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Comment: A Farewell from the Editor, Dr Cameron

Bioethics and the Future of Us All

Ethics and Medicine has taken the view that the issues covered by the little word 'bioethics', a neologism in our vocabulary for only fifteen years, are among the gravest issues faced by humankind. In especial, they represent the single most serious challenge to western civilization. For they treat of nothing less than the status and dignity of human being. In a ringing editorial Comment of the mid-1980s, critiquing the British government's Warnock Report on *in vitro* issues, we asked whether the human embryo was not, indeed, one of us, our kind of being. A decade later it becomes clearer that the central question faced by bioethics is rather 'What kind of being is our kind of being?' As the West has—tragically—stood transfixed by horror mounting horror in Bosnia, we have been reminded how thin is the meniscus of civility and how fragile the web of humanity even in that Europe which is the heir to centuries of a tradition founded on the doctrine of humankind as constituted by its bearing the *imago Dei*.

And yet there are subtler challenges to human dignity in the easy appeal to human self-determination which has swamped the Netherlands and which threatens now the United States (driven by the double logic of autonomy and economy, a deadly partnership). We have seemingly come to terms with a generation of liberal abortion, such that the U.S. President threatens to veto a ban on its most perverse example, in which—so we are told; it still seems hard to believe—viable babies are born while their brains are being sucked out to ensure that they shall not live. Macbeth murdered sleep; no less have we slain motherhood and medicine together. The liberal mantra of reproductive choice has been laid bare as a defence of the unconscionable. Yet that is the whole point. The unthinkable has become thinkable, the conscience of the culture has begun to adjust to the awfulness of the values of the New Medicine, in which the sole surviving value lies in the power of choice of those who have the power of choice.

What should trouble us greatly is that the stories have hardly begun to unfold—the story of what we are able to do to ourselves and to each other, and the story behind that one, of what we allow to be done to us and to each other. Bioethics, if we can use that disciplinary term to stand for the medical-scientific and moral stories alike, is in its very infancy. The extraordinary possibilities of medical science and the opportunity of rewriting our moral vision, twinned fatefully in the twilight of the West, alike beggar the limp imaginations of us all.

For that is the location of bioethics, not on the fringe of the human experience, but at the heart of the options for the reinvention of human being, the reconstruction of human nature in accordance with the 'choice' doctrines of the abortionists (where the mother chooses, or is said to) and the medical killers at the other end of life (where it is alleged to be the patient: 'medicide' is Dr Kevorkian's term for it, and it is really quite a good term: that species of homicide which is committed in the practice of medicine). The reason these cases are of such importance is plain—for nothing more eloquently defines our notion of human nature than those conditions which are considered sufficient for the taking of human life. This discussion is therefore not an end in itself, but the prolegomenon to every other issue in bioethics, all the way to the human genome project and beyond, since it identifies the agenda as focusing not on this or that new technology or resourcing issue (hugely important though these may be) but on the nature of human being; what theologians call anthropology. Abortion and euthanasia bracket that question so clearly because neither is necessarily connected to anything special in the modern world. They are as old as fallen human nature; and the change from permission to proscription, which marked an earthquake in western culture, was as surely the fruit of the Judeo-Christian victory over paganism (which ensured the Hippocratic triumph in our medical ethics) as the reversion to medical killing in our generation marks the end of the Christian centuries.

Yet who would believe that all this is taking place under a plain brown wrapper bearing an obscure academic label? And who will therefore be able to offer an articulate challenge to this nascent culture of ambiguity and the redefinition of humankind? For only they will be well able to engage the bioethics agenda as it lengthens into the future. The inability of abortionists and their political patrons to recognize the enormity of a 'partial-birth abortion' does not encourage us to believe that the dignity of human being will long survive the West's denial of its grounding in the image of God.

This is the final issue to be edited by Dr Cameron

Dominique Folscheid, University of Marne la Veillée, France

Bioethics and Public Policy: Will Liberal Nihilism Be Our Future?

At the present time, most physicians still devote their life to caring for the sick. However, the future of medicine is one of the most disquieting problems. Why? Due to the progress of medical technology, of course. The first problem for public policy appears to be an economic and social problem, because such medicine will be more and more expensive. But that is a shortsighted point of view. The basic issue is to know whether scientific and technological progress will change the very essence of medicine.

Medical Progress and Hippocratic Tradition

The first question is whether the progress of medical technology has destroyed the very nature or essence of medicine? By tradition, the practical paradigm of medicine is unity.

It is impossible within the Hippocratic Tradition to dissociate the patient, his disease, his organism and his body. Medicine is a human activity founded on personal interaction. It is confronted with suffering, anguish and the significance of human life. So medicine and ethics are intertwined, because medicine necessarily takes care of human beings. It is much more than a technical profession, it is a human praxis. Firstly, medicine can be effective, or not. Secondly, but this should be our first basic principle, non-effective medicine remains medicine. We often tend to forget this fact.

What about our scientific medicine? It takes care of the organism and disease, but it often forgets the body and the human being. Modern medicine has inherited a paradigm deriving from Cartesian mechanistic science: the body is a machine. Mechanistic medicine is effective. It shares many characteristics with scientific investigation (for example: a rigorous problematic approach, testing of a hypothesis, collection of valid information, meticulous criticism, and so on).

However, if medicine remains a praxis, abiding by Hippocratic tradition, our new medicine, using new knowledge and new technologies, still remains a human praxis. Its essence has not been changed by new medical means. Efficiency is dependent upon scientific progress and technical means, whereas medicine is not.

The most disquieting problem is, however, the status of scientific medicine.

Everybody says that there is no problem because science and technology, although indispensable, are no more than means. For example, many physicians say that nowadays gene technology should be assessed like any other technology. So there is no peculiar moral issue. Is it a part of medicine or not? The question however, is whether gene technology is merely a means.

If medicine remains what it is—that is to say, a human praxis—such an opinion about the means is true. But this opinion depends on the underlying question regarding the essential nature of technique. Are technical means no more than tools?

Of course, it is generally believed that technique is no more than a means to an end. Thus it is ethically neutral, because morality depends on purpose, on good will, and so on. If technique is just a means, I am given a double choice: first, between doing or not doing; second: between doing good or evil. The means, or the tools, always remain neutral. With the same knife, for example, I can kill my neighbour (or not), and I can cut a T-bone steak. The knife is just a tool, and every tool is, of course, ethically neutral.

Nevertheless, we must introduce a difference between 'free technique' (which using some tools, is applied to technical objects). In the use of embryonic cloning technology, for example, we have no choice between a good and a bad use. The only choice is cloning or not cloning. But if we choose the area of cloning, all our choices are necessarily bad (from an ethical point of view, of course, and not from a technical point of view).

Adhesive technology is not ethically neutral; it tends to be neutralizing.

So we reach the conclusion that while a tool is a tool, without any doubt, technique is neither merely a tool, nor the sum of all technical means. Technique is a system, an 'applciation' to something (Heidegger says that technique is *Gestell*). Technique is one of the ways for mankind to act on the world. As Heidegger says, the essence of technique is not inside, but outside of technique itself. Remember Aristotle's joke: an axe cannot have its essence inside, otherwise an axe would be a living being. The essence of the axe lies in the blacksmith, in the purpose, in the relationship between nature and the human being. Thus technique is always a response to human demands. For the same reason, the essence of medical technology lies in medical praxis.

Our second illusion is the idea that science is pure disinterested knowledge, something which is absolutely necessary and could not be other than it is, while technique is merely an instrument with which to apply

science or knowledge. There is science on the one hand and technical means on the other. This implies that science is free and disinterested research. Such an opinion is wrong.

Francis Bacon wrote: 'Knowledge is power.' Why? First, because knowing is doing. In order to know, we have to do (that is to say, to experiment). Second, because the effective purpose of knowledge is usefulness.

Above all, we have inherited a paradigm deriving from Cartesian philosophy: God the Creator is not merely he who knows but also he who makes. In God is equally a scientist and an engineer. The result is an ambiguity in the relationship between science and technique, because knowledge becomes a means and not an end in itself.

Our Western conception of science and technology stems from the distortion of the message from the Bible and of Cartesian thought. Because the Bible removed the sacred aura surrounding nature and made it a non-magical and non-supernatural world—a non-God, in fact—mankind concluded that it could use it as it wished and give free reign to its desire for mastery and absolute domination. Descartes' legacy has also been modified: in establishing its scientific approach, he focuses on method, not substance.

Why then has our Western heritage been twice distorted? Heidegger says it is because mankind has left its being out of account, thus benefiting the phenomena, and in doing so has acted contrary to the teachings of ancient Greek philosophy, which accorded primary importance to being.

The Effects of Scientism on Medicine

Science, of course, is not a philosophy. But we need broader consideration of the role of science in our world of culture, imagination and myths. We have to distinguish methodological postulates from philosophical ones. Science needs objectivity. But scientific objects are abstractions. To be objective science needs to reduce living reality as much as possible. The research worker has to explain the complex in terms of elements, describe causal chains, use formal methods, such as classifications and mathematical models. Such a process is legitimate. But scientific objectivity cannot take in the whole of living reality. Remember Kant's question: 'What can I know?' To this scientism answers: 'the whole reality'.

Scientism is not a scientific point of view. Scientism is a totalitarian ideology, which pretends that science is the unique source of knowledge, because the whole reality is positive and objective. Such teaching, however, is no longer a methodological postulate, but a philosophical postulate—philosophically wrong, and scientifically inaccurate.

If science is everything, science is no longer science; if science is science, science is not everything.

Scientism is the most dangerous disease affecting future medicine. Its twin disease is technicism. That is to say: absolute knowledge on one hand, the all-powerful on the other, and a fool ideology in the brain.

In so far as scientism and technicism will change medical research (in genetics, for instance), and future practice, it will alter our standpoint concerning the relationship between medicine and what people want from medicine.

In fact, the very heart of the problem lies in our new approach to health, in the realm of our technological world. The heart of the problem lies in the desires of sick people. What is health? Health itself is nothing. The famous French physician Bichat said, 'Health is the silence of our organs'. A healthy body is a transparent body.

With our new ideological background, health is becoming a positive reality linked to what we feel about ourselves.

Technical patterns often take the place of moral patterns. Mankind left its being long ago, thus benefiting the phenomena. In so doing, mankind has acted contrary to the teachings of ancient philosophy, tradition and religion, which accorded primary importance to being, morality and faith. In staking everything on phenomena, people hope that technology will solve all problems, including their salvation. The ultimate consequence of this is the technicalization and medicalization of human ills.

The result is the metamorphosis of human needs, desires, requests and hopes. Nobody has forgotten Kant's questions: 'What must I do?' and 'What may I hope?' But the background is deeply changed. What must we do? We must observe and explain our nature, in order to master it, and even to manipulate and to change it. Happiness and salvation are transformed into 'quality of life'. With our refusal to accept our human condition, death or infertility are swept out of the way. Two years ago, a well-known French physician said: 'Death will be the last illness.' With genetics, science is about to become 'popular science', and 'popular science' is about to become 'imaginary science'. What is really illness? Who is sick? We no longer know because we have forgotten the reality of the human being. If I am my genes, my medical destiny lies in my genes. With genetic analysis, every human being in good health is already, unknown to himself, a sick person, who needs health care. So, medicine is going to enlarge itself without any limit. Today we already call upon medical biotechnology in some non-medical areas: for example, in-vitro fertilization programmes or soft euthanasia; tomorrow, we will call upon genetic engineering, cloning, etc. The instrumentalization of bodies is the required end. Scientific progress is only its means.

What about medicine? If the body is treated as a pure organism, then the body is no longer a body. The physician becomes a veterinarian, and medicine takes leave of medicine. The result is a new supply and demand process. Both sides are intertwined in a new sytem. However the genetic revolution is the greatest hope of our future medicine.

An Ethical and Political Challenge

Such a situation is a challenge to ethics; to bioethics also, despite its ambiguity (is bioethics ethics dealing with technobiological problems, or biological ethics dealing

with new standards, concerning itself with production and organization of life in our 'Brave New World'?) As Engelhardt in *Foundations of Bioethics* says: 'If there is nothing sacred about human nature, there is no reason why human nature should not be radically changed'. That is to say: new desires on the one hand, new standards on the other. Engelhardt is wrong; man is not simply a being of nature; he is the being that exists in the human world, the being who inhabits the dwelling (or the house) of being. Family is the best example of this difference: a husband does not say, 'My mate has brought my offspring into nature', but, 'my wife has just brought my child into the world'.

