic persons from liver transplantation.[13] Presently, concurrent alcoholic injury to both the liver and heart (cardiomyopathy) may lead to just exclusion of alcoholic patients from access to liver transplantation. Progressive cardiac deterioration would lead to a life expectancy of six months or less (such as patients with prohibitively low ejection fractions) precluding successful patient survival post-transplantation. However, the poor results with this variety of patients experiencing multiple end-organ injury should not be extrapolated to the entire group of alcoholic persons and utilized as a general rule of exclusion.

Recent work by Dr. Evans at the Mayo Clinic also demonstrates that the immediate pre-transplant condition—especially ventilator dependence—is closely correlated with survival post liver transplantation. Thus, the time-honored 'first-come, first-served' criterion for justice in organ allocation may be inconsistent with acceptable medical benefit for the outcome after liver transplantation. Patients on the liver transplantation list for a longer duration get progressively sicker as they wait for an organ and their one-year survival post transplant may prohibitively decrease. Dr. Evans has shown that ventilator dependence prior to liver transplant is an especially bad prognostic indicator. Specifically, life support dependence at the time of transplant is equal to a one year survival of only 36.4% with a cost per patient of $211,711 vs 82.9% at $114,797 respectively in patients without life support prior to liver transplantation. If medical benefit data of this genre are factored into the access to transplantation issue, their utilization may justly identify those patients whose poor survival would preclude the allocation of such a scarce, nonrenewable resource.

In summary, a historical perspective on the ethical issues engaged in the liver transplantation of alcoholic persons began in 1983 with a consensus NIH panel. Early prohibition of transplant access to alcoholic patients then was contingent on a poor one-year survival post transplant. However, the poor survival data was applied only to alcoholics and not to other similar poor outcome groups—an unjust early application of a medical benefit criterion which at some centres has unfortunately persisted. One year post-transplant survival for alcoholic ESLD has increased dramatically in the last few years but this result, per se, does very little to address more fundamental questions involved in organ allocation. However, medical benefit criteria must not be discarded in their entirety since dual organ failure in alcoholic patients (liver and heart), the concurrent presence of AIDS or malignancy, or ventilator dependence pre-transplant, may represent just criteria utilized in excluding certain candidates who would not benefit from transplantation. The earliest exclusion of alcoholic persons strongly suggested the application of social value judgements and requires further study.

## Summary of Other Arguments Utilized to Exclude Alcoholic Patients from Access to Liver Transplantation

'I pose this question: Is the listing of alcoholism as a contraindication without proof of abstinence the same as other 'objective' criteria, or is this a rather extraordinary statement—not a medical criterion at all but a prevailing social prejudice.' Atterbury[14]

Early access to liver transplantation for alcoholics was also affected by the insidious utilization of social value criteria. Such criteria were enforced through a monitored, and at times prolonged, abstinence from alcohol. Thus, during an early era of liver transplantation, abstinence became a convenient tool to block access to organs. Furthermore, microallocation decisions through 1994, in certain instances, have continued to apply this invalid and unjust criterion. A sample untilization social value criteria applied to alcoholic persons with ESLD is contained in the *Ohio Solid Organ Transplantation Consortium Statement* (Figure 1).

Like other documents addressing the same issue, the Ohio statement suggests a period of alcohol abstinence for three to six months minimum prior to waiting list placement. The continued abstinence of patients as well as well as their attendance at recovery programmes are monitored by unannounced urine and blood sampling. More germane to the utilization of social value critieria themselves, however, are requirements #4 and #5. 'The patient should have a history (*past* and *current*) of stable, personal relationships.' Further, 'the patient should have a stable work history.' Implied in the reading of this document is that despite verifiable abstinence, a history of prior alcohol dependence may still bar a patient from organ transplantation if socially acceptable 'personal relationships' or 'stable' work habits are absent. In this context, other authors are even more explicit in the application of social value criteria and suggest that the transplantation of alcoholics should occur only in those who, 'demonstate some form of accomplishment in other areas of their life despite their alcoholism'.[15] Cohen[16] suggests that 'a widespread condemnation of drunkenness lies at the heart of this issue' i.e. the application of social value criteria to alcoholic persons with ESLD. Social value judgements have also led to an arbitrary period of alcohol abstention prior to transplant-waiting list placement of as long as 2 years. In reality, few people with ESLD requiring liver transplantation will survive on a list for two years. Occasionally a six-month period of waiting may be life-threatening. The Massachusetts Task Force report addressing a Boston Center requirement for two years of abstention stated, 'exclusions, like that of the Boston Liver Center, are arbitrary and tend to reinforce negative and destructive societal stereotypes.'[17]

A proposed just application of abstinence will be addressed in more detail later. Suffice it to say at this point, however, social value judgements with or without abstention should not be utilized for the determination of transplant candidacy in alcoholic persons—or in any other group for that matter. The bias inherent in the utilization of such an approach should become immediately apparent. One member of the infamous Seattle dialysis committee actually admitted that he voted for people during the era of scarce dialysis resources who neatly fit the mold of middle-class values.[18] The utilization of a utilitarian calculus, factoring eventual economic and familial contributions to society by transplant recipients, would be an impossible goal. What should be done with a liver transplantation choice between a financially-successful homosexual business executive with hepatitis C vs an unemployed construction worker with a prior history of alcohol abuse? What hierarchy of virtue would be placed on the first candidate in contrast to the latter? A virtue scale contingent on economic contributions is an unachievable and unjust goal in the United States of America and could never be justly applied in a relativistic and pluralistic society.

## An Attempt to Reframe the Issue of Alcoholic Persons' Access to Liver Transplantation

A perspective gleaned from an historic study of the ethics of liver transplantation should engender a contemporary desire to reframe the entire question of access. The efficacy of medial benefit criteria is limited to clinical circumstances that do not apply to all patients seeking a transplant and as such they may not be consistently applied to the question of equal access in the entire group of alcoholic people with ESLD. Social value judgements are always invalid in the context of allocation and should be proscribed from ethical discourse. The dramatic recent changes in technique and survival after liver transplantation require a thoughtful reappraisal of selection criteria, benefiting from, rather than repeating, the mistakes of our predecesors during the 1980s.

One possible way to accomplish the task of reframing is to posit, amplify and support two conflicting but nonetheless tenable positions: equal access for alcohol-mediated ESLD with or without abstinence, contrasted with unequal access contingent on the development of non-prejudicial criteria. Prior to further elaboration on the seemingly contradictory positions, two confounding variables must be considered: the contribution of abstinence to the question and the far-reaching effects that a definition of alcoholism has on the issue of allocation.

## Should Abstention be Required for Access?

If one poses the question, 'how many patients transplanted for alcohol-induced ESLD return to drinking'?, the intuitive response of many professionals estimates a percentage of 50% or greater. Such a prohibitive rate of recidivism will negatively impact both professional and lay attitudes towards allotting scarce resources to alcoholic patients.

In reality, the incidence of recidivism post transplant is surprisingly low. Studies which address the percentage and duration of abstention have revealed the following rates[19]: an 11% return to drinking; only 2 of 16 patients in one study; the highest rate quoted recently, 19%; finally, the lowest rate—that of Dr. Starzl's group—only 3%. It should be clearly stated that these figures represent abstention after, not necessarily before, transplantation. Even more intriguing though, is that there is as of yet no substantive data to demonstrate that an alcoholic abstinent for six months is less likely to relapse than one abstinent for only three months or less (at least in these particular studies). The duration of abstinence alone does not seem to correlate with early or mid-term graft survival. There appears to be something 'sobering' about liver

transplantation itself which enforces a responsible attitude previously absent despite the unpleasant experiences of bleeding esophageal varices, sepsis or encephalopathy. In data only alluded to earlier—data especially germane to those who continue to apply social value criteria—the post-transplantation 'sobering' also includes gainful employment and positive mental health outcomes.[20]

Certain corollaries seem to flow from these empiric observations concerning the abstention from alcohol. First, the duration of abstinence to be enforced is at best arbitrary. In critically ill patients, periods exceeding three to six months are equivalent to a death sentence and cannot be justified. Furthermore, until now, the rationale for abstinence has not been carefully determined and remains vague. Abstinence seems to somehow represent the pledge of a good conscience towards the family of the donor and towards society's sensibilities as a whole. Second, the data suggest that allowing access to a liver transplant per se in an alcoholic person may lead to a low rate of recidivism and a reasonable expectation of a functional return to society. Whether this will remain true in the future with all alcohol-mediated ESLD remains to be seen. Some may validly raise the question whether any duration of abstinence is reasonable in light of a significant, empirically-verified trend towards voluntary abstinence after a transplant. In fact, it seems that overall attitudes towards abstinence are conditioned in great part by society's perception of alcoholism as disease versus wrongful behaviour.

