ETHICS & MEDICINE

An International Christian Perspective on Bioethics

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C. Ben Mitchell, PhD

When Learned Doctors Murder

Gerald Winslow, Chair of the Department of Bioethics at Loma Linda University, has said perceptively: 'We should watch the way we talk. Human society can be described as a long conversation about what matters. In this conversation, the language we use to describe our social practices not only reveals our attitudes and virtues, it shapes them.' That our language shapes our virtues is nowhere more aptly demonstrated than in the debate about assisted suicide and euthanasia.

Language games—particularly the use of the linguistic construct we call euphemism—have important implications for moral medicine. The proper choice of words can ennoble medical practice and the improper choice of words can corrupt it. Through the use of language we can elevate the patient from 'ward 3, 46 year-old female with hysterectomy' to 'Mary Cook, wife, mother-of-two, fearful of uterine cancer'. Even the expression '*my* patient' is superior to the more generic '*the* patient.' The language we use to describe moral medicine is not merely a matter of etiquette; it is revelatory of the way we understand the practice of medicine.

Take, for instance, the way physicians under Hitler used language to justify medicalized murder. Leo Alexander, a physician-consultant on duty with the Chief Counsel for War Crimes, wrote a devastating critique of 'Medical Science Under Dictatorship' in the July 1949 *New England Journal of Medicine.* Alexander asserted that 'Nazi propaganda was highly effective in perverting public opinion and public conscience, in a remarkably short period of time'. Alexander argued that the barrage of propaganda against what he called 'the traditional nineteenth-century attitudes toward the chronically ill' fuelled the fires of the furnaces at Dachau, Auschwitz, and the other killing centres erected under Hitler. Two silent film documentaries, *Was du erbst* (What You Inherit) and *Erb Krank* (The Hereditarily Ill) depicted images of the severely handicapped and mentally ill. Later, two additional films, *Opfer der Vergangenheit* (Victims of the Past) and *Das Erbe* (The Inheritance) were shown under order of the Führer in all 5,300 German theatres. In 1939, *Dasein ohne Leben* (Existence without Life), was produced under commission of those who ran the infamous Operation T-4 euthanasia campaign. This film was, according to documentary filmmaker John Michalczyk, 'designed to reassure those involved in the euthanasia program that this was an ethical and humane procedure'. While all copies of *Dasein ohne Leben* were destroyed, a copy of the script was recovered after the war. Michalczyk says further that, 'As the professor clinically describes the masses of 400,000 German patients in mental asylums, images of the helpless wards punctuate his words . . . In a pseudo-humane tone, the lecturer uses religious language of mercy killing to help "liberate" these creatures, while simultaneously denying these individuals their humanity. How cruel it would be to maintain these spiritually dead people as "living corpses." It is a sacred demand of charity that we eliminate the suffering of these helpless individuals, the film advocates. To show how humane this process is, the lecturer concludes by confessing that if he were struck down by a crippling disease, he himself would opt for mercy killing.'

Post-war testimonies of physicians who were under Hitler's regime confirm the impact of language on shaping their notions of the morality of euthanasia. The phrase 'life unworthy of living' became a potent euphemism to justify murder. Karl Binding, one of the architects of the moral shift which led to the euthanasia campaign, said of killing a patient who was in pain: 'This is not "an act of killing in the legal sense", but is rather the modification of an irrevocably present cause of death which can no longer be evaded. In truth, it is a purely healing act.'

That was mid-century. Today the spectre of euphemistic language applied to assisted homicide is upon us again. Oregon has become the first US state to legalize physician-assisted suicide. Both the language used to lobby for the legislation and the legislation itself were suffused with euphemisms. The Oregon 'Death with Dignity Act' states that actions taken in accordance with the act 'shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law'. This is astounding! By shear redefinition, lawmakers think they can take the sting out of a practice we would otherwise find unconscionable.

In addition to the onus of the Oregon law, one of the fiercest apologists for euthanasia has been given a platform at Princeton University. Australian philosopher Peter Singer was appointed Ira W. DeCamp Professor of Bioethics at Princeton last summer. Singer has argued that if a human being has a 'life not worthy of living', it may be permissible, or sometimes even a duty, to kill that person. In fact, Singer favours the involuntary killing of anyone who might have become a burden to family, state, or healthcare system.

Neither the Nazi physicians, Oregon lawmakers, or Peter Singer are ostensibly evil, nor are they uneducated. How can learned persons become murderers? I submit that only through the use of euphemism and other subtle language games can a person, a community, or a society make the shift we have seen take place with respect to assisted death legislation and practice. If I am right, then those of us committed to Christian and Hippocratic medicine must summon the moral courage to use explicit, non-euphemistic language to describe the devolution of medical practice evident in the justification of assisted suicide and euthanasia. That is, we must be willing to verbalize the truth that assisted death is a form of homicide and that those who practise it are guilty of murder or are accomplices to murder. It we are unwilling to be forthright and honest about what is happening, we ourselves may become accomplices.

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Reverend John Wesley (1703–1791)

Primitive Physic

Editorial note: The founder of Methodism, John Wesley (1703–1791) was, as one biographer has put it, 'an ardent reader of the medical literature'. Wesley stated in one of his letters: 'For six or seven and twenty years I had made anatomy and physic the diversion of my leisure hours: though I never properly studied them, unless for a few months when I was going to America, where I imagined I might be of some service to those who had no regular physician among them.'

The following is from Wesley's volume, Primitive Physic: Or An Easy and Natural Method of Curing Most Diseases, *which was first published in London in 1747. The first section includes the unabridged Preface. The second section includes excerpts from Wesley's collection of remedies. While many of these treatments seem to us to be quaint or even a form of quackery, we must remember that Mr. Wesley was merely the collator of these treatments, not their originator. Further, he straightforwardly informs his readers which remedies he has used himself.*

When man came first out of the hands of the great Creator, clothed in body as well as in soul, with immortality and incorruption, there was no place for physic, or the art of healing. As he knew no sin, so he knew no pain, no sickness, weakness, or bodily disorder. The habitation wherein the angelic mind, the *Divinæ Particula Auræ*, abode, although originally formed out of the dust of the earth, was liable to no decay. It had no seeds of corruption or dissolution within itself. And there was nothing without to injure it: heaven and earth and all the hosts of them were mild, benign and friendly to human nature. The entire creation was at peace with man, so long as man was at peace with his Creator. So that well might *the morning-stars sing together, and all the sons of* God *shout for joy*.

But since man rebelled against the Sovereign of heaven and earth, how entirely is the scene changed! The incorruptible frame hath put on corruption, the immortal has put on mortality. The seeds of weakness and pain, of sickness and death, are now lodged in our inmost substance; whence a thousand disorders continually spring, even without the aid of external violence. And how is the number of these increased by every thing round about us? The heavens, the earth, and all things contained therein, conspire to punish the rebels against their Creator. The sun and moon shed unwholesome influences from above; the earth exhales poisonous damps from beneath: the beasts of the field, the birds of the air, the fishes of the sea, are in a state of hostility: the air itself that surrounds us on every side, is replete with the shafts of death: yea, the food we eat, daily saps the foundation of that life which cannot be sustained without it. So has the Lord of all secured the execution of his decree, —*'Dust thou art, and unto dust thou shalt return.'*

But can nothing be found to lessen those inconveniences, which cannot be wholly removed? To soften the evils of life, and prevent in part the sickness and pain to which we are continually exposed? Without question there may. One grand preventative of pain and sickness of various kinds, seems intimated by the grand Author of Nature in the very sentence that intails death upon us: 'In the sweat of thy face shalt thou eat bread, till thou return to the ground.' The power of exercise, both to preserve and restore health, is greater than can well be conceived: especially in those who add temperance thereto; who, if they do not confine themselves altogether to eat either 'Bread or the herb of the Field' (which God does not require them to do), yet steadily observe both that kind and measure of food, which experience shews to be most friendly to health and strength.

It is probable Physic, as well as Religion, was in the first ages chiefly traditional: every father delivering down to his sons, what he had himself in like manner received, concerning the manner of healing both outward hurts, and the diseases incident to each climate, and the medicines which were of the greatest efficacy for the cure of each disorder. It is certain this is the method wherein the art of healing is preserved among the *Americans* to this day. Their diseases indeed are exceeding few; nor do they often occur by reason of their continual exercise, and (till of late) universal temperance. But if any are sick, or bit by a serpent, or torn by a wild beast, the fathers immediately tell their children what remedy to apply. And it is rare that the patient suffers long; those medicines being quick, as well as generally infallible.

Hence it was, perhaps, that the Ancients, not only of *Greece* and *Rome*, but even of barbarous nations, usually assigned physic a divine original. And indeed it was a natural thought, that He who had taught it to the very beasts and birds, the *Cretan* Stag, the *Egyptian* Ibis, could not be wanting to teach man,

Sanctius his Animal, mentisque capacius altæ:

Yea, sometimes even by those meaner creatures: for it was easy to infer, 'If this will heal that creature, whose flesh is nearly of the same texture with mine, then in a parallel case it will heal me.' The trial was made: the cure was wrought: and Experience and Physic grew up together.

And has not the Author of Nature taught us the use of many other medicines, by what is vulgarly termed *Accident?* Thus one walking some years since in a grove of pines, at a time when many in the neighbouring town were afflicted with a kind of new distemper, little sores in the inside of the mouth, a drop of the natural gum fell from one of the trees on the book which he was reading. This he took up, and thoughtlessly applied to one of those sore places.

Finding the pain immediately cease he applied it to another, which was also presently healed. The same remedy he afterwards imparted to others, and it did not fail to heal any that applied it. And doubtless numberless remedies have been thus casually discovered in every age and nation.

Thus far physic was wholly founded on experiment. The *European*, as well as the *American*, said to his neighbour, Are you sick? Drink the juice of this herb, and your sickness will be at an end. Are you in a burning heat? Leap into that river, and then sweat till you are well. Has the snake bitten you? Chew and apply that root, and the poison will not hurt you?.

Thus ancient men, having a little experience joined with common sense and common humanity, cured both themselves and their neighbours of most of the distempers, to which every nation was subject.

But in process of time, men of a philosophical turn were not satisfied with this. They began to enquire how they might *account* for these things? How such Medicines wrought such effects? They examined the human body, and all its parts; the nature of the flesh, veins, arteries, nerves; the structure of the brain, heart, lungs, stomach, bowels; with the springs of the several kinds of animal functions. They explored the several kinds of animal and mineral, as well as vegetable substances.

And hence the whole order of physic, which had obtained to that time, came gradually to be inverted. Men of learning began to set aside experience; to build physic upon hypothesis; to form theories of diseases and their cure, and to substitute these in the place of *experiments*.

As theories increased, simple medicines were more and more disregarded and disused: till in a course of years the greater part of them were forgotten, at least in the politer nations. In the room of these, abundance of new ones were introduced by reasoning, speculative men: and those more and more difficult to be applied, as being more remote from common observation. Hence rules for the application of these, and medical books were immensely multiplied; till at length physic became an abstruse science, quite out of the reach of ordinary men.

Physicians now began to be had in admiration, as persons who *were something more than human*. And *profit attended* their employ as well as honour; so that they *had now two weighty reasons for keeping the bulk of mankind at a distance*, that they might not pry into the mysteries of the profession. To this end, they increased those difficulties by design, which began in a manner by accident. They filled their writings with abundance of technical terms, utterly unintelligible to plain men. They affected to deliver their rules, and to reason upon them, in an abstruse and philosophical manner. They represented the critical knowledge of Astronomy, Natural Philosophy (and what not? Some of them insisting on that of Astronomy, and Astrology too) as necessarily previous to understanding the art of healing. Those who understood only how to restore the sick to health, they branded with the name of Empirics. They introduced into practice abundance of compound medicines, consisting of so many ingredients, that it was scarce possible for common people to know which it was that wrought the cure: abundance of exotics, neither the nature nor names of which their own countrymen understood: of chymicals, such as they neither had skill, nor fortune, nor time to prepare: yea, and of dangerous ones, such as they could not use, without hazarding life, but by the advice of a physician. And thus both their honour and gain were secured, a vast majority of mankind being utterly cut off from helping either themselves or their neighbours, or once daring to attempt it.

Yet there have not been wanting, from time to time, some lovers of mankind, who have endeavoured (even contrary to their own interest) to reduce physic to its ancient standard: who have laboured to explode it out of all the hypotheses, and fine spun theories, and to make it a plain intelligible thing, as it was in the beginning: having no more mystery in it than this, 'Such a medicine removes such a pain.' These have demonstrably shewn, That neither the knowledge of Astrology, Astronomy, Natural Philosophy, nor even Anatomy itself, is absolutely necessary to the quick and effectual cure of most diseases incident to human bodies: nor yet any chimical, or exotic, or compound medicine, but a single plant or root duly applied. So that every man of common sense (unless in some rare cases) may prescribe either to himself or his neighbour; and may be very secure from doing harm, even where he can do no good.

Even in the last age there was something of this kind done, particularly by the great and good Dr. *Sydenham:* and in the present, by his pupil Dr. *Dover*, who has pointed out simple medicines for many diseases. And some such may be found in the writings of the learned and ingenious Dr. *Cheyne:* who doubtless would have communicated many more to the world, but for the melancholy reason he gave one of his friends, that prest him with some passages in his works, which too much countenanced the modern practice, 'O Sir, we must do something *to oblige the Faculty*, or they will tear us in pieces.'

Without any regard to this, without any concern about the obliging or disobliging any man living, a mean hand has made here some little attempt towards a plain and easy way of curing most diseases. I have only consulted herein, *Experience, Common Sense*, and *the common Interest of mankind*. And supposing they can be cured this easy way, who would desire to use any other? Who would not wish to have a Physician always in his house, and one that attends without fee or reward?

To be able (unless in some few complicated cases) to prescribe to his family, as well as himself?

If it be said, but *what need is* there of such attempt? I answer, *the greatest that can possibly be conceived*. Is it not needful in the highest degree, to rescue men from the jaws of destruction? From wasting their fortunes, as thousands have done, and continue to do daily? From pining away in sickness and pain, either through the ignorance or dishonesty of Physicians? Yea, and many times throwing away their lives, after their health, time and substance?

Is it enquired, but are there not books enough already, on every part of the art of medicine? Yes, too many ten times over, considering how little to the purpose the far greater part of them speak. But beside this, they are too dear for poor men to buy, and too hard for plain men to understand. Do you say, 'But there are enough of these collections of Receipts.' Where? I have not seen one yet, either in our own or any other tongue, which contains only safe,

and cheap, and easy medicines. In all that have yet fallen into my hand, I find many dear and many far-fetched medicines: besides many of so dangerous a kind, as a prudent man would never meddle with. And against the greater part of those medicines there is a further objection: they consist of too many ingredients. The common method of compounding and de-compounding medicines, can never be reconciled to Common Sense. Experience shews, that one thing will cure most disorders, at least as well as twenty put together. Then why do you add the other nineteen? Only to swell the Apothecary's bill: nay, possibly, on purpose to prolong the distemper, that the Doctor and he may divide the spoil.

But admitting there is some quality in the medicine proposed which has need to be *corrected;* will not one thing correct it as well as twenty? It is probable, much better. And if not, there is a sufficiency of other medicines, which need no such correction.

How often, by thus compounding medicines of opposite qualities, is the virtue of both utterly destroyed? Nay, how often do those joined together destroy life, which single might have preserved it? This occasioned that caution of the great *Boerhave,* against mixing things without evident necessity, and without full proof of the effect they will produce when joined together, as well as of that they produce when asunder: seeing (as he observes) several things, which separately taken, are safe and powerful medicines, when compounded, not only lose their former powers, but commence a strong and deadly poison.

As to the manner of using the medicines here set down, I should advise, As soon as you know your distemper, (which is very easy, unless in a complication of disorders, and then you would do well to apply to a Physician that fears God:) *First,* use the first of the remedies for that disease which occurs in the ensuing collection; (unless some other of them be easier to be had, and then it may do just as well.) *Secondly,* After a competant time, if it takes no effect, use the second, the third, and so on. I have purposely set down (in most cases) several remedies for each disorder; not only because all are not equally easy to be procured at all times, and in all places: but likewise because the medicine which cures one man, will not always cure another of the same distemper. Nor will it cure the same man at all times. Therefore it was necessary to have a variety. However, I have subjoined the letter (*I*) to those medicines which some think to be *Infallible. —Thirdly,* Observe all the time the greatest exactness in your regimen or manner of living. Abstain from all mixed, all high-seasoned food. Use plain diet, easy of digestion; and this as sparingly as you can, consistent with ease and strength. Drink only water, if it agrees with your stomach; if not, good clear, small beer. Use as much exercise daily in the open air as you can without weariness. Sup at six or seven, on the lightest food: go to bed early, and rise betimes. To persevere with steadiness in this course, is often more than half the cure. *Above all, add to the rest, (for it is not labour lost) that old unfashionable Medicine, Prayer.* And *have faith in God who 'killeth and maketh alive, who bringeth down to the grave, and bringeth up.'*

For the sake of those who desire, through the blessing of God, to retain the health which they have recovered, I have added a few plain, easy Rules, chiefly transcribed from Dr. *Cheyne.*

I

The air we breathe is of great consequence to our health. Those who have been long abroad in Easterly or Northerly winds, should drink some thin and warm Liquor going to bed, or a draught of toast and water.

Tender people should have those who lie with them, or are much about them, sound, sweet, and healthy.

Every one that would preserve health, should be as clean and sweet as possible in their houses, clothes and furniture.

II

The great rule of *eating and drinking* is, To suit the quality and quantity of the food to the strength of our digestion; to take always such a sort and such a measure of food as fits light and easy to the stomach.

All pickled, or smoaked, or salted food, and all high-seasoned is unwholesome.

Nothing conduces more to health, than abstinence and plain food, with due labour.

For studious persons, about eight ounces of animal food, and twelve of vegetable in twenty-four hours is sufficient.

Water is the wholesomest of all drinks; quickens the appetite, and strengthens the digestion most.

Strong, and more especially spirituous liquors, are a certain, though slow, poison.

Experience shews, there is very seldom any danger in leaving them off all at once.

Strong liquors do not prevent the mischiefs of a surfeit, nor carry it off so safely as water.

Malt liquors (except clear, small beer, or small ale, of due age) are exceeding hurtful to tender persons.

Coffee and tea are extremely *hurtful* to persons who have *weak nerves.*

III

Tender persons should eat very light suppers; and that two or three hours before going to bed.

They ought constantly to go to bed about nine, and rise at four or five.

IV

A due degree of *exercise* is indispensably necessary to health and long life.

Walking is the best exercise for those who are able to bear it; riding for those who are not. The open air, when the weather is fair, contributes much to the benefit of exercise.

We may strengthen any weak part of the body by constant exercise. Thus the lungs may be strengthened by loud speaking, or walking up an easy ascent; the digestion and the nerves, by riding; the arms and hams, by strongly rubbing them daily.

The *studious ought* to have *stated times for exercise,* at *least two or three hours a-day:* the one half of this before dinner, the other before going to bed.

They should frequently shave, and frequently *wash* their feet.

Those who read or write much, should learn to do it *standing;* otherwise it will impair their health.

The fewer clothes any one uses, by day or night, the hardier he will be.

Exercise, first, should be always on an empty stomach; secondly, should never be continued to weariness; thirdly, after it, we should *take care* to *cool by degrees; otherwise we shall catch cold.*

The *flesh brush* is a most useful exercise, especially to strengthen any part that is weak.

Cold-bathing is of great advantage to health: it prevents abundance of diseases. It promotes perspiration, helps the circulation of the blood, and prevents the danger of catching cold. Tender people should pour water upon the head before they go in, and walk swiftly. To jump in with the head foremost, is too great a shock to nature.

V

Costiveness cannot long conflict with health. Therefore care should be taken to remove it at the beginning: and, when it is removed, to prevent its return, by soft, cool, opening diet.

Obstructed perspiration (vulgarly called catching cold) is one great source of diseases. Whenever there appears the least sign of this, let it be removed by gentle sweats.

VI

The passions have a greater *influence on health,* than most people are *aware of.*

A COLLECTION OF RECEIPTS

Abortion, (to prevent.)

Women of a weak or relaxed habit should use solid food, avoiding great quantities of tea, and other weak, and watery liquors. They should go soon to bed, and rise early; and take frequent exercise, but avoid being over-fatigued.

If of a full habit, they ought to use a spare diet, and chiefly of the vegetable kind, avoiding strong liquors, and every thing that may tend to heat the body, or increase the quantity of blood.

In the first case, take daily half a pint of decoction of *Lignum Guaiacum;* boiling an ounce of it in a quart of water for five minutes.

In the latter case, give half a drachm of powdered *Nitre,* in a cup of water-gruel, every five or six hours: in both cases she should sleep on a hard mattress with her head low, and be kept cool and quiet.

The Asthma.[1]

Take a pint of *cold water* every morning washing the head therein immediately after, and using the *cold bath* once a fortnight.

Or, cut an ounce of stick *Liquorice* into slices. Steep this in a quart of water, four and twenty hours, and use it, when you are worse than usual, as common drink. I have known this give much ease.

Or, half a pint of *Tar-Water,* twice a day.

Or, live a fortnight on boiled *Carrots* only. It seldom fails.

Or, take an ounce of *Quicksilver* every morning, and a spoonful of *Aqua Sulphurata,* or fifteen drops of *Elixir of Vitriol,* in a large glass of spring-water at five in the evening. —This has cured an inveterate *Asthma.*

Or, take from ten to sixty drops of *Elixir of Vitriol,* in a glass of water, three or four times a day.

☞ Elixir of Vitriol *is made thus—Drop gradually four ounces of strong oil of vitriol into a pint of spirits of wine, or brandy: let it stand three days, and add to it Ginger sliced, half an ounce, and Jamaica pepper, whole, one ounce. In three days more it is fit for use. But if the patient be subject to sour belchings, take the mixture for the Asthmatic cough, after the Elixir of Vitriol.*

Or, into a quart of *boiling water,* put a teaspoonful of *Balsamic Æther, receive the steam into the lungs, through a fumigater, twice a day.*

☞ Balsamic Æther *is made thus.—Put four ounces of spirits of wine, and one ounce of Balsam of Tolu, into a vial, with one ounce of Æther. Keep it well corked. But it will not keep above a week.*

For present relief, vomit with a quart or more of *warm water.* The more you drink of it the better.

☞ *Do this whenever you find any motion to vomit; and take care always to keep your body open.*

A Dry or Conclusive Asthma.

Juice of *Radishes* relieve much: so does a cup of strong coffee: or, *Garlick,* either raw, or preserved, or in syrup:

Or, drink a pint of *New Milk* morning and evening.—This has cured an inveterate *Asthma.*

Or, beat fine *Saffron* small, and take eight or ten grains every night.—Tried.

Take from three to five grains of *Ipecacuanha* every morning; or from five to ten grains every other evening. Do this, if need be, for a month or six weeks. Five grains usually vomit. In a violent fit, take a scruple instantly.

In any *Asthma,* the best drink is *Apple Water:* that is, boiling water poured on sliced apples.

