

# ETHICS & MEDICINE

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Agneta Sutton

# Consultation Paper on Cloning

On 29 January 1998 the Human Genetic Advisory Commission (HGAC) and the Human Fertilisation and Embryology Authority (HFEA) issued a joint consultation paper on cloning.

While the two bodies declared that they were morally opposed to the idea of 'reproductive' cloning, the consultation document mentioned two main reasons for consulting the public about its views on cloning. It suggested that cloning might be a way of overcoming the present shortage of organs for donation and, secondly, that it might be a way of overcoming mitochondrial disease.

In Britain the creation of a child by cloning is forbidden under the Human Fertilisation and Embryology Act 1990, since it is forbidden to implant in a woman an embryo that has been tampered with. However, the creation of cloned embryos in the laboratory is not forbidden under the act; the act rules only that no laboratory-created embryos be kept beyond fourteen days. This means that there is scope for developing cloning techniques under the present law.

The pressure to develop techniques to overcome the shortage of organs for transplantation purposes is enormous. Already biotechnology companies, such as Monsanto, are growing human skin from human skin in the laboratory. Such skin can be used to treat patients who have suffered severe burns. Small pieces of skin, or a few skin-cells, can be taken from a part of the body that has not been burned and, then, grown into layers of skin-cells to cover burned areas. This overcomes the problem of rejection, since the tissue is the patient's own.

Blood vessels have been grown in similar ways from the kind of cells making up the different layers of blood vessels (see, the *New Scientist*, 24 January).

These techniques, which are uncontroversial, must be distinguished from certain other techniques of growing tissue or organs for transplantation purposes. They must not be confused with techniques involving the use of human egg-cells.

The consultation document issued conjointly by the HGAC and the HFEA, suggests a procedure involving the removal of the nucleus of an egg-cell and the insertion of a different nucleus, taken from another cell, for example, a skin-cell obtained from an adult, a child or a fetus, in need of an organ transplantation. The new entity would be a clone of the adult, fetus or child from whom the nucleus was taken. It would have 46 chromosomes, 23 from the father and 23 from the mother of the adult, child or fetus

from which the inserted cell-nucleus derived. Forty-six chromosomes (23 of paternal and 23 of maternal origin) is, of course, the number of chromosomes in an ordinary one-cell embryo. Thus, if the created embryo were totipotent—as it would have to be for the technique to work—it would be just like an ordinary embryo. But it would be one generation removed from the genetic parents of the cloned individual. In other words, what the HGAC and the HFEA are suggesting is that human embryos might be used to produce cells or tissues of particular types for transplantation. The embryo would be allowed to develop for a short period. Then its development would be halted. And stem-cells for the production of specific tissues would be cultured. To solve the problem of organ shortage by these means would be to breed human embryos in order to cannibalise them for human repair. Could we sink any lower?

The second technique, suggested in the joint HGAC-HFEA consultation document, would involve nuclear transfer to help women with mitochondrial diseases to have healthy children.

Even if most of the genetic material in the human egg-cell is to be found in its nucleus, there is also some genetic material outside the nucleus, mitochondrial DNA and this passes unchanged from mother to child. Hence, if a woman has a genetic disease linked to this DNA, then the disease is passed on to the child.

The consultation document suggests that transmission of mitochondrial disease might be avoided by transferring the nucleus from an egg-cell, provided by a woman—call her Alpha—with the disease, into a donated egg-cell, the nucleus of which has been removed. In other words, a healthy woman—call her Beta—would donate an egg and its nucleus would be removed, while the mitochondrial DNA would be left. Only the nucleus would be replaced. The new 'combi-egg'—with a nucleus from Alpha and mitochondrial DNA from Beta—could be fertilised in the test-tube or replaced in the body of Alpha and fertilised naturally. In either case, the child would be the genetic child of both women, even if most of its genetic make-up from the maternal side would come from Alpha. The child would, therefore, have three genetic parents: two mothers and one father. This is surely one too many!

It is to be hoped that respondents will see the gravity of what is being proposed in the consultation document and reject these proposals as an affront to human dignity.

## Hypnosis, Healing and the Christian

John H. Court

This book explores the controversial subject of hypnosis. The dangers of this powerful phenomenon are considered, together with examples of clinical hypnosis by Christians, who have found emotional and spiritual benefits from its use. Ethical concerns about the use of hypnosis are set within a framework of the available biblical material.

**John Court** is Director of Counselling at Tabor College, Adelaide, Australia. He has written a number of books including *Pornography: A Christian Critique*. 0-85364-802-6 / pb / 229 x 145mm / £9.99

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# Are Advance Directives an Advance?

'An advance directive is a document intended to govern the kind of life-sustaining treatment that a competent person will receive if he or she later becomes incompetent.'<sup>1</sup> So begins a recent ambitious attempt by the Advance Directive Seminar Group (ADSG) of the University of Toronto (headed by physician Peter A. Singer) to assess the strengths and weaknesses of arguments concerned with the propriety of employing advance directives (ADs) in clinical medicine and, consequently, to offer a reflective answer to the question, 'Are advance directives an advance?'<sup>2</sup> The Group's answer was a qualified yes, recommending that the introduction of ADs into the Canadian Health Care system should proceed, albeit with caution.<sup>3</sup>

In light of the (legal and ethical) premium placed on patient autonomy, the general belief that autonomy is somehow extended by the use of ADs, and the apparent overall success of the Patient Self-Determination Act of 1990 in the United States<sup>4</sup>, this decision is not at all surprising. Nevertheless, there is reason to be sceptical of the ADSG's conclusion in this regard,<sup>5</sup> for what appears to be one of the most promising lines of criticism *against* endorsing the current widespread use of ADs was not satisfactorily explored by the ADSG group. I am referring to the first of seven considerations weighing against the use of ADs that was to be critically examined by the ADSG, *viz.* (A) '[P]eople who have become incompetent, such as those in a persistent vegetative state, are greatly changed from when they were competent, and the decisions they would make if they could communicate might be different. It may be inappropriate to project the autonomous wishes of competent people onto future situations of incompetence.'<sup>6</sup> It is noteworthy that in its otherwise exhaustive analysis, the ADSG has failed adequately to elaborate on this statement. This is a failure which could hardly have been accidental. The statement generates several thorny problems whose potential for engendering confusion cannot be overestimated, problems which the ADSG has seemed to find it prudent to avoid.

As I see it, the most pressing of these problems has to do with questions concerning AD *content and justification*—concerns that are *prior* to all of the other concerns which are otherwise carefully analysed by the ADSG. Briefly stated, the central questions can be phrased as follows: (i) What, precisely, is one attempting to convey by way of an AD?; and (ii) What justifies our taking any particular AD as being authoritative? That the answers to these questions have appeared so obvious to so many people suggests to me that almost no one has been paying careful attention. The fact that the AD revolution in the US is in full swing and that it is being considered for exportation to Canada is evidence of this phenomenon.

There are, of course, a number of possible interpretations of precisely what message it is that one is attempting to convey when one composes an AD; likewise, there is a set of popular answers that are typically offered in the face of questions about AD authority, namely, answers which invoke some version of the principle of patient autonomy. But the form that some of these answers take are deeply problematic. With no clear sense concerning what it is that many patients who have composed ADs are attempting to communicate, and with no clear idea concerning the source from which many ADs derive their authority, there can be, in at least a significant number of cases, no clear idea concerning the value of these directives.

## I

What message, precisely, is a competent person attempting to convey to his or her current or future caregivers by means of an AD? Consider the following three possibilities:

- (1) If Jones, who is competent with respect to treatment decisions prior to a particular moment, is judged by some relevant group of medical experts to be incompetent with respect to treatment decisions at that particular moment, then Jones at that moment is subject only to the treatment regimen specified in that AD composed by Jones prior to it.
- (2) Although Jones does not now (i.e., while competent, prior to that particular moment) know what treatments he would *then* (at that future time) desire, Jones, while competent, now desires and autonomously specifies in an AD that he receive a particular treatment regimen, at that time, if it should come, when he is judged to be incompetent.
- (3) If Jones were judged to be incompetent with respect to treatment decisions at that particular moment Jones would desire and autonomously choose to receive at that moment the particular treatment regimen specified in his AD (which he composed, while competent, prior to it).

Let us examine each of these options in turn.

(1) specifies for Jones' caregivers the treatment regimen of Jones' choosing should he at some later time be deemed to be in an incompetent condition. The consequent of the conditional specifies precisely the treatments that Jones deems permissible should he be judged to be in the condition specified by the antecedent. Although (1)'s syntactical and semantical structure is perspicuous and logically uncontroversial, the reason why one's caregivers ought to consider those particular specification as being *authoritative*

in guiding Jones' treatment remains obscure. (Surely the justification for which we are searching cannot be a function of the mere fact that the patient emitted verbalizations which appear to constitute consent for a specific treatment regimen and only for that treatment regimen in the circumstances specified. For, even a seizure caused pattern of behaviours can *appear* similarly to convey consent. What is needed is some justification for believing that these *apparently* informed and autonomous choices on the part of the patient (i) actually *are* informed, autonomous, and hence, according to current wisdom, authoritative choices, and (ii) are able to reach ahead into future states of affairs during those times at which the patient is, in fact, incompetent.)

Although the *meaning* of directive (1) is clear, it is also clear that more is needed here in way of *justification* in order to demonstrate the appropriateness of complying with the treatments there specified. The expressed central purpose of invoking ADs, after all, is as a means for extending the autonomy of competent patients into regions of incompetence. And, clearly, one cannot claim that this means has been established without explicating *some* justification for taking seriously the propriety of the decisions regarding the chosen treatments.

I take it that (2) and (3) are intended to make intelligible the authoritative propriety of the decision to invoke only those particular treatment specifications made explicit in (1) by making manifest the reason-desire structure from which these treatment specifications have been derived. (2), for example, attempts to ground the reasons which undergird these treatment specifications in *present* desires and autonomous choice. The claim is that the propriety of Jones' AD judgement is grounded in the fact that Jones (prior to a particular moment) desires and autonomously chooses when that moment arrives, to receive a particular treatment regimen. But (2) suffers from a defect similar to (1), that is, a gap in the crucial connection between the treatments Jones *now* desires and those he has *now* autonomously specified to receive then. How, precisely, are his *present* desires and autonomous choices supposed to guide treatment specifications under the specified *future* conditions?

One seemingly popular answer to this question can be found in (3). The present desires and choices on which appropriate treatment specifications are claimed to be predicated owe their structure to what one *would* desire and choose if one *were*, at some time, to become incompetent. Now this counts as a legitimate attempt to make clear the required link between the treatments one has specified and the reasons *these* particular treatments (rather than some other have been specified. Some variation on this form of linkage is at the heart of many AD decisions.

Notice that (3) is an example of a *subjunctive* (or *counterfactual*) conditional proposition, i.e., a proposition that has the general form: 'If P *were* the case then Q *would* be the case.' Furthermore, given the central motivation for employing ADs (that is, the desired extension of one's autonomy) (3) is best construed as being a *counterfactual of freedom*, i.e., a proposition of the form: 'if person S *were* in circumstance C at time t, then S would *freely* choose treatment regimen T at t.' The central idea behind many ADs, therefore, might best be expressed as follows: Supposing that Jones is a competent, autonomous agent at an earlier time, he is in a privileged position with respect to what

treatments he himself *would* freely specify at some later time if he *were* then incompetent with respect to treatment specification decisions.<sup>7</sup>

But *is* Jones in a privileged epistemic position with respect to the content of (3)? There are two general reasons that are often given for doubting this. First, some philosophers have argued that there is good reason to doubt that *any* counterfactuals of freedom are non-vacuously true. The arguments undergirding this position are numerous and complex. Suffice it to say that the central concern here has to do with the problematic nature of the manner in which the alleged truth-values of counterfactuals of freedom are *grounded*. Although a precise specification of what it means to say that 'Proposition P is grounded' is obscure, the general nature of the 'grounding problem'<sup>8</sup> may be partially conveyed by analogy with what is widely thought to be the grounds for truth-conditions of present-tensed indicative conditionals, i.e., propositions of the form, P\*: 'If P is now the case, then Q is now the case.' This indicative (and, hence, non-subjunctive) conditional is true if both P is now the case and Q is now the case. Suppose, for instance, that P denotes that 'Some hearts obey Starling's Law', and Q denotes that 'Some hearts are pumps.' Then P\* is true *because of some hearts' now obeying Starling's Law and some hearts' now being pumps*. Both of these *states of affairs*<sup>9</sup> obtain or are *actual*. It is presently occurring actual states of affairs that are thought to ground the truth of true present-tensed indicative conditional propositions (perhaps by, in some sense, *corresponding* to these propositions).

The grounding or non-present (i.e., future or past) contingent propositions is more obscure since the states of affairs that correspond to them and, hence, that *make* them true, although *actual* are not *present*. The alleged grounding relation involving true counterfactual propositions with false antecedents (i.e., *strict* counterfactuals) is even more obscure, for such counterfactuals allegedly correspond to states of affairs that are neither present nor actual. So, to what do they correspond? What is it that makes them true?

It does no good to surmise that the truth values of strict counterfactuals of creaturely freedom are grounded in certain things that we know about ourselves, for we do not know that much about ourselves when faced with decisions about what we would specify under a number of conditions far removed from the one that we are presently in. This is partly because we do not have a good idea about what it would be like to be in any of a number of possible future conditions in anticipation of which our ADs are commonly composed.<sup>10</sup> But even if it *were* the case that we had a good idea about what it would be like to be in these conditions, how is *this* knowledge supposed to help us in the composition of ADs?

There are some seemingly insurmountable conceptual problems that confront us when attempting to formulate a satisfactory answer to this later question. First, especially in the AD context, many of these possible future conditions are such that we cannot say what it would be like to be in them. Suppose that person S is comatose, immobile, and cognitively inert,<sup>11</sup> then the consequent of the appropriate corresponding counterfactual conditional is *impossible*, i.e., it is not possible both for person S to be in an immobile, cognitively, inert comatose state at t and for S to specify *any* treatment-regimens at all *at t*. Ascertaining the truth values

of counterfactuals with *possible* consequents are problematic enough; counterfactuals with *impossible* consequents (i.e., what I shall call 'consequent-counterpossibles'<sup>12</sup>) are, conceptually speaking, even more problematic. For such counterfactuals, if grounded at all, cannot, it seems, be grounded in any set of *possible* worlds (at least there is no hope of this in extant possible world semantical schemes for counterfactuals). But if not *possible* worlds, then what? *Impossible* ones?<sup>13</sup>

The preceding discussion prompts a further question which needs to be considered. What precisely is it that a significant number of individuals find *aversive* about being kept alive while in total darkness,<sup>14</sup> and what precisely is it that grounds this aversion? Necessarily, if one is in total phenomenal darkness, then one has no conscious experiences; and if no conscious experiences, then no conscious suffering whatsoever, and if no conscious suffering whatsoever, then whence comes the aversion?

Second, I have often noticed a subtle but clear conceptual shift that occurs in the context of discussions concerning propositions like (3). This shift manifests itself in a pervasive confusion regarding what it is that one is thinking about while considering such propositions. What (3) requires, I think, is a projected treatment specification for Jones from the perspective of Jones *while* Jones is incompetent, *not* a projected treatment specification for Jones from the perspective of Jones *while* Jones is *not* incompetent. But, I will argue, it is the latter conceptualization on which AD decisions are often based. This will require some elaboration.

Suppose that Jones presently enjoys both mental and physical health and that he is asked to fill out an AD which makes explicit just those treatments he would request if he were to be diagnosed as having advanced Pick's disease (a condition which often includes *inter alia* severe dementia, incontinence, and contractures). Further suppose that Jones has an aunt with advanced Pick's disease for whom he had been the single carer for three months. Based on this experiential knowledge, Jones specifies in an AD that he receive no life-saving medical treatment in the event that he too should suffer from this condition. Such a specification would, in all likelihood, satisfy most potential critics; after all, Jones seems clearly to know what sort of life he would be facing, what he desires, and he has, while still competent, made his informed request quite clear in an AD. Case closed.

But does Jones *really* know what he is requesting? If he thinks that he has a reasonably good idea, much less *knowledge*, about what treatment options he would specify if he *were* in that condition, he appears to be deeply mistaken at least on *inductive* grounds from cases of others who are (or have been) similarly afflicted. How many people suffering from *advanced* Pick's disease have clearly expressed a desire to die or a desire to have a certain treatment withheld or withdrawn? Very few, it seems. And if the question were changed to 'How many people suffering from advanced Pick's disease have clearly expressed an informed and *coherent* desire to die or a desire to have a certain treatment withheld or withdrawn?', the answer here would obviously be 'None'. Yet numerous individuals who do *not* suffer from advanced Pick's disease *do* claim that they *would* have such a desire and, hence, make such a request. What is the explanation for this discrepancy?

It seems that many people want it both ways when making this judgement: they want to imagine *both* being in an incompetent state (thereby adopting the perspective of one who is severely demented) and *not* being in an incompetent state (thereby adopting the perspective of one who is not severely demented). But it is clear that one cannot take on both the first and the third person perspectives concurrently in this context. From the third person point of view, one might find being in an incompetent state intolerable; on the other hand, from the first person point of view it might appear quite tolerable if only because one is incapable of appropriately reflecting on one's predicament while incompetent.

Suppose, for example, that there were a disease called 'caninalia' in which your brain is gradually and permanently transformed into a dog-like brain. The result would be that you would act and feel like a dog. You would prefer to eat off the floor, defecate and urinate wherever and whenever you had the urge, sniff interminably, bark, crawl on all fours, beg for table scraps, etc. Further suppose that you have recently been exposed to neuropsychiatric wards full of individuals so afflicted and that you think this is all quite disgusting. Surely the most popular caninalic-specific AD would be to forego life-sustaining treatment should one suffer from advanced caninalia and should a life-threatening complication ensue. But no advanced *caninalic*, just as *no canine*, would so properly specify, if only because advanced caninalics, as well as canines, *cannot* so properly specify. Such patients and such non-human mammals are, after all, not now competent properly to make such specifications. Here then is the deep problem: ADs are supposed to extend one's autonomy into regions of incompetence, *but in many cases they cannot*, because the one who is attempting this extension has presupposed that one is able reliably to envision those *competent* judgements one would make at times during which one is *incompetent*, and this is patently incoherent. Besides, in many cases there is a shorter and much more trustworthy route to such specifications, *viz.* simply *asking* S about treatment specifications while S is actually incompetent. But, of course, we do not need an AD to do *this*.

This 'perspectival problem' is a problem for ADs, independent of the aforementioned 'counterfactual problem'. For suppose that counterfactuals of freedom do possess truth value. The perspectival problem both (a) puts these truth values out of our introspective reach (How would *we* know what it is like<sup>15</sup> to be in a particular state with its attendant cognitive disruption?); and (b) transforms these counterfactuals into consequent-counterpossibles, a transformation which threatens their very intelligibility.

It is not entirely adequate to respond to this objection by attempting to shift the basis for the required judgement on society or on one's caregivers in the following manner: 'The resources being used to take care of me, the familial strife that my being kept alive will engender, and my caregivers' burdens could be alleviated if treatment were stopped for me should I become incompetent. So, if I am ever in an incompetent state, stop life-sustaining treatment.' The predicted extension of autonomy which underlies the typical rationale for involving ADs is, in this context, greatly compromised for two reasons. First, given the nature of this statement, a positive change in one's social environment

appears to carry with it the force of a *veto* with respect to the AD outcome toward which one was originally inclined and this may, thereby, compel one to be kept alive indefinitely in contradiction to one's otherwise originally explicitly stated wishes. Second, why is *the patient* the best judge of any of *this*? Surely he or she is not. Such a decision (perhaps formed in conjunction with the patient, perhaps not) severely compromises the intended degree of autonomy patients typically expect in these contexts.

There are, to be sure, routes to the making of AD judgments which do not suffer from the above liabilities, but these paths are not commonly travelled if only because they appear to be somewhat circuitous. Consider, for example, the following: Suppose that Jones believes that *all* human persons who are incompetent with respect to treatment decisions *ought* to receive a certain standard of treatment, that Jones is a human person in the specified incompetent condition, and that Jones ought to receive the treatment specified *because* he is a human person in this incompetent state. Then, it seems, if there were no good *independent* reasons for not treating Jones, while incompetent, in the manner specified, his caregivers ought to treat him in the specified manner. The AD judgement in this context is the conclusion of a valid deductive argument, *not* the confused output generated by perspectival incoherence.

Some Orthodox Jews, for example, believe that all innocent human beings ought to be kept alive indefinitely. He who believes this and who believes himself to be a live human and who believes that his life ought to be preserved indefinitely *for* this reason (*and* in the absence of good independent reasons for the foregoing of life-sustaining treatment), *can* properly convey to his caregivers how he would like to be treated in the circumstances specified.<sup>16</sup>

But how often is *this* sort of justification actually offered as the basis for AD decisions? Probably quite rarely. Typically (at least in the US) one's individual autonomy is forcefully asserted in the following manner: 'I have no view on what *other* people *ought* to do while incompetent; that's their business. I just know what *I* would want *for me* should I ever become incompetent;' or, 'People should be able to be treated any way in which they specify should they become incompetent; I can't make that decision for them; they've got to make it for themselves; I only know what *I* now want with respect to some future state I may be in.'

Neither of the above assertions is of any use in helping us ascertain on what authoritative *grounds* the treatment specified is being advanced by Jones over some *other* treatment specification.

For, again, not just *any* vocalization which *appears* to be a reflective authoritative treatment specification is acceptable in this domain. Only *autonomously* generated treatment specifications are acceptable. At least, that is *supposed* to be the idea. So, seizure-generated vocalization, psychotic outbursts, and baldly incoherent rationalizations appear to be categorically impermissible in these contexts.

## II

The conceptual problems concerning ADs to which I have alluded may be further reinforced by a variety of other criticisms of the AD strategy chronicled in philosophical

and legal literature. One of the most important contributions to this corpus has been made by Allen E. Buchanan and Dan Brock (1989). Buchanan and Brock raise questions about the moral authority of ADs by critically exploring the following central presupposition that appears to undergird the AD strategy: 'If, as the courts and most bioethicists now agree, the competent individual has a virtually unlimited right to refuse treatment, even life-sustaining treatment, then the same choice ought to be respected when a competent individual makes it concerning a future decision situation through the use of an advance directive.'<sup>17</sup>

Specifically Buchanan and Brock present five reasons for having serious reservations about the propriety of accepting this presupposition, four of which concern certain significant morally relevant *asymmetries* between the present treatment choice of a competent person and those AD treatment specifications which govern future treatment decisions. (Similar concerns have been raised by Rebecca Dresser.<sup>18</sup>) The first of these asymmetries involves the possibility of unforeseen therapeutic advances which may significantly impact one's prognosis and, hence, which might have promoted a radical alternation in the direction of one's treatment had this advance been known at the time the AD was drafted.