## Exactly What is the Alcoholic State Itself—A Disease, A Sin, or Combination Thereof?

The literature in toto concerning alcohol-induced ESLD and access to liver transplantation may also be divided into early and later eras. In so doing, another curious dichotomy arises. As illustrated earlier, the first period was predominated by a negative attitude towards the transplantation of alcoholic individuals. The attitude itself was multifactorial with social value judgements and medical benefit criteria predominating. Lately, the majority opinion, like a pendulum, has swung towards free and equal access for alcoholic persons even without any period of abstinence.[21] Despite the recent improvements in survival for the group in question, there must be more to the change in attitudes than better post-transplantation results. Could the essential definition of alcoholism—disease or sin—impact attitudes towards access? The provision of a definitive answer to this question may go a long way in determining allocation priorities.

Post-modern culture has accepted a disease model for a number of behaviours previously viewed as transgressions or wrongful behaviour. Alcohol-abuse, like homosexuality and drug addiction, is seen by contemporary culture solely as a disease.[22] In reality, a number of alcoholism's characteristics fit nicely into the contemporary disease model with definite genetic overtones. For instance, because of enzyme disparities, females require significantly less alcohol exposure than males to develop cirrhosis. Studies of alcoholism in identical twins, parents and children, and adopted children of alcoholic parents into non-drinking families all suggest a genetic susceptibility to alcoholism[23] 'Male-limited' alcoholism occurs in a father-son pattern with antisocial behavior and difficult to change lifetime drinking habits—and is transmitted to successive generations.[24]

If one were to perceive and define alcoholism as just another inherited 'addictive-disease', the response to alcoholic persons would be conditioned by the definition. Treatment programmes would become voluntary, access to liver transplantation would be equal even without abstinence and why not? The system could not presume to change genetically determined behaviour or 'punish' alcoholism if the individuals so afflicted had absolutely no control over their life. Indeed, medicine has gone a long way in determining society's response to a number of such behaviours by making the disease model almost all-encompassing. Payne realizes this as he trenchantly observes, 'the cause of the problem (i.e. addictive behavior as disease or transgression) virtually determines its solution. In medicine, the diagnosis determines the treatment.'[25]

It would seem that a majority of Christian dialogues in the context of the Christ vis-a-vis culture model[26] would take exception to the alcoholism-as-disease-only hypothesis. Though drunkenness itself may have a physiologic basis, therefore making some individuals more prone to the ill effects of alcohol than others, the behaviour leading to drunkenness is still categorically inconsistent with Scriptural admonitions.[27] Implicit in these admonitions is that alcoholic persons are still ultimately responsible for their actions—even if they are more sensitive to the effects of alcohol. The contemporary model for alcoholism is beset with a myopic reductionism. Medicine's view that genes are the ultimate basis for all behaviour exceeds any reasonable ontology. It would therefore appear that a strict adherence to a theological construct for alcoholism and its treatment would necessitate the realization that alcoholism is primarily a sin despite the glib application of modern psychological labels. The majority of contemporary secular authors favour equal access to donated livers for alcoholic persons—either implicitly or explicitly—only because they as a group perceive alcoholism as a genetic disease. Such a difference in worldview perspectives and resultant ontology does indeed impact attitudes towards allocation.

## A Synthesis: Equal Access for Alcoholic Persons

The substantially improved results, survival and abstinence characteristics of this group seem to support at least a reasonable degree of access to donated organs. In essence, an outright refusal of all access would result in death ostensibly as a punishment for drunkenness. Though the appraisal of total access refusal as a form of capital punishment may seem prima facie extreme, the inevitable death of the alcohol-ESLD person without transplant—coupled with a potential significant alcohol-free survival post-transplant—supports such an implication. Even in an extreme application of theonomy[28],

drunkenness is not a capital crime. An outright, unconditional refusal of access to alcoholic persons comprises a worldview perspective grounded in grace as, 'no individual life (alcoholic or otherwise) is beyond the scope of life to which God is committed no matter how unlovely or unworthy by human standards.'[29]

One must be careful not to exclude from consideration the impact such free inclusion has on other persons with non-alcohol mediated ESLD. A consequentialist ethic, solely justified by the good outcome of the alcoholic person post-transplantation, may be skewed unfairly. To ensure that alcohol-induced ESLD is not the only population receiving donor organs, a lottery may represent the only way to ensure justice.[30] The lottery would have to be structured in such a way as to permit a reasonable access for non-alcohol ESLD. A lottery would protect the essential goals of justice in organ allotment for both groups: i.e. first, equal provision for *all* in need; second, in situations of scarcity, equality necessitates that each patient should be provided with an *equal* opportunity to obtain treatment.

## Another Synthesis: Access but Never Equal

It would seem most difficult, especially within the context of a Christian worldview perspective, to totally exclude alcohol-ESLD from transplant consideration. Exclusion arguments rely on social valuations, financial considerations and convenient misapplication of medical benefit criteria as well as minimizing grace. None of these arguments should inhabit Christian ethical discourse. Might the transplant access of alcoholic-persons be permitted in *unequal* fashion however, and then justified by the Christian community? Such a heterodoxy on this particular issue may well exist.

Three aspects of completely equal access for alcohol ESLD might disturb some Christians. First, if alcoholism is strictly defined as a sin, does treatment without vigorous attempts at abstinence *prior to transplantation* qualify as a serious redemptive response? Is a resultant teleologic or consequentialist ethic, which considers only the successful transplantation of alcoholic-ESLD as a good outcome, unfair to other patients with ESLD? Finally, does the application of the expensive technology in the context of transplantation represent a 'New Medicine'—as such a medicine characterized as messianic brinkmanship? This term describes a post-modern medical paradigm which proposes utopia through physical, technologic healing without a spiritual dimension. Responses to the three difficult questions must be provided.

> The Bible is not first of all a book of moral truth. I would call it instead a book of truth about the way life is. Those strange old Scriptures present life as having been ordered in a certain way, with certain laws as inextricably built into it as the law of gravity is built into the physical universe. When Jesus says that whoever saves his life will lose it and whoever loses his life will save it, surely he is not making a statement about, how morally speaking, life ought to be. Rather, he is making a statement about how life is. Frederick Buechner[31]

> Discernment, in other words, shows a kind of attentive respect for reality. Thus the discerning person notices not only the differences between things, but also the connections between them. He knows what God has put together and what God has kept asunder, and can therefore spot the fractures and alloys introduced by human violation of creation. Plantinga[32]

The duration of alcohol abuse leading to ESLD may be in the order of 15–20 years. During that time, the vast majority of alcoholic patients require multiple hospital admissions, often for life-threatening complications of liver disease (e.g. bleeding esophageal varices). It would be the exception rather than the rule, so to speak, to have a patient with alcohol abuse not be warned repeatedly that continued alcohol intake will lead to ESLD and death.