However, there is neither a human world nor a human being without nature. We have to respect man's natural condition, which is the basis of man's humanity. Medical care is part of this basic condition. But the humanization of man concerns ethics and politics, which consist of the most important form of praxis. When technicism replies that to humanize man, we have to change human nature (that is to say, to change the nature of nature), above all it wishes to change natural human nature into artificial nature.

Nowadays, in medicine, the real problem is not the 'mind-body problem'; it is the 'body-organism problem'. The human being only has a body, because there is no body without a mind, and no mind without a soul. Otherwise, the human body would be reduced to some raw material.

But what is a human living material? A slave. At the present time, the embryo is becoming a slave. Remember the ancient tradition: a human being who can be killed is a human being who can become a slave. Embryo is classed by Engelhardt among 'human non-persons'. Aristotle wrote: 'A slave is a part from the master's body'. Some people say: 'The embryo is neither a person or a thing, it is a part from the mother's body'. To be a material, or to be a patient, that is the question.

What is to be done with human being? What is our purpose?

Engelhardt repeats Protagoras: 'Man is the measure of all things, of existing things that they exist, and of non-existing things that they do not exist'. He specifies: 'it is persons who are the measure of all things'. But I ask: who are these persons? Scientists? Physicians? Parents? Governments? And what is the measure of such a measure? The Good in itself? God? Tradition? In all probability, the answer is: our phantasmal wants, and our own interests.

Such a situation is a challenge to our democracies, because liberalism is now thrust into an intellectual and moral crisis. The very meaning of freedom has been distorted. We have forgotten the difference between freedom, together with its conditions and limits, and savage free will, or individual licence. Denying any objective knowledge of the human good, we have no standards of human excellence, human good life, rights, duties, justice and responsibility any more. In an atomistic and pluralistic society, tolerance is necessary; but tolerance is also a neutralizing process as far as values are concerned.

So, we have to meet human nature once more, in order to recall the foundations of the socio-political imperatives. Indeed, the vacuum of the 'being' is the background of nihilism, and nihilism is the background of materialism.

It is vital to redefine the ultimate purpose of medicine from the standpoint of mankind itself. We need patient-centred and person-centred medicine. It is up to mankind to guide science and technology in a specific direction.

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Hippocratic Medicine and the Teaching of Medical Ethics

Introduction

In what follows I argue for an approach to the teaching of medical ethics which must find its foundations in a reflection of and a commitment to the nature of medicine itself, and not in any other extraneous considerations.

The universal nature and meaning of medicine itself, which is Hippocratic in origin, constitute the grounds of the universal, non-partisan, significance and content of medical ethics. Medicine is inherently ethical, and in this understanding of medicine *medical ethics* is regarded as a *medically based* ethic.

I. The Goal of Medical Education

Medical education aims at making of students *good doctors*. Medico-ethical education, as part of an overall medical education, has this same aim in view. I assume this as a shared agreement among those assisting the very process of medical education, the teachers, and

those undergoing that process of learning, the students. I see my own task as a teacher of medical ethics to medical students to be serving this educational goal.

But aiming at helping others to become good doctors is not an individualistic task, 'me and my students'. It takes place within a context of medical practice, a medical community, that although concrete in a particular place and time is also of universal significance. For medicine as a practice is 'already there', with a meaning, a history and a long tradition of self-understanding. In every cultural context medicine is needed, recognized and valued by all (even if some of its practices may be deeply resented). Anyone who wants to become a doctor enters into this well-established practice of medicine; he or she can choose the school of medicine to attend, but they cannot choose the meaning of 'being a physician'[1]; that meaning is 'already there'. It is a meaning designed to become real and continue in every newly qualified doctor. Through medical education the great wealth of medical wisdom, knowledge and experience is handed down and entrusted to every medical graduate. This is an entrustment aiming at *preserving* and *developing* good medical practice and what it entails. That is, in medical education we are aiming both at making *good doctors* and at preserving and fostering *the practice of good medicine*. Two fundamental aspects of the same reality.

II. Medicine is Intrinsically Ethical: 'The Medical Good'

What is good medicine? Who counts as a good doctor? These are very large questions which I do not attempt to address here. I want to focus on something more modest, although related to these two questions, and to the idea of the good. Now, the term 'good medicine' as used above is not intended to be contrasted with 'bad medicine'. Rather it is meant to bring to the fore that medicine is something good in itself, a worthwhile and honourable human activity, a 'profession' to which so many men and women devote their lives; an endeavour full of value, and capable of fulfilling a person's life with human interest, effort and achievement. Medicine is something noble and laudable; both a good and an excellence. This good of medicine is what medicine is about, what it aims at; that which makes medicine to be medicine rather than law, or politics. Let me call this good *the medical good*.

Ethics is concerned with 'the good', described by Plato as 'the aim of all endeavour'.[2] His follower, Aristotle, tells us in his *Ethics* that 'Every art and every investigation . . . aims at some good'—and adds—'since there are many actions, arts and sciences, the aims turn out to be many as well; health is the aim of medicine . . .'.[3] Since ancient times the particular good with which the medical endeavour is concerned has been focused on one word, 'health'.

But we may add that this end or good is realized in the concrete in the central concern of medical activity, namely, 'the *doctor-patient healing relationship*'. What is involved in the reality of this human relationship is what makes medicine 'ethical', a moral activity, an activity with its own intrinsic moral worth. In other words, medicine is intrinsically ethical because of the good which medicine aims at. Hence the moral norms to be followed to attain it, the excellence of character required of its practitioners for its realization, as well as the right activities that accomplish that good, are constitutive of medicine itself.

Thus, medico-ethical teachings are derivable from the nature of the healing relationship. Ethical aims, norms, principles, excellencies and activities, are the various dimensions of medical practice. Therefore it is my contention here that we can take the core of medicine to be the 'doctor-patient healing relationship', and that in this core (the 'medical good') we find the medico-ethical components with which a medical ethic is concerned. We cannot understand medicine without its ethics, we cannot understand medical ethics without an appreciation of the nature and meaning of medicine. This is the foundation for my claim that medical ethics is *a medicine based* ethic.[4]

Clearly, this idea of medicine as intrinsically ethical determines the approach to the teaching of medical ethics. In what follows I want to illustrate that this idea of medicine is Hippocratic in origin and in character, and that it has a transcultural and universal significance. By 'Hippocratic medicine' I mean that kind of medicine which can speak 'timelessly' to doctors and patients of all cultures precisely because its centre is the relationship between the doctor and the sick, the one to be healed, a relationship which remains basically the same for all places and times. I claim, with the Hippocratic physician, that the meaning of this relationship (as with all true human relationships) is ultimately moral, embedding a recognition and fellow feeling for the other as the human being, who is both a moral and an embodied being. It is upon this recognition that medicine as a healing and caring activity is founded, and became a professional body bounded by its own professional code.

III. Approaches to Medicine and to Medical Ethics

By affirming that medicine is an intrinsically ethical activity, and hence that medical ethics is a medically based ethic, I am aware of going against popular current conceptions of medicine. And hence I am going against those approaches to medical ethics which accompany those conceptions. Let me briefly dwell on this point.

Medicine is currently being regarded by some to be a *morally-neutral activity*, value free (like science or technology as some would hold). Doctors, some would claim, are not healers but scientists. Admittedly, medical technical knowledgte and skills (whether in surgery, use of technology or drugs) can be used for good or ill. Techniques or skills, are said not to have intrinsic moral goals. What counts as a 'good use' of medicine is not intrinsic to the medical skills and techniques themselves, but rather to the 'ethics' of the user. A good doctor will know how to use those skills well (like any other skilful technician) but his or her ethical outlook and opinions are independent of them. That is, this view defines medicine

by its techniques and skills, being a contractual trade governed by a know-how a *techne*, whose 'ethical' use depends on 'external ethical principles'. Hence the use of the skill may be seen as divorced from specific moral goals and from the moral character of those involved (which may be matters considered 'private' and personal). In this view the external ethical principles governing the *good use* of medicine are regarded as derived from religious codes,[5] or from socially determined customs,[6] or the law,[7] or the opinions of the doctor, and or the wishes of the patient.[8]

Conceiving medicine as purely scientific and technical and value *free* is consistent with much of our current liberal, legal (and litigious) cultural milieu. For 'the ethical' in our modern world (that is, what is good and evil—the objects of our love and the very nature of our moral characters), is nothing absolute. Rather it is something contingent, relative, very much a matter of individual or cultural opinion and outlook; it is also something private, or a 'mystical' intangible non-scientific dimension added to the objective scientific data and evidence; it is something independent of history and tradition; something 'pluralistic' since there are so many varied ethical outlooks; and something that must be 'rationally' validated, and argumentatively justified, according to a pre-determined standard of reason.[9] In other words, medicine is currently considered to be amoral, scientific, a skill or know-how, a-historical, pluralistic, individualistic and a rationalistic exercise.

Within the current liberal perspective, the external ethical principle which makes the 'neutral' use of medicine something medically 'good' is the idea of unconstrained freedom, 'the right to choose', freedom to do what one pleases. This is the primary ethical principle in our culture (which includes even 'the right to choose to be killed' or to kill). In this social context medicine has become 'a service', a trade which gives the patient (a client) what he or she wants. The doctor is there to serve the autonomy of the patient.[10] And when this autonomy cannot be exercised, then he or she has to carry out what is the most compassionate or benevolent thing to do in the best interests of the patient, including a 'mercy' to kill.

Needless to say the law has become the best ally to sustain this conception and practice of medicine. For traditional medical ethics and medical practice has been changed by the continuous chain of judicial rulings and court cases, in USA, Europe (including Ireland), and recently in Australia with the legalization of euthanasia in the Northern Territory on 25th May 1995. That is, with this new outlook doctors have unwittingly handed over their ethical self-governance (for they seem to have accepted that it does not belong to them), while 'society' and 'the law' have taken full control of the medico-ethical domain.[11] With the acceptance of state medical services the Doctors' Governing Body have failed to remind their members and the State that doctors' professional duty is subject to their professional body. Doctors cannot carry out 'health policies' which would contravene their duty to care. The most fundamental medico-ethical norms therefore become medico-legal requirements. If there are doctors (or patients) who do not agree with these new judicial requirements, 'a conscience-clause' is to be invoked (and sometimes granted).

This overtaking of the medico-ethical domain by the law is depriving the medical profession of its rightful ethical autonomy (partly with its consent whether implicit or explicit). This amounts, in my judgement, to a disintegration of medical goals, demanding increasing 'conscience clauses' to cover those physicians who cannot professionally agree with the new legal rulings; this makes the practice of medicine more and more difficult for them, while it creates two strands of medicine, a conscience governed medicine, and a law governed medicine, whereby the truly ethical self-governed medicine has disintegrated. The legalistic trend in medicine is also, in my view, a direct attack on the right use of practical wisdom, of true medical discretion, of that prudent judgement of the doctor on the spot, which medical practice requires. Moral wisdom is 'legalistically' destroyed, for the legalistic trend is entering and changing genuine moral thinking, genuine moral governance, and genuine moral acting. I agree with those who conceive our cultural task as emerging from a cultural crisis which is 'intellectual, moral and spiritual'.[12] So, in view of this crisis, what practical approach may be suggested in the teaching of medical ethics?

In attempting to answer this question we can turn our eyes to the idea of Hippocratic medicine, as mentioned above, which is summarily articulated in the Hippocratic Oath as it has been handed down to us.[13] Other authors, in particular Leon Kass, have done so excellently, from which we all can learn. Looking back to ancient Greece for an understanding of medicine and its timeless universal nature is not to have an undue devotion to tradition or history, and to disregard the new scientific and technological era in medicine. It is only to recognize that the idea and meaning of medicine is a legacy we have received, not newly invented, and that by looking at its origins and history, we can better understand this meaning and gain a deeper insight into the truth. We should allow the Hippocratic writing to speak for itself. Then we may ponder about its inspirational impact on the medical profession for about two thousand years. But even if we leave this remarkable historical fact aside, we may be able to recognize the writing as an articulation of that understanding of human nature and of medicine that captures its centre, its essence, its core; what I have called the medical good, making the meaning of medicine timeless and universal.