Second, requests to withhold treatments of various sorts may be made without a clear understanding of the myriad circumstances in which these treatments may be indicated, some of which—unbeknownst to the individual drafting the AD—may result in a significant therapeutic benefit.

Third, an individual's interests (i.e., whatever it is that one believes would contribute to one's good) while incompetent may change in such radical and unforeseen ways that his or her capacities for leading a satisfying life may also significantly change. For example, 'Just as it might be difficult for an executive to appreciate the value of life of the confused, incontinent, socially isolated elderly person who lies about a filthy home, surrounded by thirty wailing cats, so a competent individual may fail to appreciate the value of his or her own future life under greatly altered conditions.'<sup>19</sup>

Fourth, certain important informal safeguards that are operative during the decision making process by a competent person (e.g., initial opposition to a competent person's decision to forego life-sustaining treatment by concerned family members) are unlikely to be optimized in the process of drafting an AD.

Buchanan and Brock's fifth concern relies upon arguments concerning the metaphysics of personal identity elaborated by Derek Parfit.<sup>20</sup> Parfit has vigorously argued that psychological continuity is a necessary condition for personal identity over time and, hence, that some patients who have undergone serious neurological impairment (e.g. advanced Alzheimer's disease or the persistent vegetative state) are different *persons* from those previously competent persons who drafted the ADs. Certainly, in this or any other case, *one person's* AD could not properly be applied to *another*.

It is significant to point out, first, that Buchanan and Brock themselves do not see these asymmetry consideration as posing a significant threat to the propriety of the general AD strategy. They claim, in fact, that 'It seem unlikely ... that many cases will arise in which the special

limitation on the moral authority of advance directives should actually come into play ... Therefore, acknowledging in principle the special limitation on the moral authority of advance directives need not undercut the authority and usefulness of these directives in general. At least in the great majority of cases, those in which following the advance directive would not be clearly contrary to the patient's most basic interests, an advance directive, like the contemporaneous choice of a competent patient, can provide a justification for withholding any form of life-support[.]<sup>21</sup>

Second, note that neither Buchanan and Brock (1989) nor Dresser (1986, 1995) question the *intelligibility* of typical ADs, either in the context of raising their Parfitian metaphysical concerns or in those allegedly rare cases in which the aforementioned asymmetries obtain. Rather, they are concerned with the authority of justification for acting in accord with AD documents which, antecedently, have been judged to be intelligible.

### III

There remains yet another deep problem with how ADs are presently understood, namely, despite appearances to the contrary—and despite the vigorous protestations to the contrary by many AD proponents—AD legislation has in effect already legalized both (assisted) suicide and other forms of homicide in the US. This gives those of us who find such practices morally repugnant good reason, *independent* of previously adumbrated considerations, for opposing the AD strategy as it is presently being deployed.

The plausibility of this objection depends on the plausibility of the claim that employing so-called *passive* processes (i.e., the withholding or the withdrawing of treatment) in order to bring about the death of an innocent person, no matter what the circumstances, is immoral, even in those cases in which the treatments that are withheld or withdrawn are judged to be futile. This is not to say that such passive killing has moral parity with active processes driven by the same intention. Insisting on such parity appears to have led to deep confusion in the contemporary euthanasia debate.<sup>22</sup> For suppose that there is no such parity. It does not follow from this that it can be a *good* thing sometimes to intend the passive death of an innocent human. For it is compatible with this lack of parity that, of necessity, *all* intended human deaths, including intentional deaths that are passively effected, are morally evil, yet of a variety of evil that is incommensurate with, or simply not as serious as, the correlative intentional deaths that could have been *actively* effected.

If it is the case that all intentions to bring about the deaths of innocent human beings are immoral, then clearly at least *some* persons who sign ADs are participating in the bringing about of such deaths. For it is uncontroversial to point out that at least some patients sign ADs with the intent that the withdrawal or the withholding of care terminate in their deaths, and that at least some health care workers withdraw or withhold treatment *in order* that patients should die. I do not say that all deaths that result from actions<sup>23</sup> performed in accord with ADs are intended, but merely that these documents both lend themselves to be used in

this manner and have been used in this manner. But the important point is that there is no explicit attempt made in the crafting of medical directives, and no explicit training for those who are designated to secure and execute them, to *prohibit* their execution in the event that the person who procures the AD document has good reason to think that such homicidal intentions are operative.

I am not suggesting here the dissolution of the 'killing-letting die' distinction. No matter how difficult it is to make out, it appears clear to me that there is such an action-theoretic *metaphysical* distinction. What I am emphasizing is the *moral* kinship between intentional killing and intentional letting die. We are often distracted from appreciating this kinship in virtue of the sheer numbers of people that we let die each day. By not giving \$100 to a relief agency, we have all allowed some people to die today. But surely we are not all morally responsible for untold numbers of deaths on a daily basis. Perhaps some of us are, if some of these deaths were deaths that we had intended (and if some of these omissions were to have consequences for which we can be morally responsible). But, surely, the most of these deaths are not intended by us.

Ironically, the tables are often turned in the contemporary euthanasia arena. Although it is rare for someone to refuse to give money to charity *in order* that others might die, it is, in all probability, *not* so rare for some person S to fill out an AD because S feels that he 'would rather die than to live like *that*', or for the carer of S to withdraw treatment '*in order* that S may die'.

We must not confuse unintentional killing with intentional killing and unintentional letting die with intentional letting die. Traditional discussions of what is called the killing-letting die distinction in the western medical arena have often conflated these four notions into two. It is then often argued that letting patients die (*via* the withholding or the withdrawal of care) is morally permissible but that killing them is not. But in the context of actual western medical practice, the aforementioned pairings are often mismatched. Those patients that *are* killed by their health care providers are typically killed *unintentionally* (for example, by way of a mistaken prescription, or the slip of a surgeon's scalpel). And in the *many* cases in which treatment is withdrawn or withheld, it is not uncommonly intended for the patient *to die* as a result of this. (I appeal here to what I know about how medical staff have often proceeded on medical wards where I have cared for patients.) There is good reason, then, to think that *many* medical killings and *many* medical lettings die are morally permissible and morally impermissible, respectively, *not* the other way around.

One thing that the modern euthanasia movement is attempting to do is to introduce into the medical arena a *kind* of killing that has not heretofore been an accepted part of western medicine, *that is, intentional killing*. This is rightly being resisted, but often only at the expense of overemphasizing the allegedly normative nature of letting patients die in the western medical tradition. But, again, as currently practised in western medicine (again, at least in my experience), we not uncommonly tolerate (and even encourage) the withholding or the withdrawing of treatment *so that* patients die. But this is precisely what we ought *not* do.

Daniel Callahan's recent comments concerning the



moral import of the 'killing-letting die' distinction exemplify many of the confusions to which I have already alluded.<sup>24</sup> Partly as a result of these confusions (in spite of the other virtues of his piece) nearly all of his attempts to lend clarity to the issues central to this debate fail.

Callahan claims that in its broad implications, the eradication of the moral distinction between killing and letting die would imply:

That death from disease has been banished, leaving only the actions of physicians in terminating treatment as the cause of death. Biology, which used to bring about death, has apparently been displaced by human agency. Doctors have finally, I suppose, thus genuinely become gods, now doing what nature and the deities once did.<sup>25</sup>

That this is the implication to be drawn here is not at all obvious. This can be shown in at least two ways. First, Callahan has failed to demonstrate that his interlocutors are committed to the thesis that treatment omissions have any *causal* consequences at all. If omissions have no causal consequences, then clearly physicians' treatment omissions do not cause any deaths at all. There is, in fact, a live controversy in contemporary philosophical literature concerning whether or not failures to act do actually have causal consequences.<sup>26</sup> Of course, if one person intentionally allows another person to die (by, for example, intentionally refraining from doing something which would have been sufficient to preserve that person's life) this would be immoral *only if* the intentional refraining was the *cause* of the other person's death. And, of course, even if omissions have no causal consequences, it would not follow that they could not be immoral. Thus, if at a certain time someone refrained from effectively treating a dying patient, so that that patient died at a later time might the action be immoral even if it were the case that refraining from treatment at the earlier time in no way causally contributed to the patient's death later?

Second, there need not be any *displacement* here. Suppose that refraining at a certain time actually did causally contribute to the patient's later. Surely more than one cause (or causal contribution) can have a single effect, as when, for instance, (borrowing a common example from medieval literature) two men cause the movement of a boat by pulling it with ropes. Perhaps such *concurrent* (or *co-operative*) action is precisely what is at work in these cases. Perhaps the action of nature *and* the treatment-terminating (or treatment-withholding) actions of physicians *co-operate* to effect the death of the patient.

Callahan suggests that the principal confusion in this debate lies in the failure to appreciate differing conceptions of causality (specifically, differing conceptions of when something counts as a direct physical cause of death) and differing conceptions of culpability. He surmises first, that it is a mistake to think that a physician's action of stopping treatment can be a *cause* of one's death, for 'the physician's omission can only bring about death on the condition that the patient's disease will kill him in the absence of treatment;<sup>27</sup> although, perhaps, we might rightfully 'hold the physician morally responsible for the death, in the case of omissions, we do not cause death even if we may be judged morally responsible for it'.<sup>28</sup>

This is very puzzling. What, precisely, is Callahan trying

to say here? Is he implying that one can be morally responsible for some states of affairs without making any causal contribution at all to them? This claim, made without any accompanying argument to make it plausible, seems incredible. *How* is one *responsible* for a state of affairs A in this context if one is not somehow *causally* responsible for A? I do not say that this is *impossible*, although perhaps it is. All I say is that Callahan owes us an explanation here, but unfortunately, no explanation is forthcoming.

We normally hold people morally responsible for certain omissions in certain circumstances; in addition, we sometimes do claim that such omissions were the causes of those states of affairs for which we hold people responsible. When asked what caused the wreck of a train, for example, we find perfectly intelligible the explanation that it was caused by the rail-switcher's failure to switch the rails; similarly, it is clear what is meant when one is told that a physician negligently caused a patient's death from status asthmaticus due to failure to administer beta-agonists and corticosteroids. In these two cases, judging by our ordinary linguistic practices, it at least appears that failures to act can make causal contributions to the states of affairs in question in virtue of the fact that these failures appear to play causal roles in the structuring of those states of affairs. Such failures to act appear to be pivotal in suppressing *other* causal contributions which would have significantly altered the outcome and, hence, appear to play an essential role in any *complete explanation* of the states of affairs in question.

Callahan further argues that:

[a] lethal injection will kill both a healthy person and a sick person. A physician's omitted treatment will have no effect on a healthy person. Turn off the machine on me, a healthy person, and nothing will happen. It will only, in contrast, bring the life of a sick person to an end because of an underlying fatal disease.<sup>29</sup>

But how is any of this relevant? First, Callahan's illustration does not involve a genuine treatment *omission* (i.e., an intentional refraining or a failure to act without refraining). The physician in Callahan's example does not omit to act, rather, he *does* perform what is uncontroversially a non-refraining (exterior) *action*, that is, turning off a machine. Second, consider a dose of a poison which will kill all people who have end-stage liver failure, but would have no effect at all on healthy people. Give this poison to me and nothing will happen. It will, in contrast, bring to an end the life of Mr. Jonesian (who is, sadly, afflicted with end-stage hepatitis). Clearly, it does not follow from this that my intentionally administering an amount of this poison to Jonesian is of no moral significance, or that I would not be morally responsible for Jonesian's death simply in virtue of the fact that the administration of the poison to *me* would have no effect. Yet Callahan appears to be committed to the claim that this *does* follow.

Callahan goes on to warn us that:

If we fail to maintain the distinction between killing and allowing to die ... there are some disturbing possibilities. The first would be to confirm many physicians in their already too-powerful belief that, when patients die or when physicians stop treatment because of the futility of continuing it, they are somehow both morally and physically responsible for the deaths that follow.<sup>30</sup>

But *is* this a genuine possibility? Perhaps, but note that the only way that this actually *would* confirm any such belief is if physicians *already* held the *mistaken* belief that stopping a patient's treatment and *not* intending that person's death is in every case immoral. But why would they think this? Might they not adequately appreciate (as Callahan appears not adequately to appreciate) the potential moral gulf between, for example, withdrawing treatment without intending the death of a patient and withdrawing treatment *in order that* the patient should die?

This is not an unreasonable interpretation of the situation in light of Callahan's other doomsday prophecies predicted on the abolition of the moral distinction between killing and letting die, for instance, in light of his statement 'that, in every case where a doctor judges medical treatment no longer effective in prolonging life, a quick direct killing of the patient would be seen as the next, most reasonable step, on grounds of both humaneness and economics'.<sup>31</sup> But surely this would be a remote possibility in those contexts in which intending the death of *any* human being—whether or not the intended death is active or passive—is readily recognized as being always and everywhere morally impermissible.

#### IV

My discussion thus far has been entirely negative. I have outlined reasons for being deeply suspicious of ADs on logical, semantic, metaphysical, epistemological, and moral grounds. How then ought we to proceed? Ought we abolish *all* ADs?

This is a difficult question but I am inclined to answer it in the negative, principally because it is *possible* properly to compose an AD and, in fact, some ADs *have been* properly composed (e.g., some of those composed by Orthodox Jews). But there is good reason to believe that properly composed documents of this type are in a distinct minority. Clearly, an AD composed while in the grips of conceptual incoherence or one that is composed with the intent that one die by whatever means should be disregarded. I suspect that the percentage of AD decisions in this disjunctive class is quite high. If this suspicion is accurate, what then? What is the alternative?

My preliminary suggestion is a simple one. Assign to each patient who is either unwilling or unable properly to compose an AD a group of *guardians* in much the same way that guardians are sometimes assigned to severely disabled infants. The role of the guardians would not be to decide the 'life or death' question. Rather, all members of this group would be chosen partly because they share the following conviction: one ought never to intend (either actively or passively) the death of an innocent human being. In one important sense, the 'life or death' question is thereby decided beforehand. What is needed then from the guardians is a set of judgements concerned with the continuing, withdrawing, or withholding of treatment.

How ought these guardians to be chosen? First, as noted above, they ought to be persons who are convinced that intending the death of innocent humans is to be avoided at all costs. Second, they ought to be deemed wise in other human matters as judged by the historically entrenched

canons of wisdom of the communities from which they arise. Third, they ought to possess those intellectual virtues necessary for appreciating some of the complexities of medical patient management, treatment, prognosis, etc. (A select group of physicians would be ideal guardians in this regard.) Last, they ought to have at least a rudimentary theoretical understanding of ethical discourse.<sup>32</sup>

The collective judgement of such groups of decision makers who together possess the wisdom and accompanying other-regarding virtues to a degree which the patient (at least at the time) happens to *lack*, would thus assist patients by preventing them from making potentially critical decisions in a *non*-autonomous manner. Such groups of guardians would, in this manner, secure what is one of the principal goals of the AD strategy. Perhaps in this way, the (presently broken) relationship between autonomy and rationality, at least as it relates to decision making concerning incompetent, medically ill persons, would thereby dare to be reconsummated.<sup>33</sup>

#### References

1. Strictly speaking, the term 'life-sustaining' ought to have been omitted from this characterization. Clearly, one can construct an advance directive that says nothing about *life-sustaining* treatment.
2. Singer Peter A., et al., 'Advance directives: Are they an advance?' *Canadian Medical Journal* 146(2) (1992), pp. 127-34.
3. 'Are advance directives an advance? We believe that they are. However ... they contain limitations. Having identified and addressed some of these limitations we hope that the introduction of advance directives in Canada will proceed with due caution.' (Singer et al (1992), p. 134).
4. The Patient Self-Determination Act of 1990 was enacted as Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508 which requires all Medicare and Medicaid provider organizations to inquire about whether or not patients have yet composed ADs.
5. I am not alone in having reservations about the general AD strategy. See, for example, Allen Buchanan 'Advance directives and the personal identity problem', *Philosophy and Public Affairs* 17(4) (Fall 1988), pp. 277-302; Buchanan, Allen E. and Brock, Dan W., *Deciding for Others: The Ethics of Surrogate Decision Making* (New York: Cambridge University Press, 1989); Dresser, Rebecca, 'Dworkin on dementia: elegant theory, questionable policy', *Hastings Center Report* 25 (1995) pp. 32-38; Jessiman, I.M.C.D., 'BMA division disagrees with association's stance over advance directives', [letter] *British Medical Journal* 312 (30 March 1996) pp.850-851; Peppin, John F., 'Physician neutrality and patient autonomy in advanced directive decisions', *Issues in Law and Medicine* 11(1) 1995, pp. 13-27; Robertson, John A., 'Second thoughts on living wills', *Hastings Center Report* 21(6) (1991), pp. 6-9; Ryan, Christopher James, 'Betting your life: an argument against advance directives', *Journal of Medical Ethics* 22 (1996), pp. 95-99; Short, David, 'A physician's misgivings regarding the advance directive', *Ethics and Medicine* 9.1 (1993), p. 1; and Stone, Jim, 'Living wills, autonomy and unintended death', *APA Newsletter on Philosophy and Medicine* 90(3) (Fall 1991), p. 41.
6. Singer et al., (1992), p. 138.
7. The sort of freedom which is most commonly invoked in this context is freedom in the *libertarian* sense according to which person S is free with respect to action A at time t if S freely performs A at t and S is not determined to perform A at t.
8. This 'no grounds' objection to there being any non-vacuously true counterfactuals of freedom has been advanced by (among others) Robert M. Adams in his 'Middle knowledge and the problem of evil', *American Philosophical Quarterly* 14 (1977), pp. 109-17, and his 'An anti-molinist argument', *Philosophical Perspectives* 5 (1991), pp. 344-53; and by William Hasker in his *God, Time, and Knowledge* (Ithaca: Cornell University Press, 1986).
9. Where states of affairs are represented by italicized (or underlined) clauses with the following grammatical structure: *Xs being Y*. This state of affairs is said to *obtain* if and only if it is *true* that Xs are Y.
10. A similar point is made by Buchanan and Brock (1989).
11. The term 'cognitively inert' is meant to convey an absence of *all*

cognitive processes whether conscious or unconscious. I phrase this supposition in this manner for the simple reason that I do not believe that one's being comatose is incompatible with one's possessing conscious awareness. I argue for this thesis in 'Philosophical reflections on coma', *Review of Metaphysics* 47 (June 1994): pp. 735-755. For a more thorough-going, specific critique of contemporary views held by the vast majority of medical 'experts' concerning the mental life of persistent vegetative state patients, see my 'The 1994 Multi-Society Task Force Consensus Statement on the Persistent Vegetative State: A Critical Analysis', *Issues in Law and Medicine* 12(1) (Summer 1996), pp. 3-29.

12. David Lewis, in *Counterfactuals* (Cambridge, Mass.: Harvard University Press, 1973), and others have discussed only counterfactuals with impossible antecedents. Lewis calls these conditionals 'counterpossibles'. I call them 'antecedent-counterpossibles' in order to distinguish them from 'consequent-counterpossibles', reserving the term 'counterpossibles' to refer to the entire set of antecedent and consequent counterpossibles.

13. See the attempt by Linda Zagzebski to make intelligible a semantical scheme for counterpossibles in an impossible world framework. ('What if the impossible had been actual?' in *Christian Theism and the Problems of Philosophy* (Ed. Michael D. Beaty [University of Notre Dame Press: Notre Dame, 1990], pp. 165-83.) I am not convinced that any such attempt is doomed to fail. Still, the problem is not only metaphysical in nature, but epistemological also. Even if counterpossibles were truth-valued, how are patients supposed to access their truth values?

14. An informal poll taken by Richard McCormick ('Clear and convincing evidence: the case of Nancy Cruzan', *Midwest Medical Ethics* (Fall 1990), suggests that most people do find the prospect of being in such a state aversive.

15. See Thomas Nagel ('What is it like to be a bat?') *The Philosophical Review* 83 (1974): 435-51 for a seminal discussion of the role of knowing what it is like in our mental lives.

16. See, for example, the Federation of Jewish Philanthropies of New York's *The Compendium of Medical Ethics* 6th ed. (New York: Federation of Jewish Philanthropies of New York, 1984) in which it is implied that the preservation of human life under the stated conditions is *always* of great value.

17. Buchanan and Brock (1989), p. 152.

18. See Rebecca Dresser, 'Life, death, and incompetent patients: Conceptual infirmities and hidden values in the law', *Arizona Law Review* 28 (1986): pp. 379-81.

19. Buchanan and Brock (1989), p. 106.

20. Derek Parfit, *Reasons and Persons* (New York: Oxford University Press, 1986).

21. Buchanan and Brock (1989), p. 108-9.

22. See, for example, James Rachels' insistence that *ceteris paribus* there is no morally relevant difference between killing and letting die in his 'Active and passive euthanasia', *The New England Journal of Medicine* 292, no. 2 (9 January 1975): 78-80. He goes on to argue that killing human beings is preferable to letting them die in some instances.

23. I am using the term 'actions' to include *refrains*. When one intentionally refrains from action A, one is performing another action B, where B is a refraining from A. It would be a mistake to think that by so refraining one is performing no action at all.

24. Daniel Callahan, 'When self-determination runs amok', *Hastings Center Report* (March-April 1992): 52-5.

25. Callahan, 53.

26. See, for example, Elazar Weinryb, 'Omissions and responsibility', *Philosophical Quarterly* 30, no. 118 (January 1980): 1-18, and John Martin Fischer, 'Responsibility and failure', *Proceedings of the Aristotelian Society* 86 (1985-6): 251-72. Callahan concurs with Weinryb here (but probably for different reasons) in thinking that omissions have no causal consequences.

27. Callahan, 53.

28. Callahan, 53. Presumably, Callahan means that such a judgement of moral responsibility would be *appropriate* in spite of the fact that we are not a *cause* of the patient's death.

29. Callahan, 53.

30. Callahan, 53-4.

31. Callahan, 54.

32. This list is, at best, partial and, hence, is deserving of future reflection.

33. I am grateful to Douglas K. Blount, Thomas P. Flint, and W. David Solomon for helpful comments on earlier drafts of this essay. An earlier version of this essay was presented in May 1994 at an international conference on bioethics at Trinity Evangelical Divinity School in Deerfield, Illinois.

