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Editorial Addresses

In the UK: Center for Bioethics and Public Policy
58 Hanover Gardens, London, SE11 5TN
Tel: 0171-587 0595 Fax: 0171-587 0595
Email: 100524.1567@compuserve.com
In the USA: The Center for Bioethics and Human Dignity,
2065 Half Day Road, Bannockburn, Illinois 60015 USA
Tel: 00 1 847 317 8180 Fax: 00 847 317 8153
Email: bmitchell@cbhd.org

Sponsors

The Centre for Bioethics and Human Dignity*, Bannockburn, Illinois 60015 USA. Tel: 847-317-8180 Fax: 847-317-8153
Email: cbhd@banninst.edu
The Centre for Bioethics & Public Policy, Address as above.
The Prof. Dr. G.A. Lindeboom Instituut, Postbus 224, NL6710 BE Ede, Netherlands.
Tel: 318-696333 Fax: 318-696334
Email: lindinst@che.nl
www.che.nl/lindeboom

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C. Ben Mitchell, Ph.D.

The Protest of a Troubled Bioethicist

On my way to Scotland this past January I experienced an exceedingly interesting welcome to the country. When I arrived at the immigration desk I was asked the customary questions: 'How long will you be here?' and 'Where will you be staying?' The customs agent next inquired, 'And why are you here?' To which I replied, 'I am here for the annual board meeting of the journal I edit, *Ethics & Medicine*'. 'Oh, that's interesting', he responded, 'did you hear this morning's BBC news? They've cloned a monkey back in the States. Her name is Tetra.' In fact, I had not heard the news about Tetra. Whilst I was in the arms of the airlines, wrestling in the arms of Morpheus on my transatlantic flights, news was breaking of still yet another development in biotechnology, namely, the cloning of a primate. As interestingly, perhaps, was the fact that I was informed of this event not by a colleague and member of the bioethics guild, but by an ordinary person (sorry, I'd call most bioethicists, including myself, anything but ordinary); and not only an ordinary person, but a person on another continent.

This event was a stark reminder to me that biotechnology, and therefore, bioethics, is not just the concern of a few so-called experts. Because decisions about biotechnology impact all of us, bioethics—thinking critically about the moral dimensions of biotechnology—should be on all of our minds.

Moreover, biotechnologies, like cloning, do not merely impact Americans, or Britons, or Australians. Because our globe has been shrunk by these technologies, bioethics should be international.

Nevertheless, decisions made about whether or not, for instance, to clone a sheep, a cow, a primate, or for that matter, a human being, are not given the attention they deserve. Yes, cloning has been in the news for several years now. Yes, a couple of national bodies have issued reports on the subject. But nowhere has there been significant public discussion of the matter. Nowhere have those who will be most impacted by the technology been educated and asked for their informed view on the matter. We have proceeded down this road toward human cloning without adequate education and reflection. This is, in my view, a recipe for disaster. In fact, I have every reason to believe that by the time this editorial is printed, someone, somewhere will have already tried to clone a human being.

To make matters worse, we have no settled international policy on cloning, much less *human* cloning. Biotechnologies are of such scope and impact that they seldom, if ever, impact only one locale. In fact, in a global marketplace and laboratory, biotechnologies are global. If genetically-altered foods are allowed in one country, they will make their way to others. If bovine growth hormone is used in one country, it becomes increasingly difficult to refuse it in another. If human beings are cloned in one country, the technology, not to mention the person him or herself, will emerge in another country. Is it not time for all of us (i.e., those of us impacted by biotechnology) to call for some form of international oversight of biotechnology (i.e., that which impacts all of us)? In my own country, prescient leaders saw that atomic energy presented amazing potential for both tremendous benefit and excruciating burden. Not only has tax-funded research been under the auspices of the Atomic Energy Commission for the last half-century, but privately-funded research has been as well. The potential hazards of biotechnology are at least as great as those of atomic energy. In my own view, biotechnologies in general and cloning in particular require comprehensive, international, collaborative oversight.

If this does not happen, we will find ourselves rushing at break-neck speed into a state of affairs too grave to imagine—and sooner rather than later, I'm afraid. Frankly, I really try hard not to be a Chicken Little, heralding at every sign of rain, 'The sky is falling! The sky is falling!' But the matter before us, namely the cloning of a highly complex mammal, is just the kind of thing that ought to scare us to death. Instead, we race proudly toward . . . what? Paradise or oblivion? It is just because we don't know how this is going to turn out that we need to employ our best minds and give our best efforts to try to discover what all this means for the future of humanity. Of course, that also demands that we re-learn how to think and that we come to some agreement about where we think we are going. This is no small task in a post-consensus society, much less in a pluralistic world. Nevertheless, we had better give it a try. As philosopher-ethicist Leon Kass has so famously said, 'Nothing less than the future of our humanity hangs in the balance.'

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Glenn M. Hultgren, DC

Alternative Therapies: Making a Difference through Spiritual Evaluation

The Origin of Life

In Genesis 2:7 we read that *'God formed man from the dust of the ground and breathed into his nostrils the breath of life, and man became a living soul'*. There is much to think about in this verse. Man is composed of the same chemicals as the soil or earth upon which he stands. But God took those chemicals and brought them together in the form he wanted and placed within that figure a soul, a life, a spirit. These are nonphysical and immaterial. The chemical/physical make up is inanimate material, not unlike the soil upon which we stand. Our human structure is both animate and inanimate. In the Hebrew the word *'nepes'* or *'nephash'* which has been translated 'soul' literally means *'the essence of life, the act of breathing, taking breath'*.[1] In Genesis 1:20, the living creatures created by God are also said to have *'nepes'*, the same as word as in 2:7 where man is called a living soul. It is translated some 400 times in the Old Testament as *'soul'*. Vine goes on to explain that in the Greek and Latin 'soul' is contrasted with body but in the Hebrew, as used in Genesis, the contrast is between the inner self and the outer appearance.[2]

In the Greek the word translated 'soul' is 'psyche' and the word *'pneuma'* is translated 'spirit'. The difficulty in differentiating these words is evidenced in Hebrews 4:12, *'For the Word of God is quick and powerful and sharper than any two edged sword, piercing even to the dividing asunder of soul and spirit . . .'* Vine says that generally speaking the spirit is of the higher nature and soul of the lower element. The spirit is that special nature bestowed on man by God, and the soul, like that of animals and other living creatures, is that which is inherited from parents. Both are a result of a special creative act of God, immaterial aspects of living creatures, which when combined with the inanimate, form all living beings, the spirit being in man only and the soul in humans and animals alike.[3] The creation of life was a one time creative act of God. It was accomplished in the first chapter of Genesis and the command to all living beings was to go forth and multiply. Procreation was the gift which God gave to living things. But nothing which is dead, *(does not have that which God placed in it, the soul, spirit, or life)*, can bring forth another life. This is a principle which God established. Man cannot bring to life from that which is inanimate, any form of living creature. Neither can that which is inanimate create that which is animate. We must accept the fact that the immaterial aspect of living creatures is given directly by God, created by him, but reproduced in succeeding generations. It is not created in a laboratory, or even dissected and studied by scientists on a laboratory bench.