The food should be light and easy of digestion. *Ripe Fruits* baked, boiled, or roasted, are very proper; but strong liquors of all kinds, especially beer or ale are hurtful. If any supper is taken, it should be very light.

All disorders of the breast are much relieved by keeping the *feet warm,* and promoting perspiration. *Exercise* is also of very great importance; so that the patient should take as much every day, as his strength will bear. *Issues*[2] are found in general, to be of great service.

Dr. *Smyth,* in his FORMULÆ recommends *Mustard-Whey* as common drink, in the moist Asthma: and a decoction of the *Madder Root,* to promote spitting.

☞ The decoction is made thus.—*Boil an ounce of Madder and two drachms of Mace, in three pints of water, to two pints: then strain it, and take a tea-cupful three or four times a day. But the most efficacious medicine is the* Quicksilver *and* Aqua Sulphurata. N.B. *Where the latter cannot be got, ten drops of* Oil of Vitriol, *in a large glass of spring water, will answer the*

same end.—I have known many persons greatly relieved, and some cured, by taking as much *Jallop* [Jalap] every morning as would lie on a sixpence.

To cure Baldness.

Rub the part morning and evening, with *onions*, till it is red; and rub it afterwards with *honey*. Or, wash it with a decoction of *Boxwood:* Tried. Or, electrify it daily.

Bleeding at the Nose, (to prevent.)

Drink *Whey* largely, every morning, and eat much *Raisins:*

Or, dissolve two scruples of *Nitre* in half a pint of water, and take a tea-cupful every hour.

To cure it, apply to the neck behind, and on each side, a cloth dipt in *cold water.*

Or, put the legs and arms in *cold water:*

Or, wash the temples, nose, and neck with *vinegar:*

Or, keep a little roll of *white paper* under the tongue:

Or snuff up *vinegar* and *water:*

Or, foment the legs and arms with it:

Or, steep a *linen rag* in *sharp vinegar*, burn it, and blow it up the nose with a quill:

Or, apply *Tents* made of soft lint, dipped in *cold water*, strongly impregnated with *Tincture of Iron*, and introduced within the nostrils quite through to their posterior apertures. This method, Mr. *Hey* says, never failed him:

Or, dissolve an ounce of *Alum* powdered, in a pint of *vinegar:* apply a cloth, dipt in this, to the temples, steeping the feet in *warm water.*

In a violent case, go into a pond or river. Tried.—See Extract from Dr. *Tissot.*

Bleeding of a Wound.

Make two or three tight *Ligatures* toward the lower part of each joint; slacken them gradually:

Or, apply tops of *Nettles* bruised:

Or, strew on it the *ashes* of a linen rag, dipt in sharp *vinegar* and burnt:

Or take ripe *puff-balls.* Break them warily, and save the powder. Strew this on the wound and bind it on. *I*—This will stop the bleeding of an imputed [amputated] limb without any cautery.

Or take of *brandy*, two ounces, *Castile-soap*, two drachms, *Pot-ash*, one drachm. Scrape the soap fine and dissolve it in the brandy; then add the Pot-ash. Mix them well together, and keep them close stopt in a phial. Apply a little of this warmed to a bleeding vessel, and the blood immediately congeals.

Spitting Blood.

Take a tea-cupful of stewed *prunes*, at lying down, for two or three nights: Tried.

Or, two spoonfuls of juice of *nettles*, every morning, and a large cup of decoction of *nettles* at night, for a week: Tried.

Or, three spoonfuls of *sage-juice* in a little *honey.* This presently stops either spitting or vomiting blood: Tried.

Or, half a tea-spoonful of *Barbadoes tar*, on a lump of loaf sugar at night. It commonly cures at once.

Vomiting Blood.

Take two spoonfuls of *nettle juice.*—

☞ (This also dissolves blood coagulated in the stomach.) —Tried.

Or, take as much *salt petre*, as will lie upon half a crown, dissolved in a glass of cold water, two or three times a day.

To dissolve coagulated Blood.

Bind on the part for some hours, a paste made of *black soap* and *crumbs of white bread:*

Or, grated root of *burdock* spread on a rag: renew this twice a day.

Blisters.

On the feet, occasioned by walking, are cured by drawing a needle full of *worsted* through them. Clip it off at both ends, and leave it till the skin peels off.

Boils.

Apply a little *Venice turpentine:*

Or, an equal quantity of *soap* and *brown sugar* well mixt:

Or, a plaister of *honey* and *wheat flower:*

Or, of *figs:*

Or, a little *saffron* in a white bread poultice.—'Tis proper to purge also.

Hard Breasts.

Apply *turnips roasted* till soft, then mashed and mixed with a little *oil of roses.* Change this twice a day, keeping the breast very warm with flannel.

Sore Breasts and Swelled.

Boil a handful of *camomile* and as much *mallows* in milk and water. Foment with it between two flannels as hot as can be borne every twelve hours. It also dissolves any knot or swelling in any part.

A Bruise.

Immediately apply *treacle* spread on brown paper: Tried.

Or, apply a plaister of chopt *parsley* mixt with butter:

Or, *electrify* the part. This is the quickest cure of all.

To prevent Swelling from a Bruise.

Immediately apply a cloth, five or six times doubled, dipt in *cold water*, and new dipt when it grows warm: Tried.

To cure a Swelling from a Bruise.

Foment it half an hour, morning and evening with cloths dipped in *water* as hot as you can bear.

A Burn or Scald.

Immediately plunge the part into *cold water*. Keep it in an hour, if not well before. Perhaps four or five hours: Tried.

Or, *electrify* it. If this can be done presently, it totally cures the most desperate burn.

Or, if the part cannot be dipt, apply a cloth four times doubled, dipt in *cold water*, changing it when it grows warm:

Or, a bruised *onion:*

Or, apply *oil;* and strew on it powdered *ginger*.

Windy Cholic.

Parched peas eaten freely, have had the most happy effect, when all other means have failed.

To prevent the ill Effects of Cold.

The moment a person gets into a house, with his hands or feet quite chilled, let him put them into a vessel of water, as cold as can be got, and hold them there till they begin to glow. This they will do in a minute or two. This method likewise effectually prevents chilblains.

A Consumption.

Cold bathing has cured many deep consumptions: tried.

One in a deep consumption was advised to drink nothing but *water*, and eat nothing but *water-gruel*, without salt or sugar. In three months time he was perfectly well.

Take no food but new *butter-milk*, churned in a bottle, and *white bread*.—I have known this successful.

Or, use as common drink, *spring-water*, and *new milk*, each a quart; and *sugar-candy* two ounces.

Or, boil two handfuls of *sorrel* in a pint of whey. Strain it, and drink a glass thrice a day: tried.

Or, turn a pint of skimmed milk with half a pint of small beer. Boil in this whey about twenty *ivy-leaves*, and two or three sprigs of *hyssop*. Drink half over night, the rest in the morning. Do this, if needful, for two months daily.—This has cured in a desperate case: tried.

Or, take a *cow-heel* from the tripe-house ready drest, two quarts of *new milk*, two ounces of *hartshorn shavings*, two ounces of *isinglass*, a quarter of a pound of *sugar-candy*, and a race of *ginger*. Put all these in a pot: and set them in an oven after the bread is drawn. Let it continue there till the oven is near cold; and let the patient live on this.—I have known this cure a deep consumption more than once.

Or, every morning cut up a little turf of fresh earth, and lying down, breathe into the hole for a quarter of an hour.—I have known a deep consumption cured thus:

'Mr. *Masters*, of *Evesham*, was so far gone in a consumption, that he could not stand alone. I advised him to lose six ounces of blood every day for a fortnight, if he lived so long; and then every other day; then every third day; then every fifth day, for the same time. In three months he was well.'—(Dr. *Dover*.) Tried.

Or, throw *frankincense* on burning coals, and receive the smoke daily through a proper tube into the lungs: tried.

Or, take in for a quarter of an hour, morning and evening, the steam of *white rosin* and *bees-wax*, boiling on hot fire-shovel. This has cured one who was in the thir stage of a consumption.

Or, the steam of sweet *spirit of vitriol* dropt into warı water:

Or, take morning and evening, a tea-spoonful of *whi rosin* powdered and mixt with *honey*.—This cured one i less than a month, who was very near death.

Or, drink thrice a day two spoonfuls of juice c *water-cresses*.—This has cured a deep consumption.

In the last stage, *suck a healthy woman* daily. This cure my Father.

For diet, use *milk* and *apples*, or *water-gruel* made wit fine flour. Drink *cyder-whey*, *barley-water*, sharpened wit *lemon-juice*, or *apple-water*.

So long as the tickling cough continues, chew well an swallow a mouthful or two, of a biscuit or crust of breac twice a day. If you cannot swallow it, spit it out. This wi always shorten the fit, and would often prevent consumption.

Corns (to cure.)

Apply fresh every morning the *yeast* of small beer, sprea on a rag:

Or, after paring them close, apply bruised *ivy-leave* daily, and in fifteen days they will drop out: tried.

Or, apply *chalk* powdered and mixt with water. This als cures warts.

Some corns are cured by a *pitch plaister*.

All are greatly eased by steeping the feet in hc water wherein *oatmeal* is boiled. This also helps dry an hot feet.

Costiveness.

Rise early every morning:

Or, boil in a pint and a half of broth, half a handful c *mallow-leaves* chopt: strain this and drink it, before you ea any thing else. Do this frequently, if needful:

Or, breakfast twice a week or oftener, on *water-gruel wit currants:* tried.

Or, take the bigness of a large nutmeg of *cream of tart* mixt with *honey*, as often as you need.

Or, take daily two hours before dinner a small tea-cupfu of *stewed-prunes:*

Or, use for common drink, *water*, or *treacle-beer*, impreg nated with *fixed air:*

Or, live upon *bread*, made of *wheat-flour*, with all the bra in it.

Or, boil an ounce and a half of *tamarinds* in three pints c water to a quart. In this strained, when cold, infuse all nigh two drachms of *sena*, and one drachm of *red rose-leave* drink a cup every morning.

A Cough.

Every cough is a dry cough at first. As long as it continue so, it may be cured by chewing immediately after yo cough, the quantity of a pepper-corn of *Peruvian bark*. Swa low your spittle as long as it is bitter, and then spit out th wood. If you cough again, do this again. It very seldom fai to cure any dry cough. I earnestly desire every one who ha

any regard for his health to try this within twenty-four hours, after he first perceives a cough.

Or, drink a pint of *cold water* lying down in bed: tried.

Or, make a hole through a *lemon* and fill it with *honey*. Roast it, and catch the juice. Take a tea-spoonful of this frequently: tried.

An Asthmatic Cough.

Take *Spanish liquorice* two ounces, *salt of tartar* half an ounce: boil the liquorice in three pints of water to a quart. Add the *salt* to it when it is blood-warm. Drink two spoonfuls of this every two hours. It seldom fails: tried.—I have known this cure an inveterate moist asthma.

A Consumptive Cough.

To stop it for a time, at lying down keep a little *stick liquorice* shaved like *horse-radish*, between the cheek and the gums. I believe this never fails.

A Convulsive Cough.

Eat preserved *walnuts*.

An Inveterate Cough.

Wash the head in *cold water* every morning:

Or, use the *cold bath:*—It seldom fails:

Or, peel and slice a large *turnip*, spread *coarse sugar* between the slices, and let it stand in a dish till all the juice drains down. Take a spoonful of this whenever you cough:

Or, take a spoonful of syrup of *horehound*, morning and evening: tried.

Or, take from ten to twenty drops of *Elixir of Vitriol* in a glass of water twice or thrice a day. This is useful when the cough is attended with costiveness, or relaxation of the stomach and lungs.

A Pleuritic Cough.

Powder an ounce of *sperma-ceti* fine. Work it in a marble mortar with the yolk of a new-laid egg. Mix them in a pint of white wine, and take a small glass every three hours.

A Tickling Cough.

Drink *water* whitened with oatmeal four times a day:

Or, keep a piece of *barley-sugar*, or *sugar-candy* constantly in the mouth.

Violent Coughing from a sharp and thin Rheum.

Work into old *conserve of roses*, as much as you can of pure *frankincense* powdered as fine as possible. Take a bolus of this twice or thrice a day. It eases presently, and cures in two or three weeks:

Or, take half a grain of the inspissated milky juice of *sowthistle*, once or twice a day. It has the anodyne and antispasmodic properties of opium, without its narcotic effects. Or, it may be made into laudanum, in the same manner as opium is, and five or six drops taken on a lump of sugar, thrice a day.

The milky juice of all the sowthistles, dandelions, and lettuces, have nearly the same virtues.

Or, use *milk* diet as much as possible.

A Cut.

Keep it closed with your thumb a quarter of an hour. Then double a rag five or six times; dip it in cold water, and bind it on: tried.

Or, bind on *toasted cheese*. This will cure a deep cut.

Or, pounded *grass*. Shake it off after twelve hours, and if need be, apply fresh.

Deafness.

Be *electrified* through the ear: Tried.

Or, use the *cold bath:*

Or, put a little *salt* into the ear:

Or, drop into it a tea-spoonful of *salt water:*

Or, three or four drops of *onion-juice* at lying down, and stop it with a little wool.

Deafness from Wax.

Syringe the ear with warm *water:*—Tried.

Deafness with a Dry Ear.

Mix *brandy* and *sweet oil:* dip black wool in this, and put it into the ear. When it grows dry, wash it well in brandy; dip it and put it in again.

Deafness with a Head-ach and Buzzing in the Head.

Peel a clove of *garlick*: dip it in *honey*, and put it into your ear at night with a little black wool. Lie with that ear uppermost. Do this, if need be, eight or ten nights. Tried.

A settled Deafness.

Take a red *onion*, pick out the core; fill up the place with oil of *roasted almonds*. Let it stand a night; then bruise and strain it. Drop three or four drops into the ear, morning and evening, and stop it with black wool.

Worms.

Take two tea-spoonfuls of *brandy* sweetened with loaf-sugar every morning:

Or, a spoonful of juice of *lemons:* or, two spoonfuls of *nettle-juice:*

Or, boil four ounces of *quicksilver* an hour in a quart of clear water. Pour it off and bottle it up. You may use the same quicksilver again and again. Use this for common drink: or at least night and morning, for a week or two. Then purge off the dead worms with fifteen or twenty grains of *jalap:*

Or, take two tea-spoonfuls of *worm-seed*, mixed with *treacle*, for six mornings:

Or, one, two or three drachms of powdered *fern-root,* boiled in *mead.* This kills both the flat and round worms. Repeat the medicine from time to time.

Or, give one tea-spoonful of syrup of *bear's-foot* at bed-time, and one or two in the morning, for two or three successive days, to children between two and six years of age; regulating the dose according to the strength of the patient.

Syrup of *bear's-foot* is made thus:—Sprinkle the green leaves with vinegar, stamp and strain out the juice, and add to it a sufficient quantity of coarse sugar. This is the most powerful medicine for long round worms.

Bruising the green leaves of *bear's-foot* and smelling often at them, sometimes expels worms:

Or, boil half an ounce of *aloes,* powdered, with a few sprigs of *rue, wormwood* and *camomile,* in half a pint of *gall,* to the consistency of a plaister: spread this on thin leather, and apply it to the stomach, changing it every twelve hours, for three days; then take fifteen grains of *jalap,* and it will bring vast quantities of worms away, some burst, and some alive. This will cure, when no internal medicine avails. See Extract from Dr. *Tissot.*

Flat Worms

Mix a table-spoonful of *Norway-tar,* in a pint of *small-beer.* Take it as soon as you can, in the morning, fasting. This brought away a tape-worm thirty-six feet in length:

Or, take from two to five grains of *Gamboge,* made into a pill or bolus, in the morning, fasting; drinking after it, a little weak green-tea, and likewise when it begins to operate, till the worm is evacuated. The dose must be regulated according to the patient's strength; for neither this, nor any other medicine, given as an alternative, is of the least service in this disorder. If the head of the worm be fixed in the upper orifice of the stomach, a smart shock from the electrifying-machine will probably dislodge it. Then purge.

To prevent. Avoid drinking stagnated water.

Wounds

If you have not an honest Surgeon at hand.

Apply juice or powder of *yarrow: I.*

Or, bind leaves of *ground-ivy* upon it:

Or, *wood-betony* bruised. This quickly heals even cu veins and sinews, and draws out thorns or splinters:

Or, keep the part in *cold water* for an hour, keeping th wounds closed with your thumb. Then bind on the thi skin of an *egg-shell* for days or weeks, till it falls off of itsel Regard not, though it prick or shoot for a time.

Inward Wounds

Infuse *yarrow* twelve hours in warm water. Take a cup o this four times a day.

Putrid Wounds

Wash them morning and evening with warm decoction o *agrimony.* If they heal too soon, and a matter gathers under neath, apply a poultice of the leaves pounded, changin them once a day till well:

Or, apply a *carrot* poultice; but if a gangrene comes on apply a *wheat-flour* poultice, (after it has been by the fire, til it begins to ferment,) nearly cold. It will not fail.

Wounded Tendons

Boil *Comfrey-roots* to a thick mucilage or jelly and apply thi as a poultice, changing it twice a day.

To open a Wound that is closed too soon.

Apply bruised *centaury.*

Notes

1. An *Asthma* is a difficulty of breathing from a disorder in the lungs. I the common (or moist) *Asthma,* the patient spits much.

Bioethics: A Primer for Christians

Gilbert Meilaender

Bioethics is a subject which every one will need to face at some stage of his or her life. It is, therefore, of the utmost importance that we understand the issues and their implications in how we live our lives.

In this non-technical introduction to the subject Dr Gilbert Meilaender provides a framework for Christians to think through the issues. He begins by establishing a Christian perspective on general bioethical issues such as presented by suffering, disease and healing and then moves on to discuss more specific concerns in the succeeding chapters.

Gilbert Meilaender is Professor of Theological Ethics at Valparaiso University in Valparaiso, Indiana. He has written a number of other books including *Faith and Faithfulness, Basic Themes in Christian Ethics* and *Body, Soul and Bioethics.*

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In Vitro Fertilization and the Ethics of Procreation

Many moral philosophers and theologians object to *in vitro* fertilization (IVF)[1] on the grounds that it is typically linked to other actions that are morally wrong, such as the disposal of surplus or defective embryos, experimentation on embryos, the indefinite freezing of embryos, and so on. The purpose of this article is to argue that IVF is inherently wrong even apart from other actions that typically accompany it. The argument has implications for the ethics of having children in general. For example, it implies that artificial insemination and the cloning of humans are morally impermissible. The main argument consists of twelve propositions (which are outlined, below). I shall number and state each proposition, offer clarification and justification as necessary, and make the logical connections among the propositions explicit as I proceed (Part I). I shall then raise and answer some of the more obvious objections to the argument (Part II). Next, I shall offer some reflections on the connection between the argument and other moral problems surrounding IVF (Part III). I shall conclude by situating the issue of IVF within its broader social context (Part IV).

I. The Argument Against IVF

1. Everything that can be benefited is an existing entity.

To benefit something is to confer on it an advantage or desirable quality that it did not have prior to the conferral; it is to make it better off than it was before. However, there can be no benefit without a beneficiary. One cannot confer an advantage on a non-existing entity, since there is nothing on which the advantage may be conferred.[2] It follows then that only existing entities can be benefited or, equivalently, everything that can be benefited is an existing entity.

2. No as-yet-unconceived child is an existing entity.

A child comes to exist (at the earliest) at conception, when a sperm cell and egg cell fuse to form a new, growing organism linked by genetic identity and continuous development to the mature human it will one day become (barring any disruption of its development). An as-yet-unconceived child is a merely possible, not an actual, entity.

3. Therefore, no as-yet-unconceived child is a being that can be benefited. (from 1 + 2)

4. Therefore, no as-yet-unconceived child is a being that can be benefited by the act of bringing it into existence. (from 3)

Proposition 4 follows immediately from proposition 3. If a merely possible entity cannot be benefited in any way, then it cannot be benefited by the conferral of a particular type of benefit, such as existence.[3]

5. If no as-yet-unconceived child is a being that can be benefited by the act of bringing it into existence, then every choice to bring an as-yet-unconceived child into existence is a choice to cause a child to be solely in order to benefit persons other than the child.

Every action aims at some benefit for some person or persons. Since an as-yet-unconceived child does not exist and so cannot be benefited, the choice to bring an as-yet-unconceived child into existence cannot aim at a benefit for the child. Yet it must aim at a benefit for someone; otherwise, the choice would be unintelligible. Therefore, it can aim only to benefit persons other than the child. One can easily draw up a list of possible benefits which may motivate a choice to cause an as-yet-unconceived child to exist: the child may be viewed as a source of emotional gratification and fulfilment for the parents and grandparents; a source of support in the parents' old age; an heir to carry on the family business; an extra hand to help with the chores or framework; an heir to the throne; a source of harvestable organs or bone marrow for an older sibling[4]; a playmate for an existing child; a sign of the father's virility; a source of prestige or status for the mother; and so forth.[5]

6. Therefore, every choice to bring an as-yet-unconceived child into existence is a choice to cause a child to be solely in order to benefit persons other than the child. (from 4 + 5)

7. Every choice to conceive a child by *in vitro* fertilization (IVF) is a choice to bring an as-yet-unconceived child into existence.

Proposition 7 follows from the definition of IVF. No one opts for IVF except as a means of bringing an as-yet-unconceived child into existence.

8. Therefore, every choice to conceive a child by IVF is a choice to cause a child to be solely in order to benefit persons other than the child. (from 6 + 7)

9. Every choice to cause a child to be solely in order to benefit persons other than the child is a choice that treats a child as a mere means to the ends of others.

The choice to cause a child to exist cannot be motivated even partially by a desire to confer a benefit on the child, since benefits can be conferred only on existing individuals. Thus, the choice (now) to cause a child to be (in the future) cannot treat the child (now) as an end in him—or

herself; it treats the child (now) as a mere means to the end of benefiting another or others.

10. Therefore, every choice to conceive a child by IVF is a choice that treats the child as a mere means to the ends of others. (from 8 + 9)

11. Every choice that treats a child as a mere means to the ends of others is a morally impermissible choice.

Every human being, from conception to natural death, possesses human nature. Human beings are rational beings. Thus human nature is a rational nature. Therefore, all human beings are rational beings in so far as they possess a rational nature, even when this rational nature is not yet fully developed or is impeded in some way. Their rational nature confers a special moral status on them.[7] They must always be treated as ends in themselves and never as mere means or instruments to the ends of others.[8] Thus, in evaluating actions morally, one must focus on more than their future consequences. One must also, and first of all, focus on the actions themselves at the time they are performed and determine whether they then treat persons as mere means. If they do, they are wrong, no matter how much happiness they may generate in the future.

12. Therefore, every choice to conceive a child by IVF is a morally impermissible choice. (from 10 + 11)

This completes the initial statement of the argument. Parallel arguments demonstrate the moral impermissibility of the artificial insemination and cloning of humans. To construct these arguments, one need only substitute 'artificial insemination' or 'cloning' for 'IVF' in the preceding argument.

II. Objections and Replies

Attentive and critical readers will no doubt have many questions and objections. In what follows, I attempt to anticipate and answer at least some of the more obvious questions and counter-arguments.