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# The Health Care Institution-Patient Relationship: A Paradigm Lost

## Introduction

The origin of our present day hospitals and hospices lies in the Byzantine Empire through the Orthodox Christian Church. The Byzantine Empire was a community of 'moral friends'.<sup>1</sup> They were a community with shared values which included a belief in respecting and protecting vulnerable patients. Numerous forces and factors have caused a dramatic shift to a secular moral foundation for a vast majority of hospitals today. Many of these same forces have profoundly changed the traditional understanding of the patient-physician relationship. As the strength of the patient-physician relationship wanes, other relationships

are taking new prominence. The patient-institution relationship is rarely discussed in relevant literature but it has become an important factor in defining relationships with patients.<sup>2</sup> The patient-institution relationship has a strong economic focus that will only increase as financial constraints continue to build. Although that relationship has an economic focus, it does not follow that such an economic model is necessarily less moral, less ethical or less focused on patient care. However, we should be concerned, especially those of us who are Christian health care professionals, with the developing ethos of current health care institutions. The pressure to decrease spending and improve profits will not abate and in fact will become

stronger as managed care organizations assume greater power in medical care; clearly it is cheaper to euthanize and abort potentially expensive 'customers'. As Christians, our response to this problem may be limited. Political approaches are problematic since they are based on the attainment of a political power base rather than on moral authority. Establishing and managing distinctly Christian health care institutions is also problematic because of the very high costs involved. Christians must start thinking ecumenically when it comes to health care institutions. The Roman Catholic health care system may be our last chance for maintaining a truly Christian health care system in this current post-Christian age. Focusing and strengthening this system may be our last hope. Without health care facilities which express Christian values, health care professionals may be in the untenable position of having licenses predicated on performing cost-saving procedures, such as euthanasia, physician-assisted suicide and abortion. In the future, without a Christian health care system, and since we cannot convince a post-Christian society of the merits of Christian morality, we may find ourselves practising a very different kind of medicine, perhaps in monastic settings.

### Evolution of a Relationship

For hundreds of years health care institutions in the East and West were clearly Christian in their values and approach to patients. 'Modern hospitals trace their origins, and even their name, not to Indian treatment centers, Greek asklepieia, or Roman valetudinaria but to the hospices and hospitals established by the Christian church during the late Roman Empire.'<sup>3</sup> In AD 370 St. Basil of Caesarea opened a hospital in Asia Minor where physicians and nurses treated patients free of charge and St. John Chrysostom, in AD 390, supervised the hospitals of Constantinople. During the fourth century the Orthodox Christian Church built and maintained hospices. Enlightenment scepticism propagated the myth that these institutions were poorly equipped, poorly manned and offered minimal care; however, nothing could be further from the truth.<sup>4</sup> Although, from their inception these hospitals were designed for treating the poor, they were very sophisticated and employed the best physicians of their day.<sup>5</sup> By the 12<sup>th</sup> century the Byzantine hospital, Pantokrator Zenon, had five specialized wards, 17 physicians, 34 nurses, 11 servants and a pharmacy.<sup>6</sup> The wealthy used these hospitals in stark contrast to the West where hospitals for the poor and destitute were shunned except by those who had no other alternatives.

It was the Byzantine empire, and the Orthodox Christian Church, that developed the concept of the modern day hospital in an atmosphere of Christian values and Christian charity. Unfortunately Enlightenment philosophy has had a tremendous impact on the structure and function of today's hospitals. Hospitals under the medical advance of western Europe and the banner of 'scientific medicine' began to pull away from their religious underpinnings and detach themselves from the 'superstition' of religion.<sup>7</sup> The marginalization of Christianity has not been restricted to the secular realm but has also come from within the Christian Church itself. Concerning the erosion of Christians' private morality Eliot, in 1940, made the

prophetic comment, '[A]s for the Christian who is not conscious of [this] dilemma—and he is the majority—he is becoming more and more de-Christianized by all sorts of unconscious pressure: paganism holds all the most valuable advertising space.'<sup>8</sup> Further marginalization comes from recent attempts to develop and aggressively implement a Christian political morality, *vide infra*.

Although many of us may lament the loss of institutions with religious values, those in the secular arena do not see the need for maintaining religiously oriented medical institutions and find the notion archaic. Today there are few hospitals which openly declare Christian values and most of these are within the Roman Catholic health care system.<sup>9</sup> Yet even these institutions are slowly becoming secularized. In Holland, for example, patients are blessed by Catholic priests before being euthanized at State-controlled Catholic hospitals.<sup>10</sup> *Prima facie* it is clear that institutions such as those we have been describing have a distinct ethos. It also seems obvious that secularization has had a powerful impact on the values to which hospitals adhere, from Christian to secular, from deontologic to relativistic, from virtue to something else.

As Starr pointed out in 1982, the radical transformation of medicine and medical institutions we are currently witnessing 'may prepare the way, moreover, for ... the rise of corporate enterprise in health services, which is already having a profound impact on the ethos and politics of medical care as well as its institutions'.<sup>11</sup> The medical-industrial complex has become the power behind medicine in the late twentieth century and the current driving force behind medicine in the United States is financial.<sup>12</sup> Although there are numerous economic models of relationships with patients, not all of them necessitate unethical and immoral actions. For example, in Houston, Texas, at Methodists' Hospital, there is an entire floor established for VIPs with high *per diem* charges. The profits from this type of service allow Methodists' Hospital to provide care for the indigent and the poor.<sup>13</sup> Although many critics of the economic model suggest that the trust given to physicians by patients will be irreparably harmed with the institution of an 'economic model' this is not so evident.<sup>14</sup> There is no reason why patients cannot develop trust in an institution, rather than an individual physician, and there is no reason why a focus on economics is unethical in and of itself. But this shouldn't be our concern. If a patient trusts an institution to provide quality care and to act in his/her best interest and that institution saves money in the process why should this cause us consternation? Christian health care institutions must save money no less than any other health care institution. As Christians we are stewards of the resources given us by God. This implies a profound responsibility to eliminate waste and to use our resources appropriately.<sup>15</sup> However, when the efforts to save money are built on a post-Christian value structure this should cause us great concern. As costs continue to increase, the pressure to limit care, especially for those who cost the system the most money (i.e., the elderly, the chronically ill, the infirmed, the disabled, and the mentally retarded) will be overwhelming. Euthanasia, physician-assisted suicide and abortion will all be much more attractive cost saving options. So, although the patient-physician relationship has changed, and perhaps has become archaic, this in itself

should not be our major concern. Institutions have large political and financial power bases. Combine this power base with financial constraints and a post-Christian value structure and we have a very dangerous combination. Vulnerable patients will be at the mercy of cost conscious hospitals who will eliminate them as a cost saving measure. Business ethics is not currently in a position to replace medical ethics and provide a framework where vulnerable patients can be protected.

It is important not to overlook the dramatic societal changes that have impacted the patient-physician relationship over the last few decades. Our society has become extremely mobile especially in large metropolitan areas. Physicians, no less than anyone else in our society, are also very mobile, perhaps more so because of their financial and societal position. What we have then, is a society where the previous concepts of the patient-physician relationship do not apply. Patients do not continually see the same physician over years of time. For physicians to follow patients from birth to death, seeing them grow up, marry, delivering their children, etc. is an exception to today's rule. As multi-specialty groups grow, urgent care facilities develop and Hospitalists become more prevalent a patient may see literally hundreds of different physicians in a life time.<sup>16</sup> Therefore, if it takes time to develop a traditional patient-physician relationship, what we have is a fragmented relationship at best. The patient-physician relationship as presented by Pellegrino and others is, unfortunately, an archaic notion and more myth than fact.<sup>17</sup> The development of trust as a foundational component of the patient-physician relationship may no longer exist in any traditional sense. Loyalty to a hospital where 'I have always been treated well' is more common than loyalty to an individual physician. Since physicians and other health care professionals are in a state of flux the patient focuses on a building, a solid structure that will not move or change locations. They put their trust in the potential stability of the institution. This is where the patient-institution relationship begins to develop.

Health care institutions are more stable from the perspective of both the patients and society. One may change jobs, homes, health insurance and physicians, yet keep the same hospital and clinic.<sup>18</sup> Further, our basic societal structure would belie the traditional view of the patient-physician relationship. As May suggests, 'we live in a society of strangers'.<sup>19</sup> This is a concept upon which Engelhardt builds an entire medical ethic.<sup>20</sup> When all of these aspects of American society are taken into account it seems obvious that the view of the patient-physician relationship as facilitating trust through 'continuity of care' or years of relationship lacks credibility.

### **Institution-Patient Relationship**

Before we discuss the patient-institution relationship we should first look at what is frequently called the 'economic model' of relationships with patients. This model is frequently decried in relevant literature. 'We must resist the tremendous tendency within U.S. society to believe that the ideal solution for every complex social problem is the market and economic accountability'.<sup>21</sup> Yet it must be pointed out that economics have always been, and will

always be a part of medicine and caring for patients; Someone must pay the cost.<sup>22</sup> Even in the fourth century, St. John Chrysostom was well aware of this axiom, '[I]n the reception of strangers, and the care of the sick, consider how great an expenditure of money is needed, and how much exactness and discernment on the part of those who preside over these matters. For it is often necessary that this expenditure should be even larger than that of which I spoke just now, and that he who presides over it should combine prudence and wisdom with skill in the art of supply, so as to dispose the affluent to be emulous and ungrudging in their gifts'.<sup>23</sup> So paying for medical care cannot be the critics' major concern. As May further points out, '[M]oney motivates people, lubricates the movement of resources, mobilizes talent and breaks down some barriers, ... The Profession, at least in part, belongs to the world of money'.<sup>24</sup> As can be seen from St. John Chrysostom's earlier comment, money has been a part of medicine for hundreds of years. The problem, according to most critics is that, 'money distorts, as well as corrupts, distracts, and vulgarizes the professional relationship'.<sup>25</sup> But why would money do this in the twentieth century any more than it did in the fourth century? I think the answer lies in the basic moral foundations upon which the Byzantine society was built. Its members shared a common moral vision, a common religious truth: the truth of Christianity. Those values are non-existent today in any global sense. Critics are expressing, whether explicitly or implicitly, a concern about the basic value structure from which the economic model operates.

To Emanuel however, the economic model views patients as consumers and physicians, hospitals etc. as providers.<sup>26</sup> Just buying a dishwasher, consumers should compare costs between different providers. Successful providers attract more consumers and make higher profits. Although Emanuel sees the 'fundamental locus' in this model as between consumers and providers, this is becoming less and less obvious.<sup>27</sup> Health care institutions have become the 'locus' between consumers and providers or patients and health care professionals. Emanuel is well aware of the risk of the economic model taking precedence. 'Such a ruse/portraying physicians as caring professionals while forcing them to act like economic producers will ultimately discredit the entire practice of medicine and sow distrust and cynicism that cannot easily be overcome'.<sup>28</sup> Others however, such as Haavi Morreim, see health care institutions as having important and critical obligations to patients. 'There is good reason to regard managed care organizations as fiduciaries of patients'.<sup>29</sup> The term fiduciary was once reserved for professionals, such as physicians and attorneys. However, Morreim feels that health care institutions have a fiduciary relationship with the patients they enrol that is no different from that between physician and patient. This is a unique view and one that takes into consideration the evolving patient-institution relationship. Additionally, Morreim's article gives impetus to the view that business ethics is not in a position currently to provide protection to patients.<sup>30</sup>

### **The Christian Response**

It is fairly obvious that health care institutions have values that are acted out in numerous ways within the patient-

institution relationship.<sup>31</sup> The early Christian hospitals treated the poor freely out of love for Christ, basing their care on Christ's teaching: 'Truly I say to you, to the extent that you did it to one of these brothers of mine, even the least of them, you did it to me'.<sup>32</sup> Yet there was a much more intimate relationship with the physician, based on a strong shared value structure, which does not exist today. The only way to reinstitute this type of setting is through distinctly Christian health care institutions. Currently the patient-physician relationship is increasingly being trumped by that of the patient-institution interaction. As Starr further comments, 'the organization of medical care cannot be understood with reference solely to medicine, the relations between doctors and patients, or even all the various forces internal to the health care sector. The development of medical care, like other institutions, takes place within larger fields of power and social structure.'<sup>33</sup> Starr sees clearly that medicine has a number of what might be described as different layers each of which has its own set of values, the health care institution no less than the physician. Although, as some critics suggest, American patients generally wish to continue the classic model of accountability, in which they trust a physician to hold their patients' well-being above other concerns, this lacks evidential support.<sup>34</sup> Patients respond in a very normative way towards hospitals in their community, *vide supra*. They see the stability of a physical institution and will maintain their loyalty to that institution perhaps much more so than to specific individual physicians.

There are a limited number of possible approaches Christians have to the current focus on an economic model in a post-Christian value matrix. As Christians we may decide to organize and manage distinctly Christian health care institutions. These would, of necessity, be ecumenical with multi-denominational support. Christian physicians and nurses would be recruited and they would function in a Christian value structure and atmosphere. One can quickly see that a major problem with this approach is the cost which would be prohibitive, even if the petty squabbling of Protestant denominations was quelled.<sup>35</sup> Political approaches are also problematic since they are based on the attainment of a political power base rather than moral authority. In 1994 Guroian wrote: 'To justify Christianity because it provides a foundation of morality, instead of showing the necessity of Christian morality from the truth of Christianity, is a very dangerous inversion.'<sup>36</sup> Christianity is not beneficial, it is *true*; it is not just a good way of being, it is *truth*; it is not a system of politics it is a way of life; and it is not just a way of life but a way of life with God at the centre of our entire life. The truth of Christianity must be manifest in all that we do. We make a difference to society only through the life we live based on the truth of Christ and not through the politics we espouse or the power base we build. Lastly, as Christians from a plethora of denominations we could support the last remaining institution that maintains a semblance of Christian values, the Roman Catholic health care system. Christian physicians, nurses and other health care professionals should purposely seek employment in such institutions. Christian pastors could apply for chaplaincy positions and laypersons could help financially. Christians would then fortify this system and help to rebuild its Christian value base.

Since the Roman Catholic health care system is already in place it seems to be the most tangible response to the continued and fast eroding values in an economic model of health care. Without this system nothing Christian will remain of our American medical system.

If the Roman Catholic health care system becomes fully secularized or collapses, the question Christians would then need to address is their continued participation in a 'truly' post-Christian health care system. At this point in history this question may be only academic. Professional licensure may be predicated on performing procedures such as euthanasia and abortion or referring for such procedures. Those Christians who refused would no longer be allowed to practise medicine in any contemporary or technological sense. Christian health care professionals would need to retreat to isolated communities, to avoid legal entanglements, to care for patients. This would be our final recourse; a monastic type of health care.<sup>37</sup>

### Conclusion

Although early hospitals were distinctly Christian in their value structure, this religious foundation was not founded on political movements, but rather on the truth of the Christian faith. This foundation has been eroded until currently only the Roman Catholic health care system can be called Christian, though it exists only thinly in some locations. Institutions have values that are expressed in a number of ways and the fact that financial concerns have become paramount in our culture should not give us prima-facial concern. Neither should an economic model of a patient-physician or patient-institution relationship. However, combine this with the lack of a Christian value base for that relationship and we have a dangerous combination. Financial constraints will be strong enough to allow for euthanasia, physician assisted suicide and abortion as cost-saving measures. Christians have three possible options in response. They can develop their own distinctly Christian health care institutions, the cost of which would be prohibitive. They can engage in political action, although this is motivated by a desire for a political power base and not moral authority or the truth of the Christian faith. Current efforts at Apologetics may suffer from the same criticism. The only logical and timely response is to support the current Roman Catholic health care system both financially and pragmatically. With the continued erosion of Roman Catholic health care institutions Christian physicians may find their licenses predicated on performing morally repugnant procedures. Without a medical license the realm of technological medicine will be closed. We may yet find an avenue to care for patients in a more monastic setting. Patients would seek us out, as they do today, for spiritual as well as physical healing. Care would occur at the bedside, perhaps bringing us full circle to the more classical patient-physician relationship in a Christian setting.

Although the future may appear pessimistic, Christians have always been called to seek holiness, not morality or political power. Holiness should always be our primary objective and will ultimately bring a sagacious and lasting spiritual benefit to our patients and colleagues. If we really believe that spiritual health is important, this is where we

should place our focus. However, before we begin to provide direction in spiritual healing we must be on that path ourselves. 'The highest aim of man is to attain knowledge of God' and 'The healing of the soul, nous and heart leads a person to the vision of God and makes him know the divine life. This knowledge is man's salvation'.<sup>38</sup> Salvation of the soul has never been viewed as more important than saving one's body, at least in our western culture. With the implementation of a post-Christian health care system and the collapse of the Roman Catholic health care system, we may begin to place more importance on the infinite importance of a patient's soul.

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# Non-Treatment Decisions in the Care of the Newborn Infant

In this article I am considering the specialist care of newborn infants and the sort of questions which arise from different forms of treatment. I will seek above all to provide some background to the decisions which we face. These concern, first, the explosive advances in neonatal care and, secondly, the ethical and philosophical debate which undergirds these

issues. I would also like to talk about my own personal practice as a paediatrician at a major tertiary centre and the way forward for resolving, at least, some of the desperately difficult and painful issues in this area of medicine.

The very low birth-weight baby accounts for approximately 1% of all births. This means several thousand births

in England and Wales—and across the world a far greater number. Over the last thirty years there has been a quite dramatic explosion in the use of technology. Although, as Dr Nicholson rightly says, medical technology as a whole has not had a dramatic impact on survival in this particular group of infants, the introduction of technology has undoubtedly had a dramatic effect. The chances of survival of a very low birth-weight baby thirty years ago would have been approximately 20%. Now at major centres such as University College Hospital, London, the chances of survival are more like 80–85%. That change is mainly as a result of improvements in technology after birth, although not exclusively. There have been improvements in antenatal obstetric care as well.

But the question is: is it appropriate to provide intensive neonatal care in the case of all low birth-weight babies? In particular, the spectre of brain injury is a major concern. The statistics vary, but approximately 10–15% of all extremely low birth-weight babies will suffer permanent brain injury. The commonest cause for this is hypoxic-ischaemic injury—injury due to shortage of oxygen and blood supply. In addition there is haemorrhagic injury in the extremely pre-term baby.

Many medical groups, our group included, have been involved in long-term follow-up studies in order to improve our ability to obtain a prognosis, that is, to predict outcome from studies of the baby immediately after birth. One of the techniques we have used is cranial ultrasound. Newborn babies have an anterior fontanelle, the soft spot, through which it is possible to obtain good images of the brain with ultrasound. Even in very sick babies undergoing intensive care, it is possible to get good images of the brain. And a number of long-term prospective follow-up studies have shown that we are able to predict long-term outcome much more reliably than previously on the basis of ultrasound images. More high-technological methods, which I have been more particularly involved in, are also available. With nuclear magnetic resonance techniques it is possible to obtain very detailed information. Images of the brain can be obtained and also phosphorus spectra which allow us to assess brain energy metabolism. There is also another technique, called near-infrared spectroscopy which enables infra-red light to be passed through the brain as a means of determining brain oxygenation and perfusion.

The reason for emphasizing this is that as technology has advanced, so also has our ability to determine the severity of brain injury, and its likely prognostic significance within the first few days of life. There is no doubt that this trend will continue. This is a major research enterprise in which I and many of my colleagues are involved. The question is, as the information becomes more accurate and we are able to predict with a relative degree of accuracy the long-term outcome for any particular baby, how do we use this information in order to make decisions about intensive support?

To step sideways and refer to some of the philosophical background of these issues, I have been intrigued by a trend which is taking place among a group of philosophers. Basically, it involves redefining the newborn infant as a different category of being, compared with how babies have normally been viewed within medicine and society. John Harris from Manchester is a proponent of this view. He has said, 'Nine months of development leaves the human em-

bryo far short of the emergence of anything that can be called a person'. Peter Singer from Australia takes a similar view: 'When I think of myself as the person I now am, I realise that I did not come into existence until some time after birth.' Michael Tooley was the philosopher who initiated this concept of personhood. For Tooley, personhood is a question of having a 'continuing self'. A person is a being who is capable of understanding that they have a continuing self. The implication of this is that if you are not aware that you exist, then you have no continuing self. If you have no continuing self, then you have no rights, no individual rights, no ethical or legal rights of the kind that self-conscious persons in our society do. In particular, you have no right to life.

Singer points out that there are many non-human animals whose rationality, self-consciousness, awareness, capacity to feel, and so on, exceed that of a week old, a month old or even a year old human baby. According to him, an adult chimpanzee has more right to be described as a person than a newborn baby. In fact, many domestic animals would be persons on Singer's criteria. For, as far as animal psychologists can tell us, they have a much greater self-awareness than a term newborn baby, let alone an extremely pre-term baby.

This kind of thinking leads inevitably to the idea that ending the life of a new born baby is merely preventing the existence of a person. 'The decision to kill a newborn baby is no more and no less the prevention of the existence of an additional person than is the decision not to procreate.' Contraception and infanticide are ethically equivalent according to Peter Singer. That at least, is the implication of that particular quote. Both practices represent the prevention of a person's coming into existence. The path along this line of reasoning is a concept deriving from the utilitarian view of the world, namely that of the 'replacement infant'. If by killing a newborn baby we prevent a handicapped baby coming into existence, the parents can be encouraged to have another baby, who we hope will be normal. Since the replacement infant will bring much greater happiness into the world, the loss of happy life for the first infant is outweighed by the gain of a happier life for the second. The concept of the replacement infant is something that Singer and a number of like-minded philosophers have emphasized.

To step back historically, one of the quotes that I like comes from William Temple. 'If you don't know where you are going, it's sometimes helpful to know where you have been.' Interestingly, the debate about the status and the philosophical significance of the newborn baby is not a new debate. It has been going on for more than two thousand years. If you go back to the Graeco-Roman Classical era, the most ancient text book of gynaecology, written by a Roman physician, Soranus, in the first century AD, has a chapter called 'How to recognise the newborn that is not worth rearing'. This chapter concerns a remarkably modern-sounding neonatal examination. 'The newborn should be carefully examined to ensure that it is perfect, in all its parts, members and senses. That its ducts, namely the ears, nose, pharynx, urethra, and anus are free from obstruction, that the natural functions of every member are neither sluggish nor weak, and so on. By conditions contrary to those mentioned the infant not worth rearing is recognised.'



To summarize, an interesting body of historical scholarship relating to that era, the Graeco-Roman ethical tradition viewed newborn babies as having potential value for the future but little or no intrinsic value compared with adults. Thus, if a baby was sick or pre-term or abnormal in some way, its value for the future was reduced. Within the Graeco-Roman ethical tradition there was no general ethical duty to protect the defenceless and the vulnerable. Therefore, within that tradition intentional killing of abnormal babies was seen as both rational and morally acceptable. In fact, the Graeco-Roman classical philosophical tradition supported infanticide on eugenic grounds and on the basis of limited potential to contribute towards society.