It is important for the Christian to have a basic understanding of how this immaterial nature gives life and healing to the physico/chemical nature.

The Recuperative Power of Cells

We have heard it said, *'the body healed itself'*. What do we mean when we say this? The body by itself has no ability to heal! The physical body is just a glob of dust—chemicals—from the earth. There is no life or healing power in these chemicals and by themselves there is no life there. If it could heal itself, the dead body would raise itself from the death bed and restore itself. This it cannot do. There is, however, a natural recuperative power in the physical body. This recuperative power fights off disease, develops immune response and is capable of spontaneous healing of many conditions. In fact, if we really want to admit it, this is the same dynamic power that must be activated if any healing is going to take place in the body. But this power is not a physical part of the body. It is part of the power of the immaterial nature which gives the physical body *'life'*.

If this natural recuperative healing power is not physical, what is it? Is it mental? We have heard of patients willing themselves well, thereby using mental ability to affect the healing process. We also know that if a patient does not wish to be well, nothing that a physician can do is going to help. Conversely, the patient with the most determination to get well will have the greatest ability to overcome illness. Therefore we know that the patient's mental condition does play a definite role in the healing process. But is healing strictly a mental function? If so, how do we explain mental illness if it were the mind that is the source of healing power?

Since healing does not seem to be simply a function of the mind, we must admit that the healing process is controlled by the spirit, the soul, the vital nature, the essence of life itself. It is part of the immaterial nature which God breathed into man when he called man a living soul.

(Gen. 2:7; Acts 17:25; Ps. 36:9; Job 33:4). This nature gives life to the inanimate physico/chemical material from which man was formed. This nature distinguishes the live body from the dead one. This nature is transient within the physico/chemical substance which is here today and gone tomorrow, giving life, health, and mental function (e.g., thinking and reasoning) to that physical body, without which the body is dead. The definition of life then must involve that immaterial nature which God placed into the body which he formed from the dust of the earth, when he called that form a living soul.

Many characteristics distinguish a living body,—warmth, breath, pulse, reflexes, conscious and unconscious brain activity—from a dead body. More elaborate laboratory equipment, such as the electroencephalogram, reveals activity in the brain of a living body even when all other responses are in doubt. But when these responses are all absent, the body is dead and nothing is going to change that or bring life back. Severe physical changes and deterioration are soon going to follow and the physical substance of the body will return to the dust of the earth. It is obvious to all who witness this process of death and dying that something has happened to the once vital living body—something has left it and that something is not a visible, tangible property but rather an intangible, immaterial nature.

The Healing Principle

Because of our training as physicians in a particular discipline, many of us may feel that only our method of healing, our procedure, our discipline will work in the healing process. This obviously is not true. The spirit of the sick patient may accept any of several stimuli to do its work in the patient. Of course there are times when the wrong method or substance is used and the spirit is hindered in the healing process. We have all seen this happen. But the physician needs to know what he can do to help and not hinder the healing process. **The best physician is the one who does the least to interfere with the patient's ability to heal himself.** Many times the habits of the patient have harmful effects on the physical body and make it more difficult for the spirit within man to accomplish this healing process. Substances such as alcohol, tobacco, drugs, impure air, water and food, and other toxic substances hinder the healing processes because of the damage they do to the physical body.

Christ's Healing Ministry

We know that much of the ministry of our Lord Jesus on earth was concerned with healing the sick. This he did by the power of his Spirit affecting the spirit of the sick person. We also know that much of his healing was not just physical but was also spiritual, bringing salvation to the individual as well as physical healing. By this we can assume that the same nature which is involved with giving life to the person, the '*natural man*', the soul, is that which is subject to sin, and it is also the nature which brings about healing and recuperation to the physical body. Therefore, we can say that the process of healing, the nature of life itself, and the sin nature, are all phenomena under the control of the soul/spirit of man.

While Christ was on earth, we find that his healing ministry and his saving ministry often were simultaneous acts. This is an example of what we are trying to show, that it is the soul/spirit which is that aspect of the triune nature of man which is involved in both healing and salvation. The Greek word, ***iaomai***, is translated '*to heal*' or '*make whole*'. In Luke 5:17 this word is used of those who were coming to Christ to be healed and in the twentieth verse we are told that he healed the man with palsy by saying, '*Thy sins be forgiven thee*'. In Luke 6:18, 19 this word is used to describe the acts of Jesus relative to the demon possessed and then the multitudes who sought his virtue. In quoting Isaiah in Matthew. 13:15, Luke 4:18, and John 12:40 we find this same word is translated healing. In Peter 2:24, Peter tells us that '*by his stripes we are healed (iaomai)*'. All of these references are about healing of the body, soul and spirit (*not the physical only*) and all are using the Greek word, *iaomai*.

Another Greek word sometimes used for healing is the word ***sozo*** which is generally translated '*to save*'. In Luke 8:36 the man possessed of demons was healed (*sozo*) and in Luke 8:48 and Matthew 9:22 Jarius' daughter was raised from the dead, made whole (*sozo*). In James 5:15 we read that '*the prayer of faith will heal (sozo) the sick*'. This word has very definite usage in a spiritual sense and on the few occasions when it is used for healing it involves raising the dead or casting out demons, a spiritual healing.