Objection 1: 'Surely this argument has many unacceptable, even absurd, implications. Consider the first premise: "All beings that can be benefited are existing entities." This claim flies in the face of many human actions that clearly aim at benefits for non-existing persons. For example, an as-yet-childless couple may prepare for the children they have not yet conceived by saving money, purchasing life insurance, acquiring baby clothes, furnishing a baby's room, and so forth. They aim to benefit a non-existing entity. Or again, a philanthropist might establish a foundation to confer benefits on future (not-yet-existing) generations. Moreover, generations of religious believers have considered their very lives to be a great gift conferred on them by their Creator. Surely it makes sense to be grateful for one's existence if that existence is the free gift of a rational being, and this means that previously non-existing beings are benefited by the gift of existence. Even an atheist can recognize the coherence and appropriateness of the theist's gratitude, given the theist's conviction that his or her very life is a gift from God.'

Response: This objection fails to distinguish between *benefiting* and *acting for the sake of.* Prospective parents may act for the sake of possible children, but they do not thereby benefit those as-yet-unconceived children; the children cannot be benefited until they come to be. Philanthropists may act for the sake of future generations, but they do not thereby benefit those as-yet-non-existing humans; the benefits will accrue only when the beneficiaries exist. Religious believers are certainly right to thank God for their existence, since their *continued* existence is indeed a gift from God that benefits them and renders possible all further benefits. But even God cannot do what is logically impossible, namely, confer benefits on non-existing entities. God's initial act of creating out of nothing (*ex nihilo*) confers benefits on nothing; otherwise it would not be *ex nihilo.* There can be no benefit without a beneficiary. However, God's deliberate act of *conserving* already-created entities does confer a precious benefit on those entities, for which they should show proper gratitude.

Objection 2: 'This argument "proves" too much. Not only does it "prove" that IVF is morally impermissible; it "proves" also that ordinary marital intercourse is impermissible, at least whenever husband and wife choose to have intercourse in order to conceive a child. But that is absurd.'

Response: This objection is question-begging. It presupposes precisely what it needs to demonstrate, namely, that it is morally permissible to choose to bring an as-yet-unconceived child into existence. However, the objection does correctly observe that the argument proves far more than the impermissibility of IVF. It proves the impermissibility of *any* choice to bring an as-yet-unconceived child into existence, for any such choice can aim only to benefit persons other than the prospective child and thus treats the prospective child as a mere means to the ends of others, which is impermissible. The objection raises a fair question: how can *any* (potentially) procreative actions be permissible if the argument is sound? To answer this question we must briefly consider the nature of marriage and marital intercourse and examine the attitudes that spouses ought to have toward the offspring to which their intercourse may give rise.

Marriage is a special kind of human relationship, the intrinsic goodness of which is evident to all who choose to marry.[9] At the heart of marriage is the physical union of man and woman, the two becoming one flesh. This union reaches its culmination when it leads to new human life. Thus, it is natural for married couples to expect and even hope for children. But because every human child is a person from the moment of conception, it is imperative that spouses adopt a morally appropriate attitude toward procreation. They must make no choice and adopt no plan that would treat their potential offspring as mere means to their own or others' ends. They must enter marriage realizing that offspring are the culmination of marital union; they must be open to new life and welcome it; they must accept children as sacred charges; they must be mindful above all of the duties that attach to parenthood. If they are prudent, they will, before having children, make a special point of reflecting on the terrible handicaps that could plague their children and make raising them an onerous burden. They must *not* view children principally as a means to the end of parental fulfillment. In particular—and more to the point at hand—they must not treat their child in his or her very

coming-to-be as a mere means to their own or others' ends. This entails that they must not choose marital intercourse precisely as a means of bringing an as-yet-unconceived child into existence. They may legitimately choose to engage in intercourse as an expression of their marital union, expecting or hoping that it will be fruitful. Such expectations and hopes are, however, not the same as choosing intercourse precisely as a means of bringing a child into existence. Welcoming children as the fruit of marital union is compatible with regarding them as ends in themselves; seeking them as the goal of marital intercourse (or of any other act) is not.

Objection 3: 'The argument puts God in an odd position. In creating human beings *ex nihilo*, God is not conferring benefits on them, since that is logically impossible. So God must be acting for the sake of someone else. Presumably, God's own goodness is the final cause of his act of creation. But this would mean, according to the argument, that God is treating his human creatures as mere means, which is impermissible. The argument thus implies, absurdly, that God is immoral!'

Response: The objection makes the mistake of applying moral terms to God and humans univocally. God is utterly unique. We may know what it means to apply moral terms to human agents—to call them 'just' or 'unjust', for example—but the same terms can be applied to God only analogously. Therefore, it is far from clear that the argument implies that God is 'immoral' or that God 'acts impermissibly', if one means by these words exactly what they mean when applied to human agents. God is *sui generis*, his act of creating is *sui generis*, and his reasons for acting are *sui generis*, so one must be extremely cautious in applying human concepts and categories to him.

Objection 4: 'Like so many philosophical arguments, this one has a superficial plausibility to it, but it fails, in the end, to convince. All it takes is a brief visit in the home of parents who have had children by IVF to appreciate how silly, and even insulting, the argument is. Many children have been conceived by IVF over the last twenty years, and most are genuinely loved and nurtured by their parents. The outcome of the procedure is its justification. No doubt, when children conceived *in vitro* are old enough to understand, they will approve of their parents' decision to use IVF, since without it, they would not have come to be. Surely this shows that IVF is morally permissible.'

Response: Most of those who choose IVF no doubt intend that the child be received in a loving parent-child relationship. Nonetheless, to choose IVF is to choose a morally flawed means to a good end. Unless one wishes to evaluate actions solely in terms of their net utility—the balance of costs over benefits—one must reject the justification given in the objection.[10] Moreover, the mere fact that the child conceived by IVF is glad to be alive does not show that IVF is morally permissible. A child purchased on the black market may end up in a good home and be grateful to his parents, but this hardly shows that it is permissible to buy and sell babies. A child whose biological father is a rapist will very likely be glad to be alive, but this hardly shows that the act by which the child was conceived was morally flawless.[11]

Objection 5: 'The preceding argument is unconvincing because it transforms a perfectly innocent and wholesome act—the act of making a baby—into a morally tainted act. Bringing new life into the world is a good thing to do; the birth of a baby is, after all, a joyful occasion. Moreover, the love of parents for their children is the paradigm of love. When religious writers wish to convey to their audiences the depth and strength of God's love for his human creatures, they describe him as a Father and human beings as his children. An argument that transforms a manifestly good and wholesome act, an act that renders possible one of the highest forms of love, into something morally objectionable simply lacks the power to convince anyone who is not already in the grip of the absurd theory that gave rise to the argument in the first place.'

Response: First of all, the preceding argument does not entail that the *act* that leads to the conception of a baby is morally flawed. It implies only that the *choice* (now) to cause an as-yet-unconceived child to exist (in the future) is morally flawed. Marital intercourse that leads to new life is good, for marital union is good and its culmination—the conception of a child—is good also. The moral flaw lies in *choosing* marital intercourse precisely as a means of making a baby, for such a choice necessarily treats the prospective baby as a mere means. Marital intercourse may, and should, be chosen simply as the realization of the union of the spouses, which is intrinsically good; it should not be chosen as the means of making a baby.

A further flaw that may be lurking in the objection is a sentimental, Hallmark-Card view of parental love. Of course, *authentic* parental love is a great good and a fitting metaphor for divine love. However, even a moment's reflection on parenthood in the real world reveals that it is shot through with moral ambiguity. Consider the high incidence of child abuse and neglect; the willingness of millions of parents to abort unborn children, often for trivial reasons such as gender-selection (especially in countries like India and China); the widespread use of abortifacient means of birth control; the widespread willingness to euthanize defective newborns; the tyranny parents routinely exercise over children in many of the world's cultures; the irresponsibility with which so many become parents; the willingness of some people to purchase or kidnap babies in order to become parents. Consider also how common it is for even loving and conscientious parents to experience the rude awakening of realizing that their children will not fulfil long-cherished parental ambitions, ambitions that might include having a child who will take over the family farm or business, become a priest or nun or rabbi, attend college or medical school, carry on ethnic or religious traditions, become an athlete. Sensitive, loving parents who are rudely awakened in this way will come to realize and accept that their children are persons in their own right, ends in themselves, not mere means to the ends of their parents. The very fact that even the best parents often experience this rude awakening and must struggle to accept the autonomy of their adult children shows that the choices that lead to procreation are less straightforwardly innocent than the objection seems to assume. Many of these choices are infected from the start with attitudes that regard (prospective) children as mere means to parental ends. It is not a weakness but a strength of the preceding argument that it highlights one of the principal moral

hazards of parenthood and avoids a sentimentalized view of parental love.

Objection 6: 'Premise 9 is incoherent and inconsistent with other key elements of the argument. A choice to cause a child to be cannot be a choice that treats a child as a mere means to the ends of others, since a non-existent child cannot be treated *in any way at all*. An individual must exist to be treated in some way by others. An as-yet-unconceived child does not exist and so cannot be benefited or harmed or "treated" in any other way. It follows that IVF is morally permissible, since before conception, there is no person to be mistreated, and after conception, any deliberate mistreatment of the embryo is the result of a choice that is distinct from the choice to use IVF.'

Response: The objection fails because premise 9 uses the verb 'treat' in its broadest possible sense to encompass not merely harming or benefiting but also regarding or adopting an attitude toward. On cannot harm or benefit a non-existent human being, but one can regard or adopt an attitude toward him or her. For example, a man can create an entirely imaginary woman who exists only within his own mind and deliberately imagine himself fornicating with her, committing adultery with her, or raping her. He has not harmed her, since only existing human beings can be harmed, but he has made a morally impermissible choice, since he deliberately regards her as a mere means. The moral qualities of rightness and wrongness, permissibility and impermissibility, apply to human choices, not to externally observable human behaviour, and by our choices we can take a stance or adopt an attitude toward non-existing as well as existing persons. These stances or attitudes can have great moral significance; indeed, they often have far greater moral significance than does externally observable behaviour that actually harms or benefits existing human beings.

Objection 7: 'The preceding argument must be unconvincing to anyone who accepts as authoritative the official teaching of the Roman Catholic Church regarding marital intercourse. That teaching holds that there is an inseparable connection between the unitive and procreative meanings of the conjugal act.[12] Yet the preceding argument seems to imply that spouses should choose marital intercourse only for its unitive value, not as a means to procreation, and this would require them to act as if the two meanings of the marital act were separable or not essentially connected.'

Response: The objection fails because it assumes incorrectly that respecting the connection between the unitive and procreative meanings of the conjugal act must mean engaging in marital intercourse with an intention to procreate. Yet the Church has always affirmed that marital intercourse can be morally permissible even when spouses know that procreation is unlikely or impossible, e.g. because of infertility. Respecting the inseparable connection between the two meanings of the conjugal act means never choosing to engage in complete sexual acts that cannot make the two spouses one flesh; sexual acts cannot make the two become one flesh when, for example, there is a deliberately imposed impediment to conception, or ejaculation occurs outside of the woman's vagina.[13] The essential inseparability of the unitive and procreative aspects of the conjugal act consists in this: the two spouses cannot become one flesh (the unitive aspect) unless their sexual intercourse is open in principle to the transmission of new life (the procreative aspect).[14] Respecting the inseparable connection between the two meanings of the conjugal act therefore does *not* mean choosing marital intercourse precisely as a means to procreation.

III. Other Moral Problems Connected to IVF

I mentioned at the beginning of this paper that many objections to IVF focus on moral problems with actions linked to IVF but distinct from it, such as the disposal of surplus or defective embryos, the indefinite freezing of embryos, and research performed on unwanted embryos.[15] If the preceding argument is sound, it helps to explain why these other sorts of action almost universally accompany IVF. The preceding argument demonstrates that the basic moral defect of IVF is a choice, made by parents and doctors alike, that treats the child-to-be-conceived as a mere means to the ends of the parents. Once this choice has been made, it is easy to understand why parents and doctors would be so comfortable with the disposal and otherwise harmful treatment of embryos conceived *in vitro*, especially those embryos that do not serve the interests or meet the specifications of their parents.

IV. The Social Context of IVF

In the not-too-distant past, when less was known about human fertility and contraceptives were unavailable, ineffective, or widely frowned upon, the choice to marry was, for the vast majority, also a choice to assume the role of parent: children simply came to (most) married people, and the problem was, not having them, but spacing births prudently. Moreover, for religious believers, the choice to marry (or not) was above all a vocational choice, driven by a desire to discern and follow God's will in one's life. In this bygone era, the quaint-sounding phrase, 'my station and its duties', summed up the attitude of millions of ordinary men and women toward their lives as spouses and parents: men and women accepted and raised children because doing so was a duty that pertained to their divinely ordained station in life as married people. Today, religious belief has weakened, while knowledge of and control over human fertility have increased enormously. The roles of spouse and parent are no longer linked as they once were: the choice to marry is followed for many by a second, distinct choice, either to become a parent or not, and many unmarried people also choose to become parents. Meanwhile, the religiously-based focus on 'my station and its duties' has given way to a more secular focus on 'my fulfilment and my rights'.[16] Not coincidentally, this shift in focus has occurred most strikingly in the affluent societies of the first world, in whose free-market economies 'the consumer is king'. The upshot of these converging trends is that, instead of being accepted humbly as sacred charges, biological children are increasingly sought, often aggressively and at great expense, as a means to parental fulfilment. The choice to become a parent is becoming for many a 'lifestyle choice' in which the principal focus is on the interests of the

chooser. The slogan, 'every child should be a wanted child', turns out to have a moral ambiguity that many of its proponents do not appreciate. Of course, every child should be welcomed and loved from the moment of its conception. However, no child should be sought as a mere means to the end of parental happiness. Bringing a wanted child into the world is morally permissible only if in wanting the child the parents do not regard it as a mere means to their own ends; and increasing the proportion of wanted children in the world will be most likely to benefit children only if those who want them also cultivate the habit of regarding them always, even before they are conceived, as ends in themselves.[17]

Notes

1. IVF involves removing sperm and eggs from the prospective parents, mixing them *in vitro* ('in a glass', i.e. in a Petri dish), waiting until the eggs are fertilized, and then placing several fertilized eggs (embryos) into the mother's uterus in the hope that at least one will implant itself in the uterine wall and develop into a healthy fetus. The first baby conceived *in vitro* was born in 1978. Those who choose IVF typically suffer from infertility, but some couples choose IVF to allow pre-implantation diagnosis of familial diseases and the culling of defective embryos. On pre-implantation diagnosis, see Edward M. Berger, 'Ethics of Gene Therapy', in Bernard Gert *et al.*, *Morality and the New Genetics* (Sudbury, MA: Jones and Bartlett, 1996), pp. 219–220.
2. One can *act for the sake of* a non-existing entity, such as a merely potential human being, e.g. by protecting the environment, but one cannot *benefit* a merely potential entity; see the reply to Objection 1, below.
3. Those who crave completeness may wish to insert the following premise between propositions 3 and 4: 'Everything that can be benefited by being brought into existence is a being that can be benefited.' Since this premise is tautologous, however, it need not be added to make the inference valid.
4. 'Conceived to Save Her Sister, A Child Is Born', *The New York Times* (April 7, 1990), p.8; cited in C.E. Harris, Jr., *Applying Moral Theories*, 3rd ed. (Belmont, CA: Wadsworth, 1997), pp. 156–7.
5. And then there is the case of Frau Bergmeier, a German woman held in a Soviet prison camp after World War II, who deliberately became pregnant by a camp guard in order to expedite her reunion with her husband and children in Germany; see Joseph Fletcher, *Situation Ethics* (Philadelphia: Westminster, 1966), pp. 164–5.
6. Jews, Christians, and Moslems express this theologically by saying that human beings are made in the image and likeness of God (Gn. 1:26–7).
7. For a defence of the thesis that all human beings from conception to natural death are persons with moral rights, see Patrick Lee, *Abortion and Unborn Human Life* (Washington, DC: Catholic University of America Press, 1996) and Germain Grisez, 'When Do People Begin?', *Proceedings of the American Catholic Philosophical Association*, 63 (1989) pp. 27–47. Other philosophers who argue that all human beings have moral status wish to use 'person' merely to denote beings with advanced cognitive abilities, such as mature, healthy human beings: see Richard Werner, 'Abortion: The Ontological and Moral Status of the Unborn', in *Today's Moral Problems*, ed. Richard Wasserstrom (New York: Macmillan, 1979); Alan Donagan, *The Theory of Morality* (Chicago: University of Chicago Press, 1977), pp. 168–71; Don Marquis, 'Why Abortion is Immoral', *Journal of Philosophy* 86 (1989) pp. 183–202. I take this to be a merely verbal disagreement and stipulate that 'person' shall refer in this paper to all and only those with moral status, regardless of their level of cognitive development at any given moment.
8. For the classic statement of this principle, see Immanuel Kant, *Fundamental Principles of the Metaphysic of Morals*, trans. Thomas K. Abbott (Indianapolis: Bobbs-Merrill, 1949), pp. 45–6. Some will object, in the spirit of Hobbes and Bentham, that it is impossible to treat others as ends in themselves, since every action is motivated only by the agent's desire to further his or her own happiness. This is the thesis of psychological egoism. For discussion and decisive refutation of psychological egoism, see Joel Feinberg, 'Psychological Egoism', in *Reason and Responsibility*, ed. Joel Feinberg, fourth edition (Encino, CA: Dickenson, 1978), pp. 529–539; James Rachels, *The Elements of Moral Philosophy* (New York: McGraw-Hill, 1986), pp. 53–64; Louis Pojman, *Ethics: Discovering Right and Wrong* (Belmont, CA: Wadsworth, 1995), pp. 63–69.
9. For a detailed statement of the account of marriage presupposed here, see Germain Grisez, *The Way of the Lord Jesus*, Vol. 2, *Living a Christian Life* (Quincy, IL: Franciscan Press, 1993), ch. 9, esp. pp. 569–574.
10. For a utilitarian defence of IVF, see Peter Singer, 'Creating Embryos', in *Ethical Issues in Modern Medicine*, fourth ed., eds. John D. Arras and Bonnie Steinbock (Mountain View, CA: Mayfield, 1995), pp. 436–47. For a refutation of theories of moral obligation that make our obligations dependent exclusively on weighing and comparing good and bad consequences of actions (utilitarianism, consequentialism, proportionalism), see John Finnis, *Natural Law and Natural Rights* (Oxford: Clarendon, 1980), pp. 111–8, and Germain Grisez, *The Way of the Lord Jesus*, Vol. I, *Christian Moral Principles* (Chicago: Franciscan Herald Press, 1983), ch. 6.
11. I do not mean to suggest by this that IVF is as gravely wrong as rape, but only that an action does not become morally permissible merely because it has an outcome that is good in certain respects. An action can be morally impermissible and have an outcome that is good in certain respects. An action can be morally impermissible *and* have an outcome such that one would not wish to undo the act after it is done (e.g. one would not, and should not, wish out of existence the child conceived by IVF, rape, adultery, fornication, or by any other morally flawed act).
12. See Pope Paul VI, *On the Regulation of Birth (Humanae Vitae)* (Washington, DC: United States Catholic Conference, 1968), #12 (7–8).
13. See Grisez, *The Way of the Lord Jesus*, Vol. 2, *Living a Christian Life*, pp. 634–6, 643–7.
14. 'Biologically, every animal, whether male or female, is a complete individual with respect to most functions: growth, nutrition, sensation, emotion, local movement, and so on. But with respect to reproduction, each animal is incomplete, for a male or a female individual is only a potential part of the mated pair, which is the complete organism that is capable of reproducing sexually. This is true also of men and women: as mates who engage in sexual intercourse suited to initiate new life, they complete each other and become an organic unit. In doing so, it is literally true that "they become one flesh" (Gn. 2.24).' Grisez, *The Way of the Lord Jesus*, Vol. 2, *Living a Christian Life*, p. 570.
15. Another disturbing feature of IVF, on which the preceding arguments shed much light, is the fanatical fixation on procreation that tends to lead people to choose IVF. This fixation is disturbing because those in its grip are so transparently preoccupied with their own personal fulfilment and so clearly view the child-to-be-conceived as a means of promoting that fulfilment. For some cases, see Ellen Hopkins, 'Tales from the Baby Factory', *The New York Times Magazine* (March 15, 1992), pp. 40ff., and Harbour F. Hodder, 'The New Fertility', *Harvard Magazine* (November-December 1997), pp. 54ff.
16. The increasing centrality of the concept of rights in the moral discourse of the modern era has disturbing implications for parental attitudes toward procreation. The Congregation for the Doctrine of the Faith of the Roman Catholic Church wisely observes that 'marriage does not confer upon the spouses the right to have a child, but only the right to perform those natural acts which are per se ordered to procreation'. [note omitted]

   '*A true and proper right to a child would be contrary to the child's dignity and nature. The child is not an object to which one has a right nor can he be considered as an object of ownership: Rather, a child is a gift . . .*' (italics in original), 'Instruction on Respect for Human Life is Its Origin and on the Dignity of Procreation', *Origins* 16 (March 19, 1987) p. 708.
17. For a casuistic analysis from which I drew key insights in writing the present paper, see Germain Grisez, *The Way of the Lord Jesus*, Vol. 3, *Difficult Moral Questions* (Quincy, IL: Franciscan Press, 1997), pp. 244–9.

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Palliative care from the perspective of a Consultant Geriatrician: the dangers of withholding hydration

Abstract

Dr Craig reviews arguments she put forward in a paper in the Journal of Medical Ethics in 1994.[1] This became the focus for wide debate of the ethical and legal dilemmas that arise when hydration is withheld in terminally ill patients. As a result national guidelines on the ethical use of artificial hydration were developed.[2]

Sedation without hydration is dangerous on medical, physiological, ethical and legal grounds, and can be disturbing for relatives. Doctors are fallible, and diagnostic errors not uncommon. Doctors are legally responsible for their acts and their omissions and must not abuse their power. Attention to hydration is not merely optional, it should be a basic part of good medicine and good palliative care.

Recommendations. There should be:

- An obligatory second Consultant opinion when sedation without hydration is considered.
- A confidential enquiry into the use of parenteral sedation in palliative care, and some effective monitoring system.
- A forum for resolving clinical ethical disputes during life.
- Research into thirst perception in the dying.
- A life-orientated approach to palliative care, in keeping with the best traditions of the hospice movement.

The dangers of withholding hydration

As a geriatrician I cared for many dying patients on my wards, but geriatrics is not primarily about death and dying. It is about supporting frail people in the last years of life. A holistic approach is essential, therapeutic nihilism is not. 'Our task'—to quote Professor Millard—'is not to accelerate death, but to care.' Another geriatrician Professor Sir John Grimley Evans, has spoken of the need for correct compassion.