It is interesting that within the Jewish nation, and then within the Judaeo-Christian tradition, a quite different perception of the newborn infant was current. Tacitus, who wrote frequently on the bizarre habits and beliefs of other nations, wrote with a faint air of astonishment that the Jewish people regard it as a crime to kill any recently born child. Philo of Alexandria, writing as an educated Jew wrote, 'Infanticide undoubtedly is murder, since the displeasure of the law is not concerned with ages but with the breach to the human race.'

The Judaic tradition came initially from the Torah. It sprang from the concept of the 'Imago Dei', the idea that every human being was a unique being made in God's image. And the intentional killing of a being made in God's image was regarded as in some sense a desecration of the unique image of God. To summarise the Judeo-Christian ethical tradition, all newborn babies are unique beings who bear the image of God. Hence their status and value have nothing to do with their future potential. It is intrinsic. In addition, we must remember the Judaeo-Christian concern to protect the defenceless and the vulnerable within society, the child, as well as the slave and the orphan, the widow and the immigrant. It was considered a social duty to protect those who were defenceless and vulnerable. Within that Judaeo-Christian tradition intentional killing is always wrong.

Briefly to summarize, it seems to me that same argument is still going on today. We have two views of the newborn. We have one view which says that newborns have potential value but not intrinsic value. That view, I believe, can ultimately be traced back to the Graeco-Roman tradition. It implies that medical treatment depends crucially on the choice of the parents. Parental autonomy is the crucial value. There is no *a priori* duty to protect the defenceless. Intentional killing may be appropriate in some cases, and only limited resources should be applied if the future potential is limited.

On the other view of the newborn, the child has a fundamental and intrinsic value. Medical treatment depends ultimately on the best interests of the child alone. The question of parental autonomy is secondary. There is an overriding ethical duty to protect the defenceless from abuse. Intentional killing is always inappropriate, although futile treatment may be withdrawn. Resources should not be limited merely to those who have 'a good potential'.

What strikes me as a paediatrician practising in a pluralistic society—particularly in Central London, with an enormous range of ethical beliefs and traditions—is that there does seem to be a general core of parental intuitions. These

emerge in conversations with parents when questions about the meaning of life, the world and the universe are discussed, as often happens when we are trying to debate the right course of action in the case of a particular baby undergoing neonatal intensive care.

To summarize, the majority of parents in my practice in 1997 would say: 'My baby is a unique irreplaceable member of my family; my baby is a person with a name and an identity; my baby must be treated by professionals with gentleness, with tenderness and with respect.' I think that the word respect encapsulates what parents look for in a medical system. They look for respect, for a recognition of the dignity and the unique value of their child. 'My baby cannot be replaced.'

In contrast to Singer, I think that the concept of a replacement infant is not something that many parents accept. My baby cannot be replaced although I may have other, different, unique individual children in the future. Secondly, if my baby's outlook is hopeless, the most loving thing to do may be to stop treatment and to allow her to die. In my experience, the vast majority of parents do believe that allowing a baby to die is not either morally or emotionally equivalent to deliberately killing her.

Thirdly, the parents would say: 'If my baby does die, the permanent physical reminders of the uniqueness, the intrinsic significance of that baby are very precious, and the human status, value and significance of my dead baby should be recognized by the wider community.'

To sum up, it seems to me that parental intuitions are much closer to the Judaeo-Christian tradition which attributes intrinsic significance to the baby than to the Graeco-Roman view or the modern version expressed by Tooley, Singer and others, which hold that the baby is merely a being with potential for the future, but has no intrinsic worth.

How can we translate these ideas into practical decision-making? It seems to me that within the traditional Hippocratic and Judeo-Christian tradition of medical practice there are basically two indications for the withdrawal of treatment. First, the treatment is futile. Secondly, the patient is actively dying. The most helpful way of thinking about futile treatment is to consider the balance between the burdens and the benefits of treatment. It is standard medical practice before any treatment is commenced to try to analyse the potential burdens versus the potential benefits of that treatment and to ensure that the benefits of the treatment outweigh the burdens. To give a treatment the burdens of which exceed its possible benefits is inconsistent with a humane practice of medicine. In fact, it could be seen as positively abusive. Neither is beginning futile treatment considered good medical practice.

With regard to the meaning of the phrase 'actively dying', I translate that in practice to mean that a baby is demonstrating progressive irreversible deterioration despite maximum intensive support. In particular, this will involve lung-gas exchange, cardiac output and metabolic homeostasis. Most paediatricians would actually accept that it is possible to recognize the baby who is actively dying, who is spiralling downwards to irreversible death. In those conditions the withdrawal of intensive support so that the dying process is not prolonged seems entirely appropriate.

A much more difficult question is the question of what we mean by futile treatment. I would classify futile treatment under three major headings. The first is the non-viable foetus. In current medical practice, babies who are of less than 23 weeks gestation are clearly not viable. The problem, just from a practical paediatric point of view, is that the assignment of gestational age is extremely unreliable, even with the highest technological input. The only situation where you can be certain of gestational age is where fertilization has taken place outside the uterus, that is in vitro fertilization. It is not at all uncommon for babies who are said to have a gestational age of 22 weeks, and therefore to be non-viable, in fact to have a gestational age of 24, 25, or 26 weeks, which means that the outlook is completely different. Therefore, I think that the correct attitude is one of playing safe if there is any doubt. We teach our staff to initiate resuscitation, if there is any chance of success. This is on the understanding that treatment can always be withdrawn subsequently.

The second criterion is severe generalized brain injury of such severity that the possibility of a meaningful relationship in later life with parents is effectively absent, or profoundly curtailed. The third criterion is an uncorrectable major malformation. Advances in paediatric care have meant that many congenital malformations of the sort that Dr Nicholson has been describing are, in fact, correctable with modern treatment. This completely changes the ethical issues. However, there are malformations which cannot be corrected. I am thinking particularly of a child who was born with no gut at all, no bowel, whose life had been sustained for a period by intravenous nutrition, but for whom there was no possibility of treatment that would provide a permanent life for that child. In such situations, it seems to me that the withdrawal of intensive support is appropriate—provided the burdens of treatment exceed the benefits.

Of course, modern intensive care is burdensome. Potentially, it is an extremely unpleasant experience for babies. Hence, the removal of treatment which is excessively burdensome and unpleasant is far from being unethical. Indeed, one might argue that it would be unethical to continue treatment when the burdens clearly outweigh the benefits. It is certainly possible for neonatal intensive care to become a sophisticated form of child abuse, whereby babies are submitted to extreme technological interventions without any real prospect of improvement or cure. However, I—and I think most of my colleagues and most of the parents—do believe strongly that there is a clear difference between the withdrawal of intensive support, on the one hand, and euthanasia, defined as intentional killing, on the other.

Therefore, in answer to Richard Nicholson's earlier question about whether intention is important, my answer is yes. The intention of the medical and nursing team is paramount. If my intention is to kill, if my intention is to terminate a life, then I think it is an intention which is inappropriate in the context of traditional medical practice. If my intention is to withdraw treatment that is burdensome, then I think this is not unethical but good medical practice. Now, of course, there is a fine line between those two statements. This means that I am forced to accept some version of the so-called doctrine of double effect. Inciden-

tally, I very much dislike that phrase, the doctrine of double effect. It implies that the concept of double effect is an arcane, almost Jesuitical, concept dreamt up by Thomas Aquinas in the depths of his study and that it has no relationship to every day life. But in reality the concept of double effect is part of normal practice both in every day life and medicine. It underlies our reasoning when we give treatment such as chemotherapy which is potentially profoundly unpleasant, which causes marrow suppression, bowel disorders and so on. Chemotherapy does disastrous things to patients and may in fact kill them. But this does not mean that the oncologist who prescribes the therapy is guilty, intentionally, of murdering his patients. It is quite clear that the intention of the oncologist is actually to do something different, namely to treat the cancer, although he foresees the side-effects of the treatment. To say that intention is of no significance is to be light years away from 'common sense' practice, both medically and wider in the world.

Finally, I want to emphasize the fact that withdrawal of intensive support is not the same as withdrawal of care. There is a minimum level of care which all newborns deserve, including adequate analgesia and symptom relief, milk feeds except in exceptional circumstances and TLC, tender loving care. In fact, I regard providing terminal care to a newborn infant as really not different in kind from providing terminal care to a dying elderly patient.

We have seen a huge advance in the palliative care of newborn infants. Thus I do not think that the tragic and very painful situations described by Dr Nicholson represent modern neonatal practice at its best. What is involved in the decision to withdraw intensive care? First, adequate and full discussion with parents about the diagnosis and the mechanisms of brain damage, the prognosis and the degree of certainty, the treatment options which are available and finally a medical recommendation for withdrawal of care. I believe that this is better than asking parents what they want to do. To my mind, we should give a medical recommendation. Treatment decisions are ultimately medical decisions. Life and death decisions are not decisions for doctors, treatment decisions are decisions for doctors, and the decision to withdraw treatment is ultimately a medical decision. I believe that the right approach is to put forward a treatment decision to the parents and to ask for their agreement. Can you agree to this course of action? This is effectively to offer the parents a veto.

It is important to discuss what is likely to happen if intensive care is withdrawn and to point out that very often we are not certain what will happen. I have several patients etched on my memory where I have rather confidently said that when intensive care is withdrawn this sequence of events will happen, only to be proved totally and catastrophically wrong. Therefore, we must help people to understand that doctors are not omniscient, and that the consequences of the chain of events once treatment is withdrawn cannot always be predicted with 100 per cent certainty.

Secondly, it is important to give adequate time for the parents to discuss, and 'come to terms with' the withdrawal of support. They should also be given an opportunity for discussion with other family members and with religious leaders. Perhaps also a second opinion from an outside

consultant may be very helpful. In my experience there are very few situations where a snap decision needs to be made. It is nearly always better to buy time to allow further discussion. I am very suspicious of snap decisions made immediately after birth about resuscitation. In my experience such decisions made very hurriedly without full information may well be bad decisions. It is nearly always right to buy time for full discussion and, if necessary, involvement of outside people in those decisions.

Thirdly, it is most important to provide emotional support throughout the dying process. Again I emphasize the word respect. What parents are looking for is respect for the dignity, the uniqueness, the intrinsic value of their baby. I think this means open communication of feelings between staff and family, often including feelings of frustration and sadness which affect staff in these situations. For staff to express their emotions to the family is often extremely helpful. Moreover, it is important to provide ongoing support, once the family are discharged from hospital. Helping babies to die at home is an option that we are increasingly keen to support. Babies may well

receive better terminal care at home than in a neonatal intensive care unit.

We must also recognize the importance of physical reminders, memorials, services or rituals. Today, we put a great deal of emphasis on the importance of memorial services for babies who have died. We have an annual service for all the parents of babies who have died. We have found this to have made an enormous impact. It is an interdenominational Christian service. But we have found that people from many different faiths—and none—have come to this service, because it recognizes the unique value and significance of their baby. Photographs, footprints, mementos, a book of remembrance, sometimes donations or the naming of equipment are all immensely important.

Finally, I must mention that in my experience and that of many of my colleagues, caring for the dying child is a uniquely stressful and emotionally demanding experience. Hence, in order to help babies to die well, we must provide support for staff. This means making sure staff are adequately trained beforehand and supported throughout this demanding experience.

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## Watching over Patient Life and Death: Kevorkian, Hippocrates and Maimonides

The right to die debate is raging across America spurred on by the assisted suicides conducted by Dr Jack Kevorkian. This article explores Dr Kevorkian's philosophic base and his effort to find support in Greek philosophy, culture, and medicine. We offer in contrast a biblical view of helping a dying patient as expressed in the physician's prayer attributed to the 12th century Jewish physician, Moses Maimonides. Dr Kevorkian specifically rejects the biblical views of life, death, and healing and remains trapped instead inside the views of the ancient Greeks of which one expression is the Hippocratic Oath. Kevorkian states his basic case as follows:

*As medical services, euthanasia and assisted suicide were always ethical, widely practiced by physicians and endorsed by almost all segments of society in Hippocratic Greece. The only opposition came from the tiny pagan religious sect called Pythagoreanism (which is said to have concocted the oath erroneously ascribed to Hippocrates). Despite their opposition, the Pythagoreans acknowledged that their contrary tenets could not be imposed on all of Greek society without seriously impairing its functional integrity. Later on there was none of*

*that blunt honesty and respect for mores when the Western Judeo-Christian principles, which coincided almost exactly with those of extremely puritanical Pythagoreanism, dictated harshly punitive laws against euthanasia for all of society. Such laws cannot change but can only abuse and subvert ethics by paralyzing humans through brutal intimidation and fear. Eventually, in spite of all the fearful acquiescence and repressive atrocities borne of such transgression, the mores will prevail and ethics will be disabused.*

In this passage Dr Kevorkian offers several arguments: (1) Euthanasia and assisted suicide were widely practised in Ancient Greece. Classical sources clearly support this view. (2) The Hippocratic Oath, which opposed doctor-assisted suicide, has been construed to be the generally accepted Greek position when in fact it reflected the view of the small Pythagorean school. Ludwig Edelstein<sup>2</sup> has argued this point convincingly. (3) Kevorkian equates Judeo-Christian principles with abuse, paralysis, and brutal intimidation on the one hand, and with what he calls Pythagorean puritanism on the other. Here Dr Kevorkian is seriously misled.

*Argument 1: Euthanasia and Suicide were Widely Practised in Ancient Greece*

With regard to the first point, there is no question that suicide was widespread in Ancient Greece and that assistance was often offered. Diogenes Laertius<sup>3</sup> documents the suicide of many Greek philosophers in his classic description of their lives. The great poet John Donne<sup>4</sup> provides a similar list of Greek and Roman suicides in his fascinating book *Biathanatos*. The causes were sometimes so seemingly minute as a stubbed toe (Zeno the Stoic) or a gumboil (Cleanthes). The Greeks and Romans saw suicide as freedom<sup>5</sup> because they saw life as hopeless, fatalistic, and unfree, and many killed themselves on philosophical grounds. Indeed, the early Greeks and Romans followed a number of practices which modern society would find abhorrent: (1) child exposure, which was so widespread, that it caused a population decline by the 3rd century BCE; (2) the killing or beating of people as part of religious ceremonies; (3) the forced enslavement or massacre of prisoners of war, including women and children; and (4) the restrictions on women, who lived rather sequestered lives with very limited opportunities for self-expression and personal advancement. The Greeks gave much to mankind with their accomplishments in art, theatre, government, science, and philosophy, but many of their social and religious practices would hardly be acceptable to us today.

*Argument 2: Hippocrates Reflected a Minority Position in Ancient Greece*

To answer Kevorkian's second argument requires some reference to the Hippocratic Oath:

*I swear by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgement, I will keep this Oath and this stipulation — to reckon him who taught me this Art equally dear to me as parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them his art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art of my own sons, and those of my teachers, and to disciples bound by the stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious or mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever house I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females and males, of freemen and slaves. Whatever, in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times!*

*But should I trespass and violate this Oath, may the reverse be my lot!*<sup>6</sup>

For Kevorkian,<sup>7</sup> the real source of doctors' enmity toward death as the arch-enemy of medicine lies less in the Hippocratic Oath, *per se*, than in Section II of the Second Constitution of Hippocrates' treatise on epidemics, in which physicians are exhorted by the father of their calling 'to do good or to do no harm'.

The physician must be able to tell the antecedents, know the present, and foretell the future—must meditate these things, and have two special objects in view with regard to diseases, namely, to do good or to do no harm. The art consists in three things—the disease, the patient, and the physician. The physician is the servant of the 'art' (according to Galen, 'nature' was substituted for 'art' in many manuscripts), and the patient must combat the disease along with the physician.<sup>8</sup>

Kevorkian attempts to distinguish Hippocrates' call for 'the doctor and the patient to work together to combat the disease' from the position that 'the doctor must heroically lead the patient off to do battle with death'. Kevorkian attempts to buttress his argument through separating the word 'disease' into component parts 'dis' and 'ease'. The main, indeed the only enemy for Hippocrates, he says, is disease—that is, the disturber of a person's 'ease'. 'In having taken the oath of combating death,' Kevorkian argues, 'the medical profession wantonly infringes upon both aspects of its special and genuinely Hippocratic obligation. In quixotically trying to conquer death, doctors all too frequently do no good for their patients' ease; but at the same time they do harm instead by prolonging and even magnifying patients' dis-ease.'

Kevorkian's attempt at linguistic analysis is erroneous and crude. 'Disease' was not the Greek word employed by Hippocrates but a middle English word. Breaking this middle English word into its component parts obviously has no implications for Hippocrates' use of the word, and to assert otherwise is false and misleading.

Hippocrates' position on several important points is revealed in this passage. (1) The physician is the servant of the 'art' or 'nature'. (2) The 'art' consists of three parties: the disease, the patient and the physician. (3) The disease is the enemy, something to be combated by the patient along with the physician. (4) With regard to the disease, the physician is exhorted to do good or to do no harm. (5) In the Hippocratic Oath the physician swears to 'give no deadly medicine to any one, if asked, nor suggest any such counsel'.

What is notably absent in Hippocrates is any statement of the doctor's responsibility to care for a dying patient. He must not administer deadly medicine, but what shall he do to ward off death or, at least, to ease the patient's discomfort? Shall he simply leave the patient to his fate, abandon him as Euripides describes the Goddess Artemis abandoning her worshipper, the hero Hippolytus, when he was mortally wounded?<sup>9</sup>

Dr Kevorkian is correct in saying that the Hippocratic Oath is opposed to much that occurred in Greek thought. It is very significant, however, that he fails to see that both the Oath and he himself are operating within the structure of a Greek world view which was obsessed with fatalism, suicide, child exposure, and death as freedom.

*Argument 3: Pythagorean and Biblical Prohibitions Against Suicide are Equivalent*

In his third argument, Dr Kevorkian incorrectly equates the mathematical Pythagorean position underlying the Hippocratic Oath with Christian anti-suicide dogma and 'western Judeo-Christian principles'. In fact, suicide for the Pythagoreans was wrong because it upset an abstract mathematical discipline set by the gods. There is a set number of souls, according to the Pythagoreans, that is available in the world at any time. Killing oneself creates a gap by upsetting this mathematical equilibrium, and thus must be rejected.<sup>10</sup> Further, human beings reject suicide because they fear punishment.

... that the souls of men were found in the body, and in the life which is on Earth, for the sake of punishment . . . On which account all men, being afraid of those threatenings of the gods, fear to depart from life by their own act, but only gladly welcome death when it comes in old age.<sup>11</sup>

The punitive, cold, and abstract emphasis of the Pythagorean position was not sufficient to prevent Pythagoras from letting himself be killed<sup>12</sup> and is not to be equated with the passionate biblical prohibition against suicide. The Hebrew Bible describes the Creator lovingly involved with the world. He created the world solely as an act of kindness and, in the highest expression of love and benevolence toward man, created him in the divine image. To destroy or damage any human being defaces the divine image, insults and diminishes the whole of God's creation, and reduces the divine plan of love in which the world was brought into being.<sup>13</sup> This is not a cold prohibition based on an abstract mathematical principle but a passionate commitment to the divine quality within each human being.

The Hebrew position is expressed in the physician's prayer attributed to Moses Maimonides,<sup>14,15</sup> the great Jewish thinker and physician of the 12th century CE:

Almighty God, Thou has created the human body with infinite wisdom. Ten thousand times ten thousand organs hast Thou combined in it that act unceasingly and harmoniously to preserve the whole in all its beauty—the body which is the envelope of the immortal soul. They are ever acting in perfect order, agreement and accord. Yet, when the frailty of matter or the unbridling of passions deranges this order or interrupts this accord, then forces clash and the body crumbles in the primal dust from which it came. Thou sendest to man diseases as beneficent messengers to foretell approaching danger and to urge him to avert it.

Thou hast blest Thine earth, Thy rivers and Thy mountains with healing substances; they enable thy creatures to alleviate their sufferings and to heal their illnesses. Thou hast endowed man with the wisdom to relieve the suffering of his brother, to recognize his disorders, to extract the healing substances, to discover their powers and to prepare and to apply them to suit every ill. In Thine Eternal Providence Thou hast chosen me to watch over the life and health of Thy creatures. I am now about to apply myself to the duties of my profession. Support me, Almighty God, in these great labors, that they may benefit mankind, for without thy help not even the least thing will succeed.

Inspire me with love for my art and for Thy creatures. Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and of love for mankind and they can lead astray in the great task of attending to the welfare of Thy creatures. Preserve the strength of my body and of my soul that they ever be ready to cheerfully help and support rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being. Illumine my mind that it recognize what presents itself and that it may comprehend what is absent or hidden. Let it not fail to see what is visible, but do not permit it to arrogate to itself the power to see what cannot be seen, for delicate and indefinite are the bounds of the great art of caring for the lives and health of Thy creatures. Let me never be absent-minded. May no strange thoughts divert my attention at the bedside of the sick, or disturb my mind in its silent labors, for great and sacred are the thoughtful deliberations required to preserve the lives and health of Thy creatures.

Grant that my patients have confidence in me and my art and follow my directions and my counsel. Remove from their midst all charlatans and the whole host of officious relatives and know-all nurses, cruel people who arrogantly frustrate the wisest purposes of our art and often lead Thy creatures to their death.

Should those who are wiser than I wish to improve and instruct me, let my soul gratefully follow their guidance; for vast is the extent of our art. Should conceited fools, however, censure me, then let love for my profession steel me against them, so that I remain steadfast without regard for age, for reputation, or for honor, because surrender would bring to Thy creatures sickness and death.

Impart to my soul with gentleness and calmness when older colleagues, proud of their age, wish to displace me or to scorn me or disdainfully to teach me. May even this be of advantage to me, for they know many things of which I am ignorant, but let not their arrogance give me pain. For they are old and old age is not master of the passions. I also hope to attain old age upon this earth, before Thee, Almighty God!

Let me be contented in everything except in the great science of my profession. Never allow the thought to arise in me that I have attained sufficient knowledge, but vouchsafe to me the strength, the leisure and the ambition ever to extend my knowledge. For art is great, but the mind of man is ever expanding.

Almighty God! Thou hast chosen me in Thy mercy to watch over the life and death of Thy creatures. I now apply myself to my profession. Support me in this great task so that it may benefit mankind, for without Thy help not even the least thing will succeed.

This approach is fundamentally different from that found in Hippocrates in several ways. (1) The physician has been chosen by God to watch over the life and health of his creatures. (2) The doctor prays for inspiration from God for love for his art and for God's creatures. There are three parties involved: God, the doctor, and God's creatures. (3) The disease is a beneficent messenger sent by God to foretell approaching danger and to urge him to avert it. (4) The physician has been chosen by God in his mercy to watch over the life and death of his creatures.