A third Greek word to consider is ***hugiaino*** which is best translated '*health*' but is used when Jesus healed the man with the withered hand in Mark 3:5, and the woman with the hemorrhage in Mark 5:34. In this verse we read that Christ said to her, '*Daughter, thy faith hath made thee whole (sozo); go in peace and be whole (hugiaino) of thy plague*'. In Acts 27:34 the word hugiaino is translated '*health*' when food was necessary to sustain health and strength. In John 5 we have the account of the impotent man at the pool of Bethesda. In verses 6, 9, 11, and 14 we find *hugiaino* regarding his healing (*made whole*) and in the fourteenth verse Christ admonishes him to '*sin no more lest a worse thing come upon thee*' which again links the act of healing the body with the spiritual cleansing of the soul.

The important point to notice is that none of these words is used in the New Testament to describe the work of Satan or his demons. These words are used only of Christ and his apostles and involve the healing of the whole person: body, soul and spirit. If then we do not have an example in Scripture of Satan healing the whole person even though he performs various acts of physical healing and other miracles, there must be a difference between those words which involve the spirit and those which involve only the body.

Physical Healing Without Healing the Spirit

In the Authorized King James Version, the words '*heal, healed, healing*' referring to the physical body occur 74 times in the New Testament, '*miracles*' 32 times, '*sign*' 30 times. On 20 occasions the word '*wonders*' is used and on 13 occasions '*mighty works*'. Each of these references is describing a miracle, many of which were acts of healing of the physical body. Most of these are describing miracles done by the

Lord Jesus or his apostles. But it is noteworthy that Satan also is in the business of performing miracles. Let us now look at some of the words describing the work done by Christ and his apostles which are also used to describe the acts done by Satan and his followers and the miracles which they are capable of performing.

Basically, four Greek words are used in the description of miracles. They are *dunamis, semeion, teras,* and *therapeuo.* **Dunamis** is most often translated as *power, mighty* and sometimes as *miracle.* **Semeion** is usually translated as sign but may also be translated as *miracle* and *wonder.* **Teras** is translated as *wonders.* **Therapeuo** is the base for the English word therapy and is translated as *heal,* but only when it is used in reference to the physical.

Space limits us from quoting every one of the verses where these words are used. However, an example is found in Acts 2:22 where, on the day of Pentecost, Peter says *'Ye men of Israel, hear these words: Jesus of Nazareth, a man approved of God among you by* ***miracles*** *(dunamis) and* **wonders** *(teras) and* **signs** *(semeion) which God did by him in the midst of you as ye yourselves also know.'* All three of these words refer to his healing ministry and his other miracles. In Acts 2:43 we see that the apostles did the same things, *'And fear came upon every soul; and many* **wonders** *(teras) and* **signs** *(semeion) were done by the apostles'.* In Acts 4:22 the word *'semeion'* is translated ***miracle*** and refers to a healing: *'. . . for the man was above forty years old on whom the* **miracle** *(semeion) of healing was showed.'* Again in Hebrew. 2:4 the apostles are reported as doing miracles. *'God also bearing them (the apostles) witness both with* **signs** *(semeion) and* **wonders** *(teras) and with diverse* **miracles** *(dunamis).'* It is abundantly clear that Christ and the apostles performed many miracles, including those of healing. Let us look at some examples of these acts being accomplished by the enemies of God.

In Matthew 7:12–23, Christ warns that in the last days false prophets would come doing miracles. He says, *'Not everyone that saith unto me "Lord, Lord", shall enter into the Kingdom of Heaven; but he that doeth the will of my Father which is in heaven. Many will say to me in that day, "Lord, Lord, have we not prophesied in thy Name? and in thy Name have cast out devils? and in thy Name done many* **wonderful works** *(dunamis)?" And then will I profess unto them, "I never knew you; depart from me ye that work iniquity".'* Christ again warns us in Matthew 24:24 *'There shall arise false christs and false prophets and shall show great* **signs** *(semeion) and* **wonders** *(teras); insomuch that, if it were possible, they shall deceive the very elect.'* In 2 Thessalonians 2:8, 9, **Paul said**, *'Then shall that wicked one (the Antichrist) be revealed . . . even him, whose coming is after the working of Satan with all* **power** *(dunamis) and* **signs** *(semeion) and lying* **wonders** *(teras).'*

Satan and his followers can perform healing miracles according to Revelation 13:13, 14, *'and he (the false prophet) doeth great* **wonders** *(semeion) . . . and deceiveth them that dwell on the earth by means of those* **miracles** *(semeion) which he had power to do . . .'* In Revelation 16:14 we are told that *'they are spirits of devils working* **miracles** *(semeion) which go forth unto the kings of the earth'.* Also in Revelation 13:3, 12 we read, *'. . . . one of his (antichrist) heads as it were wounded to death and his deadly wound was* **healed** *(therapeuo).'* Satan and his false spirits have the power to do many miracles including healing of the physical body!

How Does Spiritual Activity Affect the Physical Body?

There is ample warning that we should expect to see miracles, signs and healings by forces and powers which are not of God in the last days. The problem is how do we as believers recognize what is of God and distinguish it from what is not from God. The common criteria is that if it is good and if it helps people and if it relieves pain and suffering, it must be from God. *This just is not true.*

Several years ago I had the opportunity to visit a psychic surgeon in the Philippines, named Marcelo Juliare. Marcelo was pastor of a little church in the village of Carman on the island of Luzon. After his church service was over, Marcelo asked if any were sick, and if they wished to be healed, to come to the front of the church. One by one they would lie on the altar at the front of the church and, depending on the problem, Marcelo would move his hands over their body. If the problem were of an internal origin he would move his fingers across the abdomen and push his hand through the skin, work it around for a few minutes, remove some small bloody mass, place a ball of cotton between his fingers and thrust it into the opening in the abdomen, remove his fingers and the opening instantly would close up. Some questions obviously come to mind for the casual observer:—did I really see what I thought I saw? Was it just a magic show? Could any possible good come out of this type of procedure? If it was for real, was it of God or was it of Satan?