The sin of alcoholism, like any other sin, in one sense may be classified as foolishness and in order to escape sin-as-foolishness, at some time a person has to stop, admit that he or she is wrong, turn around, head back to safe ground to try a new route.[33] In this context, continued alcoholism—especially of the magnitude and duration necessary to lead to ESLD—is essentially a foolish attempt to reinvent reality. In this reinvention, God as the Lord and boundary keeper of life is completely ignored.[34] As Plantinga observes, to fear God is to know God is not mocked, that we must reap whatever we sow and that God's universe cannot be fooled with, scorned or ignored without consequences. Alcohol-induced ESLD is a serious consequence of repeated, wilful and sinful behaviour without repentance.

It would also seem that the protracted nature of alcoholism leading to ESLD is also consistent with a contemporary variety of medical brinkmanship, or more specifically medicine's illegitimate assumption of a messianic role. Medicine continues to provide expensive technologic solutions for 'diseases' whose real answer and cure reside in a repentant-redemptive model. It goes against the grain of the universe to presume to treat alcohol-mediated ESLD with a new liver if there is not some promise to stop the behaviour potentially leading to death.

Abstention earlier in the course of alcohol intake—in fact, even after cirrhosis is diagnosed—is still the best and least expensive treatment for liver disease. The need for a disastrously scarce, non-renewable resource such as the donated liver, would be best served by abstinence well before the crisis of ESLD. A post-modern zeigeist, reliant on medicine to remedy the problem of ESLD through transplantation, lacks the discernment necessary to recognize the 'human violation of creation' inherent in protracted alcohol abuse. Does it not seem futile to confront all of society's ills with ever-increasing technology without the discernment necessary to describe self-destructive behaviours first and foremost as wrong?

A fatal flaw with a disease-model as norm that is so prevalent today is Medicine's arrogant assertion that the fallout of any wrongful behaviour may be cured through a one-dimensional physical remedy. The alcoholic person could then justifiably ask why a behaviour consistently classified as disease or why a behaviour that is the result

of genetic determinism should be changed when medicine can correct the lethal outcome at a later date? In fact, in this way alcoholism and liver transplantation have become like homosexuality and AIDS. Rather than curbing homosexual licence, which leads to a fatal disease—one hopes that without a spiritual dimension medicine will cure the fatal, physical outcome through research and treatment.

A redemptive response—cogniscent both of alcoholism as sin and strongly considering those with non-alcohol ESLD in the equation—may allow unequal access to alcoholic persons as well as require abstinence (approximately 3 months) prior to waiting list eligibility. Even though abstinence may develop spontaneously post transplantation—its earlier presence in the course of ESLD signifies a more God-centred attitude and serves as a pledge of a good conscience towards a scarce resource donated by a bereaved family.

Unequal access would then be implemented by a two-tiered lottery. A certain percentage of donated organs (around 25%) would enter the lottery for alcohol-ESLD with the majority set aside for non-alcohol etiologies. This model would prevent the sole consumption of the scarce resource by a single group, but at the same time not unjustly or completely exclude that group from consideration. The 25% allotment is arbitrary and could be changed, though any lower a figure might become ethically questionable.

## Conclusionary Observations

Engaging the topic of liver transplantation and alcoholic persons leads to certain inescapable conclusions. Access to donated organs may not be determined by social value judgements or enforced by excessive, potentially fatal periods of abstinence. Though medical benefit criteria are utilizable in some instances, many patients will still warrant other ethical criteria for inclusion or exclusion. Finally, outright exclusion of the group in question may not be substantiated.

A Christian response to the issue is inhabited by a tension between grace and justice. The foundational definition of alcoholism is at the heart of the question. Though access would be allowed within a heterodoxy, a spiritual healing and redemptive response must confront alcoholism from a Christian worldview perspective as well as confront contemporary medicine's illegitimate messianic function.

The Christian is left to decide exactly how to utilize the wealth of data concerning this issue in engagement during the contemporary culture wars. One particular aspect of the dilemma seems to cry out for care and attention while engaging an alien, post-Christian culture.

In the early 1900s, Alcoholics Anonymous was undergirded by the Oxford Group.[35] The spiritual aspect so necessary to the healing of alcoholism was never ignored. Like the evolution of many other agencies in the post-modern world, AA has totally lost its essential spiritual roots. The vacuum thereby left may represent one of the more important ministries in medicine. Our ancestors really appreciated the lethal fallout of alcohol and acted accordingly in a New Testament manner. Though it may be justified to say no to some in the context of liver transplantation, it is never justified to avoid the offer of grace in an essential spiritual realm of healing. The condemnation of the alcoholic without an offer of the gospel is far more tragic than the loss of a donor organ.

1. The gauntlet for alcohol-mediated ESLD and access to donor livers was laid down by the National Institutes of Health Consensus Development Panel during an earlier era in liver transplantation (JAMA 1983; 250: 2961–2964). The panel stated categorically that alcoholic cirrhosis should be an indication for liver transplantation in 'only a small number of cases'—in whom abstinence was deemed essential.
2. Update obtained from Life Banc of Ohio (216–752–LIFE) (March, 1994).
3. DeVita, M. A., Snyder, J. V., Grenvik, A. History of organ donation by patients with cardic death. (1993) Kennedy Inst of Ethics Jour 3 (2): 123–124.
4. *Ibid.*, DeVita, M. A., et al (1993) p. 123.
5. Office of Technology Assessment, Agency for Health Care Policy Research. Assessment of liver transplantation. Rockville, Md. (1990) U.S. Department of Health and Human Services 3:25. See also: Moss, A. H., Siegler, M., 'Should alcoholics compete equally for liver transplantation?' (1991) *JAMA* 265: 1295–1298; Killeen, T. K. 'Alcoholism and liver transplantation; ethical and nursing implications.' (1993) *Persp in Psych Care* 29 (1): 7–12.
6. Blank, R. H., 'Lifestyle choices and medical terminology: allocating organ transplants'. (1991) *JHHRA* (Winter): 269. Other authors have set the price range of liver transplantation anywhere between $100,000–$300,000. For this additional information see Beresford, T. P., Turcott, J. G., Merion, R., et al., 'A rational approach to liver transplantation for the alcoholic patient'. (1990) *Psychosomatics* 31 (3): 243.
7. No author expressed the verifiable statistic for this contention, but Erich Loewy noted that as of 1987, at a *minimum*, one in seven Americans was medically indigent; at a median cost of greater than $200,000 per liver transplant, without medical insurance, liver transplantation would essentially be precluded for lower to middle socio-economic strata. One can see just such a valuation of expense verses need clearly in the Oregon rationing experiment for Medicaid patients. In Oregon, liver transplantation is not a viable alternative for ESLD in Medicaid patients. Further, since a significant proportion of ESLD from alcohol occurs in indigent patients, taxpayers may resent the utilization of their money to treat such a stigmatized group. Though finances will not be addressed further in this particular paper, the consideration of expenditures by third party payers suggests that they will have a substantial impact on future availability of liver transplantation. Please see: Loewy, E. H., 'Drunks, Livers and values.' (1987) *J Clin Gastroenterol* 9 (4): 436–441.
8. Op. cit.; Moss, A. H., Siegler, M. 1991. 1295–1298.
9. Allen V. Mansour. 86–73429. C District Court for the Eastern District, State of Michigan (1986).
10. Scharschmidt, B. F., 'Human liver transplantation: analysis of data on 540 patients from 4 centers'. (1984) *Hepatology* 4 (S-1) 955–1019. In reality, the evolution of poorer to better survival after liver transplantation occurred more smoothly and continually from the 1960's through 1980's. Over this period, overall 1 year post-transplant survival increased from approximately 30–65%. Survival of transplanted alcohol-ESLD lagged a bit behind these figures, but by the late 80s–90s also reached gratifying levels.
11. Starzl, T. E., Van Thiel, D., Tzakis, A. G., et al., 'Orthotopic liver transplantation for alcoholic cirrhosis.' (1988) 260: 2542–2544. This is the prototypical study and though it may be guilty of 'selecting the data' if you will, it is the most frequently quoted and represents the results of the prestigious University of Pittsburgh transplant program. Other similar studies looking at positive outcomes for ESLD in alcoholic patients include: Bonet, T. H., Manez, R., Kramer, D., et al., 'Survival of patients transplanted with alcoholic hepatitis plus cirrhosis with those with cirrhosis alone.' (1993) *Transp Proc 25 (1)*: 1126–1127. Knechtle, S. J., Fleming, M. R., Barry, K. L., et al., 'Liver transplantation in alcoholics: Assessment of psychological health and work activity.' (1993) *Transpl Proc 25 (2)*: 1916–1918. This study should be read in detail, since in addition to a positive medical outcome, it also demonstrates that alcoholic patients do as well post transplantation in terms of continued, gainful employment as well as evidencing a low

incidence of depression. Belle, S. H., Detre, K. M., 'Report from the Pitt-UNOS Transplant Registry. (1993) *Transpl Proc 25 (1)*: 1137–1142. Finally, Bird, G. L. A., O'Grady, J. B., Harvey, F. A. H., et al., 'Liver transplantation in patients with alcoholics cirrhosis: selection criteria and rates of survival and relapse.' (1990) *BMJ 301*: 15–17.