The fundamental reason why Hippocratic medicine can speak timelessly and relevantly to us today is because our *embodied* humanity is the same now as it was in ancient Greece. Hence, the activity of healing and caring for the sick is essentially the same, it cannot change. Nor can the desire of the sick to get well. The basic understanding of our being healthy as a natural condition of our embodied selves working well is also the same. Clearly human beings have not invented animal or human health. Whatever our difficulties in understanding people of other times, other languages and other cultures, 'we are all products of similar natural processes and we all live out our lives under the same skies and this gives us at least enough in common to recognise each other's

humanity . . . [I know] that honey tasted as sweet to Achilles as it does to me'.[14] Medicine as a dedication to healing is founded upon our embodied and moral nature, that is, on our human nature.

IV. The Core of the Hippocratic Ethic

Let me now focus on the *third* paragraph of the Oath[15] since it is not possible here to consider the entire Oath in detail. This paragraph reveals to us in a nutshell, the core of medicine, and so, the core of the Hippocratic ethic. It states:

I will apply dietetic measures
for the benefit of the sick
according to my ability and judgement;
I will keep them from harm and injustice.

The overall spirit of the Oath is portrayed in this paragraph; it does not draw a line between the technical dimension of medicine and the ethical one. All the provisions of the Oath flow from its understanding of the essence of medicine not as an ethically neutral technique but as an activity constituted by a notion of the good, that is, as a praxis embedding the understanding and realisation of that good.[16]

The main ideas contained in the four provisions of this paragraph, if properly unpacked, would yield the rich content proper to a Hippocratic medical ethic. Here I limit myself to draw attention to some of its salient points.

(a) 'For the benefit of the sick'

With these six words the overall meaning and end of medical practice as a healing relationship is disclosed; this is what medicine is for: the benefit of the sick.

In this goal the essence of our human condition is identified, from this medical point of view, as an *embodied* and *moral* nature. Let me say why. On the one hand, we become sick because we are embodied beings, or bodily living beings; non-living beings and 'spirits' cannot get sick or be healthy or unhealthy. But apart from being capable of getting sick, we also desire the good, discern between what is good and what is not, and set ourselves to doing good. We also expect naturally (as little children do) that good be done to us; when the expected good, the expected courtesy, is not done to us we become disappointed. Human beings set themselves the goal of benefiting, of doing good to themselves and others, because they desire and want to attain and to generate good; this is our moral nature.

Therefore I suggest that the particular, and also universal, good of 'benefiting the sick' is the core of the Hippocratic ethic. This good can be taken as an expression of *the Hippocratic vision of the human being*, both as an embodied being and as a moral being. Around these two dimensions of our earthly existence, the bodily and the moral, Hippocratic medicine revolves; and in these two dimensions our spiritual nature is also manifested, as the Oath also recognizes. I believe that in order to understand Hippocratic medicine with its intrinsic ethic, one has to a large extent to share, accept and even empathize with or feel its image of the human being. In other words, the Oath presents us with a comprehensive view of the human being, and encapsulates what I would like to describe as *the sense of the reality of the sick human being.* Without this sense of what it is to be sick, the Hippocratic idea of medicine as a medico-ethical art cannot be grasped, and without it the 'doctor-patient healing relationship' is meaningless. Again, my major claim here is that in the Oath the sense of the reality of the sick human being is fundamentally a *moral* one.[17] By this 'sense of the reality of . . .' I refer to ways of recognizing our fellow human beings in which our intellectual, moral and affecting sensitivities all play a part.

What does it mean to be sick? First of all the Oath acknowledges that when the human being is sick, he or she *is in need*, precisely because of being sick; and because sick (and not for any other reason) must be helped, and *is worthy* of help; this is *a moral recognition* which makes the physician 'a physician' towards the sick, in recognizing the need, and in the necessity to respond to it—and not as a mere 'body-technocrat' who only does repairs on demand, but because the sick patient is not a mere body, but *a human being in need.* To benefit the fellow human being when ill is to enable them to emerge free from that need. Simone Weil identified human need as the soil of our moral life, giving rise to the imperative of obligation, i.e., to the doing of good. 'Where there is a need there is an obligation' she says.[18] The sick human being suffers from bodily need, a health need; so it is in healing—through the healing relationship—that the need will be assisted.

(b) 'According to my ability and judgement'

The sick human being is seen by the Hippocratic physician as deserving the unconditional assistance and respect which call for the full dedication of 'his ability and judgement'. That is, the sick must be attended to with the best of knowledge, skill, as well as caring sensitivities, and virtues; in particular the virtue of practical wisdom, discretion or prudent judgement, which the concrete condition and situation of the patient demands. The physician here recognizes that it is upon 'his ability and judgement', that is, upon their knowledge and character that the healing activity depends.

The healing relationship cannot be but between individual human beings and of its nature individualized. This is part of the sense of the reality of the sick or injured human being, which is a 'recognition' that the embodied human being cannot be but *individual* and unique. Hence, the doctor does not primarily serve society, or the community, or human welfare, or the state, or the greatest good for the greatest number, or some other abstract conception. The doctor serves a patient, a sick human being. 'The health of my patient will be my first consideration.'[19] That is why the doctor's vision of the human being, of who and what he is treating, is the central component of his ethical outlook. As it has been described the idea of the human being is 'the organisational principle' in medical ethics.[20] For the general understanding of 'health' and its conditions in the healing activity is always, in the last analysis, a concrete

reality: 'the health of my patient', an individual human being. Aristotle with his profound sense both of the general and of the concrete says in this respect: '. . . what the doctor appears to consider is not even health universally, but the human being's health, and even more than that, presumably, *this human being's health*, since it is particular patients that he heals'.[21]

(c) 'I will apply dietetic measures'

When the Hippocratic physician focuses concretely the means of his activity of healing, he commits himself with this provision: 'I will apply dietetic measures.' We know that diet is not the whole of therapy, yet it is central to it. As Kass puts it, 'We are, in a sense, what we eat.'[22] The malnutrition and starvation that millions of our fellow human beings suffer today, as well as our problems of overeating, obesity or toxic 'ingestibles' point to the fact that food, eating, and our diets are intrinsic to our well-being. They are, and they will always be, central in the role of benefiting the sick, for food and embodiment are inextricably linked. Food, eating and diet directly relate to our bodily condition. Our attitudes towards food are inseparable from our attitudes towards our human embodiment. Thus the Hippocratic doctor's attitude (and any doctor's attitude) to the human body, to our embodied human nature, becomes the central inevitable part of his or her moral concern. Hence, there are certain things that 'a good doctor' must recognize about nourishment and about the body in order to be such a 'good doctor'. For diet as part of therapy is related to what the body *is*.

What is the body? How do we think about the body?[23] Let me briefly point out here two essential features of our embodiment which are central to the idea of medicine and the role of the physician. The human body is a living being, a living whole with its own peculiar wholeness. A whole which possesses its own manner of physical existence, its unity, its physiopsychic balance, harmony, well-being, well-working order. This is its natural state of health. When that balance, order or harmony is lost it is sick, 'we become sick', for we are those bodies. To restore the body to its harmony, to its wholeness, to its integrity, is the aim of the physician in co-operation with his patient. Ultimately this wholeness of the patient is what the physician serves. This is an important realization with enormous significance for our evaluations concerning transplants and the manipulations involved in genetic engineering.

In seeking the restoration of health the doctor and patient must recognize that *the primary healer is the body itself*. Mysteriously to us, still, but undeniably so, the body is its own maker, and its own healer, its own 'repairer'. This makes medicine, the healing activity, one of assistance, of co-operation, but not of transformation. The physician, as much as the patient, ministers to, is subordinated to, this healing power of the body; a healing power that the whole of living nature possesses and that places us in the realm of participation with its spiritual, non-visible, divine, non-man-made, origin. So much are the body's powers of health and healing *its own*, that we the embodied creatures have no full accessibility to them. The uncertainty of what is good for it in sickness (or in health) may baffle the understanding of physician and patient. Also our own ignorance, foolishness or wayward habits can lead the body astray. Ministering to our bodies is ministering to ourselves as embodied, and also to the whole of the cosmic nature of which we are a part. By necessity a good doctor will also be, at least in attitude, a good environmentalist, and good here means more than 'environment-friendly'. Our good depends on the good of the earth and on the cosmic good.

(d) 'I will keep them from harm and injustice'

Ministering to bodily wholeness is more than ministering only to the body, it is ministering to the patient. I and my body are one. Because doing good to the sick, benefiting the sick by healing them, is the goal of the physician, anything which does not serve this benefit and good is not to be done to him or her. The medical good sets the parameters of goals and activities that fall within the range of healing, and of those that either are alien, or evil as contradicting the good. The Oath characterizes the evil not to be done with the general terms of harm and injustice. In these two terms the basic ethical outlook of the Oath is contained. Though closely related terms, 'harm' and 'injustice' are not identical. Other paragraphs in the Oath specify in the concrete what these evildoings are. They are all violations of the sick human being (whether bodily or otherwise). These violations are recognized to be gravely harmful and unjust by the physician, as also ratified in the last paragraph of the Oath. There, the physician obliges himself to endure suffering and disgrace so that justice may be vindicated, if he were to fail in his commitments and promise, or to enjoy prosperity in life and art if he is faithful. His plea is for justice.

At this point let me draw attention to something I consider to be very important in relation to the distinction between harm and injustice as evildoings. The distinction between 'harm' and 'injustice' points very clearly to the inseparability of our bodily and moral mode of existence, leading to a true understanding of the nature of evil done and of evil suffered. This is a difference contained in the Oath. The difference is something like this: When a harm is done, say a bodily harm (poisoning, starving or killing the body) the human being harmed not only suffers the harm in his body, or his being, but also suffers the injustice done, for it is a kind of treatment that is not due to him or her. The perpetrator doing the harm, say the physician, is acting in such a manner that he appears (perhaps even to himself) to get what he wants when the harm is done and finished; that is, he may think that his evildoing business is finished when the harm is done. But this is not so, the evildoer does not cause harm and injustice to others only, he harms himself as well; he gets evil in return *by becoming an evil-doer*. Socrates' claim that 'it is better to suffer wrong-doing than to do it'[24] expresses this view about evil doing, as harm and injustice. Evildoing affects the whole of the evildoer's being, whether he recognizes it or not; his judgements, his affections, his habits, are all morally affected and

corrupted by the evil; he *is* an evildoer. The evil atrocities carried out by very many learned and experienced physicians under totalitarian regimes manifest this connection between evil doing and becoming evil, the moral corruption of one's own being.