(5) The physician specifically prays to remove from his patients 'all charlatans and the whole host of officious relatives and know-all nurses, cruel people who arrogantly frustrate the wisest purposes of our art and often lead Thy creatures to their death'.

Maimonides can thus be contrasted with Hippocrates in at least five areas: (1) Whom does the physician serve? (2) Who are the relevant parties? (3) How is disease viewed? (4) What is the role of the physician with regard to good and harm, life and death? (5) What is the role of the physician with regard to inducing death?

For Hippocrates, the physician serves nature and, along with the patient, combats the disease. Maimonides, in contrast, sees the physician as serving God, and the disease as a beneficent messenger sent by God to foretell and avert approaching danger.

Hippocrates, perhaps reacting to the suicidal nature of the Greek culture, specifically forbids the doctor to give the patient any lethal medicine or to make any suggestions to that effect. But this is a cold injunction, not accompanied by a positive instruction to tend to a patient in his last hours. Maimonides gives no specific instruction to the physician not to give lethal medicine. Indeed, he does not need to, as the biblical world view does not equate freedom with suicide, as do the Greco-Roman Stoics, but with fulfilling God's commandments in life.<sup>16,17,18</sup> Maimonides' physician does pray that his patient be shielded from those charlatans, know-it-alls, officious relatives and cruel people who would lead him to his death. In addition, however, the physician is specifically instructed to watch over the life and death of God's creatures to give them all the help and comfort possible in their last hours.

#### *Where Does Kevorkian Go Astray?*

Let us grant that Dr Kevorkian correctly senses the lack of human compassion in the Hippocratic view, and that he sincerely wished to alleviate the pain of his patients in the most thorough and foolproof manner. On the surface, Dr Kevorkian does not turn his back on the dying patient as do Artemis and Hippocrates. However, he seeks to answer a Greek problem with the classic Greek solution — suicide, which ironically also implies turning away from one's patient, of washing one's hands of the patient in distress.

Kevorkian follows in his practice the way of Sophocles' Antigone.<sup>19</sup> Antigone's obsession with burying her dead brother leads to her being buried alive. 'Not burying the dead' symbolizes the indifference of a medicine that unfeelingly turns away from the suffering patient in need. 'Burying the living' represents the approach of Dr Kevorkian, who perhaps fearing that the patient will reach a point where he loses the ability to deal with his own pain, kills him prematurely. Dr Kevorkian is thus a tragic figure trapped in his misguided inability to escape the Greek polarized and fatalistic vision.

It does not occur to Kevorkian to make use of the higher compassion inherent in a biblical approach to medicine as reflected in Maimonides' prayer. Indeed, Dr. Kevorkian sees 'medicine as a purely secular profession, like engineering and many others'. 'Any religion ought to be irrelevant to the strictly secular doctor-patient relationship.' Medicine

is part of the empirical world while religion belongs to the 'uninvestigatable' world, and the two cannot mix.

This blind spot of Kevorkian is extremely unfortunate for it is the biblical world view that contains the hope necessary to counter the Greek sense of despair. Physical, spiritual, and social support of the suffering patient is in harmony with the highest biblical ideal of freedom, emphasizing the preciousness of every moment of life. Who knows how much good can result from a small act or word of goodness by an apparently insignificant person in a seemingly lost moment—even if that person is in great pain? In Maimonides' view, the doctor's caring for his patient is a religious commandment. The patient is offered freedom within that relationship. Kevorkian is too immersed in the tragic Greek vision to see this. Here freedom can occur only through suicide. Indeed suicide becomes the highest expression of freedom and death becomes a right rather than an inevitable fact. Suicide becomes in itself a worthy goal and objective.

It is instructive to compare the recent deaths of Jack Leatherman, one of Kevorkian's later suicides and that of Joseph Cardinal Bearnardin. The two men were of similar ages, Leatherman, 72, and Bearnardin, 68; and had similar diagnoses: terminal pancreatic cancer. Both refused prolonged treatment. However, this is where the similarity ends. A video tape shot by Kevorkian shortly before Leatherman's death reveals his self-expressed insistence that he must 'control his own destiny'. With Kevorkian's help, Leatherman commits suicide while he is still functioning fairly well because he insists he is less terrified of death than of the end of life. Cardinal Bearnardin finds peace not through control 'but by putting his life in God's hands'. Giving up this pseudo-control over life and death allows Bearnardin to live as fully as his strength permits to the very end, completing many final tasks he had set for himself. These two stances vividly reflect the Greek versus biblical views of freedom discussed previously. The Greco-Roman Stoics needed to control their death and equated suicide with freedom.<sup>20</sup> The Rabbinic view, in contrast, asserted that one was born and died against one's will and freedom was expressed in the way one lived one's life.<sup>21</sup>

Our contemporary culture is obsessed over the terminality of a patient because it is afraid to face the fact that as mortals, we are all terminal. We are obsessed with control because we sense that we really have very little control over the most important things in our lives. 'Helping a patient die' is not the same as 'helping a patient commit suicide'. Rather, it is to help the patient through the dying process when his time to leave this world has come. Is not Kevorkian as phobic about death as the medical establishment he opposes? Shall the physician's role be to bring death or to apply as best he can the many methods, physician and psychological, of relieving pain and bringing the patient comfort? As Maimonides acknowledges, the physician can help bring a patient into the world. He need not abandon the patient when he leaves the world, instead aiding him in the dying process with a similar application of technical skill and compassion.

Assisting a suffering patient to kill himself is, in a sense, to collude with the world's abandonment of him. In Maimonides' view, God does not abandon the patient even in great suffering or at the moment of death. The physician

acts as representative of a God who cares deeply above human life and who does not rejoice in the death even of the wicked. Maybe the patient will repent and 'seize the world' even in his last moment.<sup>22</sup>

Hippocrates being wrong does not make Kevorkian right. The Hippocratic posture is too disengaged from the dying patient while Kevorkian becomes overly involved in the dying process. Maimonides stands as a bright and hopeful alternative to both Hippocrates and Kevorkian, providing a model for the physician of watching over the life and death of his patient who is God's creature.

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## Book Reviews

### Ethics and Perinatology

Edited by A. Goldworth, W. Silverman, D.K. Stevenson, E.W.D. Young and R. Rivers  
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ISBN 0 19 262379 6

This is an immensely satisfying book which meets a pressing need for balanced, in-depth discussion of the many difficult issues confronting those whose work is involved with the unborn, the newborn and their families. It takes a multidisciplinary approach and there are contributors from the UK, Canada, the USA and Australia.

In the Foreword John Lantos considers how neonatology supremely exemplifies the paradoxical nature of medical progress and questions whether neonatology is a stunning success or a misguided effort. Technology is, ultimately, value-neutral. We must invest it with meaning. This book attempts to do that, in my view with a considerable measure of success. It does not come up with simple answers but it does look deeply at the problems as well as the progress, and helps us all to work through our own position on difficult questions.

The book is organised in such a way that a chosen theme is addressed by one author, followed by a companion piece which may complement and further develop the thinking in the first paper, or may argue from a quite different perspective. There is a particularly enlightening discussion on quality of life issues,

in which Professor Campbell argues that in the difficult and poignant realm of decision-making about life-sustaining treatment of severely abnormal or damaged infants quality-of-life predictions are inevitable. He does not see this as negating respect for the infant as a person or reverence for life 'as most people wish to live it'. There is then a careful examination of the ethical and legal implications of such thinking across international boundaries. Helga Kuhse takes the argument further—and in my view thereby demonstrates its weakness. In her philosophical school the status of 'personhood' is attributed only to those beings who are aware of being a 'continuing self'. Kittens and fetuses are taken as examples of beings who cannot desire their continued existence, and it would not therefore be directly wrong to kill them painlessly. She is therefore able to meet the charge of discrimination against impaired infants in allowing them to die by showing that they do not have a 'right to life' because they have no interest in their own continued existence. The argument is at the extreme end of the 'quality of life' position, and would not be shared by many who subscribe to the general principle, but it is a logical if dreadful proposition.

A disappointment in the book is the general dismissal of the sanctity of life position but in an analysis of government regulations in the UK Margaret Brazier raises the question: are

damaged babies too expensive to keep alive? She goes on to argue: 'If respect for human life is to retain any meaning, that respect must be accorded whatever the age of the human entity.' Such clear sanity is a relief in the mine-field of conflicting interests and relative values.

The companion papers on nursing ethics provide insight into nursing perspectives on the dilemmas of perinatal care, emphasizing the assumptions with which nurses work and the holistic understanding which they apply. Nurses, Penticuff contends, are unlikely to question whether the newborn infant is a person in the philosophical sense, rather they will see the infant as a baby, a member of the human community, worthy of attempts at a chance for a life. The writer does not however minimise the burden of NICU treatment in terms of the suffering of the infant and the frustration and helplessness of parents. She holds that most nurses would feel that parents should have substantial input in decisions about their infant's treatment. In the companion chapter the emotional work of nursing is analysed by a non-nurse. 'Nurses touch and feel suffering . . . this also challenges the loyalty of nurses to the enterprise as a whole.' The writer contends that nursing-based values would provide a sound base for decision-making in neonatal units, and that nurses should have equal standing with physicians in planning treatment. A view I can only endorse wholeheartedly. I recommend

these chapters particularly as essential reading for nurses working in this area, but the whole book is immensely valuable to all with an interest in ethics and technology at the edges of life.

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### Moral Choices: An Introduction to Ethics

Scott Rae  
Grand Rapids: Zondervan Publishing House,  
1995  
ISBN 0-310-20013-X, 255 pp., hardback \$24.99

Anyone reflecting on western ethical practices will soon notice that our moral patterns reveal a confusing mixture of secular and Judeo-Christian moralities, systems which have fundamentally different views of ethical authority, goals, and motivation. Some biblical ideals have been so deeply ingrained in the fabric of western institutions and life that they have continued to sustain the moral practices of many westerners. But the foundations are under severe strain. Since the 1960s, in the United States particularly, secular philosophies have powerfully influenced the principles of ethics in education, politics, economics, and medicine. The notion that humans are autonomous and that morality should not emanate from religion has contributed significantly to our contemporary confusion over moral values and practices.

In *Moral Choices: An Introduction to Ethics*, Scott Rae has produced an undergraduate textbook that is sure to clarify the distinguishing elements of Christian ethics. His purpose is to expose his readers to 'foundations in ethics and to the application of those foundations to the most pressing moral issues of the day' (p. 13). The book is well structured, moving logically from a study of the major figures in the history of ethics to ethical systems to an examination of six contemporary ethical issues from a biblical perspective.

This volume has many strengths. Rae's spirit is irenic throughout, although unapologetic in strongly affirming biblical points of view. He fairly and respectfully describes opposing points of view and interacts with significant proponents of them, as well as United States' court cases. His reconnaissance of the key US Supreme Court decisions on the issue of abortion, for example, is excellent and accurately describes the serious obstacles US opponents of abortion face in the legal arena.

The section of the book describing major figures in the history of ethics and ethical thought provides a very useful introduction to the major thinkers from Socrates through Immanuel Kant. Philosophical terms are defined in simple language so that readers without philosophical training will be able to follow the contribution made by each thinker, especially as his work influences Christian ethics. I found myself disappointed that this section of the book was not lengthened to include figures from more recent centuries such as Karl Marx, Friedrich Nietzsche, Ayn Rand, John Dewey, and Joseph Fletcher, among others, whose critiques of, and alternatives to, Christian ethics have so strongly affected much modern ethical thinking.

Rae's description of various ways of moral reasoning (chapter 4) is cleverly illustrated by

his imagining a panel discussion in which a proponent of each of the six differing ethical theories gives his position on physician-assisted suicide. This enables the reader to see how each theory might be expressed concretely.

Chapter 5, titled 'Making Ethical Decisions', offers a practical model for ethical decision-making based on the application of principles along with a teleological element. In the model, based on one developed by William W. May of the University of Southern California, facts are gathered, alternatives considered, principles are applied, and expected outcomes are taken into account. Rae applies the model to cases to demonstrate its usefulness in 'insuring that all the relevant questions are asked when attempting to resolve an ethical dilemma' (p. 116).

Models like the one Rae proposes are commonly used in clinical medical decision-making. What limits their value is the inevitable conflict over what principles are given authority on the front end, and how they are weighed. A proponent of natural law, Rae makes room for principles from sources outside the Bible. He writes: 'It is critical to identify these principles, and in some cases, to determine whether some principles should be weighed more heavily. Clearly, biblical principles should be weighed more heavily. Also, principles that speak to the case may come from other sources, such as the Constitution or natural law, which would supplement the applicable biblical principles' (pp. 101-2).

The difficulty with this is that widely divergent decisions on the same case could be reached based on what principle 'trumps' the others. In my own experience in trying to apply a model like this in a secular setting, patient 'autonomy' usually overrides most other principles, biblical or not. Rae admits the difficulty in applying his model in different cultural settings. He writes: 'You cannot assume that everyone shares a Christian worldview, and, to a point, you must respect the beliefs of others' (p. 115). The problem, then, for the Christian ethicist, is whether a respect for other worldviews requires him to accept their principles as authoritative for his model. Rae never really addresses this, other than to conclude: 'When dealing with people whose culture and worldview differ from yours, you must frequently face difficult choices' (p. 115).

Perhaps the strongest parts of the book are the chapters in which Rae analyses contemporary ethical issues. It is clear that he has done the most thinking in the medical areas. The chapter titled 'Reproductive Technologies' is excellent and reflects the research done for the author's previously published book on the subject, *The Ethics of Commercial Surrogate Motherhood* (Westport, CT: Praeger, 1994). The chapter on abortion (pp. 117-36), were it published separately, would make a terrific booklet to give Christians confused by 'pro-choice' arguments.

In the otherwise very strong chapter on euthanasia (chapter 8), Rae accepts the distinction between active and passive euthanasia (pp. 163-4), a distinction which I think leads to confusion. John Jefferson Davis (*Evangelical Ethics: Issues Facing the Church Today*) and others argue—wisely, I think—for the reservation of the use of the term 'euthanasia' for the deliberate taking of human life. By calling the withdrawal of life-support that is merely

prolonging dying 'passive euthanasia', we are forced to defend certain forms of euthanasia as morally acceptable, while vigorously opposing others.

The section on the perplexing matter of withdrawal of mechanically provided nutrition and hydration (pp. 176-80) does not address the important issue of the reliability of the diagnostic criteria for the persistent vegetative state (PVS). In fact, Rae refers to PVS as the 'permanent vegetative state' (p. 176) and therefore gives the impression that such a state is always permanent. I agree with Rae's view that medically provided nutrition and hydration may be seen as medical treatment, and as such are not always required when burdens outweigh benefits or there is no reasonable hope for the patient to regain consciousness. What is exceedingly difficult is deciding how long the nutrition and hydration should be continued before determining that the persistent vegetative state is a permanent one and the artificial feeding provides 'no reasonable hope of benefit to the patient in regaining consciousness' (p. 179). This is frequently hardest to determine when the brain injury is of ischemic or hypoxic origin rather than from blunt trauma in which the upper brain matter is irrevocably destroyed.

My criticisms are minor and are not intended to detract from the overall merit of this book. The difficulty in writing a book of this scope rests in deciding what to omit in dealing with very complex issues. Given that Rae is writing an introductory ethics textbook for college students, the material he presents is well chosen. He has produced a well-written introduction to ethics from a distinctively conservative Christian viewpoint. I recommend it strongly and hope it finds wide use as a textbook in Christian colleges and universities.

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### Playing God: Dissecting Biomedical Ethics and Manipulating the Body

R. C. Sproul Jr., Editor  
Grand Rapids: Ligonier Ministries (Baker Books), 1997  
ISBN 0-8010-5725-6, 96 pp., paperback \$10.99

Seeing the slender size of *Playing God*, edited by R. C. Sproul Jr., (only 96 pages including study questions) I half-expected a similarly slender content. While *Playing God* is not, by any stretch of the imagination, a textbook, it is far from a 'quick read'. Fifteen short chapters by a variety of authors address issues relating to biomedical ethics. The topics include euthanasia, abortion, and genetic engineering, as well as the underlying ethical and moral concepts involved.

Part One, 'Dissecting Biomedical Ethics', begins with a chapter by Nigel M. de S. Cameron called 'Healing, Suffering, and the New Medicine'. He describes medicine as an exercise of power, and notes a change in medicine from healing to consumerism, with attendant problems. For example, he warns, 'if medicine is consumer driven, death may be what the consumer wants' (p. 13). He urges a return to Christian Hippocraticism.

Michael Beates compares medical progress



to religion, and concludes, 'Biomedical technology, like all technologies, is a god that limps, and, ultimately is unable to save' (p. 19). The sanctity of life is a constant theme through the book. 'We can never [maintain our lives as long as we can] at the expense of another human life, no matter how deformed that life may be in our eyes' (p. 19).

A chapter by Harold Brown on euthanasia parts layers of euphemisms and compares 'mercy killing' to putting a dog or cat 'to sleep'. Ken Myers wonders if Christians are even asking the right questions in the moral debates that are raging, and George Grant stresses the importance of orthopraxy as well as orthodoxy. *Playing God*, we may note, is written for a specifically Christian audience. Heavy reference is made to Scripture.

'Advances in the biomedical arena are occurring so rapidly that they often occur in a legal vacuum', writes Kenneth Connor (p. 34). He notes that the link between legal rights and moral rights (based on transcendent values) has been broken. 'Merely because something is permitted, however, doesn't make it right' (p. 35). The questions 'can I?' (technical) and 'may I?' (legal) are not always accompanied by the ethical 'should I?'

J. P. Moreland discusses utilitarianism and how it leads to treating people 'as a means to an end, not as creatures with intrinsic dignity' (p. 43). R. C. Sproul points to the law of God as an unchanging standard. 'The great gulf between relativism and absolutism is the conflict between the will of the creature and the will of the Creator' (p. 48).

Part Two of *Playing God* is called 'Manipulating the Body', and R. C. Sproul talks about humanity's desire and striving for autonomy. He notes, 'As a culture we have sold our souls to rebuild our bodies' (p. 52), and concludes, 'We cannot be gods. Only God can be God' (p. 56). Randy Crenshaw points out the lack of success derived from trying to find contentment in medication—our attempt to adjust our chemical make-up fails on the deepest levels.

W. Andrew Hoffercker's section on 'Prenatal Techniques' poses the question how to interpret the command 'be fruitful and multiply'. Does it mean using any and every technology to do so? In 'The Human Body Shop', Ken Myers talks about the commercialisation of the body, and the change in viewpoint from the sacred to the secular.

Michael Beates concludes that 'At the root of our cultural obsession to manipulate the body is a fear of losing the body' (p. 76). We have separated our bodies from our souls, and he urges a return to a holistic view of humanity. Ken Myers compares our quest for knowledge to gnosticism, where the pursuit of knowledge itself is what is important. But knowledge itself is not enough. 'Science and technology are good gifts of God to sinful people, who are capable of discovering ways to misuse even the best gifts' (p. 80).

Mike Malone concludes *Playing God* with a plea to place a priority on the soul, not the body. 'The preoccupation with the material world, specifically the body and its preservation, or the malicious destruction of the body when it no longer serves our purposes, will lead to the atrophy and death of the inner world of the soul' (p. 85).

In a book this size, extended discussion is, of course, impossible. Ideas and concepts are pre-

sented, but not examined in detail. I, personally, would have preferred a more extended treatment. There are generalisations, and not all readers will agree with all the conclusions reached. (I, for example, find it difficult to concur with the assessment that medicine is a pure exercise of power, and that clinical situations are a time for manipulation. Surely not all!)

*Playing God* is a book of starters, designed to stimulate interest, discussion, and more in-depth reading. The authors avoid detailed technical language and keep the book accessible to lay readers. For a general audience, perhaps in a church study group, *Playing God* should serve its purpose well.

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### The Proposal

Angela Hunt  
Wheaton: Tyndale House Publishers, 1996  
ISBN 0-8423-4950-2, xiii + 321 pp., paperback \$11.99

Theodora Russell, the aspiring writer heroine of Angela Hunt's medical thriller *The Proposal*, is not a pro-life activist. Widow, Sunday school teacher, and mother of a Down's child, she is opposed to abortion but has never taken an active stance.

At a writing conference, a case of mistaken identity lands her with another writer's book proposal—a proposal that links breast cancer with first trimester abortion. When the other author disappears—and is later found dead—Theodora decides to pursue the story.

She rapidly realises that somebody doesn't want the book written. She becomes the target of journalistic and physical attacks. Theodora turns for help to physician Ken Holman, a man who has a personal stake in the controversy. What begins as a search for information rapidly deepens into romance.

The trail leads to Bio Tech Industries, a corporation which 'recycles' foetal tissue into treatments for chronic ailments, such as Parkinson's disease. Bio Tech's directors fear that widespread knowledge of an abortion-breast cancer link will reduce the number of abortions, diminish supplies of foetal tissue, and lower profits. Their tactics, which include murder and bombing, are aimed to portray Theodora as a deranged anti-choice activist.

Theodora learns that passive disapproval of abortion is not an option for her. She also learns to abandon her self-confidence and trust God.

Hunt writes in a clean, uncluttered manner that makes for easy reading. Theodora's character is the best drawn in the novel. She displays a tendency to act on the basis of emotion rather than reason; a response that becomes tiresome as she runs distraught from one crisis to another. Dr. Ken Holman is less well portrayed—he seems the passive recipient of much misfortune. We know little of *The Proposal's* antagonists' motives beyond the obvious. As Theodora battles against two hit men, the real antagonists remain mere shadows in the background. This diminishes the compelling nature of the conflict.

Plenty of action keeps *The Proposal* moving until a climax where Theodora's life hangs by a thread. The ending, though, is somewhat melodramatic and implausible.

The proposed connection between breast cancer and abortion strikes me as being insufficient to lead to the antagonists' severe responses, but does raise interesting questions.

Could lawsuits arise from abortion-related breast cancer? We are already seeing lawsuits against tobacco companies for smoking related disease. Would knowledge of an abortion-breast cancer connection cause people to choose against abortion because of the risk of cancer years later? Would someone desperate to end a pregnancy take into full consideration an effect that might not manifest itself for decades?

In some cases, perhaps. Although, to cite another example, in my clinical experience the threat of AIDS has not served to lessen promiscuous behaviour—rather, such behaviour is cloaked under a mythical mantle of 'safe sex'. Rather than make lifestyle changes or hard decisions, people settle for more frequent testing—even for a disease fatal when contracted. Present concerns frequently outweigh future worries.

Hunt quotes newspaper reports (not always the most accurate source of medical information) to add veracity to her premise, but at present the medical literature does not reflect consensus. My Medline search turned up articles both favouring and disparaging a link between abortion and breast cancer. But Hunt's use of a medical idea in fiction is perfectly legitimate.