Obviously I do not have all of the answers and I must admit that I was very confused for a long time after witnessing this act. However, after viewing my films a hundred times and reviewing in my mind what transpired, I have come to some conclusions. **(1)** It was not a magic show. **(2)** Marcelo did not do this for money and was very seriously concerned that he was doing the will of God and healing his parishioners. **(3)** Yet if it were a true act of spiritual healing according the power of our God of Heaven, why did he have to open the body up to perform the healing? Christ spoke the word and he healed. The apostles laid hands on the believers and prayed but never do we have a report of them opening the body up and removing an offending substance. **(4)** If it was not according to biblical pattern and did not follow healing as practised in scripture, most likely it was not of God. Therefore it must have been another spirit that I witnessed in that church which had the power to perform a supernatural act. Whether it was successful and beneficial or not, I could not be sure. I did have opportunity to examine a twenty-year-old woman who had had her appendix removed by a psychic surgeon when she was about thirteen. There was a stretch mark of sorts in the area of the appendix and the patient had had no further symptoms of appendicitis. Whether the appendix had actually been removed was impossible to know without actually opening up her abdomen. The psychic surgeons of the Philippines have a world wide following and claim miraculous results with thousands of cases. Can this apparent act of kindness and benevolence, which harms no one and may indeed do much good, all in the Name of Christ, still be the work of Satan? If we believe Matthew 7:21–23, then it indeed very well may be.

How can we know if a miracle of healing is the work of

God or the work of a false spirit or false prophet? If the healing process of the physical body is controlled by the soul/spirit of man then it stands to reason that anything which can affect the soul/spirit will have the greatest opportunity to cause change. The natural spirit of man is influenced by outside spirits, both the Holy Spirit of God and false spirits. Christians are too ready to give credit to God for all spiritual activity, especially if it appears to be good or helpful. Satan is the great deceiver and is in the world to deceive God's people at every opportunity and how better to do this than through healing of the physical body. Therefore, we must admit that his spirits are capable of interacting with our spirit to do that which may at first appear to be good.

If the healing process is one of the works of the spirit of man and it is influenced by outside spirits then logically spiritual means should be one of the first methods of healing for the Christian to consider. For this reason the Bible tells us to pray for healing. *'If there be any sick among you, let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord'* (James 5:14).

The Philosophy of Healing

In philosophical terms the inborn spiritual nature which God has placed into man which seems to be in control of the healing process in addition to giving life to the physical body is called the vitalistic nature. In his *Encyclopedia of Philosophy*, Paul Edwards approaches this subject from a secular view point but he does shed much light on our understanding of the nature of man which is involved in the healing process. From a secular standpoint, Paul Edwards describes two types of vitalism, critical vitalism and naive vitalism.

What we have been describing in the previous paragraphs could well be defined as **theistic or critical vitalism**. Paul Edwards defines critical vitalism as, *'primarily a metaphysical doctrine concerning the nature of living organism . . . it is that which distinguishes living from non-living things . . . it is the presence in living systems of a substantial entity that imparts to the system power possessed by no inanimate body . . . it holds, first, that in every living organism there is an entity that is not exhaustively composed of inanimate parts and, second, that the activities characteristic of living organisms are due, in some sense, to the activities of this entity'*.[4] This is not to be confused with **naive vitalism** which, as a philosophy, is far more common in today's world of New Age medicine, and which Edwards describes thus: *'life is regarded as a material substance, usually a fluid body . . . life is flatly identified with a material fluid, the breath or the blood . . . the doctrine of spirits, as occurs in Galen and his successors, is an example of this sort of vitalism. The process of etherealizing the life culminates in the view that it is a fluid but one that is assigned no properties other than its power of animating an organism.'*[5] In the philosophy of naive vitalism we find that the essence of life is given to some real or imagined anatomical or biological part which controls all bodily functions. Life is a fluid or an energy in naive vitalism. Today we find the New Age holistic healers are balancing life energies, unblocking the flow of life's impingements, stimulating meridians, reading auras, ingesting life energy from nature, calling upon spirits, and using methods which have little or no empirical value, methods which do not conform to God's created order of anatomical circuitry or system physiology, in their healing practices. By this we mean that the naive vitalist works with systems which are not a part of God's created order, not anatomical, not visible in the laboratory, not measurable on instrumentation, but which work because of the faith or spirit of the healer doing the work. The Bible tells us to *'try the spirits to see if they are of God'* (1 John 4:1).

Critical vitalism was first proclaimed by Aristotle in his treaties *On the Soul* and *On the Generation of Animals*. 'Aristotle takes the soul as the model of life and attributes to life the power of achieving and maintaining organic form',[6] according to Edwards. Although Edwards offers no explanation for the origin of life, as Christians we know that this entity has been placed in matter by none other than the Creator himself at the origin of the creation and it is passed on to succeeding generations by the process of procreation. This entity which in Scripture is called *'soul/spirit'*, is responsible for all living processes, for thinking, memory, self preservation, reproduction and also for healing of physical and mental dysfunctions. The critical (*or Theistic*) vitalist must accept the fact that the Creator works within his model, through his created order, by his anatomical circuitry, using the plan which he established when he created and organized the body for its proper function and self preservation. The process of separation of the *'soul/spirit'* from the body is called death.

Christ tells us in John 6:63 that *'It is the spirit that quickeneth (makes alive); the flesh profiteth nothing.'* Christ was talking about the new birth and the Holy Spirit who comes to give new life to the sinning soul. But is it not also true that it is the natural spirit which gives physical life to the flesh and the flesh *(physico/chemical body)* is of no profit by itself, as it pertains to the life giving, healing, and recuperative powers of the individual?

In contrast to the vitalistic hypothesis, is the secular scientific model which is one of **reductionistic** or **mechanistic philosophy**. Webster defines this as *'a doctrine that holds natural processes (as of life) to be mechanically determined and capable of complete explanation by the laws of physics and chemistry.' . . . 'it is a procedure which reduces complex data or phenomena to simple terms.'*[7] Paul Edwards defines **mechanism in biology** as a *'philosophical theory about the nature of biological systems . . . mechanism is sometimes said to be the theory that living organisms and all of their living parts are machines . . . stated less formally, mechanism is the view that every biological event is a pattern of non-biological occurrences.'*[8] Edwards asks the rhetorical question, *'What distinguishes living from non living things?'* He answers that for the mechanist it is, *'a complex pattern of organization in which each element of the pattern is itself a non living entity'*.[9] This is a philosophy which is more acceptable to the scientific mind and it effectively removes the spirit from the world of empirical science. This may be necessary as far as non-biological empiricism is concerned, but is the medical scientist ready to call *'life'* a material substance? Is life, as the mechanistic philosopher believes, a combination of inorganic ingredients? The examination of the living cell cannot be reduced sufficiently to find life under a microscope. Even though the chromosomes and genes can be studied, separated, split, dissected, transferred, replaced, altered, or whatever,

nothing happens in their function if there is no life in the cell! But, the element *'life'* cannot be found in the cell! Life cannot be created in a laboratory. No combination of ingredients will ever duplicate the function of a thinking, living, reproducing organism without the living vitalistic nature. *The mechanistic philosophy just does not have the answers necessary to satisfy the Christian believer.*

It is not difficult to understand why the secular scientific mind of man in the days of Nazi Medicine and also in the modern research laboratories, the abortion clinics, the fetal tissue research centres, the genetic engineering and cloning laboratories, can proceed endlessly along their path of inhuman research when they refuse to recognize the spiritual entity in the living being. If their philosophy of life is materialistic, mechanistic and reductionist, they have no knowledge of the presence of God or appreciation of his work.