Attention to hydration was routine on my wards, and drips were used when necessary. It would have been inconceivable for my team to have deliberately allowed a patient to die of dehydration. I was therefore shocked to discover the intensity of opposition to drips in the hospice movement a few years ago, when it was as futile to ask for a drip as to ask the incoming tide to turn. I criticised this attitude in a paper in the Journal of Medical Ethics[1] that became a focus for debate, leading to the publication of national ethical guidelines on the use of artificial hydration in terminally ill patients.[2] It is now acknowledged that a rigid policy for or against artificial hydration in terminal care is ethically indefensible. The aim now is to encourage palliative carers to make patient-centred decisions, weighing up the potential benefits and burdens of intervention. So at last the tide is turning. Much progress has been made, for which I thank all concerned.

There are times in palliative care when a drip is not necessary, even when a patient cannot drink, for example if the patient is overhydrated or in heart failure. Some patients die suddenly without becoming dehydrated, so the problem of maintaining hydration does not arise. However, a rigid antagonism to artificial hydration under all circumstances in the dying is dangerous. I know of cancer patients who have been sedated and left without fluids or nourishment for over a week until they died, grossly dehydrated, despite the protests of their relatives. To watch a loved one die in this way is profoundly disturbing and can cause post-traumatic stress. Yet I realise that some people who specialise in palliative medicine see prolongation of life as undesirable, even meddlesome, a mere prolongation of the dying process. This may explain much of the reluctance to use drips. If death is seen as a welcome relief, it is convenient to regard hydration as optional, rather than obligatory. Convenient, but morally debatable. There is a view that is shared by many thoughtful people, that hydration and nutrition are basic human needs, and should not be regarded as treatment that a doctor may give or withhold. In my opinion attention to hydration is not merely optional, it should be a basic part of good medicine and good palliative care.

Withholding hydration is dangerous on medical, ethical and legal grounds. It may shorten the life of patients, add to their distress, and cause their relatives anguish.[1]

First the medical dangers. Doctors are fallible. Patients

referred for terminal care may not be terminally ill. They may have been misdiagnosed. They may have a treatable complication such as sepsis after surgery for cancer, or diabetes associated with cancer of the pancreas. Small liver lesions can be mistaken for cancer deposits on ultrasounds or scans, and so on. Accurate histological diagnosis is also essential. One doctor reported a patient who is alive and well seven years after being written off with extensive malignant disease. A last ditch biopsy showed a type of tumour that responded to chemotherapy.[3] As Dr Caplan of the Hastings Centre once put it—'The new era of diagnostic paraphernalia has brought about a shift, not in the overall rate of diagnostic error, but in the type of error that is made.'

A rigorous post-mortem study published in the Journal of Pathology in 1981 showed that in 39% of over 1000 hospital autopsies, the main clinical diagnosis was not confirmed, or was only a subsidiary cause of death.[4] In half of these cases a different treatment would have been given had the correct diagnosis been known. Diagnostic errors rose from 22% in the under 45s, to 53% in the over 75s. In 1981 16% of patients who were thought to have died of malignancy had died of something else, such as infections or clots in the lungs. The Royal Colleges Working Party Report of 1991 quotes a figure of 25%,[5] so there is cause for concern and humility. Doctors must be absolutely sure of the diagnosis before making irreversible treatment limiting decisions. Many people could die for want of a drip.

A closer look at patients dying of a terminal confusional state might uncover a plethora of treatable conditions, yet treatment by sedation without hydration is thought to be acceptable. Any confusional state treated in this way will prove terminal. And what about the problem of intractable pain? Is infusion of midazolam and morphine without hydration for days on end until death occurs, really an acceptable solution? Is it really acceptable that such treatment can be given on the word of one doctor or a hospice team, without the patient's truly informed consent, and without prior discussion with the next of kin? How would you feel if it was your husband, or your wife lying there, unable to speak, the last goodbyes unsaid? I think you would feel shocked and betrayed. It would be like a nightmare.[6]

Society has spent much time considering the ethics of withdrawing hydration and nourishment from patients in a permanent vegetative state. Surely equally careful attention should be given to hydration in the dying. When sedation without hydration is considered for any reason a second Consultant opinion should be obligatory, for 'Consultants are as likely as anyone else to make mistakes or err in judgement'.[7] I would like to see a confidential enquiry into the use of parenteral sedation in palliative care, and some effective monitoring system.

Sometimes fluids are withheld by doctors who genuinely feel that treatment is futile or the quality of life too poor, or even that the burden on relatives is too great. This is a danger area, not only for cancer patients, but also for elderly stroke patients, who are sometimes left to die untreated, and incompletely diagnosed, although conscious and aware. Yet they, like many hospice patients, may find life worthwhile and precious despite their frailty. It is unethical to deny such people life by withholding hydration.

If a patient cannot speak for himself, it is good practice to ask the relatives what the patient's views about treatment might be, but relatives have no standing in law in such matters in the UK. Also the well being of the patient must not be compromised for the sake of relatives—or indeed health care staff, whose response to a difficult situation may be to wish the patient dead and out of misery.

No one should be forced to watch a loved one die while doctors refuse to give fluids, but sadly such cases still arise. It is not widely known that subcutaneous fluids can be given in a community setting. Not so long ago a woman watched her sister die in a nursing home after a severe brain stem stroke. She lay for six days without fluids, although the sister asked for a drip and agonised about thirst. A drip would probably not have altered the fatal outcome for the patient, but it would have spared the relative intense distress. Never underestimate the pain that such relatives suffer. Do not ignore their views or exclude them from discussions. If you do they may never recover from the experience. It is our job as doctors to ensure that the family can go on living, without being haunted by the manner of their loved one's death.

Society must address the issue of how best to resolve clinical ethical disputes during life. Some forum in which relatives can participate is needed, as Gillon pointed out[8], in addition to ethical guidelines. The Department of Health see this as a matter for local and professional discussion and are unlikely to give guidance. They have however commissioned guidelines on pain management.

I would like to move on to discuss the value of hydration in symptom control, and to consider the problem of thirst.

Fainsinger and colleagues on the palliative care unit in Edmonton Alberta, now offer subcutaneous fluids to all their patients who are dehydrated or likely to become so, because dehydration can cause unpleasant symptoms. They find that about two thirds of their patients, especially those who deteriorate slowly, need subcutaneous fluids, and they are given for 14 days on average.[9]

The consequences and symptoms of dehydration are summarised in table 1, which is based largely on information from Fainsinger et. al. with some additions of my own. As you see dehydration can cause confusion and restlessness, a dry mouth, impaired speech, thirst, an increased risk of bed sores, circulatory failure and renal failure. Renal failure causes hyperkalaemia and cardiac arrest. A rise in morphine metabolites may cause additional symptoms as indicated. The end result of dehydration is death.

Table 1: The consequence and symptoms of dehydration
Confusion and restlessness*
Dry mouth*
Impaired speech
Thirst*
Increased risk of bed sores*
Circulatory failure
Renal failure*, hyperkalaemia, cardiac arrest
Rise in opioid metabolites*—confusion, constipation, nausea, myoclonus, seizures*
Death
*After Fainsinger et al 1994

Given the ease with which dehydration can be prevented, it is neither kind nor necessary to leave it untreated.

The problem of thirst is of great concern. McCann and co-workers found thirst or a dry mouth to be a major symptom in 66% of patients, but it tended to decrease as death approached.[10] It has been suggested that cancer patients have a reduced thirst sensation. This is an interesting possibility, but how good I wonder is the evidence? Those who think only in terms of symptom control will argue that if thirst is reduced, dehydration is irrelevant and fluids unnecessary. I would argue that if thirst is reduced, patients are at increased risk of dehydration, as Phillip's group have shown in the healthy elderly.[11] Neglect of dehydration could lead to an escalating spiral of decline. Attention to hydration could improve the prognosis.

There is scope for important research here, to determine whether thirst really is reduced, and if so, what is the mechanism? Could it be for example, due to drugs, to tumour cytokines, or to destruction of nerve pathways by tumour? According to McCullagh, unless the hypothalamic thirst centre is destroyed, thirst can persist even in the presence of severe damage to other parts of the brain.[12] In the absence of firm evidence it is not safe to assume that dehydrated terminally ill patients do not suffer from thirst.

Traditional methods of suppressing thirst by moistening the mouth may give only transient relief. Physiologists report that thirst quenching involves three phases that are sequential and overlapping, as shown in Figure 1. This is taken from a chapter by Verbalis in a book on thirst, published by Springer-Verlag in 1991.[13] As you see there is an initial oro-pharyngeal phase involving neural reflexes that are provoked by the act of swallowing liquids. This is followed by a gastrointestinal phase due to gastric distension by fluid, and finally there is a postabsorptive phase as the fluid restores plasma osmolality to normal. Therefore sustained thirst relief is best achieved with fluid replacement. To try to suppress thirst without giving fluids makes little physiological sense.

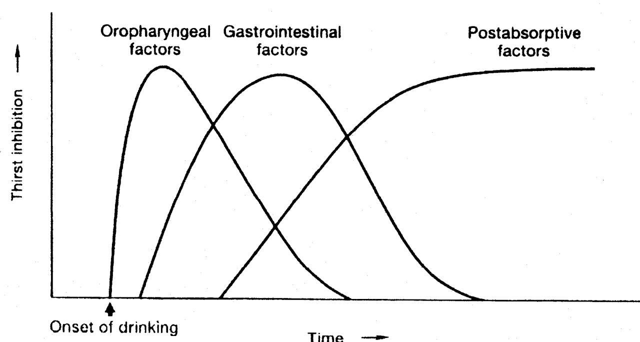

Figure 1: Schematic diagram depicting the onset and duration of various inhibitory signals to continued fluid ingestion following initiation of drinking in response to body fluid deficits. Although each signal by itself is capable of terminating ingestion (depending upon the species), it is the overlapping nature of these sequentially activated mechanisms that produces and sustains the inhibition of further water ingestion. (From Verbalis (1991), with permission.)

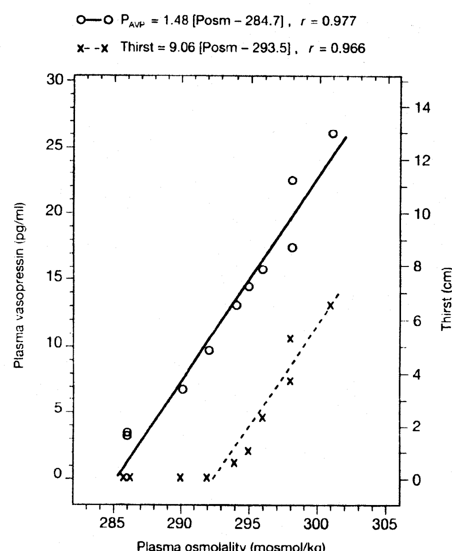

Figure 2: The relationship of thirst and plasma vasopressin to plasma osmolality during the infusion of hypertonic saline in a healthy adult. Thirst values are expressed in centimetres from the starting point of an analogue rating scale. (From Robertson (1984), with permission.)

Fluid balance is closely monitored and delicately controlled by the body. Figure 2, from the work of Robertson shows the relationship of thirst and plasma vasopressin to plasma solute concentration, or osmolality.[14] As you see, with rising plasma osmolality there is a rise in the hormone vasopressin and a rise in thirst levels. The resulting increase in drinking and in renal fluid retention restores the situation to normal in health. Vasopressin and thirst are controlled by similar monitoring systems, and vasopressin is thought to enhance osmotic thirst.

Central release of vasopressin is influenced by endorphins[15] and prostaglandins amongst other things, so morphine and other drugs may impair fluid balance control, and alter thirst unpredictably. It is best to consider all patients on morphine and sedatives to be at risk of dehydration. The greater the level of sedation, the greater the risk. Even lightly sedated patients, especially the elderly, may drink too little and become quietly dehydrated, unnoticed in a corner of the room. Heavily sedated patients on midazolam for example, will be unable to drink at all. If hydration is withheld prolonged dehydration will end in death, whatever the pathology. Even a fit Bedu tribesman, riding in the desert at night can survive for only seven days without food or water. What chance therefore do patients have?

Finally a word about the legal dangers of withholding hydration in terminal care. This is an area of great difficulty on which few lawyers are prepared to express an opinion. However it is quite clear that to sedate a patient and deliberately withhold hydration until the patient dies, leaves the medical team on very shaky legal ground. Mr Justice Ognall, speaking at the Medico-Legal Society pointed out that the distinction between deliberate acts intended to kill, and letting die, is not free from difficulties. He said 'Is a doctor who allows a terminally ill patient to die guilty of murder? Our law says *no*, but providing his intention in

omitting to act is to hasten the patient's death, what is the distinction in that circumstance, between an act on the one hand, and an omission on the other?'.[16] That I think is the key question. Some lawyers are now saying that a law is needed to prohibit intentional killing by omission.

The law as it stands is generous to the medical profession, and it is open to abuse. It is not morally justifiable to invoke the doctrine of double effect in a doctor's defence, if the doctor has, by intent or oversight, failed to treat predictable and potentially lethal side effects of medication, such as dehydration.[17,18] Doctors are legally responsible for their acts and their omissions.

Sadly there are times when sedation without hydration seems tantamount to euthanasia. This is bad for the image of the hospice movement and strengthens the hand of those who are pressing to legalise physician-assisted suicide. Good palliative medicine is a major defence against euthanasia, but please heed my warning. Sedation without hydration has enormous potential for misuse. I would like to see this regime consigned to the dustbin of history. If you look at what is happening in Northern Australia you will see the dangers clearly. Their self-deliverance homicide machine mark 2 induces coma—you may be sure that it does not hydrate! Closer to home a doctor, speaking in London, told how a man with advanced motor neurone disease had asked to be killed. 'I can't do that' replied the doctor, 'but I can make you unaware of your situation'. So he sedated the man and withheld hydration until he died. 'What was I supposed to say?' he asked when challenged—'Tell him that I could do nothing? A doctor's duty is to relieve suffering.'

In the case of Annie Lindsell, who sought euthanasia, her doctor was careful to state that he intended to sedate her when her motor neurone disease affected her swallowing. The High Court case was withdrawn without a judicial ruling.[19] The Judge warned that he could not grant Ms Lindsell's doctor immunity from prosecution.

Ultimately what is on trial in all this is the integrity of the medical and legal professions. The doctrine of double effect must not be used as a smoke screen for euthanasia.

The main dangers of withholding hydration that I have touched on are shown in Table 2.

Table 2: Main dangers of withholding hydration.
Dehydration and death
Ethical and legal problems
Abuse of power by doctors
Thirst and other symptoms
Hell for relatives.

I have said enough about the death-orientated approach. I will end by considering a life-orientated, life-supportive approach to palliative care. This is summarised in Table 3. As you see many of the features tally with the best traditions of the hospice movement. Doctors with this approach will support life in comfort and dignity, do no harm, attend to the mental, spiritual and physical needs of the patient, and will be sensitive to relatives. They will treat symptoms safely and use technology wisely, not only for pain relief, but also to maintain hydration, if possible to the end, providing that fluid administration is not in itself a burden to the patient. Application of this ethical principle, put forward by the House of Lord's Select Committee on Medical Ethics, would simplify many difficult treatment limiting decisions.

Table 3: Life orientated approach to terminal care.
Support life in comfort and dignity.
Do no harm.
Attend to mental, spiritual and physical needs.
Be sensitive to relatives.
Treat symptoms safely.
Use technology wisely.
Maintain hydration if possible to the end.

The message I would like you to take home with you is that '*Attention to hydration is not merely optional, it should be a basic part of good medicine and good palliative care.*'

Finally there is a wider aspect to this debate that takes us beyond the realm of science and medicine, into the realm of the human heart and spirit. Human life is precious, we do not pass this way again. We as doctors, have a special duty to support life wisely, until it comes to a natural end. It is not our role to launch the soul on it's longest journey. Heaven can wait.

Acknowledgements

This paper was based on one given by Dr Craig at a conference on palliative care in general medicine, held at the Royal College of Physicians of London on June 4th 1997.[20] For a fuller discussion of ethical and legal aspects readers are referred elsewhere.[1, 16–18]

Addendum. A relative's testimony

A member of the public commented—'I would like to confirm what Dr Craig has said . . . My husband had cancer and suffered pain in his left leg. He went to a hospice for pain control. He was, and remained, clear in his mind and showed no sign of immediate terminal illness. We thought we had a lot more living to do together.

One night, without consultation, a doctor made the decision and changed my husband's medication. I learnt later that he was being given midazolam. My request for him to receive sustenance was ignored, he drifted into a coma and died seven days later. His tongue was so dehydrated it had curled up tight at the back of his throat.

My Member of Parliament gave every support in trying to get two independent medical opinions, which I feel I am entitled to, but to no avail. It seems to me that the National Health Service complaints procedure is failing the ordinary person in the street. Most of us cannot afford legal advice.

I have never been able to grieve. My whole existence has been affected by the way my husband died. What ever deliberations are made in the future, the public must be protected.'

Source confidential. Quoted with permission.

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Book Reviews

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Man Made Man
Ethical and Legal issues in Genetics
Ed Peter Docherty & Agneta Sutton
Open Air, Four Courts Press, Dublin 1997
ISBN 1-85182-278-X 116pp Pb

Here is a book which goes a long way towards de-mystifying the subject of Genetics for the non-scientist, and providing a simple introduction to the Genome Project. It aims to show how the new knowledge can be used to further human welfare and not corrupt it.

The contributors include a professor of molecular genetics, a professor of legal studies and specialists in bio-ethics. The team has an international flavour, with representatives from France, Italy and Portugal, as well as from the United Kingdom which, as one of the authors reminds the reader, was the birthplace of the double helix discovery.

There is a chapter devoted to a consideration of the moral and legal basis for decisions regarding the limits appropriate to the application of genetic knowledge in practice. In it, the author examines three theories: radical subjectivism, utilitarianism, and ontological personalism. This last theory, which places the dignity of the human person (identified with the human being) at the centre of ethics and law, is regarded as being the only one which makes it possible to fix the limits of progress of genetic engineering objectively, in such a way that it is genuinely respectful of human nature. Accepting such a basis, the reader might expect a strongly conservative approach throughout the book, and in particular a total rejection of such contentious ideas as germ-line manipulations. But it is not like that.

The two major subdivisions of genetics, from a practical point of view, are genetic testing and genetic therapy. Genetic testing aims to predict the risk of disease in the individual and for future generations. There are conditions such as Huntington's disease which are monogenic and can be predicted with a probability close to 100%; but for most diseases, all that can be determined is a probability higher than that of the general population. It is interesting to be told that we all carry some defective genes, and that 'bad genes' confer, in several cases, protection against other diseases.

One of the great problems of predictive testing is confidentiality. The presence of a genetic abnormality which makes a person who is currently healthy more liable to fall ill and die at a young age is a matter of concern not only to the individual but also to any prospective employer and insurer. How the information is to be used is one of the great unresolved problems, and is discussed at some length.

These are two basic levels of gene therapy: somatic and germ-line. Somatic therapy attempts to correct a genetic abnormality after birth and affects only the individual treated. Germ-line therapy attempts to correct an abnormality in spermatozoa or eggs or their precursors, or in cells in the early stages of embryonic life.

There has always been a deep concern regarding the justification of germ-line interventions both because of the unpredictability of their effects and because of their influence on future generations. In somatic therapy, any adverse results end within the life-time of the individual patient, but in the case of germ-line therapy, the effects go on and on. One author argues that germ-line gene therapy of very serious diseases can be justified because the outcome is otherwise hopeless.

Much as one might want to avoid consideration of genetics, this is not an option in today's world. A considerable proportion of children continue to be born with genetic defects, and it is only reasonable to want to do all that is possible within ethical limits to reduce this burden of suffering and expense. At present, the main way in which this is attempted is by prenatal screening using amniocentesis or chorion villus sampling, followed by termination of the pregnancy if the fetus is found to be abnormal.

This, of course, leads to the vexed question of eugenics. Genetics and eugenics are indeed inseparably linked. Some form of eugenics is an inevitable consequence of the advance of the science of genetics. The point is made that although there are obvious advantages in attempting to prevent the birth of damaged individuals, there is a down side. One is the effect it would have on the attitude of society to

disabled people. Another is that it would be impossible to maintain a strict dividing line between serious medical conditions and non-medical characteristics such as appearance, behaviour, aptitudes and intelligence. So-called 'enhancement' genetic engineering is categorically rejected as being an attempt by one generation to impose on future generations certain characteristics according to its own capricious choices—apart altogether from the risk of unpredictable unintended consequences.

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God and the Biologist
Faith at the Frontiers of Science
R J Berry
Apollos, Leicester, England, 1996
ISBN 0-85111-446-6 143pp Pb £12.99

Professor Berry sets out his aim as being to show that there need be no barrier between real science and real faith. The particular areas on which he concentrates are evolution, the nature of man and his genetic relationship with other creatures, the historicity of Adam and Eve —which he accepts—the question of whether life begins at conception, the concept of personhood, reproductive technology—he includes a section on the working of the Human Fertilisation and Embryology Authority (HFEA) —and the individual's responsibility for the global environment. He writes from the standpoint of a Bible-believing, evangelical Christian and describes his pilgrimage towards faith, leading to 'my acceptance of Christ as my Saviour'.

Professor Berry makes a number of arresting and provocative statements. Here are a few. 'As a scientist, I have no doubt whatever that evolutionary change has occurred and that its mechanism is along the lines described by neo-Darwinian theory.' 'The evidence is against the proposition that life begins at conception.' 'Nowhere are we told in the Bible that life is sacred.' The author believes that Adam was 'an ape inbreathed by God's Spirit, with an evolutionary history but with a unique relationship with the Creator'.

The author unashamedly describes himself as an evolutionary biologist, and he informs the reader that some of the greatest evangelical theologians of the last 100 years, men like Warfield, Orr, Hodge and Strong, embraced Darwinism. He quotes Warfield as saying: 'It is to theology, as such, a matter of entire indifference how long man has existed on earth.' He takes issue with those who misuse the term 'the theory of evolution', implying that it is merely speculative, and asserts that a theory in scientific language is an established interpretation of facts.

[Professor Berry's credentials are impressive: professor of genetics at University College, London, England, and recipient of the Templeton UK Individual Award for progress in religion in 1996 for his 'sustained advocacy of the Christian faith in the world of science' He has been involved in many influential committees: member of the HFEA, chairman of the Working Party for the General Synod of the Church of England to advise the Church on modern reproductive technology, author of the Ethics Report which formed part of the UK response to the World Conservation Strategy of the United Nations Environmental Programme, and chairman of the Working Party which formulated a code of environmental practice for the Economic Summit Nations (G7) as a basis for the Heads of State meeting in Texas, 1990.]

There is a fascinating chapter on the history of the rise of science and the developing conflict with the teaching of the Church, including a reference to Philip Gosse's provocative book 'Omphalos' with its seemingly frivolous yet profound and intriguing question as to whether Adam had a navel.

Another valuable chapter deals with our genetic constitution. Berry states that we share almost all our genes with chimpanzees. Indeed, we differ from them genetically less than two species of gibbon differ from each other, or willow warblers differ from chiff-chaffs (bird species very difficult to tell apart). He puts the importance of our genetic constitution into perspective in stressing that, although our behaviour is affected by our genes, it is not controlled by it. He illustrates this by reference to the inheritance of an extra Y chromosome. When a high proportion of tall men committed to institutions for the criminally insane on account of their aggressiveness were found to have an extra Y chromosome (that is, to be XYY), their disability was hailed as proving the inheritance of original sin—until other XYY men were found living perfectly normal lives in the community!