*The Proposal* also contains an afterward by professor of biology and endocrinology Joel Brind of Baruch College of the City University of New York in which he states, 'Abortion is the single most avoidable known risk factor for breast cancer', and, '... abortion is a cause of breast cancer' (p. 321).

Equating a risk factor with a cause may be stretching matters. In his recent review article ('Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis', *Journal of Epidemiology and Community Health* 50 (1996): 481-96) Brind and his co-authors are more cautious: 'We believe that the present review and meta-analysis summarizes a literature that documents a remarkably consistent, significant positive association between induced abortion and breast cancer incidence . . .' (p. 494).

Another recent review reaches the opposite conclusion, 'Studies to date are inadequate to infer with confidence the relation between induced or spontaneous abortion and breast cancer risk, but it appears that any such relation is likely to be small or nonexistent'. (K. B. Michels and W. C. Willett, 'Does Induced or Spontaneous Abortion Affect the Risk of Breast Cancer?' *Epidemiology* 7 (1996): 521-8).

Lacking statistical or epidemiological training, I am not qualified to judge the relative merit of the studies. Hunt's characters say, 'No one has been willing to flatly state that abortion can cause breast cancer. . . . For every study that suggests a link, some so-called expert refutes it' (p. 104). Given the disparity of research studies, this appears an accurate statement.

It would seem, though, that until consensus is reached in the medical literature, caution should be exercised, and statements formulated as opinion, not as accepted fact. Dr. Brind may be correct, and, if the risk does exist, it needs to be acknowledged and publicised, regardless of a researcher's personal position

on abortion. But by the same token, the opposite possibility should be acknowledged, and the link ought not be overstated until the facts are in. As physicians and Christians, we are obligated to provide our patients with the most accurate information available, neither understating nor inflating our concerns.

Dr. Brind makes the (to my mind, sensationalist) claim that the abortion-breast cancer connection is 'the true story that medical associations, the media, and the federal administration do *not* want you to hear' (Afterward, p. 321); a comment that immediately raises the spectre of conspiracy.

While I have no objection to Ms. Hunt creating a conspiracy for fictional or dramatic purposes, such an assertion from a researcher belongs more properly in a non-fiction book with supporting documentation. Calls to three medical organisations (American Academy of Family Practice, American College of Obstetrics and Gynecology, and the Christian Medical and Dental Society) revealed that none of them have stated an official position on this particular issue.

In the article referenced above, Dr. Brind writes, '... there is indirect evidence to suggest [a trend in bias] against the publication of data which reflect a positive association [of induced abortion] with breast cancer incidence' ('Induced abortion', p. 489). Indirect evidence, though, is hardly proof of a cover-up. Indeed, he says, 'we are aware of no specific cases wherein positive data have been withheld from publication' ('Induced abortion', p. 490). Brind criticises several researchers as well as prominent journals and notes 'the conspicuous absence of any mention of induced abortion relative to breast cancer risk in prominent medical journal reviews' ('Induced abortion', p. 490).

Even if the abortion-breast cancer link isn't as strong as implied, *The Proposal* makes other telling points. The use—legal or illegal—of foetal tissue as 'spare-parts' for those desperate for a cure is a daunting societal and ethical issue. Hunt illustrates the devaluing of human life from a sacred gift of God to the subject of scientific experiments.

Perhaps most important of *The Proposal's* points are the moral questions. 'Right moral choices strengthen us; when morals are discarded, the very fabric of our society—even our individual character—is irreparably weakened' (p. 230). Hunt goes on to ask, 'Have we twisted logic to the point where we recognize the humanity of cadavers but not fetuses?' (p. 230).

She could have written the epitaph for our society: 'This generation is literally consuming its offspring. We are harvesting the next generation for spare parts, taking tissues for the elderly from the youngest and most innocent lives. We have gone as far as we can go. We have reduced life to nothing more than matter for manipulation. Death has become a solution for social problems' (p. 190).

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#### The Cyborg Handbook

Chris Hables Gray, Editor, with the assistance of Heidi J. Figueroa-Sarriera and Steve Mentor  
New York and London: Routledge, 1995

ISBN 0-415-90848-5, xx + 549 pp., paperback price not given

This is a most unusual book. It is a lengthy, eclectic, often wild collection of essays and musings about the science and literature of cyborgs. Articles by engineers and feminists, science fiction aficionados and movie and literature experts co-mingle. But first the reader must permit the basic definition, the basic premise.

The various authors of this collection generally define a cyborg as an organism which contains elements of the mechanical and the organic, or an organism which is a union between two different organic systems. If one accepts this two-fold definition, there are two types of cyborgs, fictional and actual. Examples of fictional cyborgs are: Dr. Frankenstein's monster; the Six Million Dollar Man; the Bionic Woman; Robocop; the Terminator; Chief Engineer Geordi LaForge and The Borg, both from Star Trek. Examples of actual cyborgs would be *Mixotricha paradoxa*; experimental animals with monitoring systems; persons with artificial limbs, implanted eye lens, pacemakers, or artificial heart valves; people who have been immunised or genetically engineered, or contain collections of cells from other species.

If one accepts this fairly broad definition, then cyborgs are common; many humans are classic cyborgs. As Donna Haraway points out:

... the term, 'cyborg' was coined by Manfred E. Clynes and Nathan S. Kline (1960) to refer to the enhanced man who could survive in extra-terrestrial environments. They imagined the cyborgian man-machine hybrid would be needed in the next great technohumanist challenge—space flight. Most Western narratives of humanism and technology require each other constitutively: how else could man make himself? Du Pont had the right idea: 'better things for better living'. A designer of physiological instrumentation and electronic data-processing systems, Clynes was the chief research scientist in the Dynamic Simulation Laboratory at Rockland State hospital in New York. Director of research at Rockland State, Kline was a clinical psychiatrist. Their article was based on a paper the authors gave at the Psychophysiological Aspects of Space Flight Symposium sponsored by the U.S. Air Force School of Aviation Medicine in San Antonio, Texas. Enraptured with cybernetics, they thought of cyborgs as 'self-regulating man-machine systems'. Space-bound cyborgs were like miniaturized, self-contained Gaias (the Gaia Hypothesis is James Lovelock's theory that the earth is a dynamic, self-regulating homeostatic system that is itself a life form). One of Clynes and Kline's first cyborgs, a kind of pilot project for Gaia-Man, was our standard white laboratory rat implanted with an osmotic pump designed to inject chemicals continuously to modify and regulate homeostatic states. The rodent's picture was featured in the article that named its ontological cyborg condition. (p. xv)

The other form of cyborg, that involving a union between two biological systems, is perhaps best illustrated by explaining the life-form known as *Mixotricha paradoxa*. *Mixotricha* is a protist inhabitant of the hindgut of a South Australian termite. This little creature is

composed of about one million individuals of five kinds of prokaryocytes. When the congeries reach a couple of million, the host divides. All of the entities live in symbiosis or confederacy, nested in each other's tissues, which in turn are nested in the gut of a termite. It is as if predators settled down in their prey, like mitochondria inhabiting the cytoplasm of cells.

The reader will find that this book is difficult to read cover-to-cover; it is best read as a hand-book, a provocative skim. Manfred Clynes delineates the types of cyborgs; Jennifer Gonzalez distinguishes between machine cyborgs and organic cyborgs (monsters and transgenic constructions); Mark Oehlert breaks down comic-book cyborgs into controllers, biotech integrators, and genetics; Monica Casper describes 'Technomoms and Cyborg Fetuses'; Linda Hogle explains cadaver donors; David Hess discusses low-tech cyborgs; and the editors evaluate the epistemology of cyborg (thesis, antithesis, synthesis, and prosthesis). Just when the reader is tempted to toss the book aside, someone will make a point (like the fascination with the Terminator reflecting our hope for a superstrong mechanical saviour of the future) that gives one reason to keep reading. It is a fascinating concept, this man in the machine loop.

The theological underpinnings of cyborgism seem deeply rooted in postmodernity. The editors note that 'the issue of (post)modernity is addressed in many of the contributions here, including our own, so suffice it to say that there is a startling temporal and geographical correlation between cyborgism and postmodernism'. But the reader may reject these underpinnings and still find the book fascinating.

As I was glancing at various chapters I found myself looking anew at the interactions I personally have with machines and other inorganic materials. I have metal teeth implants (crowns) and fillings. I am unable to see without the help of artificial lenses (glasses). I depend on many machines including the computer, fax, and phone for extending my personal communication with the world. In addition, I have multiple subtle biological implants, including a number of vaccinations (measles, mumps, rubella, tetanus, pertussis, diphtheria, typhoid, yellow fever, hepatitis B, and polio). Perhaps these vaccinations alone would not make me a cyborg, because the injection of foreign protein is short-lived. But researchers are now working on DNA vaccines, which are incorporated into a person's own DNA and manufacture the necessary immunological proteins. These vaccines have the most promise to cure or prevent hepatitis C and AIDS, because the body then would replenish its own immune system. The patient would then be a mosaic of DNA material—his or her own DNA plus the implanted DNA in the hot spot of the arm. All forms of genetic engineering raise the issue of cyborgism.

One can go both ways with cyborgs. Suppose one began with a machine, and grafted on skin—ectoderm—living tissue. This would make machines self-healing, self-repairing. I heard an advertisement the other day that touted a 'self-healing cable'. Self-healing neural networks have redundancy which enable the system to continue functioning even when some part fails.

The sexual nature of cyborgs is varied; they are both asexual and sexually predatory in

modern fiction. But the future of man and machine links must also include some reproductive component. Machines are said not to have feelings or emotions—but when Garry Kasparov plays Deep Blue, the logic and memory chips of the IBM computer are formatted to include—what is it—perhaps intuition? The computer can see more moves in advance than the human. It can calculate infinitely faster. Kasparov struggles. It is the start of a new era, a time when computers are acknowledged to be potentially intellectually superior to human beings. Why then would we not wish to meld with them?

And indeed, what is to keep us from mating with them, if not a Christian morality system of the need to be faithful to one's own spouse? For I pose you a morality test. Suppose a virtual reality system is developed in which a willing computer simulation of your deepest sexual fantasy can be played out. You can mate with the computer without fear of sexually transmitted disease, or your spouse discovering hairs on the pillow. Yet the biological nature of the sex will be real. How long do you think it will be before such virtual sex becomes possible? Five years or ten? If I can make you feel you are flying an aeroplane, why can't I program a computer to make you feel you are being propositioned by a safe sexual slave? Or will the slave someday become the master? One need not worry about the issue of human cloning when this more pressing issue, the issue of cyber-morality, is so close at hand. 'Let the marriage bed be undefiled' the Bible says. Will you be able to resist cyber-sex, if you have ever secretly watched a pornographic movie?

I encourage you to think about these topics even if you don't agree with these broad definitions of cyborg or with the content or style of this book. We urgently need a theology of cyborg. We need to decide how to think about our interactions with our increasingly brilliant and attractive machines.

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### Body, Soul, and Bioethics

Gilbert C. Meilaender  
Notre Dame and London: University of Notre  
Dame Press, 1996  
ISBN 0-268-00698-9, 134 pp., cloth \$21.95

### Bioethics: A Primer for Christians

Gilbert Meilaender  
Grand Rapids and Cambridge, UK: Wm. B.  
Eerdmans Publishing Co., 1996  
ISBN 0-8028-4234-8, 131 pp., paperback \$10.00

Gilbert Meilaender, now a colleague of mine at Valparaiso University, Indiana, is widely recognised for his work in theological ethics as well as biomedical ethics. He writes as a Lutheran, but as a Lutheran influenced significantly by the Roman Catholic philosopher Josef Pieper, the Reformed theologian Karl Barth and, of course, his mentor, Paul Ramsey. Readers will welcome these two brief works, clearly and winsomely written, though they are more likely to find their appetites whetted than satisfied. Brevity is, perhaps, a virtue, but at best only a minor virtue when one is reading reflections as rich as Meilaender provides.

In both books Meilaender champions the cause of a more substantive, theologically-thick approach to issues of medicine against a minimalist bioethic driven by public policy concerns and the need to achieve consensus in public policy. *Body, Soul, and Bioethics* is a sustained argument for a more substantive approach, an attempt to persuade that 'background beliefs about human nature and destiny' are ignored at our own peril. *Bioethics* provides a rudimentary account of the substance that Christian ethics might bring to medical ethics.

*Body, Soul, and Bioethics* argues that contemporary minimalist bioethics assumes a view of humans that, upon reflection, we would do well to reject. These operating assumptions about persons imply an insubstantial agency whose desires are all important, a self lacking the metaphysical and religious concerns that characterise the persons we know, yet whose desires we recognise as our highest authority. Thus, in chapter one Meilaender discusses method in medical ethics, examining and rejecting, in turn, 'communitarian medical ethics', the 'principlist' method of Beauchamp and Childress, the casuistry of Jonsen and Toulmin, and, finally, the Aristotelian medical practice of Leon Kass. In contrast, Meilaender advocates what might be described as a 'teleological' principlism rather than the 'consensus' principlism that elevates autonomy to primary position. Meilaender's 'teleological' principlism would identify relevant moral principles in the light of a Christian construal of the nature and destiny of persons. The result might well overlap the Beauchamp-Childress principles of autonomy, nonmaleficence, beneficence, and justice, but these would be interpreted and specified within a theological understanding of persons. Meilaender's examination of 'principlism' is deft, his rejection of contemporary casuistry, telling. His objections to Kass, while less convincing, are, nonetheless, stimulating.

In chapters two and three Meilaender argues that contemporary bioethics typically misconstrues the moral significance of the human body. The second chapter is a marvellous presentation of what it might mean to take seriously 'the natural history of bodily life', to regard ourselves as '*terra animata*'. Think, for example, of how different advance directives look when considered in the following light: 'To point to some moment in this history as the moment in which we are most truly ourselves, the vantage point from which the rest of our life is to be judged—a moment at which, presumably, we have personhood, and not just another of the many moments in which we are persons—is to suppose that we can somehow extricate ourselves from the body's natural history, can see ourselves whole. It is even, perhaps, to suppose that in such a moment we are rather like God, no longer having our personal presence in the body' (p. 49). If there is one chapter to read of *Body, Soul, and Bioethics*—perhaps if there is only one chapter to read of all of Meilaender—this would be a good one. Discussions of death and dying in the literature of minimalist ethics are thin brew indeed by comparison.

In chapter three Meilaender continues his attempt to take seriously our embodiment in an extensive critique of John A. Robertson's work on reproduction. Meilaender moves us beyond the Robertsonian obeisance to the self and its

projects to a consideration of the identity of the self and the location of human projects in marriage. And a consideration of marriage and the family does indeed enrich the analysis of reproduction. But, surprisingly, there is little explicit theology in his discussion of marriage. That may enable a better conversation with Robertson, but I am unconvinced that reason without revelation will lead us to the picture of marriage with which Meilaender enriches the conversation.

Chapter four is a case of study of the 'poverty of bioethics', the exemplar of this poverty the Report of the Human Embryo Research Panel, established by the Advisory Committee to the Director of the National Institutes of Health. The book concludes with a brief discussion of 'the issue that will not die', abortion, reminding us of what some arguments defending the moral permissibility of abortion encourage us to forget—the natural process of birth and the community we share with the developing foetus. These are wise and helpful words. If there is more critique than constructive work in *Body, Soul, and Bioethics*, there are, nevertheless, healthy indicators of what that constructive work looks like.

*Bioethics: A Primer for Christians* is not an introductory survey of the literature and issues in bioethics. It is, rather, an attempt to initiate students into a disciplined theological engagement with contemporary medical practice. And theological engagement it is, not the basic ethical tools for public policy decision-making. In his first chapter, 'Christian Vision', Meilaender briefly develops Christian beliefs relevant as the 'background beliefs' which ought to inform Christian reflection in bioethics. The implications of baptism for our understanding of ourselves as individuals in community with God and with one another, the free and finite nature of human beings, the character of humans as embodied creatures, and the place of suffering, disease, and healing in a Christian understanding of our earthly pilgrimage, are canvassed. A primary implication is that theological ethics will be, in some shape or form, deontological. This is important material, especially helpful for introductory students. I wonder, however, whether a more thoroughly Christocentric introduction might not be more illuminating. In short, especially in a brief introduction to theological ethics, one might want to remind the students that it is God's story that norms and informs our own and that we read that story and our own stories well only in so far as we see them in Christ.

The issues discussed in *Bioethics* are procreation and artificial reproduction, abortion, genetic testing, prenatal screening, suicide and euthanasia, the refusal of treatment, the responsibility for medical decisions, organ donation, human experimentation, and the character of illness. Meilaender writes without jargon and introductory students and their teachers will find the material rich and rewarding. There is no effort to survey a wide diversity of voices within the tradition, and that is just as well, for at the introductory level students do not need an awareness of all the possible arguments on an issue but to learn how to think carefully and well and theologically. Exposure to a smaller array of arguments will better serve the student. Meilaender's *Bioethics*, thus, will serve the student very well indeed.

For those who have felt uneasy with what

they might term the 'dryness' of current works in medical ethics, Meilaender provides both account of the problem and antidote. Readers of this journal are but a few of those who will be grateful to him for this.

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### **Euthanasia in The Netherlands: Sliding Down The Slippery Slope?**

John Keown  
CBPP, 58 Hanover Gardens, London SE11 5TN, UK  
ISBN 0-9574-760-X, 36 pp., Pb £2.00

The Netherlands is the only country in the world in which euthanasia is officially condoned and widely practised. Dr John Keown, lecturer in the Law and Ethics of Medicine in the Faculty of Law, University of Cambridge, carried out empirical research there in 1989/1991. His conclusions are based on personal observation, supplemented by a critical analysis of the reports which have come out of the country since that time. This concise study is reprinted from the major review on euthanasia: 'Euthanasia Examined: Ethical, Clinical and Legal Perspectives', edited by John Keown, 1995, and published by Cambridge University Press. It forms a body of compelling evidence, whose importance cannot be exaggerated.

The material falls into three parts. Part I outlines the relevant law and the guidelines for euthanasia. Part II summarises the evidence indicating widespread breach of the guidelines. Part III examines the slide from voluntary to non-voluntary euthanasia in Dutch practice, and the shift in Dutch opinion towards condonation of non-voluntary euthanasia. The author concludes that, within a decade, the so-called 'strict safeguards' against the slide have proved signally ineffectual. It is apparent that the original Dutch proponents of euthanasia began with a narrow definition of euthanasia as a strategy for winning acceptance of the general practice, which would then turn to relief of suffering as its justification in cases in which patients are unable to request euthanasia. This is a warning which must be heeded.

Aberdeen PROFESSOR DAVID SHORT

### **Trying for a Baby: What You Need to Know about Fertility Treatment**

Pete Moore  
Lion, 1996, £6.99 ISBN 0-7459-3421-8

Ten years ago I wrote a shortish book on the ethics of artificial means of fertilisation and embryology entitled *Whose Baby?* The demands of work since have led me away from medical ethics to focus on other areas. I was therefore interested to return to this subject a decade later, to read a book which covers similar ground in an easily accessible, non-technical style, not least to assess the scope of new developments and see how much the debate has moved on.

Pete Moore writes regularly for newspapers and journals and leads group discussions 'at the interface of Christianity, science and

medical ethics'. He has clearly talked to many parents struggling with the problem of infertility and a sensitive, compassionate streak runs through the whole book. The text is peppered with real-life stories of couples like John and Alison, Alan and Sara, etc., who are contemplating resort to artificial means of fertilisation, and there is an appropriate balance between stories that have a happy and not-so-happy ending. Moore has three well-explained, replete-with-diagram chapters in which he takes the reader deftly through the biology of birth, overcoming problems using surgery or drugs, and solving problems by handling sperm and eggs. This revealed the development of several techniques with vivid acronyms which still lay on the horizon in 1987, notably POST (Peritoneal Oocyte and Sperm Transfer), SUZI (Sub-Zonal Insemination) and MESA (Microsurgical Epididymal Sperm Aspiration).

When Moore comes to evaluate the morality of these different techniques, however, the key issues of debate remain exactly the same—and just as unresolved. When does a human life begin?, asks Moore in chapter 6. His answer: 'As far as I can see, scientific evidence indicates that a human being most certainly exists by the time twelve weeks of development have occurred. An individual organism exists that is more than likely to develop into a baby once fourteen days of development have passed. The genes defining many of a person's characteristics are grouped together shortly after fertilisation. I do not believe it is possible to use current scientific information to define the moment when a human life starts with any greater precision' (p. 126). Later, he says that 'After a lot of thought, I have come to the conclusion that an embryo should be treated as human life, but not given quite the same value as a fetus, a newborn baby or an adult. Any human embryo should be treated with care and respect and procedures that involve damaging or destroying one are highly suspect, even if the data gained may save the lives of many others' (p. 147).

Moore ends up with a qualified acceptance of most of the new techniques. By using donors of gametes, couples are weakening the exclusive nature of the marriage contract, but he does not rule the process out completely. The freezing of embryos throws up so many dilemmas that he is very uneasy about it, but so long as it 'is kept to an absolute minimum', it is acceptable. So is embryo selection where a 'clear genetic condition' is present. Surrogacy is deemed out of order. Throughout his discussion, there might have been more reflection on the possibility that some of the dilemmas we are facing are quandaries we should never have got ourselves into the position of encountering in the first place.

Not surprisingly—because the issues are so difficult—I was less impressed by the evaluative chapters than the descriptive ones. Moore certainly highlights the key dilemmas, but is less than sure-footed in the way he deals with them. Too often he ends up saying 'in my view' or 'my conclusion is' without explaining the steps by which he got there. His opinions therefore come over as a series of personal hunches, rather than views worked out in a rigorous way. His categorisation of philosophical and theological views is distinctly crude, and he could usefully have collaborated with someone

with greater expertise in those areas. There is a useful appendix on Bible passages which may have some bearing on the issues, but I felt this might have been better incorporated into the main text.

Despite these reservations, I still think this a good book to commend to couples facing hard choices about fertility treatment. Its friendly approach and even-handed assessment make it an attractive read. For those for whom artificial techniques do not work, or who feel that the moral obstacles are too high, it concludes with a positive affirmation of marriages which are 'child-free', rather than childless—but it recognises the difficulty many will have in arriving at that understanding.

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**The Idea of the Postmodern: A History,**  
Hans Bertens  
London & New York: Routledge, 1995  
ISBN 0-4150-6012-5 ix + 284 pp. pb \$22.99

This book is a survey of the way the concept of 'the postmodern' arose, has been used and developed since the early 1960s. The author is Professor and Director of American Studies at the University of Utrecht, The Netherlands. On the cover the book is described as 'a witty and accessible guide for the bemused student'. There is the occasional dryly humorous comment, but the accessibility will depend on the knowledge which the student brings to the book. It is not a book for the beginner who is looking for an easy way in to understanding what all the talk about 'postmodernism' is about.