The Oath, by upholding and invoking justice, recognizes and upholds an unconditional respect for the sick and for the physician's professional and moral integrity. This recognition and respect is also also at the centre of the Judeo-Christian view of the human being. But, I also hold, it is a recognition inherent to the very nature of medicine as a healing practice as understood by the Hippocratic physician. Note that, according to the Oath, he would treat with equal respect both the free and the enslaved human being. The slave, for him, was not merely a body, the 'property' of his owner and master; the slave was a human being deserving respect like any other fellow human being. Here, in my view, we could find the seed of that non-discriminatory and universal concern for the sick and injured that medicine upholds: 'Doctors must practise without consideration of religion, nationality, race, politics, or social standing'.[25]

Let me finish with some words which I usually mention to the medical students I teach; they come from a variety of different local, non-local and 'foreign' cultures, and from different religious and non-religious backgrounds to *learn good medicine and how to become good doctors*. 'A "good doctor", can be a good doctor anywhere he or she goes; for their goodness as a doctor depends on their having adopted the medical aims of the profession, their expert medical knowledge and practice, and their good human character as a doctor. "Medical goodness" does not primarily depend on the geographical or cultural place where the doctor happens to exercise his or her profession. Medicine is of universal significance because "the good it pursues" is its own aims: healing, caring and comforting the sick. It is this good, and its proper understanding, that constitutes the subject matter of medical ethics.'[26]

1. This topic of 'the meaning of physicianship' is masterly treated by Leon Kass in his work *Towards a More Natural Science*, (The Free Press, Macmillan, New York, 1988), particularly chapters 6 to 9. I am highly indebted to Kass's writings for the shaping of my view concerning the nature of medicine and of medical ethics. Any one who reads Kass will profit abundantly from his wisdom. In my judgement he is the best author in the field.
2. *Republic* VII, 505e.
3. *Nicomachean Ethics*, 1094a–8.
4. See (1) above p. 226.
5. Cf. Johnson, A.G., *Pathways in Medical Ethics* (Edward Arnold, London, 1990), Chapter 5.
6. Cf. Black, D.B., Iconoclastic Ethics', *Journal of Medical Ethics*, 1984, 10: 179:82; there a 'relativist' view of medical ethics is portrayed.
7. Cf. Gillon, R., also for a treatment of (5) and (6), in *Philosophical Medical Ethics* (Willey, 1986).
8. A recent exponent of the idea that medicine serves the autonomy of the patient can be found in Charlesworth, M., *Bioethics in a Liberal Society* (CUP, 1993).
9. The primacy of 'reasoned argument' in founding ethical values is found in (7) above and also in authors such as Singer, P., *Practical Ethics*, (CUP, 1979) and in other of his writings. For a criticism of the views presented there see R. Gaita's *Good and Evil. An Absolute Conception* (Macmillan, 1991), Chapter 17, 'Fearless Thinkers and Evil Thoughts'.
10. This is the main thesis defended by M. Charlesworth in (8) above.
11. In a recent article in *The Lancet* Vol. 345, June 3, 1995, p. 1423, 'Cultural Lag and the Hippocratic Oath' by Eugene D. Robin and Robert F. MacCauly, in which the Medico-ethical value of the Oath is dismissed, the authors explicitly state that 'it is not physicians but society or women themselves' who have to decide the fundamental moral issue of abortion.
12. Cf. Kass, Leon, *The Hungry Soul. Eating the Perfecting of Our Nature* (The Free Press, Macmillan, New York, 1994), pp. 1–16.
13. See version of the Oath as translated by L. Edelstein, in *Ancient Medicine: Selected Papers of Ludwig Edelstein*, Oswei Temkin and C. Lilian Temkin eds. (Baltimore, The John Hopkins Press, 1967), pp. 3–63; version adopted by L. Kass and discussed by him in (1) aove, pp. 224–46.
14. C. Rhodes, *The Necessity for Love* (Constable, London, 1972), p. 234
15. Version as in (12) above.
16. See above (1) p. 229.
17. I am aware of the limits of interpretation; but the idea of justice is at the heart of the Oath.
18. Cf. *The Need for Roots. Prelude to a Declaration of Duties towards Mankind* (Routledge, London, 1978), pp. 3–9: 'The Needs of the Soul'.
19. *Declaration of Geneva* (World Medical Association, 1948) an updated version of the Hippocratic Oath.
20. See E.D. Pellegrino and D.C. Thomasna, *The Virtues in Medical Practice* (CUP, 1993).
21. *Nicomachean Ethics*, 197a10.
22. Above (1) p. 232.
23. Articles directly concerned with this topic can be found in (1) above, e.g. 'Thinking about the Body', and in Leon Kass's recent and marvellous book, *The Hungry Soul*, see (12) above.
24. This theme is masterly treated by R. Gaita in his *Good and Evil. An Absolute Conception* (Macmillan, 1991), Chapter 5: 'Evil done and Evil Suffered'.
25. This formulation is taken from the *Medical Council of Ireland Ethical Guide 1994*, Section 12.05.
26. Thanks are due to Dr Peggy Norris for having read the paper and made valuable suggestions.

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An International Workshop Life Sciences and the Concept of Person

Impact of Individual Opinions on the Respect for Human Personhood

Let me tell you how privileged I feel to give this lecture in Budapest, remembering that in 1956 Hungary was the leading country in the struggle against totalitarianism. In Paris we were fully involved and happy to participate in a number of demonstrations in support of the Hungarian people. Moreover, I cannot forget that my father, who at that time was dying from cancer, offered his life to God in order to alleviate their suffering.

For reasons which will become obvious I will extend the scope of this lecture beyond the restricted frame of Bioethics to consider the more general problem of the dignity of and respect for the human person at the end of this 20th century. I would like to address the three following points.

First I will consider several forms of exclusion that threaten the dignity of human beings and examine the inconsistent responses made by people to such attacks.

Second I shall try to analyze at least some of the factors that cause our blindness to certain offences to human dignity.

Thirdly I wish to suggest in conclusion, that the main problem raised by these observations is how we can reach an agreement regarding what is involved in the concept of human personhood and human dignity.

How Do We React to Aggression Against a Human Person?

Current events draw our attention daily to new forms of exclusion that threaten the dignity of different categories of human beings. In most cases the background to such exclusion is one of the following:

a. *Prejudice.* This can be cultural, religious, political or national.

b. *Circumstances.* Political leaders may foresee 'inescapable choices' if they grant specific rights to those who are making economical, ecological or security demands. John Kilner shows us elsewhere examples of this issue as far as health care is involved.

c. *Ideology.* Individual dignity may be sacrificed to the demands of ideological groups. This can occur between the guilty and the innocent, between the young and the elderly, between the mother and the foetus. There may also be conflicting priorities such as those between demographic growth and the survival of the earth, curable and incurable diseases. All exponents of conflicting views claim to argue from humanitarian motives which are cited to support their points of view. Such reasoning has been well documented by Daniel Callon in this session.

It may also be of interest to note here that 'scientific criteria': *biological* (such as phylogeny, ontogeny, genetics or even relating to ethnic differences), or *cognitive* (such as degree of consciousness, communicability, level of intellectual activity), are in general put forward in an attempt to justify these discriminations. Needless to say they may lead to various excuses, such as tampering with genes, programmed procreation, *'a la carte'* behavioural choices, eugenics, and, on a more general basis, they serve as a pretext for the exclusion from modern-day society of an ever-growing number of 'defective' or 'suspect' people.

Thus, through its excesses, molecular biology may become one of the most fearsome weapons of exclusion, if, for instance, one attempts to use it to discriminate against any group of people one wishes to suppress. On the other hand, the use of cognitive sciences may also serve as a means of excluding a human being from the community, as documented in the past by psychiatric abuse in the former Soviet Union, and even now by those who claim that *thinking* and *personhood* cannot be disassociated.

Needless to say, legislators will seek to curb such dangerous trends. Yet, however fine the intentions behind them, the laws aimed at safeguarding the dignity of man in his personhood will remain ineffective unless societies agree on the meaning of these terms. In other words, there are questions that have to be answered.

1. Why should we respect human dignity?
2. What do we mean by 'man', by 'person' and by 'dignity' when we are considering birth, pain and death?
3. Laws, structures and institutions are meant to guarantee societal respect for human dignity. While Ethics Committees are supposed to debate all of these things, their conclusions will need to be based on a precise definition of words such as *man*, *personhood*, and *dignity*.

If we consider how people react to attacks on human dignity we find that regardless of religious, philosophical, political or cultural differences, each person reacts in an individual way to any particular form of offence to human dignity. In other words, each person has an individual role to play in either defending or attacking the human person.

Thus, some people, while condemning the death sentence, believe that induced abortion should be legalized, or claim the right to kill incurably ill patients whose lives, as they say, are 'not worth living'.

Others who stand up for family values and the right to life of every single human being, display xenophobia, if not racism.

Others, who are justly horrified by 'ethnical purification', will readily recommend embryo sorting along with IVF. In this way the defence of the use of embryo sorting or abortion to prevent a 'particular serious disease' coexists, without arousing any concern, with opposition to any form of eugenics. Yet both involve the societal rejection of a particular category of human beings.

Others denounce the shunning of the drug abuser or the AIDS sufferer while they argue for a degree of ostracization that will affect, not without good reason, smokers and alcoholics.

And if you just watch your television sets it is clear that public opinion has been much less outraged by the drowning of Chinese new-born babies than by the death of Rwandan babies or even than by the slaughter of baby seals!

We should also consider the different degree of attention given by the media, by governments and even by international bodies to regimes under which personhood is blatantly violated. Is it not obvious that religious, ethnic or sexual discrimination, 'rehabilitation' in labour camps, child slavery and prostitution are perceived with different degrees of severity, depending on the country where such practices take place? Don't these abuses lead in one case to implacable embargos, in another place to the dispatching of UN peace-keeping forces, while elsewhere reaction is influenced by a blindness to the situation which is induced by the presence of a few oil wells, by mines or by the tempting prospects of 'fabulous contracts' and 'marvellous outlets'?

Actually one could multiply examples of this contrast between the tremendous indignation displayed by some political leaders in face of violation of human rights that are perpetuated under one or another system, and their apparent lack of concern when similar attacks come from more potent or economically more attractive regimes.

What are the Reasons for Different Reactions to Attacks on Human Dignity?

Among factors which influence our concern for questions of human dignity is the reaction of the media which appears to play a major role.

a) Through the selective denouncement of 'newsworthy' attacks on human dignity. These manipulate public opinion all the more because they are justified. But they also draw attention from other, equally serious offences against the individual.

b) By the use of words to describe such offences. Thus the phrase, 'intentional interruption of pregnancy' may well sound more acceptable than foeticide. Likewise, phrases such as 'prenatal diagnosis' even when this is without any therapeutic result and leads only to abortion, or, 'the framing of embryo diagnosis prior to their transfer' are not as shocking as 'eugenic policies designed to prevent the birth of abnormal children'. To speak of the practice of 'embryo reduction', following IVF will hide the unavoidable decision to kill extra embryos as a consequence of the persistent technical defects of IVF. The term, 'help to suicide' seems less fearsome than the 'suppression of incurable patients'.

c) We can also note that the proposition, on behalf of 'the need to limit a galloping demography' to dispatch the RU486 'contragestative pill' (actually an abortion pill) to the Third World has had less publicity than the Iraqian threat of a 'chemical weapon' during the Gulf War. This example seems to me to be particularly significant inasmuch as only those who deny to the embryo the quality of person, and a dignity equal to that of potential chemical war victims will argue that its two terms (contragestation and chemical weapons) cannot be compared.

Media Pressure is Not the Same on All Occasions

Human indignation, however justified and natural it may be, remains more or less selective and consequently unable to be brought to bear on all offences to persons. Such inability is all the more serious because it affects, without our being aware of the fact, the credibility we ascribe to accounts of such offences in the mass media.

Our level of consciousness of as well as our sensitivity to and the actual degree of the victim's suffering all mean that we do not find all instances equally unbearable or serious.

This may even lead to absurd discrepancies. We can again compare the reaction to the slaughter of baby seals and that of Chinese new-born babies.

We can also note what P. Singer says:

> A week-old baby is not a rational and self-conscious being, and there are many non-human animals whose rationality, self-consciousness, capacity to feel pain (sentience), and so on, exceed that of a human baby a week a month or even a year old. If the foetus does not have the same claim to life as a person, it appears that the new-born baby is of less value than the life of a pig, a dog, or a chimpanzee.

The ideological or cultural nature of regimes or, even more seriously, their military power or economic weight, may also influence the severity of our reactions to their leaders where attacks on human dignity are perpetrated.

Likewise the number of victims may, understandably, affect our judgement, even though, paradoxically, it may be the status of the victims rather than their actual numbers which seems to stir our consciences.

Certainly the seriousness of the inconsistencies which we have noted (though incompletely), reflects the variable degree of dignity which we ascribe to victims as well

as the price we are prepared to pay to defend respect for human dignity.

Concepts of Human Person and Human Dignity

Obviously our reactions to suppression of human rights cannot be dissociated from our opinions regarding the differences between a 'human' and a 'non-human', between 'normal' and 'pathological' and also regarding the relationship we establish between 'dignity' and 'quality' of life as well as the priority we give to each of these concepts.

The question which underlies all attempts at exclusion is this: Is the victim a *human being;* is he or she a *person*? This is indeed a fearsome question which we hardly dare to ask, for it outlines the frontier between innocent and beneficial actions and crimes against mankind.

It seems to me that there are three possible answers to such a question.

a) 'No'. If that is the answer then we have to ask further:

'On what criteria (molecular, genetic, cognitive) is this answer given?' We may note that many of these criteria apply also to other categories of human beings.

b) The second answer is, 'Not yet'. Then we have to ask, 'What event actually marks the emergence of a human being?' If there is no agreement as to when a truly human life begins, can there be any agreement as to when a truly human life ends?