One of the most important chapters is that on environmental ethics. He jolts us out of our complacency by pointing out that *my* fridge and air conditioner is 'destroying the ozone layer ten miles above the earth and causing cancers in another continent'. This is an area in which it is widely believed that, as one historian of science puts it, 'Christianity bears a huge burden of guilt'—on account of God's command to mankind: 'Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish of the sea and the birds of the air and every living creature that moves on the ground.' The author points out that, in fact, non-Christian civilisations have been every bit as bad as Christian ones in causing environmental disasters; that the basic fault is greed, and that the antidote is to be found in the concept that we are stewards in God's world, accountable to him for our behaviour towards the whole of creation.

There is a tremendous amount which is helpful here, even to those who have read and thought widely on the subject. It is a particularly valuable book for those whose work brings them into contact with young people, because it is simply and clearly written. No Christian will agree with all that the author concludes from the evidence he presents, but his basis is firm, welcoming, as he does, all the facts of science and all the teaching of Scripture.

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A Time To Live, A Time To Die
Beatrice M. A. Ash, with Lucile Allen
Minneapolis, MN: Augsburg Fortress & Bristol, UK: Alban Books, 1993
ISBN 0-8066-2664-X, 77 pp., $7.99

In her book, *A Time To Live, A Time To Die*, Beatrice Ash tackles a difficult and disturbing subject: facing death. Many books have dealt with the emotional aspects of facing death. Ash goes one step further, however, in subtly reminding us throughout her book that death is inevitable for us all. The book addresses a broad audience because it gently brings us face-to-face with the fact that death may come at any time.

Often, death is viewed as something to be faced passively. It is said to elicit the same reactions as any other trauma, such as shock, withdrawal (or denial), and recall. Ash's analysis of the dying process allows for these feelings, yet it also shows the importance for the dying person of securing some degree of control.

From her years of experience in hospice ministry to dying persons, Beatrice Ash has acquired an insight that is rare. She has seen first-hand the fear and despair that can be early shrouds to both the dying and to those they care about. Her insights offer hope and suggest an active role that can relieve some of this heaviness. Using seven sub-topics that carefully describe the process of planning, preparation, and protection of self and loved ones, the book thoroughly lays out a pattern of positive actions to follow. The tense feeling that comes from being reminded of our own vulnerability begins to melt away as the actions suggested by the author soothe our anxiety.

In the chapter on 'Having Others Present,' she discusses the importance of not becoming isolated. Though withdrawal is a common and very human reaction, she explains the extreme pain it can create for everyone involved. Speaking of a woman who withdrew from everyone, Ash describes the end of the woman's life: 'The hospice nurse introduced me. In reaction to my clerical collar, Linda began frantically shaking her head. A look of panic filled her face like that of a child threatened with severe punishment. I tried to comfort and reassure her, but the panic only increased. Finally, I moved away.' Later, in the waiting room Linda's aunt said, 'She's dying the way she lived — the hard way' (p. 12).

This type of tragedy, suggests the author, could be avoided if people took certain actions, such as being open with others about their impending deaths, and allowing them to be close to them. Also, continuing daily routines as much as possible seems to diffuse some of the power that the fear surrounding death can bring.

Discovering that no cure is available often ushers in an overwhelming sense of defeat for the terminally ill. In her discussion on 'Providing for Physical Needs', the author advises an active role in helping people deal with these feelings. Understanding pain management, ensuring proper nutrition, and discussing with the doctor what kind of treatment best fits one's needs can begin building layers of emotional and physical order and stamina.

Two of the book's chapters are devoted to focusing on others. Making certain that one's wishes are known through both a will and open discussion about the family's continued well-being is essential. Completing this task can bring relief and comfort. Furthermore, in a wonderful discussion about 'giving yourself away', Ash speaks of how the attitude displayed by people who are facing death will affect those who love them for years to come. Love may be left behind not only by the giving of personal items but also by intangible gifts such as the sharing of wisdom.

We all hope that as the end approaches we

will feel that our lives have had meaning. Ash's experiences with the elderly and dying include this observation: 'As their physical capabilities decrease, an interesting thing often happens. . . . they become storytellers. While some intentionally look back to put their lives in order, most are only aware that something is compelling them to think about the past. That almost indefinable "something" is a need for one's life to be validated, to be assured—not only by others—but by our own realization that our life has had meaning and purpose' (pp. 47–8). Ash's observations encourage the reader to begin listening more carefully to these stories from the storytellers who will soon be silenced.

In what may be the most thought-provoking chapter in the book, Ash talks about the process and progress of forgiveness. Many people's lives become trash compactors: collections of hurts and offences that have not been forgiven. This storage bin can become a suffocating weight as one unresolved human conflict builds upon another. Just as the fact of death involves the necessity of letting go physically, the vulnerability it unlocks may also allow the individual to forgive and, therefore, experience emotional and spiritual cleansing.

Those who have lived God-centred lives may find it easier to offer their own forgiveness and find peace in the end. Ash tells two uplifting stories of forgiveness which remind us that having the same heart and mind as our heavenly Father is indeed freeing.

In reality, most people avoid the idea of their mortality. Juxtaposing this against the average, healthy life seems impossible. Therefore, this subject matter could easily be deemed too morose for most readers. But today, when 'dying and dignity' is an ever-present topic of discussion, this book might be considered a 'how to' manual.

Beatrice Ash takes the difficult and makes it manageable. She treats the potentially distasteful with such verbal poise, and yet straightforward honesty, we cannot help but believe that death does not have to be preceded by darkness and despair. Rather, it seems altogether possible that life can be reviewed, celebrated, and then gradually released as we are accepted into the waiting hands of a loving God.

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The New Healers: The Promise and Problems of Molecular Medicine in the Twenty-First Century
William R. Clark
New York & Oxford: Oxford University Press, 1997
ISBN: 0-19-511730-1, 238 pp., $25.00

The story of medicine is the story of revolutions. Long periods of stasis, where little alters, are punctuated by moments of profound change — sometimes clearly seen only in retrospect — when a new insight or discovery affects the face of practice. Changes such as the use of hygiene and sanitation, the discovery of penicillin, and the development of vaccines, for example, radically altered the spectrum of disease. Smallpox, polio, and rheumatic fever disappeared as major killers. But replacements were waiting in the wings, and today many of the diseases that confront us involve derangements at a more basic level — the level of our genes. This is the domain of molecular medicine.

Are we on the verge of a new revolution in how we view and treat disease? 'Molecular medicine', writes William Clark in his prologue, 'particularly in the form of gene therapy, will be a major part of our lives in the new millennium.' Clark, Professor Emeritus of Immunology at UCLA, and author of *Sex and the Origins of Death*, refers to gene therapy as 'one of the most profound revolutions in modern medicine'. Although the success of gene therapy to date has been modest, Clark foresees a bright future for the field.

If he is correct, medicine is poised to undergo a radical change in the next century. *The New Healers* provides an introduction to the basic concepts and processes of molecular medicine. Clark begins with the very basics — the discovery of genes and the nature of heredity, charting the path marked out by Gregor Mendel that led to the identification of nucleic acids, the structure of DNA, and the nature of genes. He discusses how deleterious mutations occur, how these flaws are expressed in abnormal proteins, and how disease results.

The effects of gene dysfunction are seen most prominently in the diseases they cause, and Clark examines several in great detail — cystic fibrosis (CF), severe combined immune deficiency (SCID), and cancer ('every cancer is a disorder of DNA' [p.135]). SCID was selected as the first disease to be treated by gene therapy, as recently as 1990. Regarding AIDS, Clark states, 'gene therapy offers one of the brightest hopes on the therapy horizon' (p. 174).

Later, Clark probes deeper into the mysteries of heredity, discussing the isolation, cloning, and transfer of human genes. This leads into discussions of the clinical trials involving SCID and CF, detailing both successes and difficulties. Most trials to date involve single-gene diseases; treatment of multiple-gene disorders is beyond our current technology.

But despite the logic behind gene therapy, and our ever-growing understanding of gene operations, Clark admits that 'gene therapy in the clinic has so far had very little impact on human disease' (p.126). Clinical trials are multiplying, yet much of gene therapy remains in the realm of promise and potential — not yet effective clinical practice. But the promises are great: the development of naked DNA as 'the vaccine of the future'; cures for AIDS and cancer; the Human Genome Project providing a complete map of the human genome, including loci where diseases occur.

At this point, Clark recommends caution: 'It may be time to step aside and digest what has taken place in gene therapy thus far, and address at a basic research level some of the technical problems that have arisen with nonblood-cell gene delivery, before rushing ahead with new clinical trials involving additional genes' (p.131). When the Human Genome Project is complete, the temptation to plunge into treatment protocols will undoubtedly be immense. But technical problems regarding delivery systems remain, and, of course, the ethical implications of genetic therapy have not yet been fully digested.

Clark devotes the final chapter of *The New Healers* to a discussion of ethics. And it is here — at perhaps its most interesting point — that, to my mind, the book falls short. One cannot adequately discuss the ethical implications of gene therapy in just twenty-four pages. Clark traverses a lot of ground quickly, but with little depth. Much of what he says is well worth pondering; there simply isn't enough of it.

For example, in discussing *in vitro* fertilisation techniques and human embryo research (the work of the 'molecular obstetrician'), no mention is made of the rightness or wrongness of manipulating human embryos — or what is done with those that aren't wanted. The use of human embryos is taken for granted. Certainly from a Christian standpoint these questions deserve recognition and discussion.

Clark rightly foresees that the urge to alter our genome for reasons other than disease will arise: '. . . will the "technopeople" of the future and their "gene doctor" begin to select eggs or embryos on other bases, such as physical appearance or personality traits? And what is to stop us from *adding* genes to eggs or embryos? Will future parents demand that they be allowed to scan through the catalogue of the human genome, shopping for gene variants they would like to see in their children? This is by no means a fantasy; the technology already exists . . .' (p. 214). Clark notes that changes at the reproductive level affect not only an individual, but reach into the future. Such a scenario should give us pause.

'It is not inconceivable', Clark writes, 'that we may decide that, under certain circumstances, genetic modification is acceptable or even desirable. But this is a question too large to be left to scientists alone; we must all inform ourselves of the issues, and join in the discussion' (p. 215). Clark's point is well taken, and Christians must be among those making their voices heard in the discussion.

Other pitfalls await — the influence of gene therapy on insurance and vice versa; the use of genetic techniques in molecular forensics; issues of employment and genetic privacy. 'We must never allow molecular genetics to be used by any one group — whether defined economically, socially, racially, or by any other criterion — to enhance or even consolidate its position in the body politic. Nor must we ever allow individuals defined by molecular genetics as somehow different from the "norm", on whatever basis, to be put at risk for selective and potentially prejudicial treatment' (p. 230).

As an introduction to molecular genetics, *The New Healers* is readable and informative. I doubt that it is possible to cover such a technical field any more clearly than Clark does, yet I suspect that some laypersons without medical or scientific backgrounds might be hard pressed to follow all the details. I wonder if Clark might profitably have engaged in more speculation — where might we go, where ought we go, where perhaps shouldn't we go. Reading *The New Healers* in conjunction with a volume delving more deeply into ethical issues would render it even more valuable. For the issues, as Clark notes, will affect us all.

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The Ends of Human Life: Medical Ethics in a Liberal Polity
Ezekiel J. Emanuel
Cambridge, MA: Harvard University Press, 1991
ISBN 0-674-25326-4, 307 pp., $19.50

I offered to review Ezekiel Emanuel's book, *The Ends of Human Life*, for one very simple reason: it is one of the most important books published on medical ethics in the last decade! That is a fairly bold claim and I hope to support it in what follows. Emanuel is a very competent, prolific writer and this current work charters previously unexplored territory. It will be quickly obvious that this book was published a number of years ago, but it has received few reviews and little discussion. The absence of any discussion in the medical ethics literature on the topics contained in Emanuel's work is bewildering. The author himself admits to noticing little reflection on his work from those in medical ethics; a phenomena he has difficulty explaining (personal communication, September 1996).

However little attention has been given to the issues Emanuel broaches, they are critical. The political concept of neutrality and its impact on medicine cannot be brushed aside. In addition, these issues have helped to marginalize religious voices, a phenomenon that should be of critical concern to Christians and others who find foundation for their moral vision in medicine in their religious traditions (Lammers S.E., 'The Marginalization of Religious Voices in Bioethics', in Verhey A. [ed.] *Religion and Medical Ethics* [Grand Rapids, MI: Eerdmans, 1996] pp. 19–43).

Emanuel asks three important questions based on the 'persistent irresolution' seen in medical ethics. 1) What is the proper approach to medical ethical questions? How should the issues of medical ethics be characterized? 2) Why, in contemporary American society, do medical ethical questions seem to lack resolution? Why do we seem to lack an ethical framework in which these questions can be rationally discussed? 3) Is there a resolution to medical ethical questions? Can we construct an ethical framework that will permit these questions to be rationally discussed? (p. 6).

Before Emanuel deals with these questions he deconstructs the 'myth of technology'. Frankly, I have always been somewhat sceptical of the claim that technology has led to our inability to confront ethical issues in medicine. Proponents claim that we have developed a whole new set of issues for which we have not had time to develop appropriate moral answers. Emanuel's answer to the 'technology axiom' is that 'technology has simply outfitted these eternal questions in new clothes, but it has not altered the fundamental ethical issues beneath the new appearances ... advancement in biomedical technology does affect medical ethics issues' (p. 13). To Emanuel the 'persistent irresolution of medical ethical questions is a consequence not of medical technology but, rather of the political philosophy that informs deliberations on medical ethics' (p. 7).

In answer to the first question, Emanuel claims that, although 'medicine is committed to moral ideals', 'medical ethical questions can be rationally discussed and resolved only within a framework constituted by political philosophy' (p. 7). The particular philosophy Emanuel refers to is liberal political philosophy (LPP) as typified by Richard Dworkin and John Rawls (Dworkin R., *A Matter of Principle* [Cambridge, MA: Harvard University Press, 1985]; Rawls J., *A Theory of Justice* [Cambridge, MA: Harvard University Press, 1971]). Neutrality, espoused within this philosophy, specifies that public institutions, laws, and policies should not promote any particular view of the good. This is one aspect of LPP that Emanuel feels has hindered our society's ability to find answers to medical ethics questions. 'LPP excludes, even in theory, a shared framework for resolving such medical ethical questions . . . In the absence of judgments about what is worthy or good, we cannot decide whether a medical intervention promotes a patient's well-being or is deemed harmful' (p. 7). Resolution of differences in medical ethics, requires, 'nothing less than an alternative political philosophy, one in which laws and policies can be justified by appeal to conceptions of the good life' (p. 8). Emanuel devotes the remainder of his book to explicating the weaknesses of LPP and his response to these weaknesses.

Emanuel advocates formation of 'the liberal communitarian vision (LCV)' as his answer to the final question he posits (p. 156). He suggests that, in the area of health care, the US polity be divided into, 'thousands of community health programs (CHPs), each made up of a few thousand to a few tens of thousands of citizen-members' (p. 178). Individuals agree to 'deliberate' which has the advantage of elevating 'a citizen's perspective beyond his own self-interest, requiring that he consider the good of the entire community' (p. 165). Individuals join a CHP based on their own conception of the good life. Each CHP would have a certain amount of self-rule and would be able to exclude certain 'non-believers' in order to sustain communities. 'This is a position the liberal communitarian vision should endorse even when it means that the communities may exclude individuals from membership on the basis of age, sex, religion, and the like' (p. 239). The CHPs would be overseen by state health oversight boards who would, enforce 'appropriate membership and participation practices' and 'oversee the voucher financing aspects of the scheme' (p. 197).

Emanuel's view is strangely reminiscent of Engelhardt's libertarian social construct (Engelhardt, HT., *Foundations of Bioethics*. 2nd ed [New York: Oxford University Press, 1996]). In Engelhardtianism individuals agree not to engage in violence when attempting to persuade others to their particular views of the good life. This agreement seems implicit to Emanuel. In addition, like Engelhardt's moral communities, Emanuel's liberal communities are without geographic boundaries: 'On this view the relevant community is characterized not by a moral principle or by being in some particular location or by an arbitrary historical boundary' (p. 167). Emanuel's view is similar to Engelhardt's communities of moral friends: 'Limited democracies should enable individuals and communities to pursue their own visions of the good, while not compromising the moral commitments of other individuals and communities' (Engelhardt, p. 120). But while Engelhardt dramatically limits the power of the state Emanuel allows for much more regulation than would be sanctioned under Engelhardtianism: 'Therefore a multitude of small political communities must complement and be compatible with the primary representative institutions of large-scale modern societies . . . a federated communal system' (p. 172). Emanuel does however, *pace* Engelhardt, allow for a vast number of different pursuits of the good life, 'one community might grant a right to euthanasia and another might prohibit termination of care for incompetent patients' (p. 169). Although comparison of Engelhardt's *Foundations of Bioethics* with Emanuel's *Ends of Human Life* definitely warrants further investigation, it is beyond the scope of this review.

Emanuel discusses six objections to his LCV scheme. First, critics oppose the idea of physicians choosing their practice based on moral concerns instead of the current criteria of materialistic, climatic, recreational concerns. However, Emanuel believes that moral concerns already influence a number of professional affiliations. 'CHPs would simply make these ideals more central' (p. 234). Second, opponents perceive an inherent lack of egalitarianism different levels of medical services. However, since each CHP would have a different view of the good life and since any ranking of medical services presupposes a specific view of the good life, medical services will vary. Further, this objection 'misconstrues justice' since justice itself 'must be informed by a conception of the good life' (p. 235). A third target for critics is the voucher and its value. Again, 'the basic value of the voucher must assume some conception of the good life' (p. 236). Fourth, there is inherent and potential discrimination in the concept of the LCV. Emanuel believes that specific communities should be able to exclude certain individuals (*vide supra*). 'Sanctioning such exclusions from CHPs, however, would not deny those excluded either citizenship or the rights to form and participate in their own CHP' (p. 239). The fifth and sixth objections are the converse of each other. Does the liberal communitarian vision affirm or destroy pluralism? Emanuel believes that LCV 'affirms pluralism'. However, 'to permit all possible conceptions of the good life to flourish is an absurd standard that even liberal political philosophy rejects' (p. 240). A corollary criticism suggests that the moral commitment to a particular CHP might be superficial. Individuals could shop for the CHP that provided the best benefits at the cheapest price regardless of the moral foundation upon which it might rest. To both Emanuel and his critics this degeneration to choosing a CHP based on 'consumerist preferences' is problematic. Incidentally, this would not be problematic under Engelhardtianism, since 'for-profit health care corporations are one of many expressions of human freedom and as such have a presumptive claim to toleration' (Engelhardt, H.T. (1988). Morality for the Medical-Industry Complex. *New England Journal of Medicine*, 319, 1086–1089). Emanuel's response to this criticism is weak, 'the liberal communitarian vision, which emphasizes medical care not as a consumer item but as an element in a larger conception of the good life, militates against such conversions' (p. 243). However, what would stop a CHP from defining its concept of the good life in terms of consumerism?

Relating political philosophy to medical ethics is creative, innovative and presents an extremely important contribution to the field of medical ethics. This is a topic that deserves more reflection and deliberation. The importance of political philosophy's impact on medical ethics has been largely ignored and I cannot under-

stand why other writers in the field have not further developed this concept. Emanuel gives 3 positive contributions that can be gleaned from his book: (1) 'medicine should be viewed more as a unique moral enterprise engaging us-both physicians and patients-in interpreting our shared values for guidance concerning the ends of life;' (2) his book helps physicians in 'establishing the goal of pursing medicine as a moral enterprise by offering models for moral deliberations;' and (3) his book is a 'call for physicians to begin developing the institutional structures necessary for increased democratic deliberations on medical ethical questions' (p. 246-8). Although Emanuel focuses specifically on health care he believes that the LCV can be applied to many other aspects of society. 'In the ideal, CHPs would form the basis for distinctive communities that would establish a whole range of local policies in areas from education to housing to transportation, based on the members' particular conception of the good life' (p. 234).

Although, Emanuel's approach to irresolution of medical ethical questions seems revolutionary, I find his solution lacking force. What prevents, besides 'deliberation,' a CHP from having as its vision of the good life obtaining as much financial resources, even through violent means, as possible? This is also a criticism of Engelhardtianism (Engelhardt, p.136). What would prevent a CHP from having consumerism as its vision of the good life? What prevents significantly different levels of medical care amongst individual CHPs, i.e. very rich CHPs and very poor CHPs?

However, I strongly agree that individual groups be allowed to associate based on specific concepts of the good life. As Christians we must be concerned with the significant marginalization of religious voices, not only in medical ethics, but also in society generally. Both Emanuel's and Engelhardt's views allow Christians, and others with views of the good life based on religious traditions, to join together and form CHPs based on these views. This may be our only recourse since society is quickly becoming a post-Christian, post modernist society (Peppin JF. (1997). The Christian Physician in the Non-Christian Institutions: Objections of Conscience and Physician Value Neutrality. *Christian Bioethics*, 3, 39–54).

It should be fairly obvious that Emanuel's work has far reaching implications not only for health care but for society in general. Suffice to say, this work is 'must reading' for anyone interested in medical ethics or political philosophy.

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Striving After Virtue: A Contemporary Guide for Jewish Ethical Behavior
Kerry M. Olitzky and Rachel T. Sabath
Hoboken, NJ: KTAV Publishing, 1996
ISBN 0-88125-534-3, xvi + 187 pp., paperback
$23.00

Jewish Ethics and Halakhah for Our Time (Sources and Commentary), Volume II
Basil F. Herring
New York: Yeshiva University Press, 1989
ISBN 0-88125-044-9, xxvi + 279 pp., hardback
$19.95

In our increasingly diverse and pluralistic societies, it is essential not only for informed people to know their own tradition, but something of other relevant traditions. With their rich history of virtue ethics, combined with their eagerness to address modern ethical issues, Jewish Ethics is a natural subject for the well-informed person to study. It is natural not only for their close relation to the dominant Christian tradition, but due to their advocacy of both tightly-reasoned arguments and practical avenues of action.

Olitzky and Sabath's *Striving After Virtue* is a bridge. A bridge between those seekers after virtue from different traditions; a bridge between faiths that uphold virtue; a bridge between people; a bridge between the Jewish sacred texts of the past and the modern Jew; and finally, a bridge between God and humankind.

As such, it does a good job of connecting the theoretical and the practical. Biblical materials, Talmudic texts, collections of moral discourses are all there but neither in isolation nor unconnected to the present. The authors never let the readers forget that this is a text of *practical* importance: we are supposed to *do* something with it. We are supposed to cultivate virtues, recognising our worth and importance as vessels of God, made holy not profane. Toward that end, each chapter contains both practical advice ('Knowing, Being, Doing') and meditation sections containing contemplative material which speaks to the importance of virtues.