The Vitalistic Affect on the Body

Much has been written about the *effects* of that which we have been discussing but little is said or written about the controlling power itself. As the healing professions move farther and farther from their vitalistic base, we hear more about homeostasis, recuperative powers, natural healing power and immune response. Are these not the *effect*, the results of the active working immaterial nature, the spirit/soul? As we wrote earlier many are saying, *'the body healed itself'*. Does this not describe what is happening without explaining how the body does it? Is homeostasis, for example, the basis of it all, the source from which all healing emanates? Or what is it that controls homeostasis? Strang says, *'It is this marvelous, innate (inborn), purposeful nature which is the predominant, practical reality behind the mechanisms of homeostasis.'*[10]

Dorland defines homeostasis as *'a tendency to uniformity or stability in the normal body states of the organism'*.[11] Webster says it is *'a relatively stable state of equilibrium or a tendency toward such a state between the different but interdependent elements or groups of elements of an organism or group.'*[12] Neither of these definitions gives any hint as to what, if anything, controls homeostasis. Janse says that *'normal integrated neurological conduct equals homeostasis and health, and disturbed neurological conduct results in pathophysiology, disintegration of homeostasis and eventually the intrusion of disease.'* Strang says that *'homeostasis enables the body to stay alive in an ever changing environment. The nervous system is the prime controller of homeostasis.'*[13] We would have to disagree with Strang and Janse at this point because there is still something controlling the nervous system as it regulates and controls the homeostasis for the entire body, which it cannot and does not create by itself. If the above hypothesis were true, how do we explain diseases of the nervous system such as multiple sclerosis and poliomyelitis? These diseases also are a breakdown of homeostasis and affect the nervous system which they say controls homeostasis. This, of course, cannot happen unless something else remains in control of the nervous system. This is where we return to the immaterial nature and the concept of **theistic vitalism**.

At this point we must be careful not to deify the vitalistic nature as D.D. and B.J. Palmer did with their concept of Innate Intelligence. To them Innate was God and it had all of the attributes of God and dwelled in all living organisms. This is pantheism. What we are talking about is not pantheism, that is that God is in everything, but we are suggesting that the breath of life which God originally placed within man, has been passed to every succeeding generation from the beginning. This breath *(nepes or nephesh)* is that immaterial nature which is passed to each new generation at the moment of conception, gives totipotency to the reproductive cells, and then develops, controls, gives life to, heals, and maintains homeostasis of the individual until the moment of death when it departs from the body and the physical body returns to the dust of the earth and that immaterial, nature, soul/spirit, moves on to its eternal reward.

Empiricism and the Vitalistic Concept

The issue of vitalism and its lack of scientific empiricism is used to devalue and debase the Christian who holds to a philosophy which places God at the centre of his thinking. According to scientific empiricism, any scientific theory must be observable, verifiable, reproducible, irrefutable and unfalsifiable before it can be accepted by empirical science. Obviously the concept of theistic or critical vitalism cannot meet these demands and therefore it can not be considered empirical. However, is evolution, which is so widely accepted in the scientific community, observable, reproducible, unfalsifiable? Scientific debate, even though coming from divergent viewpoints, must be rooted in fact and be rational. Is this not a phenomenon—the immaterial nature, which is so obvious, which is unfalsifiable—that it must be accepted in all philosophical constructs? Paul Edwards states, *'In short, vitalism is irrefutable.'*[14]

Much of medicine and science today is not empirical science. Illich, in his *Medical Nemesis*, calls technological medicine a religion, a gnostic cult, that ritualizes and celebrates the nineteenth century ideal of progress. Mendelsohn characterizes the organizational behaviour of the medical profession as adherence to an allopathic religion, with respect to those who dissent from its doctrines. It is not concerned with scientific debate but behaves like a powerful and dogmatic church ruthlessly and aggressively suppressing heresy or waging a holy war on a competing religion.[15] In using these quotes, the author, Peter Borregard, D.C. of Albany, CA repeats much of what we have been discussing: *'There are two opposed understandings of nature, reductionism, (mechanism) and a vitalist understanding of nature.'*[16] Borregard goes on to say that, *'we have increasingly come to interpret biology in the reductionist manner. It takes a great deal of courage to step aside and question this world view, even after we know from our clinical experience, that the allopathic model is inadequate.'*

In conclusion, we must accept the fact that there is a spiritual side to the healing process. It is an unfalsifiable concept and, as Edwards says, *'In short, vitalism is irrefutable.'*[17] Understanding the concept of the spirit in man and how it works within the physical body, to give and sustain life, heal disease and injury, and adapt to environmental changes, is the challenge of the Christian physician. How do we best impact the soul/spirit? What can we do to aid the spirit in the healing process?

Spiritual Healing

We have already stated that it is possible that false spirits are at work in the healing process. Just as is true for the Holy Spirit, the avenue into the personality for the false spiritual beings is through the natural spirit of man. By this avenue they can affect both the physical body and the mental or emotional state of the person. For this reason we need to be particularly careful that nothing in our procedure, our technique and our therapy has any connection to the fraudulent spirit world. On the other hand, when this is understood and the Christian physician approaches it properly, it is through this same avenue that the Spirit of God can bring complete healing through the natural spirit of man, to his body, mind and spirit by the work of the Holy Spirit.

How does this change our approach and our relationship? Are there methods, procedures and remedies which the Christian patient, possessing the Spirit of God in his spirit, cannot and should not receive? Is it not possible that the Holy Spirit residing in the Christian gives warning to the patient when fraudulent spirits are trying to seek entrance through some healing process? Is it proper that the spiritual act of prayer should be included in our protocol for the benefit of the sick? These are questions which each Christian physician must answer for himself.