These are, of course, crucial questions to which our workshop will hopefully provide some responses.

c) The third answer is 'Yes'. (This is indeed a human being) Such a statement would imply, if exclusions were to be justified, the existence of,

a. *inferior* human beings (but what are the criteria for this judgement?) who are not or not yet to be regarded as *persons* and whom one would therefore have the right to suppress.

b. *superior* human beings (again what are the criteria?) who are to be considered as *persons.*

Now at this point the problem ceases to be scientific and becomes metaphysical. However, even if it is up to philosophy and human sciences to evaluate the personal dignity of each human being, the very acknowledgement of his human nature involves recognition of a series of cognitive qualities (intellectual, emotional) and eventually of genetically inherited characteristics, even if a number of pathological conditions may lead us to question the reliability of such kinds of criteria. Thus, the absence of these should not lead to the denial of personhood to deprived human beings. Unfortunately, a number of our contemporaries argue against this view. This leads to an increasing dissociation of biological humanity from personhood. This kind of dissociation operates as the common denominator for modern forms of exclusions.

Despite this, some kind of assessment of *biological humanity* remains, at least implicity. This is the 'one way' approach to the concept of person in philosophy as well as in law and social science. All these question the biologist from two points of view.

a. *Phylogenetic.* Are we indeed dealing with a human being?

b. *Ontogenetic.* When does this human life begin and end?

Professionals from universities as well as from research institutions should be able to contribute to our understanding of human personhood because of the wealth of knowledge they bring to the issue: cell and molecular biologists, physicists, psychologists, anthropologists, palaeontologists, sociologists, lawyers, economists, political scientists, theologians, philosphers, historians. . . .

Hence we believe in the possibility of and the actual need to promote and to co-ordinate research activities, guided by a spirit of cooperation and tolerance but also by scientific rigour, in order to bring about a common understanding of personhood drawn from the complementary expertise of the different fields of Life Sciences, Philosophy and Human Sciences.

What I say to you today is the logical outcome of processes of thought which date back to 1991. These have led to the view that each of us is more sensitive to one form of offence to human dignity than to another form. This means that any debate about respect for human dignity will require some kind of agreement on what we regard as the concept of a *human person.*

CERPH (the Centre for Human Personhood Recognition Studies) is a multi-disciplinary centre, concerned with looking at and collecting criteria that lead to the acknowledgement of the humanity and personhood of a living being, as well as the foundations and content of his/her dignity. Our fields of interest address the questions of current bioethical reflections as they are confronted by biology and cognitive sciences. They also have to face the emergence of new exclusion ideologies, regardless of their religious, political, xenophobic, ethnical, economical, ecological, or (under the pretext of preventing crime) security origins.

Why a Workshop?

A number of colleagues have questioned us about this workshop. So we must make clear that our workshop is not designed to bring us together in a specific place and at a definite time. We wish to create among participants a network of cooperation by means of 'mail exchanges' for which our newsletter is expected to provide a concrete support.

The scope of such a network is to develop, from a panel of opinions as large as possible, a detailed approach to the concept of *person* and thus to expand or to prepare exchanges or ideas which are too often just sketched out in national or international meetings.

Hence, in practice, colleagues who wish to participate in the workshop are invited to send us notes or comments on the subjects which are currently being discussed in the workshop. These contributions will be published in our forthcoming periodic letters in order to develop the debate we wish to establish, and last, but not

least, should lead to an annual report which will be published in both English and French.

Topics for the Workshop

Concrete issues regarding human dignity have deliberately been omitted from the programme, just because we feel that they are in the specific province of ethics meetings or committees. Far from being expected to replace these, our workshop is rather meant to document their thoughts.

Four topics are being currently debated.

a. *Genomic Studies pertaining to phylogenesis and ontogenesis of human beings.*

Do they permit us (or can we expect them to permit us in the future) to deny the humanity of a living being?

b. *Genetic abnormalities and humanity.*

Can some abnormalities justify calling such humanity into question?

c. *Contribution of cognitive sciences to phylogenetic and ontogenetic studies.*

Have they any bearing on the concept of person?

d. *Paleo-anthropological, metaphysical and cultural aspects of the person concept.*

Do they modify the idea that dignity is inherent to every human being?

Detailed information on the content and purpose of each topic is provided in issue 1 of our Newsletter.

Conclusion

The last three or four decades have been marked by a spectacular 'liberalization' of our concepts concerning personal dignity, but also, *a contrario* by an increase of ethical concern. Thus, regardless of whether one agrees with, merely accepts or actually condemns the legalization of induced abortion, one may, at least, question to what extent it may have revived our doubts concerning the identity of the human person; by denying to biologically human lives the quality of person does this not inevitably dissociate these two concepts? Have we not introduced into our societies new questions about, if not the basis for, discrimination founded on circumstantial 'necessities'? By favouring the life of the mother over that of the unborn child, have we not initiated a change from the view that any single human life bears an infinite value to one where such lives vary with respect to their dignity. Today such variations appear in terms of unequal rights to be cured, or to passive or even active euthanasia. They appear in other places in the form of political, religious, economical, health or even ethnic discrimination. Is this not actually the case, in particular with the progression of drug abuse and of AIDS?

For those who follow national as well as international debates on bioethics it is clear that they are equally concerned with the fate of human beings on behalf of the so-called 'ideal of human rights'. But it is at least as patent that, in a number of cases, the points of difference in such debates come from a disagreement regarding the limits of biological humanity. The real problem is, thus, to know what one means by a biological human being and, consequently, to specify the criteria which will determine definition of this humanity. On the answer to such a question will depend the impact of the concept of 'human rights' which becomes inevitable null and void in a society which contests the dignity of living human beings until there is proof that they are actually human beings.

Finally our workshop is a multi-disciplinary workshop aimed at collecting a set of:

a. *biological and paleo-anthropological data* likely to help to define and consequently to recognize such a human being from both a phylogenetic and ontogenetic standpoint;

b. *molecular markers of individualtiy* within the human species, such as may trigger thought on the concept of personhood;

c. *an expertise on the reliability of these several approaches.*

This is necessary, given that among the criteria of humanity outlined in our workshop programme, *phylogenetic data* are meant to distinguish the human being within the biosphere, while *ontogenetic data* may raise the questions as to whether we are:

i. already dealing with a human person prior to their appearance;

ii. still dealing with a human person following their loss or disappearance.

iii. nonetheless dealing with a human person even when they are missing.

Are we not summoned to search concertedly for the answers to these questions? How could we not wish that this meeting will open new avenues to ideas which are so vital for the fate of our mankind?

cally dependent on the mother, and although needing the relationship with the external environment, is 'substance', or in other words a subsisting subject, which is therefore 'self-existent', in that it is endowed with autonomy (certainly not in an absolute sense, but then this is also true of an adult human being) and thus capable of self-construction, being in a position to direct its own development self-sufficiently.

The relationship with the mother or with the outside environment constitutes a necessary condition, but not a sufficient one; it is a sort of extrinsic dependence which, although contributing to formation, presupposes the existence of the substance rather than constituting it. Finally, the human embryo is 'rational by nature'; in other words, rationality is a structural and specific characteristic of the biologically human being, quite regardless of the actual capacity for exercising it.

The embryo, then, being *de facto* human (inasmuch as it belongs to the species *homo sapiens*) is also a person, at least in potential terms: (i.e., potentially a baby, child, adult and old person). 'Potentiality' (in the classic Aristotelian sense) indicates the real and active possibility directed towards the end, or the intrinsic possibility in the material essence of becoming something else, by putting into effect what it is.[8] Even though the human embryo is not in a condition effectively to exercise certain specific capacities (such as the sensitive, intellective and volitional capacities), written into its nature is all the biogenetic information which, through the uninterrupted and teleologically orientated process, makes it possible for it to reach the final complete form.[3]

Being a person is a radical ontological condition. The human being does not 'become' a person, gradually acquiring certain capacities; the human being 'is' a person. Even though there is a certain degree of development of the 'personality' through age and the exercise of certain capacities, being a person constitutes the ontologial identity, though the degree of personality corresponds to the progressive psycho-physical maturing of the individual. In this sense the beginning of personal human life does not depend on the biological process of development: biological human life and personal human life are co-extensive.[9]

When there is a human being, there is a person: the zigote, which is the initial human life (in the single-cell stage), is already a person. Conception constitutes the 'qualitative leap', the instantaneous and precise, ontological radical event. Every phase of subsequent development is more or less complex, but only in quantitative terms. The person is a unified whole of body and spirit: the living human organism is animated by a 'unifying and organising principle' (assuming we do not wish to call it the 'soul', or 'substantial form' in traditional language), which unifies the multiplicity of the parts and remains present throughout the mutations that occur. It is precisely this ontological foundation which guarantees the 'unity' and the 'continuity' of the personal human being. This being is, in the ontological view, more than the sum of his or her parts and acts. The person is manifested through his/her capacities and expresses him/herself in behaviour, but is neither totally comprehended in them, not even less reduced to them.

Thus the absence of certain characteristics or facets of behaviour (as is inevitably the case with the initial prenatal life) is not equivalent to the absence of the person: one 'is' a person, one does not just 'behave as' a person. The ontological question is closely connected with the normative issue.

Moral duty and right are founded on existence: it is from the ontological identity that the ethical and juridical significance is deduced. The response to the question: 'What is the human embryo?' conditions the response to the question: 'How should the human embryo be treated?' If the human embryo is already a person, it is also both a moral and a legal subject. The passage from 'nature' to 'norm' (moral and juridical), is justified from the standpoint of final purpose; nature cannot be mechanistically reduced to mere 'fact', but rather coincides with the 'order of purposes'.

Nature is not a mere material and causal totality of facts (or even less, determinable according to the law of cause and effect), but it is a cosmos, a unity endowed with sense, and thus comprehensible to mankind. Every entity has a purpose and a reason for existing which constitutes its essence, and these are also intelligible to man. In this sense Hume's law[10] (which asserts the impossibility of inferring precepts from assertions) can be overcome; the 'must be' (the ought question) is deducible from the 'being' (the is question), inasmuch as nature itself is essentially normative, or it offers men indications and guidelines for behaviour. So then if the fullness of the life of a person 'is' the purpose written into the zigote, the human embryo 'must' be morally respected, and juridically safeguarded, even in the single-cell stage.

The recognition of the value of nascent human life is the basis in absolute terms for the moral status of the embryo, justifying the principle of unavailability and intangibility. (Intervention in this life can be justified if and only if it is therapeutic; in other words if it benefits the life in which one is intervening.) This means that the progress of science and technology have a very precise limit: respect for human life from its beginning, because it is an expression of personal life. Thus, it is not a matter of devising a 'special law' for the human embryo, so much as extending the protection recognized as appropriate to man, to the human embryo also, in recognition of the ontological equality of human beings.[11] The ownership of fundamental rights, such as the right to life, the right to physical and genetic integrity, the right to a family, should therefore be recognized for the newly conceived.[3]

In the debate on bioethics there is great diversity of opinion and even opposing opinions regarding empirical functionalism. There are two shared assumptions: the recognition of the biologically human status of the embryo from the first moment of conception, and the exclusion, at least in the primary phases of embrionic development, of the existence (anthropologically speaking) of the person. In short, according to the reductionist view, the embryo is considered as a 'human being', but is not recognized as a 'person' (not even potentially, but only possibly or probably so). The human embryo is not yet a person; it becomes a person in some subsequent moment after conception. (In certain cases there is a preference for the use of the term 'pre-embryo' or 'pro-

embryo' to denote the first phase of 'human' development, distinguished, in qualitative terms, from the subsequent 'personal' phase). The semantically co-extensive nature of the terms 'human being' and 'person' is denied; the scientific notion of 'human being' (understood as a living organism of the species *homo sapiens*) is separated from the philosophical notion of a 'person'.[12] In this context, the description of the biological status of the human embryo becomes irrelevant to the definition of a person: biological observation, at most, offers useful indications for excluding the presence of personal life, by confirming the absence of the conditions held necessary for the recognition of personal status.

The philosophical reflection is therefore independent of biological observation. The reason for the separation between the biological notion of human being, and the philosophical notion of person can be found in the nominal definition of person. The authors who support the reductionist standpoint arrive at a definition of 'person' by means of the selection of certain properties or functions (held to be particularly appropriate for indicating personhood). In this sense, non-human individuals can belong to the category of 'persons', just as certain human individuals can be excluded from it (among them, the embryo). This standpoint has been effectively identified as empiricist-actualist functionalism. It is a reductionist viewpoint which rejects ontology, subordinating the recognition of the person to the appearance of certain determined characteristics or traits of behaviour. The capacities which characterize the person are either manifested in action (even if they are not necessarily active) or they are not: at most they are 'possible' or 'probable'. But what properties or capacities allow us to identify the person?