The book is divided into three sections, 'Turning Toward Self,' 'Reaching Toward Others,' and 'Moving Toward God.' But the constant theme that underlies each section, the thesis of the text in fact, is that *commitment* expressed in committed relationships to self, others, and God is first required before progress in the virtuous life can be achieved.

Since the book does claim that one may indeed become closer to God by performing virtuous acts, some Christians may shun this work. Such rashness would be a mistake. True enough, there is at times a tendency to blur the distinction between the transcendent and immanent in how our behaviour affects both realms. Even when talking in matters of faith, there is a 'this-worldliness' to the work that Christianity would treat more in terms of pure theology. But such is Judaism. As the authors say, quoting Rabbi Heschel, 'Judaism is a theology of the common deed' (p. 173). When such a focus is recognised, the book can be better appreciated. In this vein, it reads more like an application guide to William Bennett's *The Book of Virtues*, or a more modern (and Jewish) *Nichomachean Ethics*. As such, it would be a valuable book not only for the obvious function of increasing understanding of other traditions' ethics, but useful in cultivating virtues in one's own life. One could do far worse than inculcating traits of faithfulness, honesty, integrity, commitment, and wisdom.

Basil F. Herring's book builds on the author's Volume One, adding some issues, and updating other issues (e.g. Medical Ethics) which have been particularly impacted by technology. The internal organisation likewise is the same as Volume One: each issue begins with a brief introduction, then a modified case-study, followed by the relevant Jewish Halakhah (Biblical and Talmudic texts). Each chapter then concludes with a discussion section in which Herring applies what he sees as the relevant halakhic principles.

The chapter on the right of self-defence is particularly instructive as to the complexities of applying halakhah to modern situations. The case-study involves a man who is pursued by two thieves who threaten the man with harm. The man warns them, then tries to flee, all to no avail. Finally, he shoots and kills one of the attackers. Herring acknowledges that the Halakhah does not allow one innocent life to be traded for another (p. 141), but quickly adds that Maimonides invokes the 'law of the pursuer' (*rodef*) which not only condones deadly force to save a life, but 'insists' that such be used to save innocent life against criminal and wrongful threat (p. 141).

Thus, it is not surprising that Herring concludes that the law of self-defence in the Halakhah is a 'multi-faceted one' (p. 170). It is indeed true that any potential victim has the right to decide when it is appropriate to respond with violence; it is also true that potential third party interveners must meet a higher standard before intervening, presumably due to their ignorance of what's actually going on (p. 172). But regarding the level of violence that is licit, there is less agreement amongst the rabbis. Herring quotes a multitude of sources who back every possible level of force, then concludes by saying that some Rabbis would only approve disabling but non-lethal violence, others would approve of deadly force. Thus, in the case-study for this chapter, Herring claims that force was indeed justified, but if the man 'intended' to kill rather than to disable, then some halakhic authorities 'would hold him liable on charges of manslaughter' (p. 175). This work better than almost any other illustrates the difficulty of undertaking casuistry with multiple and hierarchically equal moral sources to contend with.

Herring's tone is always careful; his scholarship solid. But when his authoritative sources disagree, his task devolves to the descriptive rather than the prescriptive. At times there is simply too much disagreement from equally authoritative sources to give clear moral guidance. Unlike Olitzky and Sabath's work, which focuses on virtue ethics and the cultivation of character, something very useful generally in our society, this work has a narrower audience and market. This book is akin to the deontological theory books of Christian ethics: the appeal is to those either within the Jewish tradition (who share the deontological concerns of the author), or to those religious or ethical scholars desirous of studying the tradition from without. Regardless, this volume lacks the general appeal of a book on virtue.

Nevertheless, as I read it from the scholar's point of view, I found the text helpful to see the reasoning process in Jewish ethics at work. Herring's format insures that each moral issue gets sufficient (at times exhausting) coverage; his irenic tone and careful scholarship gives the work believability. For its intended scope and purpose, it is a good read, deserving of a place on the scholar's shelf.

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Moral Theory and Medical Practice
K.W.M. Fulford
Dept Psychiatry, University of Oxford
Cambridge University Press, 1989
Reprinted 1995 (ISBN 0-521-25915-0)

The fact that this book has an introduction by Lady Warnock—whose book 'Existentialist Ethics' shows well the difficulty of finding a consistent base for ethics within existentialism, —speaks for itself. Having said that, it is a useful book for any one who is interested in the significance of Illness, the distinction between Illness and Disease and the effect of both on the individual.

It is of, course, written from the perspective of a psychiatrist and this limits the attempts to translate the concept of dysfunction from the realm of the mind to physical disability. The long discussions on the nature of illness could seem tendentious to those involved in every day general medicine—when it is simply a matter of assessing and treating apparent physical illness. However, we all have to come to terms with attitudes to illness, whether in ourselves or others, and the analysis of the effect of illness provides some interesting discussion. For example, early in the book there is a discussion on the concept of 'illness'. A disease is the objective condition from which the patient is suffering. But illness reflects the state of the patient and has much to do with the subjective awareness of the patient and his or her attitude to the disease concerned. The fact that we talk about 'suffering' from an illness indicates this. The work of Boorse on the distinction between illness and disease is drawn on considerably.

The 'Moral Theory' aspect essentially amounts to a discussion of the effects of illness on the individual, particularly on the ability to function in a normal way. Attitudes to both the sick individual and the presence of disease in society are analysed in depth. The author argues from the philosophy of Wittgenstein that the scientific view of medicine is too narrow and needs more philosophy. His idea of a so called 'ethics based view', that involves assessing 'action failure' rather than 'dysfunction' produced by disease, is untenable and is apparently without any moral base at all—despite the title of the book.

The content of this book would appear to be directed at the growing band of 'ethicists' and will also be of interest to anyone dealing with medical education. It does not, unfortunately, fulfil the promise of the title but the concept is a good one. Perhaps some one will take up the challenge and write a book on medical practice from a truely moral perspective.

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Modern Medicine and Jewish Ethics
Fred Rosner
New York: Yeshiva University Press, 1991
ISBN 0-88125-091-0, xiii + 460 pp., hardcover
$29.50

In the foreword of this book, the eminent Rabbi Sir Immanuel Jakobovits describes Dr. Fred Rosner as well established to be the leading medical writer on Jewish Medical Ethics. In addition to this volume, Dr. Rosner has authored *Medicine in the Bible and Talmud* as well as other related titles, some of which have been reviewed previously in *E&M*. Dr. Rosner is presently Professor of Medicine at New York's Mt. Sinai School of Medicine. Applying Jewish law and tradition to medicine and ethics has been a lifelong avocation for Dr. Rosner. He begins this book by reminding his readers that ultimately it is God who provides healing, with physicians as his instruments. Utilizing Exodus 15:26, he comments that physicians' license and mandate to heal the sick and preserve human life takes precedence over all biblical commands save adultery, murder and incest. Further quoting of the wisdom of Ben Sira, 'God bringeth out medicines from the earth and let a prudent man not refuse them. . . and to the physician also give a place', allows Dr. Rosner to state his foundational philosophy for Jewish Medicine from the outset.

This particular volume is a second revised and augmented edition, a first edition having been published in 1986. The updated edition permits engagement with contemporary diseases such as acquired immune deficiency syndrome. To Rosner, this disease presents the physician with an obligation to care. He does a solid job of offering a 'balanced view', compassion for the sufferer while at the same time not condoning homosexuality. This chapter also examines homosexuality per se and a traditional Judaic response is contained therein.

Another contemporary issue of bioethical interest is reproductive technologies. Rosner is willing to give a green light to artificial insemination if the husband is the donor. All other forms of reproductive technology seem inconsistent to Rosner with Jewish Law as contained in Scripture as well as in oral tradition.

The chapters on abortion are informative if at times somewhat confusing and unrewarding. Despite the conservative chapters on AIDS, reproductive technologies and euthanasia, Rosner permits abortion under many circumstances. This emanates from his idea that the foetus is not a person until the spirit of life is verified by respiration. He utilizes a commonly discussed text (Exodus 21: 22–23) and says it does not proscribe abortion. He becomes inconsistent, however, with his failure to explain the continuing and profound respect for the prayer of Asaph, a solemn Jewish prayer for physicians. Much like its predecessor, The Hippocratic Oath, this prayer ascribes value to preborn life inconsistent with Rosner's conclusions on abortion. A number of Rabbis are quoted (including Eliezer Waldenberg) who permit abortion up to the seventh month of pregnancy if an amniocentesis is consistent with Tay-Sachs Disease.

In fairness to Dr. Rosner, there are also quotes from Rabbis in the context of abortion consistent with a sanctity of life ethic. An invaluable observation in this regard is from Rabbi Jakobovits who observes that a physically or mentally abnormal child has the same claim to life as a normal child. To him, the destruction of a foetus is a moral offence and cannot be justified except out of consideration for the mother's life or health. To the Rabbi, the fear that a child may or will be deformed is not in itself a legitimate indication for abortion and is the same as if one were to kill a handicapped adult (p. 144). Rosner is also politically correct and consistent in the application of newspeak (pp. 159–6) by allowing pregnancy reduction which is no more than a euphemism for multiple abortions.

Rosner's chapters on euthanasia and end-of-life issues are well written. They stand in striking contrast to his views on abortion. He begins his discussion with an incomplete list of Old Testament suicides. Although he mentions King Saul, Ahitophel, Samson and Zimri, conspicuous by his absence is Abimelech in the Book of Judges. Rosner does, however, maintain the 'tension' between the older terminology of active and passive euthanasia. He realizes that men are born to die and must do so naturally without active participation by the healer. In so stating, he clearly identifies life in the context of Jewish law as not being a *summum bonum*. The chapter is also replete with quotes from Jewish physicians such as Maimonides granting a rich historical perspective.

Rosner also provides an effective overview of brain death in the context of Judaism. He quotes a number of Jewish sources and Rabbinical commentary, agreeing with them that brain death is a valid definition of death and when made correctly may lead to organ donation. The chapter comes at a time when the concept of brain death is under pressure from many circles. The topic, however, does connect nicely with a green light from Rosner for organ transplantation. This is justified by *'pikuah nefesh,'* demonstrating that saving a life is high in the hierarchy of ethical decision-making. Therefore, donation of organs in the context of a valid definition of death is an imperative in Jewish law and tradition.

The chapter on animals for research is nicely written and very consistent with man's dominion granted by God in Genesis but tempered by wise stewardship. Rosner's chapter on resource allocation and justice has some excellent background material, but ends without a bottom line. He vaguely concludes, 'the dignity of human life is a fundamental principle that should help guide the physician making life and death decisions at the bedside for individual patients, as well as governmental bodies that are responsible for deciding short and long term health needs and priorities for the population as a whole' (p. 388). He really does not offer specific criteria for justice, a very difficult and perplexing question in contemporary society.

The chapter on creation and evolution, though reasonable since Rosner ascribes creation to the God of the Old Testament, is a bit outside his expertise and not effectively researched. There has been substantial writing from the perspective of intelligent design and creationist arguments over the last ten years that did not at all impact his chapter and should have been mentioned or referenced. Other chapters of note include a chapter on visiting the sick as ministry which is wonderful; a short, incomplete, but still valuable discussion of genetic engineering; and a chapter addressing cremation.

Despite some shortcomings, Dr. Rosner continues to be a profound scholar in the subject of Jewish medicine and bioethics. His texts offer insights gained from Old Testament Scripture and Jewish oral tradition and may serve as a model for the ethically-informed Jewish practice of medicine.

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Abortion at Work: Ideology and Practice in a Feminist Clinic
Wendy Simonds
New Brunswick, N J: Rutgers University Press, 1996
ISBN 0-8135-2245-5, x + 262 pp., paperback $16.95

This clearly written record of the author's fieldwork at a south-eastern United States abortion clinic presents the organizational culture and psychological disposition that derives from the clinic's avowedly feminist philosophy of operation and morality.

The book is divided into two parts. The first section is a description of how the feminists at the pseudonymous 'Womancare Center' (referred to throughout the book as 'Center women') understand themselves, abortion, and their ideological opponents. The second portion is a study of the dynamics conditioning the 'feminist workplace,' including the challenges of administration and interpersonal relations among an ethnically heterogeneous workforce. Since Part One is the more significant segment of the book, I will first summarise Part Two and then focus on the central assertions and underlying attitudes of Part One.

Simonds highlights the practical difficulties encountered by the administration of the officially non-profit Womancare Center. As a self-consciously feminist institution, run exclusively by women, the Center sought to embody and apply feminist principles such as strict egalitarianism, horizontal as opposed to vertical authority structures, respect for individual styles, and collectivist work styles. But for all its disdain for patriarchal and hierarchical management methods, the Center found that the alternative it embraced was not practicable.

The management of the clinic was not able actually to demonstrate the sincere concern for its feminist employees it professed. Various morale problems and interpersonal resentments arose among the women for a variety of reasons, including what they perceived as financial obsession on the part of the clinic operators, demanding work schedules (sometimes at odd hours), clumsily applied changes in operation, and managers showing petty favouritism among employees. One clinic worker bitterly complained about the clinic's administrators, '[They do not care] for the lives of the women that work [here]. They exploit women who work [here], and they abuse them. . . . It's just like working for men' (p. 146).

But employees also manipulated the feminist management philosophy. One supervisor said: 'It's very hard to supervise in a feminist fashion. . . . You know, people call up, and . . . they say . . . "I'm just too depressed to come to work today." . . . I don't know what you say when people say that, you know?' (p. 142). Another worker said, 'A lot of people [haven't quit the clinic] because of the comfort level they have at their job. A lot of people stayed because what other job could you call off because your cat died?' (p. 147).

As a result, the organizational climate at the clinic became more conventional over time, and the pressure on workers to be productive increased as well. Notably, Simonds highlights the fact that in order to cut costs and streamline operations, the clinic came to use one person to function as both the 'client's' advocate and the doctor's assistant, thus raising a clear conflict of interest which inevitably reduced the effectiveness of that particular employee in each role.

The second part of Simonds's presentation of the organization deals with 'purging the enemy within': confronting racism within the clinic. Her discussion is most interesting as an example of the futile obsession with race and racism that permeates contemporary liberalism. Convincing examples of institutional racism never really emerge at the Center and in the interactions of employees with one another, but there is much hand-wringing and 'diversity' training, all to little, if any, positive effect.

However, the first part of this work, particularly chapter two, 'Feminist Abortion Practice: Getting Graphic,' makes this book important.

In chapter one, Simonds covers Womancare Center's understanding of feminist identity and feminist 'health care working' and makes clear her position as a scholar-advocate. She assails writers like Kristen Luker (*Abortion and the Politics of Motherhood*, Berkeley, CA: University of California Press, 1984), and Faye Ginsburg (*Contested Lives: The Abortion Debate in an American Community*, Berkeley, CA: University of California Press, 1989). Simonds finds herself 'troubled by their painstaking nonjudgmental and disinterested presentations,' and then, citing Celeste Condit and Kathleen McDonnell as examples of alleged feminists who have 'adopted the language of the anti-feminists', Simonds declares, 'To me, such equivocations on the part of feminist writers call for denunciations, for renewed commitment from those of us who don't see room for compromise, those of us who see anti-abortion sentiment as lacking integrity and as antithetical to our feminist agenda' (pp. 15-16). For Simonds, abortion absolutismlegal abortion anytime for any reason or no reasonis not problematic. Indeed, it is a feminist imperative, for, in her view, without it women will lack bodily integrity and complete autonomy. Even so, one who holds to this abortion totalism, by virtue of its absoluteness, is free to recognize what Simonds calls the 'complexities' and 'complications' of abortion practice (p. 16), the blood, the severed appendages, the dead foetuses described in her second chapter, and still not be swayed in her moral and personal support of abortion on demand.

What Simonds consistently demonstrates through the words of Center women, and what she herself narratively participates in, is a simple yet profoundly brutal denial of the horrific acts of killing that take place daily at Womancare Center. An elaborate language of dehumanization is adopted by Simonds and her subjects. Never is a pre-born human being killed. Rather, a 'pregnancy' is ended; the 'abortus' is extracted; 'tissue' is removed; the mid-trimester foetus deceptively 'looks like' a baby, and on and on. To read the second chapter of this book is a genuinely nauseating and assaultive experience. Typical of the evasive, shallow, and utterly un-self-critical rationalizations of second trimester abortions are the words of this clinic worker who worked in the 'sterile room' examining the bodies of pre-born human beings recently killed by abortion: 'It's just—I mean—it looks like a baby. It *looks like* a baby. And especially if you get one that comes out, that's not piecemeal. And, you know, I saw this one, and it had its fingers in its mouth; . . . it makes me really sad that that had to happen, you know, but it doesn't change my mind. It's just hard. And it makes me just sort of stop and feel sad about it, the whole necessity of it. And also . . . it's very warm when it comes into the sterile room because it's been in the mother's stomach. It feels like flesh, you know' (p. 70, italics and ellipses in original).

There are many such ruminations, never leading to anything even resembling a moral condemnation of abortion. Indeed, neither Simonds nor Center women venture deeply into moral waters, except to repeatedly denounce with undiluted vitriol the 'antis' (anti-abortion protestors) who occasionally picket the clinic. Simonds uses the word 'antis' without quotation marks, and never engages with any sophistication whatever their ethical position.

But this is not the only omission. Though proud of the purity of her feminist convictions, Simonds does not consider the misogynist use of abortion in China and India, she is unduly dismissive of gradually increasing feminist opposition to abortion in this country, and she recounts with minimal outrage a forced abortion she witnessed at Womancare Center. A woman who spoke little English arrived one day to complete informed consent forms with the help of a translator, but when she returned the next day for the abortion, she was alone. The woman struggled violently from the very beginning of the operation, only to have her legs forcibly spread open by two clinic workers, while a third held her waist to the table. Simonds notes the harshness and contempt the abortionist displayed toward the woman, and she calls the spectacle 'horrible to watch' and 'the worst I'd ever seen' (p. 75). Yet, she ultimately dismisses the event, since the woman's cervix had been dilated the day before, and so, according to Simonds, an abortion 'must occur' (p. 76). The only alternative, she notes with disapproval, was to send the patient to the hospital, but that would 'involve complex logistical arrangements and would be quite costly for the client (beyond the amount already paid to the Center)' (p. 76). Apparently the 'right to choose' doesn't exist inside clinic walls.

This book provides a valuable window on abortion practice and academic feminist reasoning. It should take its place alongside Magda Denes' *In Necessity and Sorrow* (New York: Basic Books, 1976) as a leading exhibit of the macabre, crimson world of American abortion. That was surely not its writer's intention, but the combination of her amoral framework and energetic enthusiasm to present uncloaked her feminist vision of procreative liberty reveals a perverse valuation of human life that will shock and deeply disturb.

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Religion and Medical Ethics: Looking Back, Looking Forward
Allen Verhey, ed.
Grand Rapids, MI: Eerdmans, 1996
ISBN 0-8028-0862-X, 160 pp., paperback $18.00

The 1993 Institute of Religion conference in Houston Texas was 'intended, of course, to remember and celebrate the first conference and the contributions of religious voices at the beginnings of bioethics' and to look 'ahead to the chal-

lenges and the possibilities for speaking of bioethics with religious integrity' (p. 3). So says Verhey in his introduction to this work of collected papers from that conference. Unfortunately, this work reminds me of a description of an Arnold Bruckner symphony, i.e. 'brilliant moments between boring half-hours'. Perhaps some may consider this a harsh criticism or even mean-spirited. I do not mean to imply that this book is not worthy of investigation. Rather, in my opinion, it is very uneven in quality as well as scope.

The collection opens with David Smith's contribution, 'Religion and the Roots of the Bioethics Revival'. His article is an interesting short review of contributions from religious voices to the establishment of bioethics as an academic discipline. Smith states in his opening paragraph that he is, 'eager to see religious ideas used . . . in the bioethics discussion', and that 'the absence of religious perspectives and ideas greatly impoverishes that discussion' (p. 9). Yet Smith gives no practical means of fulfilling this hope. He proposes what he calls the 'paired concepts proposal', based on Reinhold Niebuhr's love-justice dialectic (p. 16). The point here is to pair a concept with some religious foundation, i.e., love, with concepts that have less or no religious intimations, i.e. justice. The concept of the 'transfigured self . . . is the self of discipleship' becomes a 'radical alternative' (p. 17). Yet Smith himself admits that the idea of the transfigured self will not 'play in Peoria' and that his suggestions are 'embryonic' and his paired concepts proposal an 'extremely rough idea' (p. 18). I was left at the end of Smith's article asking the question, 'So What?' It seems naïve to suggest that somehow we will be able to increase the presence of religious voices by appealing to such thin and poorly formulated views as the 'paired concepts proposal'.

Steven Lammers's article, 'The Marginalization of Religious Voices in Bioethics', appears next in Verhey's collection, one of the 'brilliant moments' of this collection. To Lammers, marginalization refers to 'whether religious voices are recognized as potential partners within public conversations . . . Religious voices are thus a curiosity and not something to be taken seriously' (pp. 19, 21). He makes the profound and insightful comment, 'the status of the theologian in religious communities themselves has become ambiguous' (p. 22). Lammers feels that what 'religious people did not realize was that the language they were often using would minimize, undercut, or downplay the significance of their own religious commitments' (p. 23). So part of the reason for marginalization is directly related to the efforts of those initial theologians involved in bioethics, many of whom attended the original 1963 conference.

Lammers however feels that, 'the marginalization of religious voices in bioethics in the context of health care is, well, odd' (p. 27). This oddness is partly due to the finitude found in clinical medicine. Further, 'the writers of clinical ethics literature are not candid about the critiques that have been raised against the perspective that they presume to be true' (p. 28). In addition, 'one of the tragedies of the standard account of bioethics is that it is hard pressed to talk about the life of the professional' (p. 34). However, although Lammers is giving a lament, he is also giving 'a signal that it is important to attend to the criticisms of the standard bioethics that arise from within philosophy and from within the community of medical practitioners who are philosophically sophisticated' (p. 40). For our religious voices to have any influence we must have humility, an ability to listen, and patience. Lammers states that when it comes to developing virtuous persons, 'the irony is that on this particular subject, it may well be that religious communities will be asked to provide something that they cannot yet do, because they themselves have not been attending to the creation of virtuous people' (p. 42). Lammers gives a good review of the reasons for marginalization of religious voices in bioethics and a critique of those voices themselves. He presents a hopeful future, albeit a 'marginalized' hope.

Karen Lebacqz provides a 'boring half hour'. Her article is disjointed and without any clear point. Lebacqz attempts to 'explore briefly the theological roots and meaning of "alien dignity" in Thielicke's thought, and then develop the legacy of this term for the task of health care ethics today' (p. 45). She does describe Thielicke's concept of 'alien dignity' and feels that this concept 'protects people,' 'equalizes people,' and requires a personal and a structural response. Yet, I am left with the same feeling I had with Dr. Smith's article, So what? Unfortunately, Lebacqz gives good support to Lammers's comment, 'the status of the theologian in religious communities themselves has become ambiguous' (pp. 22–3).