One value of the book is the way it lays bare the confusion that has attended use of the term 'postmodern' and its derivatives since it came into common use in the early 1960s. Part of the problem is that it came into use in literature and the arts and was used differently in different disciplines. Literary critics used it of a turn away from narrative and representation towards self-reflexiveness. However, in some other art forms 'modernism' had meant a turn away from representation in favour of a self-reflexive exploration of the art form, for example in painting and architecture. As a result, when the reaction set in and art critics began to use the term 'postmodern' they meant by it almost the opposite of what the literary critics meant. The first five chapters of the book describe the developments in various artistic disciplines in the 1960s and 1970s. It is rather heavy going for someone not acquainted with the various books, paintings, buildings, and so on that are at the centre of the discussion of what is and what is not 'postmodern'.

In the 1980s the debate about postmodernism ceased to be almost exclusively confined to the arts and began to engage the serious attention of philosophers, sociologists and general critics of the social order, usually of a leftist persuasion. So, from ch. 6–10 Bertens presents a summary, with some critical comment, of the work of several of the prominent writers on 'postmodernism', such as Habermas, Lyotard, Jameson, Baudrillard, Rorty, Harvey and Bauman. These chapters could provide a useful starting point for studying the work of any of

these writers. Once again the picture is a confused one as different theorists concentrate on different features of recent and contemporary culture and produce rather different, sometimes opposed, theoretical constructions of what is going on in western societies at the moment.

The book ends with a conclusion by the author, which for me was the most lucid part of the book. There is no doubt that there have been considerable changes in western culture and societies over the last 30 years—whether one dates the change to the counter-culture movements of the 1960s, culminating in the riots and demonstrations of 1968, or to the crisis for capitalism brought about by the oil crisis of 1973. These changes include a loss of confidence in the Enlightenment ideals of universal objective truth and the inevitability of progress. They have been accompanied by a fragmentation of society, as expressed in rising nationalism and single-issue pressure groups. The Enlightenment ideal of individual freedom has become that of consumer choice urged on by the advertising media. All this, Bertens suggests, can be seen as an out-working of the enlightenment ideal of critical reflexivity – because critical reflection has shown that rationality cannot ground itself. So, the project of 'modern knowledge' is self-defeating. However, Bertens criticizes the theorists of postmodernism for concentrating on these developments alone, commenting that perhaps they do so because they come from the Humanities. What they have failed to take seriously is that, paradoxically, 'There is one cognitive style, one set of procedural principles that holds the promise of leading us to unconditional knowledge. It is impossible to establish beyond theoretical doubt why these principles work but they would certainly seem to do so: it takes more than the poststructuralist turn to shake the scientific community's belief that we indeed know about, say the speed of light or the second law of thermodynamics, and for good reasons' (p. 240). In other areas the theorists have also ignored 'globalizing trends' which run counter to fragmentation – the growth of the European Union, the enlargement of NATO, the growth of massive free trade agreements such as the GATT and the NAFTA. These Bertens sees as continuing out-workings of the enlightenment ideal of progress and its universalizing tendencies. For him 'postmodernity' is a development of 'modernity' itself in which, 'After an over-long period in which Enlightenment universalist representationalism dominated the scene, and a brief, but turbulent period in which its opposite, radical anti-representationalism, captured the imagination, we now find ourselves in the difficult position of trying to honor the claims of both, of seeing the values of both representation and anti-representation, of both consensus and dissensus' (p. 248). For me, Bertens' analysis make more sense than that of any of the theorists whose work he presents and discusses.

Few, other than the serious student of modern culture, will read this book from cover to cover. If you want a reference book to dip into to find out about the postmodernist debate and its participants, then this will serve you well.

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### Knowledge and the Body-Mind Problem: In Defence of Interaction

Karl R. Popper. Edited by M. A. Notturmo.  
London and New York: Routledge, 1994.  
ISBN 0-415-11504-3, 158 pp., cloth \$19.95

The late Sir Karl Popper (d. Sept. 1994), in this provocative little book, defends a view of the human person and human knowledge which has implications for bioethicists who believe that the framework of metaphysics rather than jurisprudence is a better paradigm by which we can answer the question, 'What are human persons and how should we treat them?'

This book originated as a series of lectures which Popper gave at Emory University in 1969. However, since the initial presentation, Popper and the books editor, M. A. Notturmo, have revised and reworked portions of the text.

Popper is quite critical of epistemological relativism, or what he calls pejoratively, the myth of the framework view. Although this view was not as pervasive when Popper lectured at Emory in 1969, it is now quite popular among certain intellectuals and comes under the heading of postmodernism. It is, according to Popper, one of the great intellectual evils of our time (p. 137). Defending this claim, which in hindsight, reads like a prophetic utterance, Popper asserts:

'It undermines the unity of mankind, since it dogmatically asserts that there can, in general, be no rational or critical discussion except between men who hold almost identical views. And it sees all men, so far as they try to be rational, as caught in a prison of beliefs which are irrational, because they are, in principle, not subject to critical discussion. There can be few myths which are more destructive. For the alternative to critical discussion is violence and war—just as the only alternative to violence and war is critical discussion' (p. 137).

Why should this epistemological question be of concern for bioethicists?

For one reason, those who accept the myth of the framework, such as Richard Rorty, see an intimate connection between, in the words of Rorty, the subject-object model of enquiry, the child-parent model of moral obligation, and the correspondence theory of truth (from 'Dismantling Truth: Solidarity Versus Objectivity', in *Philosophy: The Quest for Truth*, 3rd ed., ed. L. P. Pojman [Wadsworth, 1996], p. 188). Relativism of knowledge entails relativism of morally important institutions such as the family and traditional marriage. To say, for example, that there is a universal and natural obligation that parents have to children and that this obligation is not the result of autonomous choice, human invention and/or social construction is to say that we can know transcendent truths about human persons and that these truths are not relative to our interpretative communities. This means that a mother's relationship to her unborn child carries with it a greater moral force than her relationship to strangers or other people's children. Thus, appeals to autonomy or choice to justify abortion rights (as defended in the work of J. J. Thomson or Eileen McDonough) do not work.

Take for example another question getting much attention in the US: Should the state permit same-sex marriage? According to many who believe the myth of the framework, to say

that such an institution is immoral and violates natural law (as well as Scripture) and thus ought to be prohibited would be to violate the autonomy of those of the same gender who want to consummate their love in the trappings of a lawful union. However, this seems to beg the question, at least in the minds of those who oppose such unions, for the appeal to autonomy as the basis for moral action seems to assume a metaphysical and epistemological position which affirms that all traditional notions about gender, marriage, and family are phenomena which are the result of artificial social institutions relative to interpretive communities rather than the result of an immutable human nature endowed to us by either God or Nature. On the other hand, those who oppose same-sex marriage maintain that autonomy and consent are neither necessary nor sufficient conditions for an act to be legally or morally permissible and traditional notions of gender, marriage, and family, however differently expressed throughout human history and/or better understood as the result of moral reflection, are part of the furniture of the universe whose continued existence are essential to maintaining the moral ecology of human society.

I have no idea where Popper stood on these issues or if he even had an opinion on them. My point here is simply to show that Popper's concern is warranted: one's epistemology makes a difference.

In addition to epistemology, Popper is concerned about the body-mind problem. He calls his position a Cartesian dualism (p. 5), one he distinguishes from physicalism, body-mind parallelism, and epiphenomenalism. Cartesian dualism maintains that the mind is not identical to the physical brain, but is a separate substance which interacts with the brain. Physicalism is the view that the mind is identical to the brain in so far as all mind-events are reducible to brain-events. Body-mind parallelism holds that mind and matter are two aspects of the same thing (p. 109). And epiphenomenalism is the view that though mental events exist, they are merely properties of the brain, not properties of a separate substance called mind. Just as wetness is an epiphenomenon of the combination of elements in H<sub>2</sub>O (since neither hydrogen nor oxygen has the property of wetness), mental events are the epiphenomena of the complexity of the physical brain. Popper sees many problems with these three rivals to Cartesian dualism and makes a decent defence of his view. (He presents a much more sophisticated defence in the book he co-authored with John C. Eccles, *The Self and its Brain: An Argument for Interactionism* [Routledge & Kegan Paul, 1983]).

Why should this interest bioethicists? Consider the debate over abortion rights. Many pro-abortion proponents claim that the foetus is not a human person and defend this point by arguing that the foetus does not possess certain attributes that we ordinarily associate with personhood, e.g., self-consciousness, the ability to reason, concept of a continuing self, self-motivated activity, the capacity to communicate. This view assumes that human personhood is a matter of function rather than a matter of nature. The defender of this perspective maintains that a human person comes into being when the physical structures of the human body in the course of human development reach a certain level of complexity so that

certain functions can occur. This view, among other things, assumes a certain metaphysical position about reality: physicalism, the view that everything, including the human mind, is ultimately reducible to matter.

Those who maintain this metaphysical commitment typically affirm one of the three views of the human mind which are rivals to substance dualism. Critics of these views typically defend a version of substance dualism, though one more closely aligned with Thomas Aquinas than Rene Descartes. Those who hold to a Thomistic version maintain that substance dualism affirms that all members of a given species instantiate the same essential nature, since without an essential nature the entity (in this case, a human person) would be merely a property-thing, such as a car or table which literally becomes a different car or table when a part is removed and/or replaced. In contrast, a substance which loses or gains a part, such as a human person who loses his hair or acquires a new organ by transplant, is still the same substance though he has undergone accidental change. A property-thing is an entity which has no underlying bearer of properties existing ontologically prior to the whole, and no internal, defining essence that diffuses, informs and unites its parts and properties. It is merely a collection of parts, standing in external, spacio-temporal relations which, in turn, gives rise to a bundle of properties determined by those parts. Moreover, substance dualism affirms that because all members of a particular species share the same nature, 'it is... unintelligible to assert that a substance can exemplify its nature to a greater or lesser degree, since the essential nature underlying a given member of a species is non-degreed. That nature either is or is not exemplified' (J. P. Moreland and John Mitchell, 'Is the Human Person a Substance or a Property-Thing?', *EM* 11:3 [1995]: 50). As many would guess, substance dualism, if true, tends to support a pro-life view of human personhood since it affirms that personhood is not a matter of functional achievement, but rather a matter of nature. The foetus, according to the substance dualist, is not a potential person, but a person with great potential.

What is ironic is that Popper is firmly committed to naturalistic evolution, which seems metaphysically incapable of grounding substance dualism, since it seems impossible to account for non-physical substances while at the same time claim that all reality is ultimately material. Popper's attempt to resolve this fails.

There is much more to this text than I could have possibly covered in this review, such as Popper's discussions on evolutionary theory, the nature of scientific discovery and theory making, and human and animal communication and behaviour. In any event, I highly recommend this book to those in the field of bioethics who are interested in scientific epistemology and the body-mind problem.

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#### Wrong Medicine

Lawrence J. Schneiderman and Nancy S. Jecker. Baltimore, Johns Hopkins University Press, 1995

ISBN 0-8018-5036-3, 200 pp., hardcover \$25.95

The problem of medical futility is one with which every practising physician is familiar, a problem that must be confronted time and again, in the nursing home, in the intensive care unit, in the emergency room. When is enough, enough? Or yet, when is enough too much? When do treatments cease to provide benefit and merely prolong the inevitable—often at great financial or human cost?

The question of futile treatment lies at the heart of *Wrong Medicine* by Lawrence J. Schneiderman, MD and Nancy S. Jecker, Ph.D.

The authors take as their first of several examples the case of Nancy Cruzan, maintained unconscious, in a persistent vegetative state for seven years while family, the courts, the state, and religious groups argued over her fate. While legal and ethical pundits debated, the task lay upon physicians to maintain Cruzan's functioning body despite her irreparably damaged brain. Schneiderman and Jecker pose the question—is this something that physicians should be doing?

They discuss the goal of medicine, historically and Hippocratically considered as being normative: restoring health and alleviating suffering. Only later did the notion of prolonging life enter into the equation; still later the idea of the indefinite prolongation of life no matter what.

The discussion of goals leads to an examination of medical futility. Rejecting the notion that the concept of futility is too slippery to define, the authors discuss several definitions and propose their own. 'Medical futility means any effort to provide a benefit to a patient that is highly likely to fail and whose rare exceptions cannot be systematically produced' (p. 11). To this they add a qualitative aspect: 'If a patient lacks the capacity to appreciate the benefit of a treatment, or if the treatment fails to release a patient from total dependence on medical care, then treatment should be regarded as futile' (p. 17).

They propose as a criterion that if a treatment has not produced benefit in one hundred cases, it should be considered futile. They make no distinction between ordinary and extraordinary treatment. Treatments that don't work shouldn't be used.

From defining futility, the authors discuss the human and medical factors that make it difficult for physicians to say no to futile treatment, why patients and families demand tests and treatment and want 'everything done,' and then why we must say no to futile treatment.

In an increasingly cost-concerned era, Schneiderman and Jecker point specifically to the state of persistent unconsciousness, pointing out the immense cost of maintaining patients who will never-ever-awaken: One to seven billion dollars per year for 14,000–35,000 patients (p. 42).

'Personhood,' they say, 'requires consciousness' (p. 12). An individual in a state of persistent (permanent) unconsciousness is still a human being, but not a person, and not owed the medical means to stay alive.

Schneiderman's and Jecker's overriding concern is for the patient. 'For although the powers of modern medicine have inspired awe, it is becoming increasingly apparent they also arouse a contrary view in the mind of the public, an inordinate fear of being trapped in a

modern, dehumanizing technology with no hope of escape' (p. 39). 'Superbly effective advances in medical treatments have become purposeless rituals without reasonable goals' (p. 45).

The book relates cases of 'medicine run amok' where patients are lost in mazes of technological or legal construction; their care fragmented between subspecialties focused on body parts to the detriment of the whole person; the totality plastered over with public relations concerns. The case of Baby K, an anencephalic infant kept alive despite the obvious futility of such action is another example of misguided medicine.

The authors deplore the pursuit of this 'technological imperative,' that focuses on technology rather than the patient. 'Medicine's focus has never been (and should never become) the biological organism as such, but is the suffering person (i.e. patient)' (p. 13). And, 'A particular treatment may be futile, but care is never futile; nor is a patient ever futile' (p. 18, italics original).

Some treatments that medicine offers are like the emperor's new clothes: full of promise, empty of substance. 'When there is no scientific evidence that *something* benefits an individual patient, it is better that *nothing* be done to that patient' (p. 144, italics original). Keeping a patient alive in the hopes that a miracle will occur is not acceptable. 'Physicians cannot and have never been obligated to produce a miracle' (p. 160).

Having considered the problem of medical futility, what is to be done about it? Schneiderman and Jecker assert, 'Attempting futile treatments constitutes irresponsible medical practice and should be condemned by the profession' (p. 62). Futility is not confined to maintaining persistent vegetative states, but any practice or treatment that does not produce a benefit to the patient—prescribing antibiotics for viral illnesses, using unproved drugs for AIDS treatment, utilising aggressive, invasive procedures in terminal patients.

They distinguish between rationing and futility, and discuss factors related to litigation. They maintain that physicians can receive permission to refrain from futile treatments; be encouraged to refrain; or be required to refrain.

Their call is for greater physician education in the realm of medical futility. Reducing fear of litigation is part of the answer. So is educating the legal and judicial system and the public. By doing so, they hope to avoid repetition of cases such as Nancy Cruzan and Baby K.

Schneiderman and Jecker caution that futility is not to be invoked haphazardly. 'Physicians should not be free to invoke medical futility unless they can justify it before their peers and before society' (p. 160). This may mean re-evaluating many current treatments, whose benefits have never been properly assessed.

*Wrong Medicine* is not written from a specifically Christian perspective, but, as noted, is Hippocratically based. Regarding the idea of sanctity of life, held by many Christians, the authors say, '... the "sanctity of life principle" in fact raises more questions than it answers' (p. 122).

*Wrong Medicine* is written in an easily readable style, free from technical jargon. As such it should be accessible to lay readers as well as medical personnel. A particular value would be for medical students, interns, and residents—

those at the beginning of their careers, who are often thrust into situations for which they have little training or preparation.

Whether or not all their conclusions are accepted, Schneiderman and Jecker make a cogent case for examining the treatments we offer patients, particularly treatments that are suspect, that degrade, rather than enhance quality of life, and which may cause more suffering than they prevent. Futile treatments harm everyone—the patients who suffer, the families, individual physicians, and the practice of medicine itself.

*Wrong Medicine* is well worth reading and considering.

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### Israel's Divine Healer

Studies in Old Testament Biblical Theology Series  
Michael L. Brown  
Grand Rapids: Zondervan, 1995  
ISBN 0-310-20029-6, 462 pp., paperback \$19.99

Healing is of central importance in people's lives, and the ancient world was no different. The Hebrew Bible places great importance on health and healing, as do the writings of other cultures of the time. Yet complete, systematic treatments of the biblical idea of God as Healer are few and far between. Readers of this journal should be very interested in Michael Brown's excellent treatment of this neglected field. His very thorough book sheds much light on what it meant for the Lord alone to be *Israel's Divine Healer* (Exodus 15:26). Since ethical issues in health care often resolve to views about what it means to heal or be healed, a biblical understanding of healing is essential to Christian medical ethics.

Brown's approach is 'comparative, canonical, and conservative' (p. 21). He spends the introduction discussing various Hebrew words associated with healing. This technical section can easily be skipped over, but it brings Brown to an important conclusion which impacts the remainder of his book. His study convinces him that the Hebrew root underlying the concept of healing, *rapa*, means to 'restore, make whole' a wrong, sick, broken, or deficient condition to its original and proper state (p. 28). The term is used of healing the sick, but is also used for such diverse actions as fixing broken pottery (Jeremiah 19:11), purifying water (2 Kings 2:21–22), and restoring the nation of Israel (Lamentations 2:13). Given this use of *rapa*, Brown argues that God's activity as Healer (*rope*) seeks to touch all aspects of our lives: spiritual, emotional, and physical. He spends the rest of the book supporting and developing this definition by examining most of the passages in which *rapa* and its related words occur.

Before examining the biblical materials in detail, Brown surveys other ancient views of physicians and healing deities. He shows how medicine and religion were intimately intertwined in these cultures, which created a significant problem for Israel. While many are familiar with the conflicts arising from God calling on Israel to avoid the pagan gods of the surrounding cultures, Brown demonstrates convincingly that this conflict often centred

around the area of healing. 'It must be remembered that the Israelites were not lured away by the sublimities of the idolatrous religions as much as by the perceived or alleged power of their gods' (p. 69). Many of these claims were based on alleged healing powers.

Brown then deals with the biblical materials in four sections: the Torah and historical books; Psalms, Proverbs, and Ecclesiastes; the Prophetic books; and the New Testament. He gives general survey information on the concept of healing in these biblical books, and also does in-depth analyses of significant passages. For example, 2 Chronicles 16 recounts the death of King Asa from a disease for which he sought physicians' help. Some cite this as evidence that biblical faith should oppose natural medicine. However, Brown exegetes this passage carefully to convincingly argue that Asa's problem was his unwillingness to turn to God. He also demonstrates the high likelihood that the physicians consulted by Asa used magical practices interwoven with pagan religion. Although Brown does not apply the passage to today, its implications for Christians getting involved in alternative healing rituals based in other religions is clear.

Brown deals with many different passages throughout his book, too many to survey here. A few of the general themes which he discusses throughout the book will give the interested reader some idea of the central issues covered. One is the tension between being faithful to God and having disease and illness in one's life. Brown notes that although a long and healthy life was always viewed as God's blessing, this did not protect a godly person from all illnesses and the frailties of old age. While many of the Psalms record people seeking to understand why God had visited them with suffering, Brown finds that the illnesses mentioned here are generally severe and life-threatening, not everyday cuts and bruises. These the Israelites treated with the best medical resources available to them.

Brown argues that the Israelites looked for connections to sin when serious, life-threatening, diseases occurred, especially if this would dramatically shorten a person's life. Serious illness was often viewed as an indication of divine wrath due to personal transgression. At times this even added to the person's suffering when it led to rejection by friends and relatives. The Psalms record the pain of alienation, but nowhere do they approve of it, and Psalm 69 condemns it. Job's friends provide the example of staying with others in their pain. 'Whether or not the sufferer had sinned was not the question; solidarity with the sick for the purpose of restoration was the higher issue' (p. 136). Brown's catalogue of healing Psalms provides a useful resource for praying the psalms ourselves or with others when ill.

Brown also tackles the tough issue of whether all sickness should be seen as punishment from God. He states that 'the biblical writers never forgot that, fundamentally speaking, sickness is a tragic state ultimately caused by a tragic act: human sin (either corporate or individual). In itself, it remains a curse, even if its final results are salutary or even salvific' (p. 149). He admits that 'a straightforward, albeit superficial, reading of much of the OT indicates that everything always goes well for the righteous, while for the wicked there is only trouble and hardship' (p. 173).

But Brown uses the example of Job in the Old Testament, and John 9:1–5 in the New Testament, to show clearly that the Bible does not teach that all sickness is caused by personal sin. There is sickness and disease which visits godly people for inexplicable reasons. These may be purely natural reasons, or, as in Job's case, they may be connected to satanic schemes (something elaborated on much more in the New Testament). However, Brown still holds that there is such a clear connection between sin and sickness, especially in the healing miracles of Jesus, that we as Christians cannot dismiss its possible connection to some of our illnesses.

Hence, this leads to his main practical applications. Given that sin can cause sickness, and that God can still judge people, an illness may be connected to sin in a person's life. Therefore, according to Brown, an initial response to sickness (or disaster) should be to confess and forsake any known sin (Proverbs 28:18 and 1 John 1:9). This should be done with the expectation of healing, at least spiritual, if not physical. However, other sicknesses will be unrelated to sin and we may never discover their causes. In these cases, the Christian should resolve to trust that God will help us through these situations. 'That he is *good* and that he is *God* should be enough for us' (p. 181).

In *Israel's Divine Healer*, Brown has provided a valuable resource for anyone concerned about the Bible and healing, and how healing can be promoted ethically. The depth of scholarship in this book can be demonstrated by the fact that his endnotes take up almost two hundred pages. However, his focus is primarily exegetical and historical, not theological or application-oriented. Hence, much remains to be said on how these materials apply to present situations. I was disappointed that Brown did not address a number of important and difficult issues in this area. For example, he affirms on-going divine physical healing, but does not discuss why it might happen in some situations but not in others. Further elaboration on what it means practically to trust God in our illnesses would have been useful. Also, as might be expected of an Old Testament scholar, Brown's New Testament section is relatively brief, but providing an excellent starting point for further study. Overall, this book is highly recommended for anyone seriously applying biblical concepts of healing in their lives.