Some authors find the constitutive property of the person in relationships, identifying the first physiological relationship with the mother at the moment of implantation, and hence the beginning of the person.[13] Other authors hold that individuality is the first requisite for the attribution of personhood and fix the beginning of the individualized person at the fourteenth day after fertilization, since before that date, division or homozigotic twinning remains a possibility.[14] Utilitarians consider sensibility (or the capacity to feel pleasure and pain, and hence to have interests) as the qualifying property for the status of person, and indicate the 14th day after conception as the minimal biological threshold; i.e. the moment of the formation of the 'primitive streak' (stria) or outline of the central nervous system (a necessary condition for exercising the capacity of sensation).[15] For some, the possession of conscious mental and pyschic states (such as the awareness of self as a continuous subject time) is the boundary between being human and being personal; this is a psychological definition of person which recognizes the beginning of the mental life of the person only after several weeks from fertilization.[16] Other authors point to rationality (understood as a 'symbolic' capacity which includes intellective, self-conscious and linguistic capacity) as the proper characteristic of the person: personal status is thus not attributable to the embryo at all, or at least not before a certain degree of development of the cerebral structures (necessary conditions for the exercise of rationality.[17] For others it is autonomy, understood in the sense of a capacity for independent life (not dependent, physically and physiologically, on the mother) which is the determining property of the person, perceivable in the biological threshold of viability or vitality (the capacity for autonomous survival.[18]

All these functionalist theories share one single viewpoint: the human embryo is not yet a person (not being a relational, or individually distinctive, or sentient, or conscious or self-conscious or rational or autonomous being). Thus the human embryo is not yet a person. So then, if the (biologically) human embryo is not (anthropologically) a person, what is its normative status? How should we behave with regard to the embryo? The bioethical functionalist adheres to 'Hume's Law' (and thus to the impossibility of inferring deontological-value judgements from assertive judgements), on the basis of the mechanistic conception of nature. Nature is a totality of extended entities which move about in space, casually or according to the laws of cause and effect. If nature is 'chaotic', it offers humanity no indications to guide its actions. The human nature of the embryo has nothing to tell us about its value or its rights; it is a mere biological fact. One may speak of a 'weak' ethical state. The human embryo has merely an extrinsic value. The individual or society, in conventional manner, may decide whether and what value to attribute to the nascent human life. The human embryo is thus a 'moral patient', in that it is the (possible) object of 'sympathy' or 'benovelence' on the part of persons. The prohibition on killing human life is thus not absolute.

Although it is illicit to kill a person, it is nevertheless licit in certain circumstances (such as the circumstances of the initial stage of human life) to kill a human being. The obligation to respect the human life of the embryo is a *prima facie* duty; i.e. not an absolute duty but one which admits exceptions (in favour, for instance, of scientific progress, or of the procreative desire of the couple). Thus new possibilities of experimental intervention in the life of the newly-conceived are opened up. In the same way, the juridical status is 'weak'. The entitlement to rights of the human embryo is not recognized by virtue of its human nature: rights are attributed formally in a 'gradual' fashion, or in relation to the embryo's development. This does not mean that the human embryo is not guaranteed any safeguard at all. It does have some sort of protection, founded on the 'sense of responsibility of the researcher'[19] and on the social attitude of 'minimal prudence'. But the idea that the human embryo is a subject of legal rights is nevertheless excluded; at best it is an 'object' taken into consideration, accidentally, by the law. Safeguarding is guaranteed to the embryo in the same way as protection is guaranteed to non-human entities, such as works of art of particular value, or a natural landscape of a corpse, for their merely symbolic value. In this way, the embryo is removed from the danger of indiscriminate disposability, it would not be reduced to a thing or an instrument, but would have some sort of dignity (even if a weak sort). On this basis, ownership of and commerce in the embryo can be forbidden, but the possibility of non-therapeutic experimentation remains open.

Following this brief analysis of the opposing philosophical viewpoints on the nature of the human embryo,[20] certain critical questions challenge the reductionist standpoint. How does one become a person without already being a person? What justifies the qualitative leap from the biological status to the personal status of the human life? Who chooses (and on the basis of what criteria) the type and the degree of development of a certain property or function, the manifestation of which is considered relevant in order to 'be' a person? And how are adult human beings to be considered when in a state of analgaesia (and thus non-sentient), or those with a loss (even if only momentary) of the capacity to reason and remember, isolated and deprived of relations with the outside world (and thus not autonomous)? And again: how can the decision be left to the subjective will to decide whether to respect the embryo? And what if wills conflict (expressing different wishes at the same time and in the same context)? Why does a human life which has lived for a shorter time have less value? How can we safeguard human life 'after' the manifestation of certain capacities and functions if it is not safeguarded 'before'? (paradoxically, if all the pre-embryos were destroyed, there would be no more life on earth).

The inconclusiveness of this discussion on the question of the embryo, which has been discussed in a lively and heated manner over the last ten years, inevitably becomes apparent. Despite the efforts that have been made to find a common solution, the question is still open, both on the theoretical and the practical planes. The merit of the bioethical debate is perhaps that it has raised the problem, creating awareness not only in expert circles but in public opinion, and has contributed to clarifying the positions through a comparison between different disciplines and viewpoints. What elements can bring together the differing viewpoints on the question of the human embryo? To discover the common elements, we must eliminate those which are responsible for the conflict.

The key dividing issue is the definition of a person. We can witness at the same time a 'restriction' and an 'expansion' of the concept of person, as a result of the separation of the 'human being'; not all human beings are persons (for instance, embryos); certain non-human beings are persons (for instance, animals or robots), in that the former are endowed with sensitivity, and the latter with artificial intelligence). This carries the paradoxical consequence that certain superior mammals or certain technological products would seem to be more worthy of respect than the human embryo. A possible way to overcome this paradox may be found in the return to the human. This means returning to the common understanding (which has always identified the human being and the person), and to what is affirmed in the statement on human rights, about which universal consensus has been registered. This is simply, that the embryo is biologically human, and is entitled to rights.

We must recover the authentic sense of 'humanism': extending universally recognized human rights to the initial 'confines' of life. It is not only slavery, racism and machoism which are discriminatory: today we are faced with new forms of discrimination in the differing importances attributed to the various stages and modes of manifestation of human life. And the highest price is paid by the pre-natal and neo-natal life (as by terminal and marginal life). But even the embryo, although quantitatively small, infinitesimal and imperceptible, is qualitatively human, and thus worthy of respect and protection.

1. This is the central question of bioethics. For a definition of bioethics, see W.T. Reich (ed.), *Encyclopedia of Bioethics* (The Free Press, New York, 1978), v.I, p. XIX.
2. For an analysis of the different philosophical perspectives in bioethical debate see L. Palazzani, 'Personalism and Bioethics', *Ethics and Medicine*, Spring 1994, 10(1), pp. 7–11.
3. E. Sgreccia, *Manuale di bioetica. Fondamenti ed etica biomedica, Vita e Pensiero* (Milano, 1994).
4. A. Serra, 'The human embryo: science and medicine in human life. Its beginnings and developments', in J.F. Malherbe (ed.), *Bioethical reflections of catholic scholars* (Ciaco, Louvain, 1977), pp. 47–67.
5. Centro di Bioetica (Università Cattolica S. Cuore), 'Identity and status of the human embryo', *Medicina e Morale* 1989, 4 (suppl.).
6. S. Boethius, *De persona et duabus naturis, Contra Euthychen et Nestorium*, III, 4–5; Tomamaso, *Summa Teologiae*, I, q. 29. a.3.
7. This is the argument of N. Ford, *When did I begin? Conception of the human individual in history, philosophy and science* (Cambridge University Press, Cambridge, 1988). For a discussion see 'The Embryo Debate (comment from the Editor), *Ethics and Medicine*, 1990, 6 (1), pp. 1–10.
8. Aristotle, *Metaphysica, IX 7*, 1048b 37–1049 a 14.
9. W. Bueche, 'Destroying human embryos, destroying human lives: a moral issue', *Studia Moralia* 1991, XXIX (1), pp. 85–115.
10. D. Hume, *A treatise on human nature*, III, pt.I, section I.
11. I am referring to the Universal Declaration of Human Rights (ONU 1948).
12. M.F. Goodman (ed.), *What is a person?* (Human Press, Clifton (N.J.), 1988).
13. J.F. Malherbe, L'embryon est-il une personne?', *Lumière et Vie* 1985, 172, pp. 19–31.
14. N. Ford (see note 7). This is the thesis also of the Warnock Report (Report of the Committee of Inquiry into Human Fertilization and Embriology, Her Majesty's Stationery Office, London, 1984). For a discussion on the Warnock Report see Nigel M. de S. Cameron (ed.), *Embryos and ethics. The Warnock Report in debate* (Rutherford House Books, Edinburgh, 1987).
15. P. Singer, *Practical Ethics* (Cambridge University Press, New York, 1993) (2nd edition); J. Harris, *The value of life: an introduction to medical ethics* (Routledge and Kegan Paul, London, 1985).
16. M. Tooley, 'Abortion and infanticide', *Philosophy and Public Affairs*, Fall 1972, 2 (1); J.M. Goldenring, 'The brain-life theory: towards a consistent biological definition of humanness, *Journal of Medical Ethics* 1985, 11, pp. 198–204.
17. T.H. Engelhardt, *Foundations of Bioethics* (Oxford University Press, New York, 1986) (a second edition is in print); D. Parfit, *Reason and Person* (Oxford University Press, Oxford, 1984).
18. For a synthesis of the most important theories of personhood regarding the initial stages of human life see D.N. Irving, 'Scientific and philosophical expertise: an evaluation of the arguments on personhood', *Linacre Quarterly* 1993, 60 (1), pp. 18–47.
19. F.J. Crosby, 'Are some humans not persons?', *Anthropos* 1986, 2, pp. 215–232.
20. For an interesting comparison between the discussion of the Western society and the East see P. O'Mahoney, *A question of life. Its beginning and transmission* (Sheed and Ward, London, 1990).

Book Reviews

Advance directives and the pursuit of death with dignity
by Norman I. Cantor
Indiana University Press, Bloomington and Indianapolis, 1993. x + 209pp, hardback, £22.50

Advance directives have been around for longer in the United States of America than in Britain, so we have something to learn from their experience and ideas. Norman Cantor is an academic lawyer who has specialized in legal aspects of death and dying, thus this book looks at the subject primarily from a legal point of view. The author believes that the successful promotion of advance directives would curb the demand for assisted suicide and euthanasia.

Professor Cantor deals with such questions as: 'Is a patient's interest in rejecting life-sustaining treatment outweighed by a state interest in preserving life or in preserving respect for the sanctity of life?', 'Is the right to reject life-preserving medical intervention confined to terminal patients nearing the end of life?', and 'Does a competent patient's right to control medical intervention include rejection of artificial nutrition and/or manual feeding?'

He makes the interesting observation that an advance directive may be less informed or considered than a contemporaneous decision to reject treatment, because there is less discussion of pros and cons. A patient making a contemporaneous decision to reject life-preserving medical intervention will usually be faced with counter-arguments from surrounding staff and concerned observers, whereas a person drafting an advance directive may not receive similar input or confrontation.

The author considers that the ideal format for an advance directive is a document appointing a health-care agent (or surrogate) together with written substantive instructions. The hardest issue to be faced in the administration of such a directive arises when there is a conflict between the instructions previously issued and the now incompetent patient's contemporaneous well-being.

Professor Cantor considers that expressions of (legally) incompetent patients should not be ignored, and that pressure from the surrounding family may be allowed to over-ride an advance directive, especially if they wish life to be preserved. He admits that however detailed the instructions, considerable interpretive discretion may remain, justifying deviation from the literal terms of the directive. He is concerned that mechanisms for enforcement of directives should be found, though he is not sure that this will prove possible.

Aberdeen DAVID SHORT

Borrowed Time: A Surgeon's Struggle With Transfusion-induced AIDS
Orville J. Messenger and Dorothy R. Messenger
Oakville, Ontario and Buffalo, NY, Mosaic Press, 1995.
153 pp.