Stanley Hauerwas provides us with the next contribution which is classic Hauerwas. He describes Paul Ramsey's writings and work in medical ethics. Ramsey found many comparisons between medicine and his own 'liberal' Christianity, although his 'account of medicine is essentially conservative' (p. 79). 'Medicine became Ramsey's church' and doctors' commitment to patients 'more faithful to the ethic of Jesus and Christians' (p. 79). The goal of this article is, 'understanding a bit better how Ramsey fits into the larger story of how and why Christian ethicists have become so fascinated with medical ethics' (p. 63). Hauerwas wants to, 'direct attention to what might be called the internal story of Christian ethics, to understand how a tradition that begins by trying to Christianize this social order now works very hard to show that being Christian does not unduly bias how we do medical ethics' (p. 65). Unfortunately, although Hauerwas's article is interesting and provocative, he ends with the comment, '[w]here has all this gotten us? Not very far, I am afraid' (p. 80). A prophetic comment that reverberates at the end of Verhey's volume.

James Gustafson's 'Styles of Religious Reflections in Medical Ethics' is the next contribution. Religious ethics are autonomous, which seems rather obvious and may be part of the reason why religious voices are marginalised. Secular medical ethics does not care if religious ethics are autonomous! They can be autonomous yet marginalized. Gustafson feels that there is continuity between religious ethics and other ethics. It is here that with an autonomous religious ethic a dialogue can begin.

Literature in religious ethics can help as it 'makes such approaches intelligible both to members of religious communities and to others by explaining or interpreting religious morality and ethics in continuity with other ethics' (p. 91). Gustafson's point 'is that in the dialectical interaction between a religious explanation and justification of morality and ethics, and here particularly medical ethics, one way that some religious writers can and do justify ethics is by enlarging the scope of the "religious" so that persons no longer identified with historic religious communities can appreciate their own sense of the divine or sacred, and articulate it in nontraditional religious language' (pp. 93–4). Yet this is part of the reason why religious voices have been marginalized. The literature and language of religious voices have been marginalized in an attempt to dialogue with 'other ethics'. But these are exactly what gives religious voices their distinctiveness, i.e. their distinctive voice. Gustafson's article is another good illustration of Lammers's comment that, 'the status of the theologian in religious communities themselves has become ambiguous' (pp. 22–3). Yet it is difficult to understand how Gustafson's approach allows us to bolster religious voices and does not further marginalize these same voices.

Reich's article is another half-hour amongst a few brilliant moments. Reich states at the outset that his approach starts, 'from within bioethics as a secular field of inquiry' (p. 96), and this is exactly how he proceeds. Reich feels that it is 'crucial that religious and theological scholars — for whom matters of meaning and interpretation are central to moral inquiry — participate more directly and more vigorously than they have in recent decades' (p. 119). Reich seems to reduce religious voices to a 'narrative' that is important in what it adds to the attention paradigm. Frankly it is hard to understand why this article was included in this volume. Reich's article is not impressive and adds little, that I can see, to the discussion of religion and medical ethics.

The remainder of the book is a summation of the working groups. The working group on The Academy states, 'Theologians in the academy can warn the academy against pride and remind it of the moral significance of other institutions and groups to serious moral discourse, character formation, and community' (p. 122). The group on The Medical Center proposes, 'if theologians want clinicians to take theology seriously, they should listen to doctors and nurses speak of their triumphs and their tragedies, nurturing and sustaining the theological reflection that health care professionals themselves are driven to undertake' (p. 124). The Religious Communities working group gives what are called, 'a number of practical suggestions' (p. 126). Health care professionals should set up support groups in their congregations, be involved in adult religious education, include the voices of women and involve pastors in continuing education in moral education. The group on Public Policy suggests that, 'the most important role for the religious communities with respect to public policy may be the shaping of conscience and character' (p. 128). There are then a series of working groups on specific issues. The Abortion working group 'pointed out the theme of "marginalization" in more than one of the presentations, and it noted the apparent ineffectiveness of the theological traditions with respect to abortion in public controversy' (p. 132). The working groups on Assisted Suicide and Access to Health Care give similar pabulum. Lammers's comment continues to haunt this volume, 'the status of the theologian in religious communities themselves has become ambiguous' (pp. 22–3). The, so called, practical suggestions and other comments by the working groups are not practical and basically have little substance.

Verhey gives the last contribution to the volume. His article is an interesting and profound commentary on Psalm 88. 'It is a temptation with us and on us whenever we would deny or ignore the sadness of this world, whenever we think our religion or our technology gives cheap and easy remedies for its sufferings, whenever we suppose that our faith eliminates its tragedy, or resolves its ambiguity into simple and clear answers. The temptation is with us and on us whenever popular preaching promises to dispense peace of mind, security, wealth, success, fame, and happiness, not to mention health and the remedy for suffering, in palatable doses of possibility thinking and calls that the hope of faith' (p. 148).

While reading Verhey's volume, Lammers's comment, 'the status of the theologian in religious communities themselves has become ambiguous' is reinforced again and again. That religious voices are marginalized in bioethics is without question. This marginalization has made religious voices weak, lacking authority or credibility. Yet, the fault, if fault there is, clearly involves the 'academy' itself. The attempts to secularize and downplay religious language in medical ethics have come not only from secular scholars but from theologians themselves. Unfortunately the response for individuals who have a religious tradition remains very unclear if we take Verhey's volume as an explication of a type of 'proper' response. Even Hauerwas gives the prophetic statement at the end of his article, 'Christian ethicists continue to leave the world as they found it' (p. 80). Such noncommittal responses would not have been found in say Orthodox Christian or Jewish perspectives, views conspicuously left out of the 1993 conference and Verhey's book. It is interesting to note that all the contributors to this volume would probably characterize themselves as Protestant theologians.

If Verhey's collection is an expression of all that religious voices in bioethics have to offer, we are in a sad state of affairs indeed. This collection was well summed up in Hauerwas's comment, 'Where has all this gotten us? Not very far' (p. 80). Verhey's collection dramatically illustrates the ambiguity of current religious voices in medical ethics and for this reason should be read by anyone interested in religion and medical ethics.

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The New Genocide of Handicapped and Afflicted People
Wolf Wolfensberger
Revised Edition, 1992, $10.00 (includes shipping)
Available from Syracuse University Division of Special Education & Rehabilitation,
805 South Crouse Ave., Syracuse NY 13244-2280, USA

I have frequently tended to view self-published and 'vanity press' works with a jaundiced eye; if legitimate publishers won't accept a work, is it worth publishing? Sometimes the answer is yes; many times, it is no. (Of course, many published works aren't worth publishing either.) Wolfensberger claims the 'controversial nature' of his monograph prevented its publication. So I was expecting the worst when I opened *The New Genocide*. At first, the poor formatting and an unimpressive writing style seemed to confirm my fears. But as I read further, I found myself more and more in agreement with much of Wolfensberger's thesis.

Wolf Wolfensberger is Professor at Syracuse University's Division of Special Education and Rehabilitation. His concern in this monograph is with 'deathmaking'defined as 'any actions or pattern of actions which either directly or indirectly bring about, or hasten, the death of a person or group' (p.1). (Perhaps a better title for this monograph might have been *'The New Deathmakers'*). Wolfensberger's special concern, as the title notes, is with groups that are especially prone to being 'devalued' by society, the handicapped, the afflicted, the unborn. But deathmaking can include many facets, among them war (nuclear and otherwise), the death penalty, abortion, infanticide, euthanasia, assisted suicide, and outright genocide (as in the Holocaust). Even pollution is included, as it spoils the Earth for future generations.

It is certainly hard to look around current western society and *not* see evidence of deathmaking. The abortion business is booming. Euthanasia is a *fait accompli* in the Netherlands (as recent reports in JAMA have highlighted), and is gaining increasing ground in the United States. Jack Kevorkian purveys death without fear of reprisal. Assisted suicide is occurring legally in Oregon. Racial tensions run high; police brutality is featured regularly in the news, as are child abuse, kidnappings and murders, and hospital and institutional 'mercy killings'.

In the world at large, genocide and ethnic cleansing doesn't only happen in Rwanda between the Tutsis and the Hutus but in Bosnia and Croatia. Militant Moslem fundamentalist groups slaughter entire villages in Algeria. Government sanctioned death squads operate in Mexico and Central and South America. Terrorism is a world-wide phenomenon; death is all around us. And, as Wolfensberger notes, 'people who enter into systematic deathmaking are not *in* control of either life or death, as they often imagine themselves to be, but are *under* the control of Death, and Death has no life or mercy or goodness in it to shower upon its slaves' (p. 79).

Wolfensberger's concern is not so much with individual acts of violence, but with 'how one entire *collectivity* of people can come to the point where it is prepared to do grave harm to an entire other collectivity, and perhaps even deprive it of life' (p. 3). Individual crime is not the point; the attitude of society towards groups of its members, is. In this regard, he says, ' the word "evil" is appropriate for systematized deathmaking, whereas its sporadic forms might more appropriately be called "sin". This might mean that a murderer on death row may well be a sinner rather than evil, while a president, politician, army general, welfare commissioner, business tycoon, or respected millionaire may be quite evil' (p. 80).

Indeed. A President who condones the atrocity of partial-birth abortion, and voters in Oregon who approve assisted suicide legislation may well find Wolfensberger 'controversial'. But I wonder if they have thought through the issues as deeply as he apparently has.

After discussing what groups are prone to being the target of deathmaking and why, he discusses the types of activities that constitute deathmaking, and these range from overt directness to very subtle, indirect ways. He discusses factors and attitudes in society that predispose a society to deathmaking activities.

Rightly, I believe, he credits materialistic philosophies as playing a major role in the devaluation of life. Materialism embraces a rejection of beliefs in divinity and divine law; and 'rejection of the Jewish and Christian faiths, and therefore of their moralities, which include an awe for the mystery of life and a respect for its sacredness' (p. 25). With materialism we get an idolisation of human accomplishments, unbridled individualism and selfishness, hedonism, and 'a belief that one is entitled to freedom from affliction and suffering, and indeed, even from hardship and inconvenience' (p.26). And so the consequences emergeif a pregnancy is undesired, abort the baby; if an elderly person is unwanted, institutionalise and overmedicate him or her to hasten death; if a person is terminally ill or incurable, propose or mandate assisted suicide. Or even, as in the Netherlands, just do it.

Deathmaking, however, is rarely obvious. To make it palatable, Wolfensberger refers to 'detoxification'strategies to make deathmaking appear other than what it is. The euphemisms with which abortion proponents sanitize their practices is one example. Wolfensberger notes, 'The widespread acceptance of abortion is about as classic an example as one can get of judicially legitimising the taking of human life by denying that human life is involved, or that killing is taking place' (p. 64). Sadly, one detoxifying strategy is to appeal to morality to make deathmaking appear to be consistent with God's will and teachings. The medical profession, historically a life-giving profession, is being called upon to be the arbiter of death. The ultimate form of detoxifying is outright denial that deathmaking is occurring.

Why is there no outcry about deathmaking? 'In a society that has allied itself to death, it should not be surprising that genocide can take place within it without attracting much attention, and without arousing strong passions' (p. 82). Our society, Wolfensberger notes, exhibits many of the characteristics of genocidal societies, the toleration of abortion, the equating of law with morality, a focus on the pragmatic and utilitarian. Some of these characteristics are reflected by inconsistencies within the individual: that is, people who oppose the death penalty may support abortion, for example, or 'people who teach their children that it is wrong to kill will give them war toys, or think nothing of having them habitually watch violent entertainment' (p. 84). Wolfensberger attempts to predict future trends, and to put a number on the individuals subject to deathmaking activities. He concludes with a list of actions to oppose deathmaking, which include non- violent resistance, education, and standing with groups threatened by deathmaking.

Although I found much to agree with in *The New Genocide*, there are points of contention and inconsistency. Wolfensberger comes close to the heart of the problem in referring to the abandonment of the Judeo-Christian ethic, and his list of action measures to consider to counter deathmaking mentions 'moral principles, de-

rived from the Judeo-Christian value system . . . which can give guidance . . .' (p. 85). But ethics cannot simply be imposed on a society; the problem of deathmaking goes beyond ethics right to the heart of the relationship between God and man, a relationship which Christians believe can be mended only by Jesus Christ. The law can mandate deathmaking; it cannot, however, compel me to 'love my neighbour as myself'. 'Faith and love', Wolfensberger says, 'can transcend and put to shame all kinds of utilitarian and technological strategies' (p. 86). But faith and love do not exist in a vacuum; they require the personal transformation that Jesus Christ offers.

Wolfensberger includes all war (conventional and nuclear) as forms of deathmaking. In an ideal world, this might be so. But should the Allies have stood back and allowed the evil fruits of Nazism to ripen to full genocidal horror? I think not. Passivity in this situation would have contributed to deathmaking, perhaps more so than war did. And when Wolfensberger issues what reads like a blanket condemnation of bioengineering, he goes too far. Some issues, unfortunately, are not as black and white as *The New Genocide* makes them appear.

One problem, as Wolfensberger notes, is the difficulty of documenting instances of deathmaking. Articles in reputable journals, for example, are few. Much documentation is from newspaper reports. I would have welcomed seeing more up-to-date references. *The New Genocide* could stand updating, revising, and lengthening. I suspect that Wolfensberger has more to say than he does here, and could go into greater detail in many areas. (End-of-life decisions would be one such).

He concludes with these words: 'Life and death have been clearly set before us. Collectively, a number of nations have chosen death, including the U.S. and Russia. Each of us now has to decide on a deep personal level whether to join this choice, or stand in contradiction to it; and if the latter, how to do so coherently and credibly' (p. 90). Death is an inescapable fact of human existence, as Wolfensberger notes. But the *how* and *why* of death are subject to many nuances.

We would do well, I think, to heed Wolfensberger's warning.

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Post-Abortion Syndrome: Its Wide Ramifications
Ed. Peter Doherty
Cambridge University Press, Cambridge, 1995
ISBN 1-85182-159-7, 120 pp

At last, a book on post-abortion syndrome, the best kept secret in health care. In the current climate, even the slightest risk of negative side effects calls for a warning to be issued with every prescription, and cautionary notes are freely labelled on food and drink packaging. But ironically the most frequently performed medical treatment is administered without any general warning of psychological damage, when some studies are suggesting that that outcome may be as likely as post-traumatic stress disorder from events such as road traffic accidents.

Peter Doherty has brought together a number of contributors to engage this frequently overheated issue from a variety of perspectives. In the first article, it is clear that Vincent Rue wishes to tackle the problem of psychological sequelae to abortion on solid, empirical grounds. There is no room here for the kind of hype that so easily clouds the issues. He is so familiar with the texture of the psychological problems resulting from abortion, and so confident that they exist, that he need never resort to unsubstantiated claims. Reality can speak for itself through sound, unbiased investigations.

After a more anecdotal and reflective study of PAS by Sandro Gindro, Rue's methodologically restrained strategy is shared by Greenwold et. al., Ney et. al., and by Rachel Anderson and her group. Many Greenwold illustrates the application of review criteria in order to isolate biased research material. It is crucial that the energies of scientists who sense the wrong being done in abortion should be harnessed to appropriate rules of research so that findings can be validated, and made useful.

Agneta Sutton contextualizes the discussion with background material on the abortion issue before we hear from psychiatrist Charles Blacker. He thinks it is quite possible that our nosological criteria do not even at this point comprehend the real illness that lies camouflaged behind coping strategies like denial which society not only sanctions but encourages. 'In fact,' he suggests, 'when seen from a Christian Biblical perspective the whole post-abortion syndrome could be turned on its head, i.e. the patient who *does* experience distress and guilt after an abortion is in fact showing an appropriate response and it is the woman who *fails* to do so whose spiritual or moral health is suspect' (p. 49). Certain psychological characteristics which are prized by society at large are not always healthy. Pathological control over feelings has been demonstrated to be costly to individual mental health, but is valued on a macro level as a vehicle of social order. But, Dr. Blacker warns, 'a society which becomes inured to certain evils presents an ideal culture medium for further evils to germinate and develop' (p. 52). Ultimately there is a huge price to pay for such shortcut problem solving.

In Dr. White's article, the usual restraints of methodological rules of research and formal logic are set aside. However, instead of wild rhetoric and non-sequential thought, we are treated to a spread of powerful anecdotes and unassailable logic. For example: 'Since 9 out of 10 abortions are allegedly performed because of the patient's actual (or reasonably foreseeable) mental health, it is strange [for the G.P.] to be told that it is important for patients to be in a good state of mental health before an abortion!' (p. 68) Any women contemplating an abortion who reads this article would be assured that she is valuable and worth being concerned about, more than just a womb for the sake of bearing a baby. Considered independently, this chapter is a valuable resource for pre-abortion counselling.

In Peter Ney's article, the difficulty lies not in the objective qualified observations, but in conclusions drawn from those observations. Having started with the hypothesis that abortions are somehow causally related to child abuse, he discovers in his investigations the complex nature of social decline that leads to child abuse, but then resolutely returns to his hypothesis. His findings call for a more comprehensive hypothesis based on a wider sociological study of the correlation between abortion and abuse.

Certainly this is a welcome volume, even if, however, one might wish that there were more in it. One cannot help but feel that the enormity of the issue warrants much more research done within the context of wider social issues. In her article, therapist Patricia Casey reflects frustrations that 'there is little scientific information on the most appropriate models of intervention in those who suffer the psychological complications of abortion' (p. 81). She calls for 'this dearth of information [to] be rectified by properly conducted studies of treatment'. Hopefully the good work represented here will serve to stimulate more of that research.

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The Patient in the Family: An Ethics of Medicine and Families
Hilde Lindemann Nelson and James Lindemann Nelson
New York and London: Routledge, 1995
ISBN 0-415-91129-X, xii +251 pp., $17.99

The call is often heard among people of faith that we need to develop a 'pro-family' approach to the concerns of modern life. What would a pro-family, or family oriented approach to bioethics look like? This book is an attempt to take seriously the role of family in bioethics, and as such is a positive and valuable contribution to a relatively small but important literature.

Despite the fact that family is virtually ignored in the canonical works in bioethics, such as *Principles of Biomedical Ethics* by Tom L. Beauchamp and James F. Childress, (Oxford University Press, 1994), there has been a small but significant trend in attempting to take seriously the importance of family in bioethics by John Hardwig ('What About the Family?' *Hastings Center Report* 20, no. 2 (March–April, 1990): 5–10), Marshall B. Kapp ('Health Care Decision Making by the Elderly: I Get by with a Little Help from My Family'. *Gerontologist* 11, no. 5 (October, 1991): 619–622), and James Lindemann Nelson ('Taking Families Seriously'. *Hastings Center Report* 22, no. 4 (July–August, 1992): 6–12). Religious bioethicists have not been as neglectful of the importance of family as have some others; see, for example, Martin Marty's discussion of family in his *Health and Medicine in the Lutheran Tradition* and other books in that excellent series (Crossroad, 1983). Yet, the mainstream of bioethics has tended to regard family as a dimension of the health care situation from which no ethical guidance is to be expected.

The authors, who have laboured at the heart of mainstream bioethics in their positions at the Hastings Center and now at the University of Tennessee, Knoxville, are themselves in a family with six children. In this book, they explore the 'rivalry of care' that has existed between the medical establishment and families in the United States for many years and attempt to provide help in creating a healthier relationship between these two systems.

Families matter, according to Nelson and Nelson, for both instrumental and intrinsic reasons; instrumental because they are the matrices within which selves develop, and intrinsically,

because we cherish our family members for their own sakes. Families are both central to the health care of their members, while invisible in the family-unfriendly hospital as well as in bioethical theory. They develop 'an ethics for families,' wherein they develop the following points: 'Family Members Aren't Replaceable By Similarly (Or Better) Qualified People, Family Members Are Stuck With Each Other, The Need For Intimacy Produces Responsibilities, Causing Someone To Exist Produces Responsibilities, Virtues Are Learned At Our Mother's (And Father's) Knees, Families Are Ongoing Stories, And In Families, Motives Matter A Lot.' They then advance a role for families in medical decision-making, and go on to discuss care of the elderly, reproductive technology, and issues of justice. Their approach is judicious and based on a wealth of knowledge about the health care issues that families face. Throughout, the lively writing style and abundant use of stories makes the reading enjoyable, and it can be recommended to people who would usually find bioethics rough going.

Conservative critics will note that the authors are not committed to the view that there is some defining essence of 'family'. They see families as households, as 'people clustered into configurations that have at least some of a wide array of characteristics,' among which are 'adult relationships of emotional, economic, and sexual intimacy, often marked by vows of fidelity and commitment to the long term' (p. 35). While Christians well may recognize the changing complexion of the modern family, they will still insist that one's spouse to whom one is bound in covenantal faithfulness occupies a place that cannot be shared with unmarried partners, and that one is bound covenantally to children and parents with indissoluble bonds that are deeper and of more significance than feelings of 'closeness' in other relationships. Without denying that people other than spouses, children, and other relatives can be of great importance in our lives, the line between families bound in covenant and other people is one with spiritual significance that must not be downplayed. Having said that, it is important to note that while the authors do not share a normative concept of family that would satisfy orthodox Christian believers, they are allies in defending the legitimacy of family against far-left critiques and are devoted defenders of much of what we might wish to call 'family values'. This book is a valuable corrective to much that is written in bioethics, and should help Christian health care professionals think through these issues while it challenges Christian bioethicists to explore more fully the importance of family.

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Ethics in Obstetrics and Gynecology
Laurence B. McCullough and Frank A. Chervenak
New York and Oxford: Oxford University Press, 1994
ISBN 0-19-506005-9, xv +278 pp., hardcover $39.95

Although a few years old, this book deals with age-old issues and therefore remains an important, and in some ways unique, contribution to the bioethics literature in obstetrics and gynaecology. Not only does it propose guidelines for resolving ethical crises, but it emphasizes ethical guidelines for *preventing* crises in the first place. The authors begin with an innovative and comprehensive analysis of bioethics in obstetrical and gynaecological settings. In keeping with the methodological requirements of philosophical reasoning, they present their arguments in a thorough, defensible and clinically applicable fashion.

The content is divided into three parts. First, a framework is laid for understanding bioethics in general, and also specifically within the gynaecologic and obstetrical practice. Second, strategies are proposed for preventing ethical conflict in these settings. Finally, in the event of the failure of preventive measures, the management of ethical conflicts and crises is discussed.

The bioethical framework proposed in the first section of the book is defended on the grounds of both philosophy and medicine. The authors argue that four virtues underlie the physician's obligation to advocate for patients' interests: self-effacement, self-sacrifice, compassion, and integrity. Patients' interests are described from three perspectives relevant to bioethics: social role interests, subjective interests, and deliberative interests. The principles of beneficence and respect for autonomy are examined, and reinterpreted in light of these interests. This is done in what the authors term 'a variant of the downwards-up' (p. 8) approach. Instead of applying general principles to specific cases to generate a set of general guidelines, the authors begin from the vantage point of specific clinical scenarios and reinterpret the principles in light of the physician's and patient's interests. The result is a series of concrete, principle-based, action guidelines that equip the reader with intellectual and practical skills for identifying ethical conflict and crises in a clinical setting.