False Healing

How can we know that the method, procedure, remedy, or technique which we choose to use is right, good and proper for the Christian physician and his Christian patient? If the spirit of man must accept the healing procedure and use it to aid in the healing process, it must be understood that what is practised by the physician is **(1)** accepted by the natural spirit of man and **(2)** that it follows God's created order (Natural Law). There are practices which are from the fraudulent spirits, which may blur, distort, or counterfeit God's Natural Law. The natural spirit of man cannot discern the spiritual source of that which is presented. But the spirit of man which has been born from above by the Spirit of God may find real conflict in that which is from the fraudulent spirits. This is the reason that even though many shamanistic techniques and procedures have been found to be effective in healing, many of God's people have a very disturbed spirit when they find themselves involved in these processes. Is it then acceptable for the Christian to say that if it works, if it gets people well, it must be all right? The spirit of the natural man may accept many different approaches without discernment as to spiritual source. If this is true, it is even more imperative that the Christian physician be very discerning as to any spiritual association implied or involved in his practice or procedure.

The four tests below can help discern practices which may be effective in bringing about healing but which may not be acceptable to the created order of God.

1. If the healing is of a supernatural nature, employing procedures which transcend the laws of nature, involving some miracle or miraculous event, and not performed in the same manner as healing which has been described in Scripture, it is probably not of God. *(Examples:—psychic surgery and Edgar Cayce's psychic diagnosis.)*
2. If the healing is associated with, or derived from, a pagan religion which is not biblical Christianity, it may be a fraudulent spirit doing the healing. *(Example:—acupuncture, yoga.)*
3. If the healing is apparently neutral as far as spiritual or religious connections are concerned but it uses methods which are not utilizing God's created order, e.g., it is not according to the natural law of anatomical or physiological circuitry, it is probably the work of a fraudulent spirit. *(Example:—applied kinesiology, iridology, reflexology, acupuncture, surrogate testing.)*

   (It should be noted that prayer to the Living God can be used in healing, even though it is not a method following God's created order of anatomical circuitry. The important thing to ask is, to whom are we praying? God can and will heal through prayer, but so does Satan through his false spirits if prayers are directly or indirectly focused away from God.)
4. If the healing utilizes occult energy fields and forces which are associated with astrology, occult practices, animal magnetism, energy balancing, hypnotism, mind control, etc. it may be working with a fraudulent spirit. *(Example:—healing touch, non-contact massage, some aspects of psychotherapy, acupuncture, positive thinking.)*

There are many examples in Scripture of healing performed by Satan and his false spirits and prophecies of that which he will do in the last days (Rev. 13:3, 12, 13, 14; Rev. 16:4; 2 Thess. 2:8, 9; Matt. 24:24). In Matthew 7:21–23, Christ warns us that many shall come in the last days, preaching, casting out devils and performing many miracles (acts of healing and others) and he shall tell them, *'Depart from me, ye workers of iniquity, for I never knew you.'* Some of these are today 'doing good', preaching powerful messages in pulpits around the world, drawing huge followings, performing miracles of healing, casting out devils, *(slaying in the spirit)* and telling the people that it is all in the name of the Lord. But Christ knows those that are his and they shall be known and judged by his Word. *'Beloved, believe not every spirit but try the spirits whether they are of God; because many false prophets are gone out into the world'* (I John 4:1).

Likewise, anyone who claims to be holistic and who claims to perform acts of healing on the whole man—body, mind, soul and spirit—is claiming something which only the Spirit of God is able to do. Acts of healing of the body only, are within the power of Satan and his followers but Christ's healing was more spiritual than it was physical and involved the spirit of man as well as the body. This, man, in his natural state, just cannot do and neither can Satan.

Conclusion

It is the task of every Christian physician to understand the philosophy of healing to the best of his ability and to conform, as much possible, his treatment protocol to his patient's needs, that his procedure, remedy, and advice, will best help the patient's spirit bring about healing to his physical body. May we learn how better to relate on a spiritual basis with those around us. Only then can we become

true godly holistic healers, body *(helping the physical body)*, mind *(giving comfort to the troubled soul)*, and spirit *(leading some to know the Lord Jesus Christ and our God, the Creator of all mankind.)*

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Glenn M-Hultgren DC is a practising chiropractioner and a member of the center for Bioethics and Human Dignity

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Brian Brock, MA

'The Death of Ivan Ilyich' and the Resuscitation of Christian Medical Ethics[1]

Surely an era in Christian medical ethics has ended when a figure as central to its renaissance as Stanley Hauerwas announces his scepticism at its usefulness, 'Where has this all gotten us? Not very far.'[2] Stephen Lammers has echoed this sentiment, adding that 'one of the tragedies of the standard account of bioethics is that it is hard pressed to talk about the life of the professional'.[3] There is no doubt that both hit the mark. The Christian medical ethics 'industry' has reached a terminus precisely because it cannot address the actual life of the medical professional.

But to say that Christian bioethics has reached an end point is not to say also that it has been unsuccessful or is without a bright future. There is room to hope that the dead end reached by the Christian medical ethics 'industry' will ultimately prove to be an instructive and enlivening detour in the thought life of Christian medicine and academia. After an examination of the successes and failures of medical ethics, I will offer several suggestions for new directions in the field. As with every sagging intellectual project, the intellectual project called Christian medical ethics must maintain its hard won lessons as well as embracing a set of fundamental changes.

Often such reorientations of thought begin with a new angle on old questions. In this case I must be explicit: I write as a moral theologian, seeking to understand the problems of ethics in many fields, including medicine. One of the strengths of medical ethics is that, by focusing on particular concrete problems, it has forced moral theologians to think more deeply. This benefit to theologians begins to look more like a project parasitic on medicine if in return moral theologians do not provide real and workable suggestions for medical practitioners.

In the service of my desire to shed light on the problems of Christian medical ethics from a slightly different angle, I will utilize resources from an unexpected quarter of the Christian tradition: the writings of Leo Tolstoy. Particularly appropriate for our discussions is his 1886 short story, 'The Death of Ivan Ilyich'. The story is rich in commentary on the practice of humane medicine, but this will be left to one side for the time being.[4] What I hope to illustrate by looking closely at Tolstoy's narrative is the inadequacy of Christian medical ethics as it has been pursued, and also to suggest the type of questions which might provide Christian medical ethics with a new lease of life. This new lease will, of course, require the inevitable period of disorientation as Christian ethicists grapple with the implications for their work, evaluating their task anew.