12. Delmonico, F. L., Jenkins, R. L., Freeman, R., et al., 'The high-risk liver allograft recipient: should allocation policy consider outcome? (1992) *Arch Surg* 127: 579–584.

13. *Hospital ethics* (1993) September/October, p. 6. as well as op. cit.; Schenker, S., (1990) p. 315. Other medical conditions that absolutely contraindicate liver transplantation include: HIV seropositivity or AIDS; malignancy outside the liver; infection outside the hepatobiliary system; (some centers) 'active' alcoholism; advanced cardiopulmonary disease. See MKSAP, Hepatology. (1993) American College of Physicians. p. 207.

14. Atterbury, C. E., 'The alcoholic in the life boat. Should drinkers be candidates for liver transplantation?' (1986) *J Clin Gastroenterol 8* (1): 1–4.

15. Lundberg, G., 'Licence to plunder or to paint.' (1983) *JAMA 250*: 2966–2967.

16. Cohen, C., Benjamin, M. Ethics and social impact committee, Michigan., 'Alcoholics and Liver Transplantation.' (1991) *JAMA 265* (10): 1299–1301.

17. Massachusetts Task Force on Organ Transplantation. In: *Human Organ Transplantation: Societal, Medical, Legal, Regulatory and Reimbursement Issues*. Ed. Cowan, D. H., Kantorowitz, J. A., Moskowitz, J., Rheinstein, P. H. (1987) Health Administration Press. Michigan. p. 219–220.

18. Fox, R., Swazey, J., *The Courage to Fail* (1974) Univ of Chicago Press. p. 232.

19. The statistics quoted above are taken from: Kumar, S., Stauber, R. E., Gavaler, J. et al., 'Orthotopic liver transplantation for alcoholic liver disease.' (1990) *Hepatology 11*: 159–164; Duffoel, M., Wolf, P., Ellero, B., et al., 'Results of orthotopic liver transplantation in alcoholic cirrhosis (1980).' *J Hepatol* 9 (S-1): 527; Osirio, R. W., Friese, C. E., Ascher, N. L., et al., 'Orthotopic liver transplantation for end-stage alcoholic liver disease.' (1993) *Transp Proc 25* (1): 1134. Randels G., 'Finding the mean: liver transplantation for alcoholics' (1993) II (2 & 3): S-23 (Randels quotes Starzl's data) respectively. A caveat must be applied to this data, however. The low rates of recidivism may only represent a carefully selected population. Certain favourable characteristics could have been chosen prior to inclusion for liver transplant. The least promising patients may have been completely ignored in these studies.

20. Op. cit.; Knechtle, S. S., et al. (1993) p. 1915–1918.

21. A sampling of majority opinion circa 1986–present: op. cit.; Atterbury, C. E. (1986) p. 1–4; Loewy, E. (1987) p. 436–441; Rosner, F., Henry, J. B., Wolpaw, Jr. et al., 'Ethical and social issues in organ procurement for transplantation (1993).' *NY State J of Med 93* (1): 30–34; op. cit. Cohen, C., Benjamin, M. (1991). p. 1299–1301; Schenker, S., Perkins, H. S., Sorrell, M. F., 'Should patients with end-stage alcoholic liver disease have a new liver?' (1990) *Hepatology 11* (2): 314–319; op. cit.; Beresford, T. P. (1990) p. 243; Flavin, D. K., Niven, R. G., Kelsey, J. E., 'Alcoholism and orthotopic liver transplantation (1988).' *JAMA 259 (10)*; 1546–47; Schwartzman, K., 'In Vino Veritas. Alcoholics and liver transplantation.' (1989) *CMAJ 141*:1262–1265.

22. No one has presented the alcohol-as-transgression model better than Shakespeare in *Hamlet* (III, iii). Hamlet forgoes his revenge on the King who is in prayer for fear of sending his father's murderer to heaven. Rather, Hamlet would like to kill the king in 'some act that has no relish of salvation in't'—e.g. 'When he is drunk asleep.' Until recently, with the appearance of a post-modern zeitgeist which defines almost every 'abnormal' behaviour as disease, there was a strong belief that alcoholism was inherently volitional and wrong. It is not surprising that Karl Menninger once queried, whatever has happened to sin?

23. Diamond, I., Alcoholism and alcohol abuse in *Cecil Textbook of Medicine* (Ed. Wyngaarden, Smith, Bennett) (1992). W. B. Saunders Co. p. 44.

24. *Ibid;* Diamond, I. (1992) p. 44.

25. Payne, E., 'Addiction as besetting sin.' (Fall–1993) *J of Biblical Ethics in Med.*

26. The majority would presumably include the 'Christ against culture,' 'Christ and culture in paradox,' 'Christ above culture,' and 'Christ the transformer of culture' models.

27. The Old Testament (Prov. 20:1; 23:19–31; 31:4–7) clearly condemns drunkenness and further study explicates a negative view of behaviour adversely affected by alcohol (Gen. 9:20–25; 19:33–35; 1 Sam. 25:36; 2 Sam. 11–13; 13:38; 1 Ki. 16:9; 20:16). The New Testament is also in agreement (Rom. 13:13; Gal. 5:19–31; Eph. 5:18; 1 Cor. 6:9–10; 1 Pet. 4:4) Dr. Payne's previous observation relies on Heb. 12–1—the behaviour of the alcoholic individual is wilful and is an act of deliberately and volitionally *besetting* sin. That the behaviour (i.e. alcoholism) may be successfully repented for is suggested in 1 Cor. 6:9–11—'and such *were* some of you.'

28. A listing of capital crimes in The Old Testament includes: homicide-child sacrifice (Lev. 20:2); manslaughter coupled with capture outside a city of refuge (Num. 35:27); keeping an animal that killed a human (Ex. 21:16); bearing false witness on a capital charge (Deut. 18:18–21); kidnapping (Ex. 21:16); insult/injury to one's parents (Ex. 21:15; 17; Lev. 20:9; Deut. 22:22–27); religious offenses (Ex. 22:18; Lev. 20:6; Deut. 13:5; Num. 1:51; 3:10; 18:7; Ex. 31:14). Adopted from Baker, W. H. *On Capital Punishment*. Moody Press, 1985, p. 39–40.

29. Kilner, J., *Life on the Line: Ethics, Ageing, Ending Patient Lives and Allocating Vital Resources*. (1992) (Wm. B. Eerdmans Co. Michigan), p. 56.