The second part of the book proposes clinical strategies for the prevention of ethical conflicts. The preventive measures are grounded in the incorporation of patient interests into the decision-making process. By building a common moral ground between the patient and the physician, and dispelling paternalism, the authors argue the patient-physician partnership in decision making is solidified. This section begins with a discussion of strategies that could be implemented in any field, for example: the informed consent process, negotiation, respectful persuasion, and the proper use of ethics committees. Special emphasis is given to the informed consent process as a powerful tool in preventing ethical conflict and crises. Included is a step-by-step approach to the informed consent process that not only fully informs the patient, but includes the patient in the decision making process.

A concrete and practical approach to preventing conflict in the gynaecological setting ensues, touching on a number of topics, including: contraception, adolescents and HIV-infected patients, ectopic pregnancy, abortion, selective termination of multi-foetal pregnancies, and gynaecologic cancer. Within the obstetric setting, where the physician is faced with obligations to both to the pregnant patient and the foetus, the potential for ethical conflict is greater. The authors discuss a variety of obstetric topics, including: assisted reproduction, surrogacy, prenatal diagnosis, foetal anomalies, cephalocentesis, and prematurity. The roles of fathers, family members, and third parties, as well as the concept of the foetus as a patient are specifically addressed.

Lastly, methods for the management of ethical crises are presented. Among the issues discussed are: refusal of care, court ordered Caesarean section, and third party conflicts such as those seen with health care institutions and insurance plans. Interjected is refreshingly original thought regarding the ethical obligation of the pregnant patient towards the foetus, as well as towards the physician. Questions of this nature generally remain unaddressed in other literature on this topic.

The book is geared towards any persons involved or interested in obstetrics and gynaecology, be they physicians, residents, other health care professionals, or patients. Its methodical organization makes this book very readable. Bold headings for each section in a chapter capture the flow of reasoning, as the concepts are developed and defended. The strength of the book lies in the combination of sound ethical analysis with clinically practical solutions. The book undoubtedly accomplishes the stated aim to provide 'intellectually rigorous, clinically based frameworks for obstetric and gynecologic ethics' (p. vii). To quote the authors, 'When fair-minded readers finish this book, we hope they will . . . come to see clinical ethical judgement and decision making as fundamental clinical skills in the practice of obstetrics and gynaecology. We believe that the practice of obstetrics and gynecology without these skills jeopardizes the integrity of the profession of medicine and the interests of patients, their families, and society' (p. vii).

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Lethal Mercy
Harry Lee Kraus
Wheaton, IL: Crossway Books, 1997
ISBN 0-89107-921-1, 379 pp., $12.99

The characters in *Lethal Mercy* grapple with the very current issue of physician-assisted suicide. The protagonist Jake Hampton is a surgeon very much opposed to helping patients die, but his wife's tortuous bout of cancer forces him to view the practical (and personal) implications of his own opposition to such 'mercy killing'. Sarah Hampton is pregnant and refuses any and all traditional means of treatment of her cancer, fearing such might harm the baby. Kraus treats the issue of patient competency and autonomy well—the dialogues between Sarah and Jake (the surgeon and husband who 'knows best') regarding Sarah's choice to treat the cancer 'non-traditionally,' have the ring of truth for the most part.

Unfortunately, the same cannot be said for how the work treats its main issue of physician-assisted suicide. The novel misses a great chance to explore this issue with some serious soul-searching on the part of Jake. It is just not realistic that Jake has no doubts about his views as he sees the pain and suffering of his wife. Where is the turmoil, the *angst* that would

plague any man? Is the author afraid to portray doubts? Who is there who has not doubted—even the most firmly held truths?

In a nutshell, this simplistic view of life is the trouble with the whole book. Towns receive names such as Taylorville, Jones City, and Grantsville. Jake, who is alone for some years after his wife's death, apparently has no sexual urges whatsoever, and when he begins to date another woman, there is no record of so much as a kiss between them!

Other lapses are typical. Frank, a derelict who works at McDonald's, and Sharon, a school counsellor, live in the same apartment complex. Realising that working in a school system seldom leads to riches, it is nonetheless true that such people make far more than those who flip burgers. How can Frank afford the place? Or, if the place suits Frank, why is Sharon living in such a dump?

Kraus, a physician, is at his best when he brings us inside an emergency room in a crisis. We see words and details that give the scene authenticity. However, the novel for the most part shows us a simplistic, almost 'Pollyannaish' view of Christianity, and its application as a worldview in modern culture. At times I felt that I had dropped in on a Campus Crusade rally, with characters dropping down to pray at a moment's notice:

> 'What do you suggest we do next?'
>
> 'I know what I do when I need answers,' he responded.
>
> Sharon's eyes met Jake's. 'Me too.' Their unspoken communication was understood.
>
> Jake reached out across the table and took Sharon's hand. It was the first time he'd done so. She squeezed his hand firmly.
>
> 'Dear God,' Jake began, 'we want to know your wisdom. We need to know your way...' (p. 295).

The dialogue is consistently spiritually forced. There is no room for doubts for believers; little room for even normal dialogue. Evil is portrayed almost cartoonishly, with little or no shades of grey. The characters in the book are simply not real to us. I don't see the crushing doubts and pain that plague all humans; I don't see the weaknesses, the frailties, the *humanity* of any of the people involved. Thus, this book is in stark contrast to such works as John Irving's *A Prayer for Owen Meany*, a book that speaks to the vast majority of normal people. It is one thing to paint a picture, as Irving does, of normal (and complex) characters who grapple with life's tough issues from a perspective of faith. It is entirely another to paint a picture using the palette of a tiny subset of Christianity to colour every single character that comes into the novel. Kraus's work is similar in this way—especially when dealing with spiritual warfare—to the novels of Frank Peretti.

I certainly recommend narrative to explore difficult issues. C. S. Lewis (among others) has paved the way. However, the Christian community would be better served to encourage authors who know the real world, who know how various and multi-dimensioned is the body of Christ, who—simply put—'get out more'. When people become believers, they don't lose their complexities, their fears, their doubts. If the writers of this genre of literature would only learn that simple truth, the Christian novel could leap to an entirely new level. As it is, the simplicity and type-casting of *Lethal Mercy* and similar works serves only to perpetuate the myth that sunshine and bright flowers are certain to follow even the worst of tragedies. Such myths usually last until the reader finds out differently for herself—but why must we find out the hard way?

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Ethics & Medicine (1999) **15:1**, 30 0226–688X

Babies and Beasts: The Argument from Marginal Cases
Daniel A. Dombrowski
Champaign, IL and London: University of Illinois Press, 1997
ISBN 0-252-02342-0, 222 pp., cloth $39.95, paper $14.95

This book concerns a topic that is often neglected by medical ethicists within the theological traditions represented in the readership of *Ethics & Medicine*: the argument from marginal cases (AMC). It goes something like this: if one holds that some human beings with limited capacities (also known as marginal cases), such as infants and the severely retarded, have a right to life, then certain animals, such as higher primates, with abilities that are the same or exceed the marginal cases have a right to life as well. Of course, one could argue in the opposite direction: because these animals don't have a right to life, then neither do the marginal cases, which means that one can experiment on and/or eat infants and the severely retarded as one would experiment on and/or eat certain animals. But, as author Daniel A. Dombrowski points out, few ethicists opt for the latter, for it seems to most ethicists that it is a well-grounded moral intuition that the marginal cases have a right to life. Thus, one must embrace the former. But this seems to run into conflict with the moral intuition that human beings are intrinsically more valuable than animals. Dombrowski argues that it is difficult to maintain this intuition after serious philosophical reflection. For example, some have attempted to ground it in the notion of species membership. But this won't do, because preferring one's species, speciesism, is morally indistinguishable from preferring one's race, which we all recognize as racism. After all, why should a Great Ape have fewer rights than a severely retarded human being with less cognitive ability? Dombrowski covers a number of different answers proposed by ethicists. He finds none of the answers to be adequate and embraces a version of what he calls moral individualism, the view that rights are dependent on the abilities and capacities of the individual in question rather than species membership. Consequently, an intelligent Ape has more rights than a severely retarded human being.

This book is clear and readable, yet philosophically sophisticated in its breadth and depth. Dombrowski goes over numerous arguments, counter-arguments, rebuttals, and replies by a number of important philosophers including Robert Nozick, James Rachels, Peter Singer, Lawrence Becker, Peter Carruthers, Philip Devine, Joel Feinberg, and R.G. Frey. Although I sometimes found myself disagreeing with the author, I found his treatment of these thinkers to be fair-minded.

EM readers will find Dombrowski's treatment of the Christian view of humanity to be less than adequate, for he seems to dismiss the view on the grounds that the truth of Darwinian evolution has replaced any notion of humanity's cosmic specialness. In addition, he does not address some of the metaphysical and meta-ethical problems of embracing Darwinism. Consider the following. It has been pointed out by some philosophers, such as Alvin Plantinga, that a belief that the human mind is the result of natural selection cannot adequately ground our epistemological intuition that the human mind is able to discover the truth, since the properties necessary for survival may be incompatible with knowing the truth about the world. Thus, ironically, embracing the metaphysics of Darwinism undermines our epistemological confidence in its truth. In addition, a consistent Darwinist must embrace some form of mind-body physicalism, but such a view of the human mind, some have argued, is inconsistent with personal continuity over time as well as libertarian free will. Thus, as a metaphysical doctrine, far from including some animals as persons, as Dombrowski concludes, Darwinism may make it difficult to believe that anyone, including human beings, are persons.

Darwinism also poses some meta-ethical difficulties that Dombrowski does not address. (These are dealt with in Francis J. Beckwith and Gregory Koukl, *Relativism: Feet Firmly Planted in Mid-Air* [Baker, 1998], chs. 15 and 16). First, if moral rules exist, they are not physical, which means that materialism is a false worldview. Second, moral rules are a form of communication. They are in the forms of imperatives, commands, and descriptions. Third, moral rules have an incumbency. And fourth, violating moral rules results in deep discomfort. There are roughly three options concerning the origin of moral rules: (1) they are an illusion, products of human invention; (2) they exist, but are mere accidents, products of chance; or (3) they are the product of a Moral Law Giver. If Darwinism is true, then our only options are 1 and 2. Option 1 seems false because one can still ask the question of whether a particular human invention is 'good.' Option 2 seems false because moral rules that have no ground or justification need not be obeyed. Illustration: if while playing Scrabble the letters randomly spell 'Go to Las Vegas,' should this command be obeyed? Of course not, for it is a result of chance. Commands are communications between two minds. Chance might possibly create the appearance of a moral command. But since no one is speaking such a command, we can ignore it. Of course, if there is a Moral Law Giver who is Creator of the universe, perhaps speciesism is justified because the created order may be hierarchical with those creatures made in his image at the top.

I highly recommend *Babies and Beasts* for both upper-division undergraduate and graduate courses in human rights, medical ethics, and political theory. This work is essential reading for anyone who wants to remain informed about current trends in bioethics, animal experimentation, and ethical theory.

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Healing By Killing
Nitzam Aviram
16 mm or VHS video; 90 or 50 minute editions
New Yorker Films, New York; 1-800-447-0196

'Never again!' This fervent exclamation has been uttered repeatedly as a declaration that humanity must never again allow any individual or group to wage a campaign of racial hygiene as was done by Hitler and the Nazis in the Holocaust. Nitzam Aviram is an Israeli film maker who joined the chorus saying 'Never again!' But as he studied the Holocaust, he wondered why he kept coming across the names of so many doctors. Why were there doctors at the death camps? His curiosity led to this remarkable, sobering, and fearsome film.

The culmination of his study, and the message of this film, is that it was the willing involvement of an unknown but large number of individual German physicians, and the silence of the German medical profession, which paved the way for the Holocaust. Without the involvement of the medical profession, either the Holocaust would not have happened, or it would have taken on a decidedly different flavour. This thesis has been denied, even scoffed at, by social activists who propose or favour legalisation of euthanasia or physician-assisted suicide. But Aviram has clearly documented that the scoffers are wrong.

The historical sequence which Aviram portrays began in 1939 in Leipzig when Professor Karl Brandt, Hitler's personal physician, killed baby Knauer with the consent of his parents. The death of this blind, retarded, and deformed baby was widely reported as noble and humane. It was quickly followed by Dr. Brandt's suggestion to German physicians that they should euthanize their handicapped patients using their own discretion. This suggestion formally evolved into two legally sanctioned German euthanasia programmes, one for children and one for adults. The 'Aktion T-4' programme (headquartered at 4 Tiergartenstrasse) was first carried out in individual healthcare institutions, and later in specially designed facilities in Brandenburg and Bernburg. Physicians, especially psychiatrists, selected the individuals to be euthanized. Physicians signed false death certificates and notified families that their relatives had died unexpectedly of some fabricated illness. Physicians designed more efficient ways to kill larger numbers of patients, first by injection and later in gas chambers.

Aviram interviews Dr. Huber, current president of the German Medical Association, who admits that the German medical profession must accept responsibility for the 70,000–100,000 euthanasia deaths of the T-4 programme, and for designing methods and programmes which became the Holocaust. But the medical profession was silent in 1941. There were only a handful of protests. Euthanasia was by and large accepted.

A public outcry about the stench of burning bodies and inadequately explained sudden deaths led Hitler to stop the T-4 euthanasia programme in 1941. But a new programme was started. The '14-F-13' programme allowed 'euthanasia' for new 'diagnoses' such as being Jewish, a communist, or an enemy of the regime. The physicians formerly involved in killing handicapped patients were convinced that it was their job to help the state kill these enemies. The out-of-work medical killing teams were transferred to Poland to staff newly constructed death camps—camps modelled after the physician-designed euthanasia facility in Bernburg. Same people, same methods of killing. The first such camp, Sobibor, was headed by a psychiatrist. At this and all the other camps, only doctors stood beside the unloading boxcars and made the selections of those fit to work versus those to be killed. It was only doctors who supervised the instillation of the gas into the chambers. It was only doctors who determined when the prisoners were dead so the chambers could be evacuated. Dr. Huber now says 'Auschwitz was a medical operation to make the world a better place.'

Aviram tells this horror story, a story the medical profession has not wanted to hear or even admit, by interviewing historians, researchers, survivors of the death camps, survivors of involuntary sterilization, an Auschwitz physician, the photographer of Dr. Mengele's infamous experiments, and colleagues of other physicians involved in both the euthanasia programme and the Holocaust. He chronicles the lives and careers of two physicians. Dr. Irmfried Eberl was a young physician who acquired his killing skills in the T-4 euthanasia programme and went on to become the first commander of the Treblinka death camp. Professor Carl Clauberg was a renowned gynaecologist who abandoned his fertility treatments in order to conduct sterilization experiments at Auschwitz.

This is not another film about the Jewish Holocaust. Only one Jewish individual appears in the film (Dr. Robert Lifton, psychiatrist and noted Holocaust scholar). This is a film about the willing involvement of the medical profession in a horrific sequence of historic events. The medical profession has not readily admitted its involvement before this. Now that it is becoming public knowledge, we must once more say 'Never again!' But this time the finger is pointing, not at Hitler or the Nazis, but at the medical profession.

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Homosexuality and the Politics of Truth
Jeffrey Satinover
Grand Rapids, MI: Hamewith (imprint of Baker Books), 1997
ISBN 0-8910-5625-X, 280 pp., $17.99

This book, written by a clinical psychiatrist with strong credentials, is a fine and compassionate overview of the biology, psychology and Judeo-Christian morality of male homosexuality. Substantial efforts are also made to document the politicisation of homosexuality by gay activists in the United States over the past thirty years. In the first half of the book Satinover examines evidence for the putative biological contributions to male homosexuality. In the second portion of the book the author examines the Judeo-Christian moral stance on homosexuality and evidence that homosexual men can re-orient their sexual preferences if motivated and associated with certain forms of therapy.

The politicisation of AIDS and of homosexuality is a consistent theme throughout Satinover's book. He argues that gay activists effectively manipulated the leadership of the American Psychiatric Association and the American Psychological Association into reclassifying homosexuality from a mental illness to a normal sexual variant. The author makes the case that the gay community continues to stifle serious inquiry into the origins and treatment of homosexuality. Moreover, Satinover contends that the political acumen and power of the leadership within the gay community is so considerable that they have effectively misrepresented homosexuality as normal, innate and irreversible to the larger community. The author challenges each of these contentions.

Satinover shifts the discussion of male homosexuality from the question of its normalcy to the more precise question of whether it is desirable. This is important because, historically, the editors of the DSM shifted the status of homosexuality from an unqualified mental illness to a mental illness if the subject did not wish to be homosexual and finally to the status of 'not undesirable,' thus removing it from the DSM altogether. To this question Satinover argues that male homosexuality is not desirable and that the negative effects of homosexual practices are equal to or greater than the negative effects of alcoholism. In this same chapter, 'Is Homosexuality Desirable? Brute Facts,' Satinover argues that there is a correlation between the unrestrained promiscuity and tactics of the gay community and those who practise other paraphiliae, including paedophilia and sadomasochism. Thus, for homosexual men and for society at large, Satinover holds that male homosexuality is not desirable.

What is the evidence that male homosexuality is a product of biology? The evidence is often antagonistic to such a notion, according to Satinover. He addresses this question by examining data from several kinds of investigations: pedigree analyses of genetically related individuals; neuroanatomical comparisons between homosexual and non-homosexual brains; correlation between intrauterine environments and later homosexual behaviour; chromosomal analyses and correlation between the psychological histories of homosexual men. Twin studies seem to show that either the data of the studies are poor or that the postnatal environment plays the decisive role in influencing sexual orientation.

The only neuroanatomical report discussed by Satinover is the study by LeVay (*The Sexual Brain*, MIT Press, 1994). He, like many other scientists, points out that the data and its interpretation in this study is quite poor. Even if such differences truly exist (and there are many reasons to doubt this) it is not clear whether the brain activity causes the sexual behaviour or the sexual behaviour changes neuroanatomy. This is an important issue for Satinover because he later argues that repeated behavioural choices may remodel the brain in such a way that the behaviours become difficult to modify. This perspective might be unacceptable for metaphysical naturalists, given that they would hold that all behaviour arises from the brain. Nonetheless, materialism is not the position of Satinover. He finds such a position both untenable for those who believe that humans are essentially free choosing beings and demeaning to human dignity.

Many scientists have found efforts to corre-

late chromosomal analyses with homosexual behaviour substantially flawed. This author does a nice job of summarising the critical issues of genetic analysis of behaviour. Satinover grants that genetics may increase the likelihood that an individual chooses homosexuality but that even if current studies were not flawed, genetics could contribute no more than 10–25% to the behaviour.

In contrast with the biological evidence there are strong correlations between the appearance of homosexual behaviour and childhood sexual abuse, opposite and same sex parental conflict, same sex rejection and peer group rejection. The author suggests that homosexuality probably arises from multiple events at critical periods of development. Further he believes that these causes are not the same for every homosexual. These multiple causes could include genetic influences, prenatal developmental events and postnatal events. Postnatal effects upon sexual orientation might include social stresses interacting with a child's unique biology and the impact of individuals' own choices and habits upon themselves.

In his last chapter Satinover warns his readers that there are important negative consequences for our culture if we concede to the neo-paganism which sustains popular acceptance of homosexuality as normal, innate and irreversible.

This is an important review of issues germane to male homosexuality and a sobering look at the impact of post-modern power politics upon careful scientific inquiry.

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Gospel Virtues: Practicing Faith, Hope & Love in Uncertain Times
Jonathan R. Wilson
Downers Grove, IL: InterVarsity Press, 1998
ISBN 0-8308-1520-1, 214 pp., $14.99

In the 90s, it's clear that many social and cultural phenomena that were once thought to be 'out,' are now back 'in.' Much to my own amazement, polyester clothing, bell-bottom pants, and even disco itself are all making a small, if determined comeback. In the academic discipline of ethics, the story is much the same. Virtue ethics, the study of the good life, usually formed around some common ideal or *telos* of the good, is making a comeback. No longer considered the sole province of Aristotelian ethics, virtue ethics today holds that the 'ethics of the right,' variously labelled 'decisionist ethics,' has been weighed in the scales of postmodernity, and found wanting.

Whether or not it is premature to read the eulogy over the grave of Kantian or Utilitarian ethics, it is nonetheless true that the recent surge in the popularity of virtue ethics does signal a present-day dissatisfaction with any ethics hitched to the wagon of Enlightenment individualism. Jonathan Wilson, who chairs the department of Religious Studies at Westmont College, has done a good job of grounding his account of the virtues in the soil of the gospel (p. 19). Wilson is consistent in his view that any *Christian* account of the virtues must not only drive beyond the cardinal virtues and *eudaimonia* of the *Nichomachean Ethics*, but must never lose its focus on the crucified one of Calvary. To do otherwise is to veer dangerously near either to the Scylla of Pelagianism or the Charybdis of a glossed-over Aristotelianism (p. 19). Thus, the *telos* of a Christian ethics will 'lie ultimately in the work of God, not in human nature as such' (p. 42).

Wilson's desire to stay grounded in the gospel is appreciated, but at times, in my judgement he over-widens the gulf between a classic and Christian account of the virtues. Quoting with approval John Milbank's account of the classic (or 'heroic') virtues, and how Christianity can have no part in such virtues, Wilson seems to agree that 'heroic virtue is no ethic at all because it has no real concept of the good' (p. 36). I think what Wilson is doing here is distancing his account of the virtues from any notion that one can somehow merit salvation through a virtuous life. Fine; but consider the following story.

Helen, a retired nurse, is an unbeliever. Not wanting to spend her retirement in a rocking chair, she takes a volunteer job as a school crossing guard. The children bond with her; and she indeed comes to love, as she says, 'my little ones'. One day, a speeding pickup careens toward a group of children crossing the street under Helen's watchful eye. Instinctively, she runs to them, pushing them out of the way of the vehicle. Sadly, she is not fast enough to get out of the way herself and dies at the scene.

Now consider the following two propositions: A) 'Helen behaved virtuously by saving those children at the expense of her own life,' and B) 'Helen has just earned her salvation.' There is no necessary or logical link that makes affirming 'B' a necessary result of affirming 'A'.

Does Wilson mean to say that such a person as Helen has not performed a virtuous act? Or, and what is more likely, would he question whether Helen performed a virtuous *Christian* act? Can only Christians perform what Wilson calls Christian virtues? Wilson could be a little clearer at this juncture.

I think some acts, to put it in the vernacular, 'cross the boundaries' between Christian and Classic virtues. Or, better, they demonstrate that there are connections of being, which is where virtue ethics makes its appeal, among all people. I see no need to restrict Jesus' words that 'Greater love has no one than this, that one lay down his life for his friends' (John 15:13) either to his own supreme demonstration of *agape*, or to Christians in general. Wilson is wary of 'elevating human achievement' (p. 36), but just what exactly is this creature called a 'human'? Is she (or he) not created in God's image, with a knowledge of good and evil within her?

My anthropological issues with Wilson notwithstanding, the author has done an excellent job weaving the theological virtues into a *practical* tapestry, grounded in the gospel, but fit for everyday use. His account of the sacred and the secular, particularly connected to the practice of education indeed could serve both as a lens for viewing the problem, and a prescription for a faith-centred higher education. *Gospel Virtues* is not only a good read, but a valuable one.

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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.*

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