Tolstoy's 'Ivan Ilyich'

In this short story Tolstoy focuses on the inner life of the dying civil servant Ivan Ilyich. Born in mid 19th century Russia, Ilyich aspires to a career in the civil service. In this pursuit, the strict and dutiful Ilyich studied law and earned top honours at university. His diligent study was rewarded with a fine legal position which was soon eclipsed by the even greater fortune of being named an examining

magistrate. Though pleased with this good luck, and intoxicated with the power that it affords him, Ilyich finds the day to day routine of the job rather boring. In an effort to reduce the boredom, he finds himself streamlining his day's work, cutting out any inessential personal interaction. This change makes time at his judicial bench a more painless affair which was, above all, pleasingly efficient.

Enlightened, liberal, well-bred, and finding himself entering the heady world of respectable society, Ilyich is eager to make the right social moves. Applying his energy to the observation of the highest social convention, he weds the charming Praskovya Fiodorovna, because it is, he believes, what 'persons of the loftiest standing looked upon as the correct thing' (114)[5]. Unfortunately, living the married life is not as easy for Ilyich as getting married had been, and he soon realizes that his wife's increasingly shrill demands for his company impinge on his jealously guarded pastimes. His refusal to curtail his evenings playing the card game whist evokes increasing rancour from Praskovya. This problem, he feels, is easily resolved, and he applies the same streamlining process learned at the judge's bench, withdrawing from his wife into a sphere of clinically efficient aloofness.

For 17 years this marital and professional arrangement continues, but its precarious equilibrium is upset by Ilyich's being passed up for an unexpected promotion. The disappointment of the missed opportunity prompts a family holiday to the countryside where, 'with no official duties to occupy him, Ivan Ilyich for the first time in his life experienced not merely *ennui*, but intolerable depression, and decided that things could not go on like that . . .' (118). Firmly determined to regain his lost fortunes, Ilyich heads for Petersburg, 'with a single object in view, to obtain, a post with a salary of five thousand roubles' (119).

Much to his delight the trip is successful and a fine position secured. Notifying his family (still on holiday) of their good fortune, he begins the process of making ready for their arrival, securing a 'charming apartment' and setting about decorating. Ilyich becomes engrossed in refurbishing the house, during which he slips on a ladder and sustains what he believes to be a minor bruise on his side.

Ilyich's efforts over the house are rewarded in the delighted faces of the family upon their arrival in Petersburg. Each family member soon settles happily into their new upper-class existence. Ilyich, too, finds the routines of work a comforting daily engagement.

> He fell instantly into his well-worn harness and prepared to deal with petitions, inquiries in the office, the office itself, and the sessions . . . In all this the thing was to exclude everything with a sap of life in it, which always disturbs the regular round of official business, and not to admit any sort of relations with people except official relations, and then only on official grounds . . . His pleasures where his work was concerned lay in the gratification of his ambition; his social pleasures lay in the gratification of his vanity; but his real delight was playing whist (123–124).

But this comfortable new arrangement was also not to last. On the demand of his wife, who complained of his increasing irritability, Ilyich is examined by a doctor to discover the source of the unknown abdominal pain (stemming from the seemingly innocuous blow to his side while decorating) about which he had been complaining. The routine of the doctor reminded Ilyich of his own pleasant professional routines. He and the physician were on common ground—professionals engaged in serious business.

> To Ivan Ilyich only one question was important: was his case serious or not? But the doctor ignored this misplaced inquiry. From the doctor's point of view it was a side issue not under consideration: the real business was the assessing a floating kidney, chronic catarrh or appendicitis. It was not a question of Ivan Ilyich's life or death but of a floating kidney or appendicitis. And this question the doctor, in Ivan Ilyich's presence, settled most brilliantly in favour of the appendix, with the reservation that analysis of the urine might provide a new clue and then the case would have to be reconsidered. All this was to an iota precisely what Ivan Ilyich himself had done in equally brilliant fashion a thousand times in dealing with persons on trial. The doctor summed up just as brilliantly, looking over his spectacles triumphantly, gaily even, at the accused. From the doctor's summing-up Ivan Ilyich concluded that things looked bad, but that for the doctor, and most likely for everyone else, it was a matter of indifference, though for him it was bad. (127)

Ilyich's foreboding that his condition is serious is heightened by his wife's constant harping on the fact that his sickness is becoming a terrible burden on his family and friends. The unceasing mental irritations provided by his body and his wife produce in Ilyich a creeping, black awareness that his whole life is poisoned. Nonetheless, he tells himself that his sickness will pass, that he must keep hold of his emotions. Largely unsuccessful at this task, his sense of anger and despair grow as he watches life going gaily on for those around him.

Ilyich's internal struggle to keep thoughts of his mortality at bay grow into an all-consuming mental task. Arguments, diversions, games, anything to keep the truth in the background, anything to forget the 'fact that I lost my life here over that curtain, just as I might have done storming a fort. Can it be possible? How terrible and how ridiculous! It cannot be! It cannot be, but it is!'(139).

As the months wear on the sickness steals his vigour and appearance, just as it had stolen his peace of mind. His comfortable life gives way to special tasteless foods, unseemly evacuation procedures, and a string of visits from respected, but maddeningly patronizing medical specialists. All this could be tolerated, he feels, except the gnawing fact that the pain is becoming intolerable now, and constant.

In this condition of isolated suffering, the ministrations of the young peasant servant Gerassim appear as a godsend. Due to Gerassim's peasant kindnesses, Ilyich comes to realize that he is pitied in his humiliating state by a genuinely caring soul. The true human interest offered by Gerassim so calms Ilyich that he soon begins to reflect on the differences between himself and Gerassim.

> What tormented Ivan Ilyich most was the pretense, the lie, which for some reason they all kept up, that he was merely ill and not dying, and that he only need stay quiet

> and carry out the doctor's orders, and then some great change for the better would result. But *he* knew that whatever they might do nothing would come of it except still more agonizing suffering and death. And the pretense made him wretched; it tormented him that they refused to admit what they know and he knew to be a fact, but persisted in lying to him concerning his terrible condition, and wanted him and forced him to be a party to the lie . . . many a time when they were playing their farce for his benefit he was within a hair's breadth of shouting at them; 'Stop lying! You know and I know, that I am dying . . .' But he never had the spirit to do it. The awful, terrible act of his dying was, he saw, reduced by those about him to the level of a fortuitous, disagreeable and rather indecent incident . . . and this was being done in the name of the very decorum he had served all his life long . . . Gerassim alone told no lies; everything showed that he alone understood the facts of the case, and did not consider it necessary to disguise them, and simply felt sorry for the sick, expiring master (143).