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### Ethics for a Brave New World

John S. Feinberg and Paul D. Feinberg  
Wheaton, IL: Crossway Books, 1993  
ISBN 0-89107-736-7, xvi + 479 pp., paperback \$22.00

In 1932, Aldous Huxley published *Brave New World*, a story of a biotechnological utopia. The features of this utopia, in the words of Freeman Dyson, were 'the cloning of large numbers of identical human beings, the free supply of euphoric drugs with no deleterious side-effects, and the benevolent tyranny of a world government . . .' (*Imagined Worlds*, Cambridge: Harvard University Press, 1997, p. 123).

While 1984 has come and gone without all the prophesies of George Orwell being fulfilled,

the premises of *Brave New World* (set farther in the future) are breaking upon us. We have witnessed the birth of new reproductive techniques, the advent of genetic engineering and cloning, the spectre of nuclear war, and many other scientific developments. The problem lies in the fact that many of these developments have proceeded without an adequate ethical foundation. In some cases—as, for instance, the cloning of the sheep Dolly and its implications for human cloning—it seems as though the ethical community (as well as governments and scientific institutions) is scrambling to catch up.

Dyson continues, '... ethical considerations can prevail over short-sighted self-interest only if the voice of religion is added to the voice of science. Both must be heard, if our ethical choices are to be at the same time rational and humane.' (*Imagined Worlds*, p. 8). But Dyson stops short. To call on generic religion doesn't help. Despite what some would insist, all religions are not the same. The ethics of Hindu India and atheist China—leading to the caste system and infanticide, respectively—do not produce the same set of ethics as Christianity.

Which brings us to *Ethics for a Brave New World*. Its title conjures images of Huxley's society—a comparison the authors make explicit in the preface: 'It is incredible to see how similar our world is today to many things Huxley imagined only for literary impact' (p. xiii). Written by two professors of Biblical and Systematic Theology at Trinity Evangelical Divinity School, *Ethics for a Brave New World* is a book aimed specifically at Christians, designed to answer some of the questions facing contemporary society and to provide a footing in today's moral quagmire.

In a society based on moral relativism, where so-called 'value neutral' judgements are heartily endorsed by a 'politically correct' establishment, where is the Christian to stand? On the Bible, reply the Feinbergs. Their book presents an explicitly Bible-based system of ethics. (We note in passing that those who aren't Christians are unlikely to be swayed by many of the authors' conclusions.)

Before engaging in discussion of issues, the authors provide a helpful first chapter regarding moral decision making, ethical systems, and hermeneutics. Chapter One forms the framework for the remainder of the book. The authors are careful to state their own preconceptions and principles. Subsequent chapters cover such issues as abortion, capital punishment, sexual morality, birth control, homosexuality, genetic engineering and reproductive technologies, divorce and remarriage, war, and the state.

Each chapter includes a survey of different positions, arguments in support or against the positions, biblical passages relevant to the topic, and the authors' own summary and conclusions. The positions the Feinbergs adopt are for the most part traditional and conservative. Roman Catholic readers will note differences from traditional Roman Catholic teachings in such areas as birth control and reproductive technologies, and capital punishment (where they are at variance with Pope John Paul II's recent encyclical). The authors point out where other ethicists disagree, and cases where insufficient evidence exists to make a definitive judgement.

Statistical data are included, and medical

facts are presented clearly. (Although there is one error on p. 51 where sickle cell anaemia is called 'a disease only males get'. One hopes there aren't other such errors.) Sixty pages of notes, a general index, and a scripture index, are also included.

The sanctity of life is a primary consideration. 'Even where death is inevitable, we have no right to take someone's life. Life and death are in God's hands, not man's. . . . The taking of innocent life is forbidden by God's word' (p. 77). This holds true even where difficult decisions have to be made.

The chapter 'The Christian and the Secular State' is worthwhile reading in the current climate where a 'Christian Position' is claimed for many issues—political, economic—not merely moral ones such as abortion or euthanasia. It is unlikely that everyone will agree with all of the conclusions presented, much though it might be desirable to have a united Christian position. But in difficult areas—such as genetic engineering, for instance, the consequences of which we are just beginning to envision—there are bound to be divergent opinions. What commends the Feinbergs' attempt is their concern for the sanctity of life, and a unified, consistent approach based on the Christian ethos.

In the long run, Freeman Dyson concludes, 'social constraints must bend to new realities' (p. 208). If there is hope for a society where ethics is impotent in the face of technology, then Christians need to be educated about the issues, informed about the alternatives, cognisant of what Christianity has to say to the world, and willing to put ethical principles into action. I would recommend *Ethics for a Brave New World* as a step in that direction.

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#### Life's Living Toward Dying

Vigen Guroian  
Grand Rapids, MI & Cambridge, U.K.:  
Eerdmans, 1996  
ISBN 0-8028-4190-2, xxvii + 108 pp., paperback  
\$12.00

This is a book which expresses deep concerns about dying. More fundamentally, it is a book that sustains a stark contrast between the contemporary culture of death and an endangered species—the traditional Christian perspective. In the preface (p. xv), Guroian lays down the gauntlet as he remarks on Walter Percy's timely *Thanatos Syndrome*, 'yet Percy manages to make his beliefs fairly consistent with the traditional Christian understanding of human existence and the moral limits that understanding places on the taking of human life . . . once faith had been set aside, the limits to taking human life . . . would not be able to stand up against the pressure to legalize physician-assisted suicide . . . the cultural crisis associated with the Thanatos Syndrome is also a crisis within American Christianity.' What follows is a book reflecting upon one Orthodox Christian's insight into the dynamics driving this crisis as well as some prescriptions for Christendom's critical response.

Since travellers on the same journey will each remember distinct sights and signposts, the following is this pilgrim's summary of the

sights which penetrated him, both cognitively and spiritually, in the context of his ministry as physician and ethicist. Paul Ramsey has provided inspiration for Guroian as he has for so many committed to the care of the dying. In this instance, Ramsey in 1980 had been prophetic as he predicted a sinister parallel history for sexual liberty and euthanasia in *Death's Pedagogy*, as he observed that, 'the humanity of mankind is at stake in how . . . we go about assaulting the last taboo: death.' He proceeded to compare the then inchoate euthanasia movement to the earlier movement to liberate the taboo of sex—with one disturbing caveat. If the euthanasia movement were to be a success, the consequences would be far more revolutionary! For example, without any normative guides in the arena of sexuality, society is obsessed with a so-called 'callisthenic sexuality', i.e. a sexuality detached from all intimacy and traditional prohibitions. Might the same philosophy, if allowed to permeate the 'last great taboo,' inexorably lead to 'callisthenic dying?' (p. xxiv) Dying would then be characterised as dignified only when it is deliberate and administered—a distinctive of the New Medicine which is now conceivable.

Indeed Guroian traces Ramsey's prophecy to its unfortunate evolution in a postmodern ethos. Society's simultaneous aversion to and obsession with death has given rise to a new variety of pornography. The natural processes of death and decay have become as disgusting for contemporary culture as sexuality was for the Victorians a century ago (p. 9). Movies like *Fatal Attraction*, *Basic Instinct* and *Interview with a Vampire* permit culture to confront the great taboos of sex and death concomitantly and as entertainment no less! As an art critic observed recently, 'other than death, the set subject is sex' (p. 10).

If contemporary culture has passionately embraced its two final taboos, it also has discovered its spokesperson in the individual whose life's passion is death itself: Kevorkian. In Guroian's own words, 'he has assumed the role of high priest to our real-world thanatos syndrome' (p. xv). Kevorkian has expanded the subspecialties of medicine to include medicide-euthanasia in institutional settings—and obituary, sanctioned experimentation on the dying. Kevorkian's challenge to Christians is supremely confident: the eventual displacement of religion by his own unique brand of 'therapeutics,' serving mankind as the ultimate mediator between life and death. Guroian describes the macabre logical conclusion as Kevorkian's own 1 Cor. 15: a death that loses its sting through the ministrations of assisted-suicide.

Guroian next delves into the area of death's parasitic relationship to love and applies the thought of C. S. Lewis and Augustine. Indeed, in his own words, 'death would not be so bitter were it not that love makes life so sweet' (p. 21). Lewis in *A Grief Observed* described death's sting as the stealing away of love, metaphorically stated as, 'so many roads once; now so many cul de sac.' Augustine likewise in *Confessions*, ruminating over the death of a boyhood friend, wrote, 'rightly has a friend been called "the half of my soul." For I thought of my soul and his soul as one soul in two bodies; and my life was a horror to me because I would not live halved. And it may be that I feared to die lest thereby he should die wholly whom I had



loved so deeply.' Yes, this is death—a state for Guroian that violates both the dead and the living. He proceeds further with the horror of death, observing that 'a being created for immortality stares into the abyss of nothingness and recoils because love will not abide desolation and nothingness' (p. 27).

As a result, a corollary arises that incriminates postmodern medical practice. Is it not a sobering fact that technology separates people from those whose love is needed most of all when they are dying? Guroian says, 'the more love we lose to death and separation, the more we fear our own mortality, and the more we fear our mortality, the more desperately we search for increasingly sophisticated technologies to combat or postpone death' (p. 29). Unfortunately this futile path completely isolates the dying from love.

Furthermore, the love-death relationship is likewise disturbed by extended care facilities devoid of intimate care. 'A society that routinely commits its elderly, chronically and terminally ill members to institutional care away from loved ones is a society in jeopardy of losing its soul and becoming truly monstrous. There is, in fact, nothing more monstrous or deadly than shutting our fellow human beings off from love' (p. 33).

If the preceding account accurately describes the attitudes of a culture of death, just where is the crisis inhabiting Christianity? Guroian chooses a trenchant paradigm—Baby Rena—to state his case. Baby Rena, 18 months of age, was dying, a victim of AIDS and heart disease. She had been ventilator dependent for six weeks. Her pain was so severe that she was constantly sedated. Simple procedures, the mere act of weighing her, caused tears to stream down her face. Her physician suggested compassionate care with the removal of intensive care and the ventilator. Baby Rena's foster parents, the pastor of their church and their friends, professing a belief in the sanctity of life, insisted on continued aggressive care. Baby Rena mercifully passed away approximately 2 months after admission.

Guroian describes the family's dynamic thus: 'They all professed a Christian belief in the sanctity of life, and yet I cannot find a basis in my understanding of the Christian tradition to agree with either their reasoning or their judgement' (p. 68). Guroian sees Christians as not understanding the essential distinction between killing and allowing to die. He coins a neologism, religious secularists, for those like Baby Rena's parents who single-mindedly seek to preserve human life at all costs. Such religion for Guroian is grounded in a 'metaphysical and moral dualism that radically separates physical existence from spiritual existence'. His clarity of thought is consistent with Hollinger (*Ethics and Medicine*; 12:3, 1996) in maintaining the tension between death as both friend and foe-essential to the confrontation of end-of-life issues. Guroian's own summary observation concerning dying in this context is that, 'This is one area in which there is no practical difference between a secularised Christianity and modern fundamentalism' (p. 76). To Guroian, although death is a great evil, at the same time it is not the summum malum.

Guroian's advice concerning ministry to the dying (p. 41 ff.) may be too sectarian for many. His primary focus is directed at the sacramentalism of the Orthodox tradition. It might have

behaved him to expand the possibilities for ministry in this arena to encompass also those outside the Orthodox faith. What of Paul's dying needs simply expressed in 2 Tim 4:6–13? On a more universal level, Paul's needs (friendship, a cloak, and Scripture) are a clarion call to a ministry to the dying that crosses over congregational boundaries. In this context, 'An Evangelical Appraisal of Orthodoxy' (*Christian History* 54, 1997) by Harold O. J. Brown offered a timely juxtaposition of Orthodoxy vis-à-vis Evangelicalism to better inform those with limited exposure to the Orthodox tradition.

Finally, two other profound contributions are made by this insightful book. First, Guroian's criticism of Sherwin Nuland's de rigueur work, *How We Die*, is helpful for witness. Nuland's naturalism is not a viable Christian response to the inevitability of death. And secondly, for those who teach bioethics with a narrative approach, this book is a goldmine. Especially so for fresh insight into timeless works that develop 'redemptive analogies.' From old, oft-quoted standards like Tolstoy's *The Death of Ivan Ilyich*, and Dostoevsky's *The Possessed* and *Crime and Punishment* are added a veritable profusion of fresh possibilities like Felix Salten's *Bambi: A Life in the Woods*, Updike's character Connor who Guroian compares to Dostoevsky's Grand Inquisitor, and Cheevers work, *The Death of Justina* among many others.

In summary, this is a book that sheds valuable light on the problems related to dying in our culture and will continue to inform my ministry in medicine and education for years to come.

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#### **Overcoming Infertility: A Compassionate Resource for Getting Pregnant**

Robert Jansen, M.D.  
New York: W.H. Freeman, 1997  
ISBN 0-7167-3055-3, xi + 474 pp., \$24.95

*Overcoming Infertility* is a comprehensive guide to everything you always wanted to know about conception and infertility. It is in the Scientific American series of books. It covers normal, natural pregnancies, diagnosing infertility, as well as various treatments for infertility, including the methods of technologically assisted conception. Jansen cleverly divides those technologies into those which help nature a little (from temperature charting and other low-tech solutions) and those which help nature a lot (what we normally consider sophisticated reproductive interventions, such as IVF and sperm injection). Jansen describes each reproductive technology in helpful detail, including how they work and what can go wrong. Most of the book is a fairly clinical discussion of infertility, its causes and its cures.

The book contains dozens of helpful sidebars which address many of the misconceptions of infertility. These include topics such as 'Clinics with Unusually High IVF Rates' (being something to watch out for, to which he adds guidelines on how to read the clinic's success statistics), 'Endometriosis and the Modern Woman,' 'Sterilization Reversal,' and 'Miscarriage and Infertility'. Also included are anecdotal accounts of Jansen's patients, such as 'An

Expensive IVF Baby' and 'What Sperm Donors Think.' Some of the sidebars touch on ethical issues such as 'Exploitation and Autonomy,' dealing with surrogate mothers, and 'Should Feminists Be Concerned?'

The majority of the book addresses the medical aspects of infertility practice and is a helpful guide to couples who are struggling with infertility. For the average couple, it may be a bit overwhelming in its details, but is well organised to permit easy access to the details the couple seeks. There is relatively little in the book that concerns the ethical aspects of infertility, though some of these things are addressed in the final section, entitled 'Getting What You Deserve'. Ethics is most directly addressed in the chapters on 'Your Physician's Duties,' and 'Embryo Research and Society.' (It is unclear why this chapter is included unless to make a statement about his research. It appears somewhat irrelevant to infertile couples). There is a helpful sidebar on moral principles in bioethics that introduces the section on the physician's duties. Ethical issues Jansen takes up include informed consent, responsibility in infertility research, and dealing with the moral status of foetuses and embryos in a morally pluralistic society.

At this point, Jansen's views become evident, and it is clear that he does not share the views of the unborn that many readers of this journal will. He clearly favours embryo research, and speaks disparagingly of moves by the Canadian government to regulate the infertility industry there. He denies personhood and rights to embryos apparently on the basis of their dependence on others and especially the mother for its existence. He denies that the nuclear family has any special claim to be the model for family and procreation and does not seem to fear any slide down a slippery slope in the future. It is difficult to critique his section on ethics apart from its clear shortcomings, because the book is not an ethics book on reproductive technologies, but primarily a medical book that, to Jansen's credit, does touch on the related ethical issues.

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#### **The Ethical Primate: Humans, Freedom and Morality**

Mary Midgley  
New York & London: Routledge, 1994  
ISBN 0-415-09530-1, ix + 191 pp., hardback \$22.95

Morality, an undeniable and significant aspect of the human species, necessarily entails human freedom. Ostensibly, the explanation and understanding of human freedom is inextricably bound to one's view of origins. While acknowledging this fact, however, Mary Midgley ignores a creationist explanation and confidently asserts that, 'no denial of the reality of ethics, nothing offensive to its dignity, follows from accepting our evolutionary origin' (p. 3). Therefore *The Ethical Primate* does not approach the issue of human freedom by juxtaposing theistic creationism with naturalistic

evolutionism in order to determine which world view provides the best model for understanding human freedom. Instead, *The Ethical Primate* presupposes and affirms the truth of evolution, while acknowledging the inconsistencies of traditional explanations of human morality within the evolutionary world view.

According to Midgley, such evolutionary explanations unfortunately have fallen into two extremes, 'one reductive and the other obscurantist' (p. 5). Each extreme, in an attempt to address the reality of human morality, has created serious philosophical tension for the evolutionary model. The reductionists are the Social Darwinists who follow the 'psychological egoism' of Hobbes where human freedom gives way to determinism. The obscurantist 'stresses mystery and discontinuity with other species' which results in morality as something that is a 'distinct, unassimilable pattern at odds with all else on this planet, and perhaps with everything in the universe' (p. 6). That is, the obscurantist explains human freedom at the expense of continuity in the evolutionary development. Each view, in its own way, explains human freedom in a way that sabotages the evolutionary model. Convinced, however, that the evolutionary model is right, and of the compatibility between the ethical nature and evolutionary development of man, Midgley offers an argument to demonstrate that the term, 'ethical primate' is not an oxymoron.

Approximately one half of the book is dedicated to revealing the inconsistencies of the two extreme positions. Here one is confronted with some forceful arguments crafted by sound logic and intellectual honesty exposing the damaging elements of the reductionist and the obscurantist. Chiding reductionism, Midgley demonstrates how the logical conclusion of this position ends up in some form of determinism. This, she poignantly points out, is inimical to morality which demands some form of true human freedom. The obscurantist, on the other hand, divorces man from other primates at the point of human freedom, thus creating some discontinuity with other species in the evolutionary process. Her point is that this is inconsistent with the basic assumption of the process of evolution. Even some form of metaphysical 'punctuated equilibrium' cannot reasonably span this obvious break in continuity. For Midgley, evolution must not only explain origins, it must also explain life as we know it today. Therefore, what she proposes in the second half of the book is a middle way that benefits from both extreme positions without the philosophically libellous elements of either extreme.

Several inconsistencies in the argument, however, seem to weaken, if not destroy, this valiant attempt to show human freedom as a natural element of evolution (p. 163). In order to craft a middle way, Midgley repeatedly denies the existence of a unified field of human knowledge. She claims that there is no such thing as one fundamental view that answers all

the questions, thus paving the way for her to borrow from both extreme approaches. Ironically, however, the argument of the book subtly appeals to a unified field of knowledge at the most basic level: that is, that the evolutionary world view is the single approach to understanding man and this life. She argues, 'But once we accept our evolutionary history as a general background, it is quite natural and proper to use it in explaining many elements of human life' (p. 14). Does this not make evolution the fundamental explanation of life? This is the very thing she says cannot be (p. 43). Furthermore, if there is no unified field of knowledge, then why be disturbed with the discontinuity of the obscurantist or the contradictory determinism of the reductionist? If there is no unified field of knowledge, why be concerned with inconsistencies within any system when it is forced to answer all the questions? The answer betrays the initial denial.

Demanding that 'the core reductive mistake is, then, the idea of a single fundamental explanation' (p. 43), she grants herself permission to employ different approaches to knowledge, all the while seeking to build an argument for ethics within the evolutionary world view. The point made is that everybody is looking at the same phenomena, but from a different perspective (as long as they look at it from the evolutionary world view), so each person is right, but not absolutely right. That is, one can only be right relative to his/her view or approach to the particulars—everybody is simply to accept that the universal is natural selection.

Midgley suggests that it is like different people viewing a mountain. What one sees depends upon the vantage point from which the mountain is viewed. What one sees may be right, but it cannot be considered comprehensive. The warning is, that 'we should never become so obsessed with one kind of approach as to forget about the other' (p. 44). Now one must admit that there is an element of truth here, but from a naturalistic framework one is immediately confronted with an obvious problem. Who knows that what everybody is looking at is, in fact, a mountain if no one has a comprehensive view? The question at once is, Who stands above it all to show how the pieces fit together? What this position calls for is almost some strange form of superhuman powers of revelation for a few to see what others do not, and yet she wants no part of that.

In fact, she takes the social scientist to task for doing that very thing but pretending it is not so. 'These people [social scientists] are clearly not just seen as one more of the cogs. Their place seems to be more that of a mechanic dealing with the machine. So it begins to look as if they are really agents somehow standing right outside the processes that they are studying' (p. 97). This, however, is the very thing required of her view of knowledge. It is as if she stands outside or above the particulars, pronounces what all the particulars should look like when put together properly. How else

could anyone know that people are looking at a mountain unless someone first had the idea of a mountain (a universal)? This is a great epistemological problem, not just for Midgley, but for all who begin an epistemological inquiry with the assumption that only particulars exist and there is no sure word from beyond man of the meaning (universals) concerning the particulars.

In another vein, *The Ethical Primate* goes to great lengths to show that human freedom is a natural component of evolution. That is, freedom is not a discontinuous property within primates. The argument set forth maintains that freedom has degrees and it is not always obvious in all other species because of memory differences. Arguing that memory is key to understanding the difference in the exercise (not the existence) of freedom between man and the other species, supposition is offered, not convincing evidence. For example, considering the question of why moral conflict appears non-existent in the ape, her answer is: 'Put in cognitive terms, the difference between the chimp reaction and the human one [in the case of aberrant social behavior and justice] is a matter of memory. The chimps seem simply to forget the offense' (p. 173). But no conclusive evidence has been offered that all other species have agency and that because of a limited memory it does not manifest itself as it does in man who has a well developed memory. This point attempts to correct the mistake of the obscurantist who sees human freedom as a mystery, something quite discontinuous with other species. The fact is that whereas there is no evidence for the claim concerning ubiquitous memory, it seems that this does not correct the mistake of the obscurantist; it only shifts the mystery from human freedom to human memory.

In the opinion of this reviewer, this arduous and often instructive enterprise falls short of delivering a compelling argument for human freedom as a logical consequence of evolution. One must, however, be impressed with the fact that Midgley takes human freedom so seriously that she understands that without it there is no real discussion of ethics. I suggest that the value (and there is value) of this book is not in what she attempts to prove (for I think she promises much more than she delivers), but in the insightful analysis of the inconsistency in the evolutionary model in terms of explaining human freedom and morals. Here I believe she raises some very important issues for those who wish to hold to the evolutionary world view and still take the matter of ethics seriously. This just might serve as a strong apologetic for considering a totally different world view—such as a Christian theistic world view.

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