30. Please refer to ibid; Kilner, J. (1992) p. 227–228. Kilner observes further that such a random selection process (i.e. lottery) also has a Biblical history. It is seen as one way to leave 'insoluble' decisions to God (Prov. 16:33; cf. Josh. 18:6–10; 1 Sam. 10:20–21; 14:42; 1 Chron. 26:132; Neh. 10:34; Esth. 3:7; Prov. 18:18; Jon. 1:7–8; Acts 1:24–26) and at the same time, ensure that the result of such decision-making does not reflect the biased preference of the decision-maker. (Num. 26:55; Judg. 20:9–10; Job. 6:27; Job. 3:3; Obad. 1:11; Nah. 3:10; Mt. 27:35). There are, however, mitigating circumstances that must be factored into this model of impartial selection. First, patients who have irreversible co-morbid conditions (e.g. cardiomyopathy, especially with a significant impairment measured by ejection fraction) would not be included because of just application of a medical benefit exclusion. Second, Evans' data, which was discussed previously, would apply appropriate medical benefit criteria to others whose transplant would have a very low likelihood of success prior to inclusion in the lottery. The only problematic category remaining in an impartial selection process as patients with an 'immanent-death' classification. Such patients might have 'acute yellow atrophy' from a toxic exposure or Tylenol overdoses with a clinical course leading to death in a matter of only weeks. It would not be unjust in such a circumstance to 'prioritize' this class of patients since non-transplant survival would otherwise be measured in a matter of days to a most weeks and earlier death would be inevitable without transplant.

31. Plantinga, C., 'The sinner and the fool.' (1994) *First things* 46:25.

32. *Ibid;* 1994. p. 25.

33. *Ibid;* Plantinga, C. 1994. p. 28.

34. *Ibid;* Plantinga, C. 1994. p. 28.

35. The ministry to alcoholics in the early 1900s was begun by the Oxford group. The group itself was a non-denominational evangelical attempt to live a first century Christianity. Alcoholics were exhorted to be penitent and witness to the transcendent strength necessary to conquer alcoholism. The Oxford group was not bashful to specifically identify that strength with Jesus Christ. See Kurt, E., *AA—The Story*. (1988) (Harper and Row, San Francisco).

# Book Reviews

**The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood**
Edited by Barbara Katz Rothman
London, Pandora. ISBN 0–86358–255–9

This is an important book which makes accessible for public debate the experience of women who undergo amniocentesis in order to have their unborn babies screened for abnormalities. The book reports on a research study, but in a way which makes compelling reading for anyone interested in the technological revolution in reproduction, and most importantly for women who are in early pregnancy or intend to start a family.

The research is based on interviews with three groups of women who were in contact with genetic counselling and prenatal diagnostic services. Chapter 2 sets the service in context, with the author's report on observation in clinics and interviews with genetic counsellors. The links with legalized abortion, the feminist movement and eugenics are also drawn out in this chapter.

The intensity of the dilemma facing women when they are offered amniocentesis is demonstrated powerfully in Chapter 3. Both sides of the debate are argued by women who have thought deeply about the choices they have made. The account also gives insight to the capacity to turn thinking around when a hypothetical question becomes a reality. For example, one woman said, while waiting for the results of the amniocentesis:

> That was a tempting plum—ugly, distorted, perverse, but still, to be assured that our lives won't be disrupted by that, was too tempting not to pluck. . . . It's truly your right but it's got a moral stink to it that sickens me.

Three weeks later she learned that her baby did have Downs Syndrome, and had the abortion.

In Chapter 4 the stories are told of the experience of amniocentesis, and the subtle effects which anticipation of the test had on feelings about the pregnancy. Women were reluctant to 'go public' about the pregnancy for fear of explanations if termination was required. The tentative nature of the pregnancy is described—a sense that the women cannot ignore it, yet cannot wholeheartedly embrace it. The issue of the reassurance which amniocentesis can offer is countered with the argument that the test is able to allay only those fears it first raises.

The question of sex selection is discussed, and in Chapter 6 there is a fascinating account of the reactions of mothers who were given ambiguous results of their tests, either due to technical error or to diagnosis of a condition on which little information can be found. The writer acknowledges the way in which our value system colours our view of such situations in highlighting the difference between her own perspectives as observer and that of a genetic counsellor.

> Where I see the parent is incapacitated, unable to parent the child knowing what they know, she sees the parent empowered by information.

In dealing with the grief of those who are 'lucky' enough to have been given the choice of avoiding giving birth to a defective child, Rothman makes it clear that she feels the pain, and wants the reader to feel it too. The women's stories are utterly convincing, and reading this book is a deeply emotional experience.

In the final chapter there is a thoughtful reconsideration of the issues raised by the research, and an extension of the argument to include the more recent test which often replaces amniocentesis, chorion villus biopsy, with its advantage of being carried out much earlier in pregnancy. While sensitive to valid reasoning in support of abortion in some dire circumstances, the stance taken throughout the book reflects deep reservations about the weight of decision making laid on women by the new technologies, and about the implications for society of choosing against disability. It presents a strong argument against the 'commodification of life' and the dangers of applying quality control principles to childbirth. One can only applaud the power of the message and hope that it will be heard.

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**Euthanasia, Clinical Practice and the Law**
Edited by Luke Gormally
The Linacre Centre, London 1994, ISBN 0–906561–08–6, 248p, paperback, £12.75.

This very readable book is really two separate ones, as it 'brings together work separated by more than a decade'. Book 1 is a further reprint of the Linacre Centre's 1982 Working Party report, 'Euthanasia and Clinical Practice: Trends, Principles and Alternatives'; and it was for me personally the most helpful section in that it contained information, with which as a relative newcomer in the world of medical ethics, I was not familiar.

It analyzes, under the headings 'practice', 'thinking' and 'conclusion', five separate clinical areas: care of the newborn, care of the handicapped, terminal care, care of the elderly and intensive care. Under 'philosophical considerations', it concludes that euthanasia always falls under the prohibition of the intentional killing of the innocent; and a thoroughly biblical chapter on 'the Christian tradition' reinforces this inescapable foundation.

The 'rights and duties of competent patients in regard to treatment' and 'the rights of incompetent patients and duties towards them' are then considered before a conclusion in terms of principles for good practice and an application of those principles to the five clinical areas introduced earlier.

There was a 'PS' to Book 1 in the form of a personal critique of the (then) recent Dr Leonard Arthur case, in which a pediatrician was charged with attempted murder for allegedly sedating a newborn baby, with Downs Syndrome, to death. Some of the most worrying evidence in 1982 was of 'euthanasiast' abuses in such cases, establishing principles and patterns of behaviour which would lead to similar abuses with adults. Although Dr Arthur was acquitted, that case probably changed practice for the better and did much to expose how dangerously badly doctors think. This, of course, leads to some of them behaving dangerously badly!

Book 2 jumps ten years to a series of papers on legal matters. The first and longest is the text of the Linacre Centre's influential 1993 submission to the House of Lords Select Committee on Medical Ethics (which Committee in February 1994 surprised many with a unanimous rejection of euthanasia). Lawyer John Finnis follows with a paper on 'Living Wills'; and Luke Gormally then exposes the logical inconsistencies of the British Medical Association's 1988 Report, which rejected legalizing euthanasia but, arguably, sowed the seeds of some of the

subsequent confusion that led to the Lords' Committee being set up. This enormously helpful collection of arguments, facts and figures is then completed with two papers, by John Keown, on the appalling situation in the Netherlands where there is, without doubt, widespread abuse of even the minimalist guidelines laid down to control euthanasia. This is not an easy book to read—although there are few typographical errors, the layout and style could perhaps have been made clearer (and on some of the pages the print was particularly tiny). Most readers will find that the nature of the philosophical arguments does not make for a light read! However, no-one could read the facts and the arguments in this book without concluding against euthanasia.

And that is the challenge this reviewer was left with! All the arguments against euthanasia were there coherently in the 1982 material. Why then did clinical and legal practice continue in a mainly downhill direction? The answer is that we failed to get the arguments across in a way that was listened to; and we failed to demonstrate Christian standards of care sufficiently to remove the demand for euthanasia.

Admittedly, the UK was set on a path of selfish 'self-determination' and wanted (non-existent) rights with no recognition of responsibilities. In other words, they did not want to listen to us. But, surely, the challenge to us all now is effectively to educate the public, patients and fellow professionals, by presenting the arguments given to us on a plate here and by putting the alternative of good palliative care into practice. Luke Gormally and the Linacre Centre have done a wonderful work, not least with this book.