It must have been about 10 years ago when I heard an epidemiologist make a prediction which I found difficult to accept. He was addressing a group of Christians and he was trying to encourage the church to minister to people with AIDS, a not yet popular endeavour among most churches in the mid-1980s. His prediction was 'within 10 years you will all know personally someone with AIDS.' Most in the audience, myself included, thought 'not very likely'. After all, HIV disease happens to people who engage in immoral behaviour; not the type of people I socialize with, in church or out.

He was right; I was wrong. Not one, but two close friends have experienced AIDS in less than his 10-year prediction. The first was a missionary who had been doing child evangelism in a Native American community for 8 or 9 years. It is not public knowledge how she contracted HIV disease, but her parents and siblings were so devastated by the diagnosis, they quietly took care of her with 'leukemia' for 3 or 4 years, and it slowly came out about a year after her death that the actual diagnosis was AIDS.

My second personal friend with AIDS has written a book. Orville sat across the lab bench from me in Histology class during our first year of medical school at McGill. We were both somewhat quiet, but when we saw each other at church, we gradually began to talk about the common bond we shared through Christ. He was campus leader of Inter-Varsity Christian Fellowship, and he occasionally persuaded me to attend a lunch-time Bible study. While we did not become buddies, it was comforting to recognize our shared faith. After graduation in 1966, we maintained Christmas-card contact. It was the 1994 Christmas card that hinted at a problem when Orville said that he and Dorothy had written this book. Denial led me to naively assume it was a story about a friend of theirs. I was wrong again.

Orville was a very busy and well respected thoracic surgeon in Moncton, New Brunswick. His family history of early coronary artery disease caught up with him in April of 1985 when he was just 42 years old. The heart attack was severe, complications ensued, and emergency coronary artery bypass surgery was done one week later. Convalescence was very slow with medical complications, and he gradually became resigned to the fact that he must follow his cardiologist's recommendation and retrain for a non-surgical career. Plans to do administrative work for the Canadian Medical Protective Association were coming to fruition when he was notified just before Christmas of that year that he had been given a blood transfusion from an HIV-positive donor. (Ironically and tragically it had happened shortly before mandatory HIV testing of all transfused blood products in Canada.)

Orville and Dorothy have written a moving chronicle of their struggle. Although I admit bias because I know them, I have given the book to others who have also been moved by reading of their experience. I would like to focus on two aspects of their struggle: social isolation and depression.

Amid their early devastation and confusion they wrestled with what to tell to whom. After tearfully sharing their burden with their two oldest children and a few close family members, they decided against revealing the truth to anyone else, even Orville's new employer. Remember, this was 1985; ignorance, fear, suspicion and discrimination often greeted people infected with HIV disease. They were moving to Ottawa to begin Orville's new career. They could start a new life; new job, new schools, new church—and develop new masks to hide their secret. They considered themselves 'fugitives from the negative social consequences of AIDS'. What could have been an exciting and challenging transition became instead a prison, self-imposed for self-protection. No friends, no support, nowhere to turn in crisis.

And crises did come. The depression was not only social and

emotional, it was spiritual as well. Besides the reality of a fatal illness, social isolation and major financial crisis, Orville felt abandoned by God. His previously secure faith was strained to the breaking point. Though he had survived previous personal and family crises with an intact concept of a personal and loving God, this seemingly final injustice left him angry and doubting. Thoughts of suicide were frequent. While in one of his deepest depressions, he called his new pastor and confided in him about his situation. The hasty prayer and obligatory 'Call if I can help' did nothing to encourage him about Christian love and support, and the pastor's failure ever to call again confirmed Orville's worst suspicions.

The book is not all negative or sad, however. Orville's second career proved to be quite successful. For a busy surgeon who hated the paperwork of practice to make a successful transition to 'bureaucrat' was perhaps a miracle. Not only did he begin to enjoy his work, he developed innovative education programmes, including both speaking and writing, which brought new life and purpose to the Canadian Medical Protective Association. The many seminars he held with physicians across Canada were invigorating, but when discussion turned to the medical/legal/ethical questions about treating patients with AIDS, as it often did, he felt a heavy burden 'to distinguish personal views from my role as a representative of the Association'. The great success of these professional seminars was tempered by the mental exhaustion which came from such ambivalence.

If Orville's experience with clergy was disappointing, at least he could expect excellent and compassionate care from his physician-colleagues, right? Wrong again. From the impersonal telephone notification of his positive HIV test, through thoughtless breaches of confidentiality in physicians's offices, to professional gossip about his diagnosis, his experiences with the medical profession were not reassuring.

The fatigue and infections began in 1989. Realizing he would be unable to continue working full time, and feeling drawn back to the more familiar medical community in Halifax (where he had been getting regular cardiology care), Orville and Dorothy decided on another major move. The Canadian Medical Protective Association was understanding and supportive, and even allowed him to open a remote CMPA office in Halifax where he would continue work part time for the next two and one-half years. While work went well, he tolerated very poorly the medications prescribed to slow the HIV deterioration (AZT and DDI). His symptoms progressed so that he found he had to retire in the fall of 1992.

One could argue that 7 to 8 years of reasonable health after a near fatal cardiac event is not too bad; he should be thankful and enjoy each day. It is one thing, however, to live under the shadow of a potential recurrence of coronary artery disease, and quite another to live knowing you carry a virus which could at any moment radically change your health status and take your life after a brief or prolonged course of deterioration. Orville opens the book describing his longstanding annual melancholy with the onset of fall. Although a beautiful time of year in the Maritimes, it always carried for him a foreboding about the inevitable change to a severe and long winter. He asks the question, 'What if fall came and lasted for years without changing to winter'? As unlikely as this is, the prolonged course of his illness has carried with it this sense of melancholy and foreboding.

There have been other books written by people with AIDS, some even by Christian physicians with AIDS. I have learned and benefited from reading several of them. I recommend this book because it is so honest, so real. It does not gloss over the experience with platitudes. It does not portray a spiritual giant. It portrays a friend, a neighbour, a patient, a parishioner in need. A need that each of us can meet in our own way. If you do not yet personally know someone with AIDS, you very likely will quite soon. This is a book written for anyone. Physicians would be well served to walk the path beside a patient carrying this burden. Christians would do well to try to understand the spiritual depression which may accompany life-threatening illness and the social isolation imposed by a disease which is not politically correct in Christian circles. Neighbours would benefit from this narrative, and we are all neighbours.

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Coping with Controversy: Conflict, Censorship & Freedom within Christian Circles
D. Gareth Jones
Dunedin, New Zealand, Visjon Publications, 1994. paperback, 198 pp.

It would be great if all Christians agreed with each other about everything. No more fights over lifestyle issues. No more arguments over political issues such as school prayers or spiritual issues such as speaking in tongues. No more disagreements about issues of medical ethics such as abortion or withdrawal of artificially administered fluids and nutrition. And no church splits over the ordination of women. If we all embraced the same doctrines, believed the same principles, and had the same convictions, then we would all get along and others 'would know we are Christians by our love' for each other.

Besides the fact that this level of agreement is not likely to happen in this life, I do not want it to happen. In fact, I don't think God wants it to happen. He did not design us all to be the same. Each of us is unique. Although each of us is made in his image, part of that image is the ability to use critical judgement and exhibit creative thinking.

So can we agree that controversy will happen, and that it is not necessarily bad in and of itself? If we can agree on the reality and acceptability of controversy, can we also agree on how to cope with controversy within the church? Probably not. Christians judge one another. Christians get angry. Christians criticize one another, even call their 'brothers and sisters' unflattering names. Christians may stop speaking to each other or even separate from each other. That is too bad—no, that is awful. I doubt that is God's plan for his people.

D. Gareth Jones has written a remarkable little book for Christians about *Coping with Controversy*. He is Professor of Anatomy and Structural Biology at the University of Otago in New Zealand. Not a philosopher, not a theologian, not an attorney, not a mediator; but a scientist! How does that qualify him to tell Christians how to get along with each other? He is well qualified, not by his education and degrees, but by his experience. He was 'taken to the woodshed' by fellow Christians, indicted, judged and penalized for putting forth an opinion which was felt by some to be inconsistent with mainstream evangelical thought. I am not sure he is right in his basic thesis, but I am sure he is right about how to cope with controversy.

I bought one of the first copies of his book *Brave New People: Ethical Issues at the Commencement of Life* when it was released by Intervarsity Press in England in 1984. It was still sitting (unread) on my bedside table when I heard that the publisher had withdrawn it from circulation because it was 'too controversial'; and besides, some pro-life spokespersons were urging Christians to boycott the publisher. I read it immediately and learned that he believed that the human person begins at conception (so far, so good), but takes on increasing worth as it progressively develops. Controversial?—yes. Disqualifying him as an evangelical?—maybe. I confess to a more black-and-white view of Christianity (and of life) in 1984. While I did feel he had been

treated unfairly by the evangelical pro-life community, I did also wonder whether he was really an evangelical Christian.

I met Gareth Jones at a conference in Sydney, Australia a few years later, and learned from listening to him speak and by talking with him personally that he has a very orthodox view of personal salvation, scripture, etc. I wanted to ask him how he had coped with the 1984 book controversy, but I felt the question too intrusive. I did not want to open old wounds; after all, he was probably still bitter (I presumed) over how he had been treated by the evangelical community and by the publisher. Perhaps he read my mind, because when I met him again a few months ago, he gave me a copy of this book. When I saw the title, it did not go unread for long.

He reminds us of Jesus's teaching in Matthew 7:1–6, 'Do not judge, or you too will be judged'; sawdust and planks in eyes, etc.; and he urges us not to use minor disagreements as a litmus test of another's salvation. He explores scripture thoroughly, looking at the hypocrisy of the Pharisees, and Jesus's teaching about false prophets and false teaching. He does not say that we should be uncritical of others's statements or beliefs, but he clearly reminds us that God is ultimately the judge. He encourages discernment. He encourages forgiveness. Forgiveness? But how or why should we consider forgiving someone for being wrong (i.e. disagreeing with me)? Here is the most important point in the book. Jones reminds us that it is critically important to distinguish the central tenets of the faith, on which there can be no compromise ('the skeleton of true biblical Christianity'), from the peripheral or disputable issues. He states that arguments over the peripheral issues are not merely intellectual, they become social, political, moral and spiritual. 'Once the breadth of the (peripheral) issues is appreciated, it becomes clearer that self-centered attitudes readily intervene, misunderstandings are frequently encountered, and therefore forgiveness is required' (p. 74).

The book contains insightful and helpful sections on unity, humility, and putting others's interests first. It also addresses the issues of being salt and light, public debate, pressure groups, censorship and the dangers of dogmatism. The author devotes 20 pages to the questions 'Where should lines be drawn?' Because the book is about the peripheral issues, he does not clearly delineate those central issues about which there can be no compromise. But he does present four options for considering the peripheral issues: (1) the issue doesn't make any difference—dismissed; (2) the issue is so important you can't be a Christian unless you believe my way—dismissed; (3) while the issue is peripheral and not strictly speaking part of the core of faith, it is so important it should be viewed as central—dismissed because the result is automatic separation, just like the second option; and (4) recognition of a hierarchy of importance on different issues. This option (the author's choice) allows Christians to disagree on some issues, but still worship together. He admits that some issues may be interpreted by some congregations as such serious deviations from biblical principles that it is better to draw a line of separation from those who disagree. However, he feels that this should rarely be necessary. He concludes the chapter on line-drawing by offering a test for the rightness or wrongness of our own attitude. 'The test is this: we should be able to disagree with people fervently, and at the same time respect them, be courteous to them, show concern for them as people (and also as fellow Christians), be happy in their company, and be active in praying for them. . . . If we fail this test, we have failed to adopt biblical attitudes' (p. 158).

Another important point I gleaned from this book is Jones's suggestion that when confronted with Christians who disagree strongly with me on one of the peripheral issues, I could benefit by adopting the attitude during discussion: 'What if they are right and I am wrong?'

He has not yet convinced me that his perspective on the human embryo is right, but he has convinced me that my attitude toward fellow believers on many issues has been wrong.

This book should be read by pastors, church leaders and Christians in the pews. It should likewise be read by Christians involved in medical ethics. There are issues where we agree with each other and disagree with non-Christians. But there are also issues where evangelical Christians in the bioethics arena disagree with each other. We should learn to cope with these controversies without allowing ourselves to become fragmented and splintered.