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**The Virtues in Medical Practice**
Edited by Edmund D. Pellegrino and David C. Thomasma
Oxford University Press, Oxford 1993, ISBN 019–508289–3, xiv + 205 pp, hardback £25.00

Spelling out his understanding of ethics in the Nicomachean Ethics, Aristotle, first asked: 'What is good for man?' He found the answer in a certain understanding of happiness, namely happiness in the sense of the virtuous pursuit of an activity chosen and enjoyed for its own sake. His Nicomacean Ethics being of a less religious bent than his Eudemian Ethics, the activity singled out in the former is the one tending towards theoretical wisdom, while in the latter Aristotle says man's chief end is to 'serve and contemplate God'. On either understanding, the activity in question both fosters and expresses a virtuous character, and so a habit of acting.

Michael Oakeshott, a modern-day Aristotelian building on this, argued (in his well-known essay 'Rational Conduct'), that different activities foster and express different habits and a different knowledge of how to act in a certain situation. Knowing how to act well, as a doctor, carpenter or chef is to possess a skill and to have internalized the rules and ways of a certain type of activity or tradition. To act morally well is, on this view, to act in accordance with the coherence of a whole moral tradition

The profession of medicine is a tradition with a long past. Its roots are to be found both in Greek ethics and in Christian morality. The authors of *The Virtues in Medical Practice* examine this tradition and seek in it the virtues, or dispositions to act, that characterise a good doctor. So doing, they ground the virtues of medicine in the nature and end of this special kind of human activity as it has, at least until recently, been traditionally practised by the standard-bearers of the profession.

The book begins with an historical account of the concept of virtue, centring on the Aristotelian and Thomist understandings of virtuous conduct. Then turning their attention to medical practice, as the activity of a moral community, they find the virtues in medicine to be: fidelity in trust, compassion, phronesis, justice, fortitude, temperance, integrity and self-effacement. However, having found these virtues, the authors are perhaps a little longwindend in their exposition of them and they risk boring the reader with a certain amount of repetition. Yet, it pays to persist. For, in these detailed accounts, one finds percipient critiques of many of the wrongs in modern health care dictated to, from outside the medical profession, by bureaucrats and politicians, whose ends and ways are very different from those of medicine. The book closes with a discussion of what impact a virtue-based understanding of medicine will have on its practice, a discussion concluding that such an ethics effectively enjoins the doctor to go beyond the (mere) call of duty, because to be virtuous is to strive towards perfection.

As a general comment, the authors might perhaps have said a little more about the true value of human life and about the concepts of personal integrity in general and personal integrity of patients, in particular, as opposed to the integrity of doctors. Is medicine not concerned with what most intimately threatens the integrity of the person and human life, namely illness? Of course, the focus of this book is on the character and conduct of the good doctor. But given that the authors place themselves in the Hippocratic Christian tradition of thinking about medicine, they might perhaps have met head on the challenge posed by the main protagonists opposing this tradition. This is because these protagonists prioritize a notion of quality of life defined by reference to notions of valueless or unworthy lives, notions which pose a threat to the concepts of human dignity and the sanctity of human life so fundamental to Hippocratic and Christian thought.

This being said, *The Virtues in Medical Practice*, is a book to be warmly recommended to all students of medical ethics and anyone else serially interested in the subject. It may not face its opponents by demolishing their arguments. But it does so by proposing a totally different way of assessing the practice of medicine.

AGNETA SUTTON

**Mind Fields: Reflections on the Science of Mind and Brain**
Malcolm Jeeves
Baker Books, Grand Rapids, 1994, ISBN 0–8010–5227–0

Malcolm Jeeves' *Mind Fields: Reflections on the Science of Mind and Brain* is a wide-ranging, thought-provoking, and fascinating layman's introduction to contemporary neuropsychology by the Foundation Professor of Psychology at St. Andrews University, Scotland. What sets this popular introduction to neuropsychology apart from other such efforts is Jeeves' attempt to evaluate the findings of historical and contemporary neuropsychological research in light of Christian revelation. *Mind Fields* is an expanded version of talks delivered by Jeeves as part of the inaugural series of New College Lectures at the University of New South Wales. The principal aim of this series is the renewal of John Cardinal Newman's vision of university education as a 'circle of knowledge' with Christian theology as the controlling science. (John Henry Newman, *The Idea of a University*, University of Notre Dame Press: Notre Dame, 1982)

According to Newman, university education ought to be centrally concerned with human meaning and value, and the relation between divine purpose and these distinctive features of humanity. Acknowledging the modern university's nearly

wholesale repudiation of this structure, Jeeves embarks on a course of inquiry into 'how the scientific study of man has affected our knowledge of ourselves as human beings, and the implications of that study for human society and for religious and other human values' (pp. vi–vii). Specifically, he focuses his attention on: (i) the implications of the 'steadily tightening link between mind and brain' (p. xi) for our concepts of human action, freedom, and moral responsibility; (ii) the manner in which a scientist's presuppositions influence his interpretation of data and theory construction; and (iii) the way in which the emerging picture of human nature culled from neuropsychology relates to the picture of human nature found in traditional Christianity.

In Chapters 1 through 4 Jeeves provides a brief historical sketch of the aforementioned steadily tightening mind-brain link beginning with the Presocratic philosopher, Empedocles, and concluding with a series of empirical and theoretical results from contemporary neuroscience. Repeatedly Jeeves points his readers to several diverse results which may be interpreted as implying that the mind and brain are, in some deep sense, intimately related; and that together they comprise the primary distinguishing feature of that 'psychobiological unity' called man (p. 120). In Chapter 5 the roles of environment and experience in the shaping of our nervous systems are explored. Chapter 6 contains a brief discussion of special problems encountered when conducting peculiarly *human* scientific inquiries. Chapter 7 provides reflections on the impact of contemporary neuroscience on our view of human nature. Specifically, Jeeves confronts the temptations some have felt to abandon our pre-scientific intuitions concerning free will and moral responsibility in the wake of the neuroscientific revolution. He attempts to lay to rest worries that the picture which results from contemporary neuroscientific inquiry is incompatible with the picture of ourselves as free and morally responsible beings. Chapter 8 is an ambitious attempt to synthesize the data of neuropsychology and the data of Christian anthropology with specific emphases on the nature of the soul and the Christian promise of life after death.

It is noteworthy that Jeeves explicitly states at the outset that he is 'not a philosopher' (p. 3) and that 'This is not a philosophical book' (p. 3). Although it is true that Jeeves is not a *professional* philosopher, he has clearly placed himself in the tradition of a philosopher by undertaking what certainly is, contrary to his disclaimer, a highly philosophical treatise. Given the myriad philosophical, theological, and scientific claims advanced by Jeeves, and the vigour with which he propounds them, it seems proper to hold him to high standards of scientific, theological, and philosophical scholarship.

His account of the present state of neuropsychology, although at times simplistic (perhaps appropriately so given his intended audience), is generally clear, concise, and accurate. However, Jeeves' understanding of the scientific enterprise in general, of sciences outside his area of expertise, and of philosophy (especially Ancient philosophy, philosophy of science, metaphysics, and philosophical theology) has many problems. I shall touch on only a few of these problem areas. First, it is patently false that 'Aristotle . . . quite unambiguously localized the soul in the heart.' Unfortunately, Jeeves provides us with no textual reference for this claim. Fortunately, Aristotle has left us an entire treatise on the soul, viz. *De Anima*. His unambiguous doctrine in that work (and elsewhere) is that the soul is the *form* of a living body, not that it is a *thing* which can somehow be localized *in* a certain *part* of a body.

Second, Jeeves' sweeping claim that 'the Greek tendency had been to separate man from the rest of creation and to give him and his mind an arrogant, aristocratic place over against nature' (p. 87) is quite contentious. Aristotle, for example, forcefully resists this picture of human disunity. Thus, one version of the anthropological view which Jeeves associates with the 'true Hebrew/Christian emphasis of the nature of man' (p. 87) is clearly found in the most important writings of arguably the most influential philosopher in ancient Greece.

Third, it is not at all obvious that Darwin's work has shown Aristotle's theory of biological kinds to be false (p. 87). Perhaps Jeeves believes this to be the case because of his idiosyncratic understanding of Aristotelian biology. In any case, Aristotle certainly did not believe, as Jeeves claims, that 'all living things are in some sense embodiments of external forms of unchanging essences' (p. 87) since for Aristotle, all plants and brute animal forms are *enmattered*; none are, therefore, in any sense 'external' to those particular plants and brute animals which are informed. (Note that Darwinian evolution is not, as Jeeves states, a theory which posits 'a dynamic and progressive process' [p. 87]. Darwinists do not understand the evolutionary process—except in a very limited, adaptation-specific sense—to be *progressive*. According to Darwinism, human beings who have adapted to their environment are no more advanced along a vector of evolutionary progress than spiders which have adapted to their environment).

Fourth, Jeeves' discussion of the role of values in the scientific enterprise is especially problematic. He seems both to recognize a peculiar distinction between statements of value on the one hand and matters of fact on the other, and to believe that science's primary goal is *value-free* knowledge. As I see it, neither of these positions is tenable. As a Christian scholar, for example, I value internal consistency. I firmly believe that internal consistency is valuable. If I am right about this, then it is a *fact* that internal consistency is valuable. Statements about values, then, if true, are facts.

Thomas Kuhn (*The Structure of Scientific Revolutions*, 2nd ed) has argued persuasively that values play pivotal roles in scientific theory construction. The values that he has in mind are certain theoretical virtues which historically have been embraced by scientific communities, e.g. internal and external consistency, accuracy, predictive power, and simplicity. Jeeves acknowledges that 'All scientists have values which are reflected in the criteria they employ for making choices between competing theoretical explanations' (p. 90). Yet he insists, that it is a confusion to think that (presumably theoretical) scientific knowledge itself is thereby value-laden. And he thinks that such value-laden theories are scientifically unacceptable. Why does he think this? Jeeves is justifiably vigilant about certain idiosyncratic or conceptually perverse values creeping into the scientific domain and thereby poisoning the process of theory construction. But, of course, it does not follow from this that *all* values whatsoever must be extirpated from any given unit of alleged scientific knowledge. Consider again internal consistency. I, as a scientist of sorts, value internal consistency and, hence, *ceteris paribus* prefer scientific theories which are internally consistent to those theories which are not. Should one of those theories $T$ which are internally consistent be true, and should I be in the privileged position of *knowing* that $T$ is true, then I would have scientific knowledge of a theory (namely $T$) which reflects one of my most cherished theoretical values (viz. internal consistency). What could possibly be wrong with that?

Jeeves' suggestion that a value-free theory of counselling is both attainable and appealing is troubling in this context, especially for a Christian counsellor. Rather than aim at securing a value-free theory of counselling—a goal which appears to me to be unattainable—Jeeves would do well to follow the lead of Alvin Plantinga ('Prologue: Advice to Christian Philosophers' in Michael D. Beaty (ed.), *Christian Theism and the Problems of Philosophy*), both in the psychological arena and elsewhere. Plantinga encourages Christian scholars to undergird their research efforts, whether empirical or theoretical, with those values which are found in Scripture and which have been handed down by the Christian faithful through her church. According to Plantinga, there may be a distinctively Christian

way of understanding each sub-discipline within the scientific domain. There may, for example, be distinctively Christian ways of doing biology or physics or mathematics. As scholars and scientists who are also Christians, we have an obligation to the community of believers to undertake our work in a manner which best serves the practical and intellectual interests of the church, whether or not this course of inquiry is respected or ignored by the prevailing intellectuals of our age. If Christianity is true, then its central values will, if integrated properly into the theoretical structures in question, enhance one explicit goal of at least a majority of practising scientists, viz. discovering truths concerning the natural world.

Fifth, Jeeves claims that the scientist's world is 'a world where one thing causes another' (p. 89). This is not invariably the case. Many scientists believe that, at their deepest level, microphysical events are uncaused. The data of quantum physics do not entail any such commitment to noncausality, but these data are compatible with such an account. In fact, this noncausal interpretation of the data is endorsed by the majority of quantum mechanists. It is, I might add, a chief strength of Jeeves' book that he underscores the centrality of the 'underdetermination' thesis in the scientific domain by repeatedly pointing out the fact that any given set *S* of empirical data is compatible with several mutually incompatible theories which can adequately account for *S* (e.g. p. 90). It is quite surprising that he has neglected to mention this important theoretical point in his discussion of causality's role in the scientific community's interpretation of quantum physical data.

Sixth, Jeeves' aversion to mind-brain dualistic interactionism is, on its face, puzzling (pp. 107–10). He, along with almost every other writer on this topic, nowhere gives a clear, even remotely plausible reason for rejecting this version of dualism. Pointing out that no one has yet elucidated the neural mechanism by which mind-brain interactionism allegedly takes place, although true, is not, by itself, a good reason to reject the interactionist hypothesis. Jeeves' favoured mind-brain view (pp. 110–11), which appears to be a form of computationalism, is vaguely stated, unclear, and perhaps because of this, only faintly illuminating.

His attempt at stating a coherent view of free will in this context is plagued by similar difficulties (pp. 113–18). Jeeves finds Donald MacKay's view of free will to be congenial. After conceding that MacKay's view is quite difficult to follow, Jeeves then attempts, with limited success, to explicate it (p. 113). MacKay's view appears to be compatibilist in nature, i.e. it is a view of free will in which acting freely is compatible with being determined to act. This view poses a significant number of seemingly insoluble philosophical and theological puzzles, at least in its traditional formulations. How, for example, is it possible for person *S* to be both determined to perform a given action *A* and to be morally responsible for having performed *A*? (In order to amplify the problem, let *A* be a sinful action and, hence, an action for which *S* may be properly damned) It is not at all helpful to have quoted a series of authorities, as Jeeves has done (viz. J. Z. Young, John Houghton, and Philip Johnson-Laird) who simply state that moral responsibility is compatible with determinism. If Jeeves has a new angle on this perennial problem which satisfies our prephilosophical intuitions concerning freedom, determinism, and moral responsibility, he has not revealed it to us. Neither MacKay's distinctive model of compatibilist freedom nor chaos theory (pp. 115–17) makes any appreciable progress toward solving this mystery. (For an insightful critique of MacKay's views, see William Hasker, 'MacKay on Being a Responsible Mechanism: Freedom In A Clockwork Universe,' *Christian Scholars Review* 1978, 130–40; and 'Reply to Donald M. MacKay,' *Christian Scholars Review* 1978, 49–152)

Finally, Jeeves' discussion concerning the human soul in Chapter 8 ignores a rich literature generated over the past two and one half millennia by several eminent Christian and non-Christian thinkers. The view espoused by Jeeves is that the human soul is identical with the whole human being, a view explicitly rejected by Aristotle in *De Anima* (Bk II, Ch 2), and a view which appears to be incompatible (at least in the way Jeeves appears to conceptualize it) with the possibility of disembodied existence. Does Jeeves really want to contradict both Aristotle and the dominant Christian tradition by rejecting this possibility? Perhaps so. If so, such a repudiation of both highly influential pagan philosophy and widely-embraced traditional Christian doctrine concerning the soul deserves greater elaboration than that which is provided in *Mind Fields*.

For all of its conceptual and textual problems (only some of which I have specified), Jeeves' book has immense value in prompting discussion on a wide variety of important, deep, and intriguing scientific, philosophical, and theological topics. No thoughtful Christian thinker can afford to ignore the revolution in neuroscience and its implications for one's worldview. Jeeves has provided a valuable service to the Christian community in bringing these foundational issues to its attention. His historical survey is especially engaging and illuminating. In addition, his discussions concerning correlation and causation (p. 39), psychosocial and biological aspects of schizophrenia (pp. 43–44), worldviews and world pictures (p. 125), and levels of analysis in neuroscience (pp. 53–58, 121) are quite useful. When discussing historical developments and contemporary advances in neuropsychology, Jeeves is at his best. On the other hand, when expounding upon the philosophical and theological implications of those empirical and theoretical results which are the fruit of this burgeoning interdisciplinary field, his proposals ought to be viewed with caution.