This book has not yet been marketed in the US or Europe, but it is well worth the trouble of ordering it directly from the publisher in New Zealand (Vision Publications, 37 Garden Place, Glenleith, Dunedin, New Zealand).

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Death and Deliverance: Euthanasia in Germany 1900–1945
Michael Burleigh
Cambridge University Press, Cambridge, 1994,
ISBN–0–521–41613–2, paperback xvii + 382 pp

The history of the Jewish Holocaust is well known and, indeed, notorious. The facts about Hitler's euthanasia and sterilization programmes, on the other hand, are far less well known. They are, however, supremely relevant at the present time, when the pressure for the legalization of euthanasia is strong and relentless in Europe and the USA, and China has recently introduced a eugenic law. *Death and Deliverance is*, therefore, in a high degree timely, especially for politicians, and for all in the caring professions; particularly psychiatrists.

This book claims to be the first full-scale study in English of the German 'euthanasia programme'. It uses a wealth of original archival material and is fully documented with detailed case histories of those involved in administering euthanasia and their victims. The author is Reader in International History at the London School of Economics. He has researched at first hand the archives of the period with which he deals, and has even unearthed some propaganda film which had been lost.

The development of a euthanasia programme in Germany is popularly linked with the name of Hitler, and it is widely believed that he forced it upon the German people. This book shows convincingly that the foundation for the programme was laid many years before Hitler's rise to power. Back in the 1890s, the concept of 'life unworthy of life' was promoted by Ernst Haeckel, the zoologist and populizer of Darwin. He argued that euthanasia was an act of mercy, and that it would save a great deal of public and private money.

The First World War had a great influence on popular thinking. Millions had died, and hard choices about resources had been made. After the War, dire conditions prevailed in mental asylums, and many psychiatrists became receptive to drastic 'eugenic' solutions long before 1933. An important tract was published in 1920 entitled: 'Permission for the Destruction of Life Unworthy of Life'. The authors were Karl Binding, a jurist, and Alfred Hoche, professor of psychiatry at Freiberg. Hoche claimed to have contacted every German asylum in order to establish the cost of caring for all the inmates. He claimed that 20–30 'idiots', with an average life expectancy of 50 years, represented 'a massive capital in the form of foodstuffs, clothing and heating, which is being subtracted from the national

product for entirely unproductive purposes.' The widespread economic depression of the early 1930s intensified the debate about the appropriate use of resources in a nation which its leaders argued was fighting for its very existence.

Before he gained power, Hitler had conceived a policy which involved the elimination of the unfit and unproductive members of society. He prepared the ground by a propaganda campaign. As part of his campaign, he opened the mental asylums to the public. Each tour culminated in a lecture by the asylum authorities illustrating, with the aid of human subjects, the symptoms of the principal psychiatric illnesses emphasizing the necessity for eugenic measures. Parties of school children were taken round and made to write essays recording their reactions to what they had seen, and to calculate the saving that could be made if the nation could be relieved of the burden of caring for the asylum inmates.

Public interest was fanned by a sensationalist press. Derogatory terms were widely used to disparage the mentally ill and handicapped. They were referred to as 'beings', 'creatures', 'existences', 'idiots', 'travesties of human form and spirit', 'parasites' and, especially, 'life unworthy of life'. Sexual offenders were dubbed 'beasts in human form'. Caring for chronic or geriatric patients was described as 'a luxury that Germany could not afford'.

One of the most powerful propaganda tools was the use of films. These were expertly produced and caricatured the mentally and physically handicapped. Their continued existence was said to be against nature. The Darwinian concept of natural selection with elimination of the weak and the survival of the fittest was designated 'a sacred command'. The economic arguments were forcibly presented. Pre-marriage counselling was advocated, with a view to the sterilization of the unfit. It was alleged that there had been a vast increase in the proportion of those with hereditary illness, and that the Jewish race was particularly heavily represented among the insane. These films did not need to make audiences into active apostles of compulsory sterilization. It was sufficient for them to make ordinary people angry, impotent and morally confused in the face of a 'problem' whose proportions were deliberately magnified so as to be beyond individual comprehension or resolution. A survey of parents of children in an asylum showed that the majority would support the painless killing of their children.

Protests by church leaders were few and muted. There is indeed some evidence that the Church had foreknowledge of the 'euthanasia' programme and tacitly sanctioned it. There was however one courageous voice of protest, and that came from the RC bishop of Munster. He detailed what he knew of the killing of patients, and he warned his congregation (and the nation) of what was likely to happen. 'If you establish and apply the principle that you can kill "unproductive" human beings, then woe betide us all when we become old and frail!. . . Woe betide loyal soldiers who return to the homeland seriously disabled as cripples, as invalids. . . .Woe to mankind, woe to our German nation, if God's holy commandment: "Thou shalt not kill" is not only broken, but if this transgression is actually tolerated, and permitted to go unpunished.'

The German medical profession, and especially the psychiatrists, were deeply implicated in the euthanasia and sterilization programmes; but they were unwilling to admit it. At the Nuremberg trial of the doctors, no senior medical figure could be persuaded to attend to represent the German Medical Association. After the trial, all copies of the report were bought up by the GMA and pulped. The report was never mentioned or reviewed in medical circles. Clearly, there was a determination to brush the past under the carpet and to regard any misdeeds as being the actions of a few 'bad apples' in an otherwise sound barrel. Until 1986, no comprehensive study of the euthanasia programme had been published by a German author. Several valuable studies had been produced by foreigners, but none was translated into German.

Burleigh has done an outstanding service to the English-speaking public. Germany may not want to know about it, but it is essential that the world at large should do so. In my opinion, this book is an essential resource for all those who are seeking to resist the repeated waves of pressure for the legalization of euthanasia. From this account, I would judge that we stand today where Germany stood in the 1920s.

Aberdeen PROFESSOR DAVID SHORT

Dispatches from the Front: Theological Engagements with the Secular

Stanley Hauerwas

Durham, Duke University Press, 1994. ISBN 0–8223–1475–4, 235 pp., paperback $14.95, hardback $26.95

'I want to be liked but cannot seem to make anyone happy,' reflects Stanley Hauerwas in his latest collection of essays, *Dispatches from the Front* (p. 18). He is not likely to make many American Christians happy by asserting that they, aided by theologians, have made God boring (p. 1). I'm sure his students are not happy to be told he does not want them 'to learn "to make up their own minds," since most of them do not have minds worth making up' until they learn to think as he does (p. 5). Neither will he make many academics happy by noting that universities dilute significant disagreements to differences of opinion in the interest of keeping the liberal 'peace' (p. 15). Few medical centres will enjoy being compared to medieval Catholicism (p. 27)!

Anyone who risks alienating most of his readers before they finish his introduction needs to have good reason to do so. Hauerwas does! His purpose is not to alienate, but, as his title states, he is writing from the battle front. He is calling Christians to arms, but most do not even know there is a battle going on. He is angry at Christians, including himself, for being so compromised that the world no longer sees what difference it makes to be a Christian (p. 25).

For those who respond to Hauerwas, Part 1, 'Behind the Lines', gives some basic training to prepare to engage the secular world. Part II, 'Engagements', shows what some of these interactions might look like. Although his essays cover a variety of topics, there are some common themes. One is that the Christian life should be characterized by forgiveness and reconciliation, coupled with nonviolence. A second major theme is that Christianity is not just about beliefs, but is about a life of action lived in community. He is controversial in how he links these. He claims that one cannot have a community of forgiveness without nonviolence; and one can have neither without worshipping the God of Christianity (p. 26).

Hauerwas argues that we are at an important point in the history of Western civilization. Society is moving from modernity to post modernity. This presents Christians with a unique challenge, as well as an opportunity. Hauerwas notes that the postmodern critique of modernity and liberal society gives prepared Christians the opportunity to engage the secular and display the truthfulness of Christianity. One forthcoming collection of essays warns that postmodernism 'may dwarf Darwinism in its impact on every aspect of thought and culture' (Dennis McCallum, ed., *The Death of Truth* [Minneapolis: Bethany House, forthcoming], p. 10). To prevent this, Christians will need to respond differently than they did to *The Origin of Species*.

Hauerwas sees his first two essays as the heart of his book. The first deals with the virtue of 'constance'. He summarizes

how others have tried to define this virtue. Constancy is that part of our character which can be trusted to remain steady in our on-going dealings with others. Yet constancy also requires the ability to change, for which forgiveness is needed. Constancy helps account for our individuality (p. 4–7). The difficulty of defining constancy demonstrates Hauerwas's claim that some things cannot be explained well in abstract ways. They must be lived out before they can be understood. Novels can show us how to do this, and hence may be used for moral instruction.

He begins his second essay with Barth's description of honour. Hauerwas believes that Barth has 'extraordinary insights about human behavior,' but his methodology leaves one unsure whether or not that behaviour is appropriate for Christians (p. 66–7). What Barth lacks, according to Hauerwas, is the concreteness which the 'real people' in novels could have given him. In these two essays, Hauerwas uses the novels of Anthony Trollope as examples. This essay is an excellent example of how a novel can be used to flesh out theological ideas and concepts.

He concludes Part I with another essay using an Anne Tyler novel. Originally given as a commencement address at Goshen College, this essay summarizes Hauerwas's general theme that a life of truth must be lived in communities which practise forgiveness, reconciliation and nonviolence.

The second half of his book covers three general topics. Two essays are critiques of American liberalism, three deal with the ethics of war, and three with issues related to medical ethics. He questions why Christians have become so enamoured with liberal democracy and family values, doubts that modern war can be distinguished from terrorism, and reveals the dangers of unchecked compassion. Hauerwas, as always, is controversial and provocative, as the title of one essay reveals: 'Why Gays (As A Group) Are Morally Superior to Christians (As A Group)'. Yet his deeper insights are apparent in the essay dealing with the subject: why are Christians not banned from the military since they are supposed to be characterized by forgiveness and nonviolence?

For those interested in medical ethics, the last three essays will provide much food for thought. In the first of these he grapples with the emphasis on autonomy brought about by liberalism. He connects this emphasis to the idea that we are responsible for only those commitments freely undertaken. Hauerwas also critiques communitarians who make community an end in itself, rather than a means to the end of worshipping God (p. 158). His second essay in this group discusses compassion and the significance of everyday life. The ethics of compassion leads to murder unless balanced by the Christian virtue of patience in God's providence (p. 174–5). The final essay deals with a number of issues involving the mentally handicapped. Although he focuses more on the church's response to those people, his ideas are directly applicable to medicine, and are equally challenging.

However, this essay also reveals the one critical concern I had with this book. For example, he critiques those traditions which place a great emphasis on beliefs. 'For what the mentally handicapped challenge the church to remember is that what saves is not our personal existential commitments, but being a member of a body constituted by practices more determinative than my "personal" commitment' (p. 183–4). What exactly does Hauerwas mean by this? How would he reconcile this with biblical claims about the centrality of belief (e.g. Acts 16:30–31; Romans 10:9)? His repeated references to the truth of Christianity show that he does not see Christianity as belief-less. Yet his critiques sometimes make it difficult to know exactly what he advocates in place of the extremes.

Hauerwas refuses to be pigeonholded into one view or another. He sometimes raises postmodern issues, and uses that terminology. He sees novels teaching 'the skills of locating and telling our individual stories' (p. 56). He praises those who 'distrust abstract claims about objectivity' (p. 87). He laments that the handicapped are 'marginalized' (p. 183). Yet he is not impressed by the fact that some postmodernists admire his work (p. 24). He remains at odds with postmodernism by viewing Christianity as the truth, but he is willing to make use of their methodology where helpful. Sometimes it is hard to see where he draws the line. But his understanding of postmodernism leads him to ask different questions, which lead to challenging assertions.

Many of the readers of this journal would agree when Hauerwas reflects: 'As a theologian, I have been drawn to medicine because it provides the issues where we might see again what difference Christian convictions or their absence might have for how we might live' (p. 162). Though some of these essays do not relate directly to medicine, the issues raised have application to many areas of Christian reflection. These essays are as insightful as they are provocative. Whether or not you agree with his conclusions, Hauerwas is invigorating to read. He is willing to call things as he sees them so that the church can more faithfully witness God's truth to the world. That is more important to him than making people happy.

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