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**The New Genesis: Theology and the Genetic Revolution**
Ronald Cole-Turner
Westminster/John Knox, Louisville 1993, ISBN 0–664–25406–3.

In the 1950s there was considerable pessimism among a few scientists about the genetic future of humanity. H.J. Muller, for example, thought the human race was heading for a genetic apocalypse. Muller's thesis was that the scientific manipulation of human genetics would supervene over the natural, and more perfect, process of evolution. (See the fine discussion of Muller's notions in Paul Ramsey's, *Fabricated Man: The Ethics of Genetic Control*, Yale University Press, 1970). Over against this rather pessimistic view of human interventions in genetics is the overly optimistic view espoused by the author of a recent contribution on the genetic revolution, *The New Genesis: Theology and the Genetic Revolution*. Ronald Cole-Turner, Associate Professor of Theology, Memphis Theological Seminary, Memphis, Tennessee, has outlined this revolution in this brief, readable, and somewhat troubling book.

*The New Genesis* is not, however, merely about genetics. It is 'intended as a contribution to Christian theology's understanding of science and technology, especially in the areas of genetics and genetic engineering' (p. 12). Furthermore, the author hopes his volume will assist Christian theology to be 'more adequate to the challenge that scientists themselves are putting to it, namely, to help in steering the future of our technologically advanced civilisation' (p. 12). Indeed, the book is very future-oriented. There is an undertone of triumphalism—genetic-evolutionary triumphalism—throughout its six chapters.

Chapter 1, 'The Age of Genetic Engineering,' is a brief survey of the development of genetics and genetic engineering from Mendel to the Human Genome Project (HGP). In 1989 the National Institutes of Health and the Department of Energy officially began a jointly-sponsored initiative, the HGP, with a

goal of identifying and creating a physical map of the 3 billion base pairs of DNA that make up the genetic blueprint (the 'genome') of a human being. The ultimate goal is the potential treatment and cure for more than 4,000 genetically-linked disorders such as cystic fibrosis, Down's syndrome, Huntington's chorea, Alzheimer's disease, diabetes, and perhaps some forms of mental illness. Funded by U.S. tax dollars, the HGP is a 15 year, $3 billion, big science project. For the first time in a major government-funded project, a percentage of the HGP budget (3%–5% for the first five years) has been devoted to the examination of the ethical, legal, and social implications of genetic engineering. It should also be noted that the U.S. component of the HGP is only one part of a larger, global project in human genetics.

In Chapter 2, 'What Are We Doing?' Cole-Turner argues that the genetics revolution presents us with the possibility of 'conscious, reflective intentionality' (p. 42) in our biological and technological evolution. Just as through agriculture 'human moral choice acted on evolution by *altering the processes of selection*,' (p. 43) so Cole-Turner believes genetic engineering will 'contribute something new' (p. 50), even if very small, to human evolution. It needs to be said at this point that Cole-Turner's entire argument is built on an evolutionary hypothesis.

The aim of 'conscious intentionality' is taken up in Chapter 3: 'The Purpose of Genetic Engineering.' The author concludes that genetic engineering clearly will benefit some of humanity, perhaps cooperate with nature's progress and purposes, and should definitely be used 'in the service of God' (p. 60ff). Cole-Turner takes seriously questions concerning who shall benefit and at what costs. There are many critical implications of manipulating human, animal, and plant genes which we simply cannot know at this point. Sadly, we may not know what we have done until after the fact. Cole-Turner concludes that 'Genetic engineering, when legitimated and limited by Christian faith, would be used primarily to serve the needs of the weak, the sick, and the poor' (p. 62).

After summarizing the views of six theologians (Karl Rahner, Paul Ramsey, Robert Brungs, Roger Shinn, J. Robert Nelson, and Hans Schwartz) and several ecumenical and denominational statements on genetics in Chapter 4, 'Responding to the New Situation,' the author begins his own theological reflection in Chapter 5, 'Redemption and Technology.' Here his work is most troubling. Space will permit reference to only three concerns.

First, Cole-Turner reinterprets the fall of humanity. He is willing to grant that nature, including human nature, is 'good yet disordered' (p. 84), but is unwilling to acknowledge such disorder is a result of the sin in the garden of Eden. 'The *explanation* of disorder as the result of a fall of angels and of the first human beings, however, is not needed by contemporary Christian theology or for our argument' (p. 84). 'I want to argue that in addition to human sin, and even prior to human sin, creation is good yet disordered . . .' (p. 86). Thus, for Cole-Turner, the disorder of nature and humanity is due to the incomplete process of evolution— 'both the good and the disorder would be seen as the cumulative by-product of countless events in the evolutionary history of life on earth' (p. 89)— a conclusion few readers of this journal will be willing to accept.

Second, the author gives only grudging accommodation, if that, to the supernatural. Thus, not only does he challenge the miraculous nature of Jesus's healings as merely the view of Jesus's followers, but he refuses to grant the existence of a nonmaterial human soul. 'There is no nongenetic or nonorganic soul, subsisting in an ethereal or spiritual substance' (p. 88). 'The soul,' he says, 'subsists in the brain, and whatever way our genes have structured our brain, they have also given us the substratum of our soul' (p. 88).

The upshot of this view is a salvific individualism grounded in our unique genetic fingerprint. 'Our inclinations to selfishness and sin are also uniquely our own. . . . Even more importantly, the Christian message of grace and salvation will need to be individually contoured' (p. 89).

Third, in keeping with his naturalistic and materialistic interpretation of human nature, in Chapter 6, 'Participating in the Creation,' Cole-Turner argues that humans, especially geneticists one is left to assume, participate with God in *Creatio continua*. Creation did not occur once, it is a continuing evolutionary process in which humans participate as co-creators. Through genetics, 'God now has more ways to create, to redeem, and to bring the creation to fulfillment and harmony' (p. 108). At this point his genetic-evolutionary triumphalism is at its nadir. 'We are in the midst of this creative and redemptive passage from creation in the beginning to the consummation of all things in the new creation. We ourselves are being created and redeemed, for we are destined to be part of the new creation God is making. But we are more than passive observers, for God has called us to participate in this creative and redemptive transformation of the creation' (p. 109). Together with God, 'through billions of years of creation' (p. 109), we will usher in the new creation through technology, especially genetics.

Cole-Turner's vision of our genetic future conflicts sharply with the pessimism of H. J. Muller. We would do well, I think, to heed the late Paul Ramsey's reminder that neither genetic apocalypse nor genetic triumphalism comports with the revelation of Scripture. Our approach to the new genetics must be guided by the answers to the questions of means and ends. That is, under God and his revelation, what are the means and objectives to be pursued through genetics? Both extreme pessimism and inordinate optimism will lead us to abuse the stewardship of genetic technology.

Lastly, one of the bothersome aspects of the HGP and the funding of research on the ethical, legal, and social implications of genetic technology is the problem of conflict of interest. That is, it is highly unlikely, given the way bureaucracy works, that the government would fund research which would be critical of the HGP. Interestingly, Cole-Turner acknowledges at the beginning of the book that his views were developed 'in conversations leading to a grant application made to the National Institutes of Health Office for Human Genome Research' (p. 7). This is not to say that Cole-Turner necessarily sought the 'deep pockets' of government grants and, so, developed an apology for the HGP. But it is to affirm that such a temptation is very real.

For these and other reasons, *The New Genesis* cannot be recommended to evangelical and Catholic Christians as a particularly useful volume. We still await a volume or a corpus of literature which will adequately explore the theological implications of genetics for our brave new world.

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