In the simple honesty of a peasant who cleaned up after his dying body, the pretence of Ilyich's life is exposed, leaving him clinging to the comfort he found in Gerassim and wondering where he had gone wrong. His sense that his whole life had somehow been wrong becomes an ever greater torture. How could he, he thinks, have lived wrongly when he had never once transgressed social convention? 'But however much he pondered he could find no answers. And when the thought occurred to him, as it often did, that it all came of his not having lived as he ought to have lived, he at once recalled the orderliness of his life and dismissed so strange an idea' (154).

Try as he might, he is unable to reconcile 'so strange an idea' with the simple humility of the peasant Gerassim, whose comforting presence keeps forcing the impossible truth upon him.

> It occurred to him that what had appeared utterly impossible before—that he had not lived his life as he should have done—might after all be true. It struck him that those scarcely detected inclinations of his to fight against what the most highly placed people regarded as good, those scarcely noticeable impulses which he had immediately suppressed, might have been the real thing and all the rest false and his professional duties, and his ordering of his life and his family, and all his official interests might all have been false. He tried to defend it all to himself. And suddenly he realized the weakness of what he had been defending. There was nothing to defend. (157)

The shock of being faced with his own misspent life overwhelms the dying man and his anguished screaming fills the apartment for the last three days of his life. His agony, he knows, is the results of his being caught vice-like between his own impending death and his insistence that his life had been lived well in his scrupulous observance of the rules.

> . . . his agony was due both to his being thrust into that black hole and, still more, to his not being able to get right into it. What hindered him from getting into it was his claim that his life had been good. That very justification of his life held him fast and prevented him from advancing, and caused him more agony than everything else. (159)

Soon after Ilyich dies, his agony at an end.

Tolstoy's Challenge to Christian Medical Ethics

Tolstoy's astute narrative observations provide us with a strategic platform from which to critique contemporary Christian medical ethics. Immediately obvious to the reader of these disturbing passages is Tolstoy's skill at crafting a tale which confronts readers at a personal level. Tolstoy makes this move, at least in part, to impress upon the reader the true import of seemingly innocuous choices springing from unexamined beliefs. In this Tolstoy's approach was characteristic of his age, as Marx, Nietzsche, and Freud also unmasked the happy self-delusions of humanity. But unlike Marx, Nietzsche, and Freud, Tolstoy elsewhere makes it clear that he believed the true agent of this human self-delusion to be sin, revealed definitively by the work of Jesus of Nazareth. In this he stands firmly at the centre of Christian tradition.

Tolstoy's focus on human self-deception has far reaching implications for his ethical method. Tolstoy alludes to these implications in his opening lines. 'The story of Ivan Ilyich's life was of the simplest, most ordinary and therefore most terrible' (109). It is the ordinariness of Ilyich's life which Tolstoy reiterates, penetrating to the heart of the modern predicament. Tolstoy recognized, even from his early vantage point in the industrial age, that the evil of our century is promulgated and sustained by increasingly complex social systems. These social systems present certain rules and prohibitions which are then internalized by the people who work within them. These internalized norms then work to make institutional systems and the people within them into a single productive unit. Here lies the root of our critique of the current tack of Christian medical ethics: It has not yet addressed the predicament of Ivan Ilyich. Ivan was scrupulous about following the rules that society gave him, but in internalizing those rules he was in incremental steps led away from ultimate truth. On this basis we can make several observations.

First, Tolstoy's observations about social systems are teamed with a clear focus on these systems' implications for individuals. His stories betray an acute awareness that thought and social systems have daily import in the lives of individuals. Thus, to examine such stories with an eye for their lessons for Christian ethics, we must observe how Tolstoy chose to frame his ethical 'problem' using a broad rather than a narrow frame of reference. He asked not 'how would a good judge act when faced with this problematic situation?' but 'how does a well lived life look?'. His enlarged ethical scope allowed him to examine why certain ultimately destructive choices seem reasonable on a day to day basis. Tolstoy took the Christian insight that sinful human nature was the force pressing Ilyich to covet power, wealth and happiness, and showed how this drive, linked with social pressures, led Ilyich to embrace *specific communally sanctioned forms* of these ends. It was Tolstoy's thesis that Ilyich, like all of us, grasped at what he saw to be the

most readily available routes to these goals as they presented themselves to him in his social matrix. Tolstoy also rightly observed that some professions (such as medicine) present these choices much more pointedly than they are faced in many other occupations.

Like Tolstoy, Christians in medical ethics have taken an interest in the problem of the ethical life. But, unlike Tolstoy, they have chosen a much narrower format in which to do so. Christian medical ethicists have offered to Ivan Ilyich guidelines on how to properly adjudicate the tough cases at the bench. But even if Ilyich could have picked up a copy of the 'Christian Journal of Legal Ethics', (which seems likely given his preoccupation with following the rules) chances are slim that it would have deeply challenged his sense of professional propriety. It is not too much to say that the average medical professional would find most of what he or she might read in Christian medical ethics journals to be 'sensible ideas.'

Providing Ilyich with Christian thought which did not call into question accepted professional practice, would have done him a disservice. What Christian ethics has failed to take advantage of is the opportunity to examine 'those scarcely detected inclinations of his to fight against what the most highly placed people regarded as good, those scarcely noticeable impulses which he had immediately suppressed'. Failing to take advantage of this moment is to pass up an opportunity to expose the possibility of a real freedom from the internalized constraints of institutional systems. What has been offered instead is thoughtful, Christian advice about narrowly-defined problem cases, which strengthens rather than challenges larger illusions about reality. A mountain of case-specific advice would not actually have led Ilyich to a questioning of his presuppositions about his professional practice or his life. My point is that in not using cases to question the presuppositions of the medical profession, and with it all of western society, Christian medical ethics has become exactly the type of literature which solidifies the rule-guided self-understanding of the Ilyiches within medicine (and Christian ethics for that matter). It is what Barth was getting at in saying 'ethics is sin'.

Unlike Tolstoy's broad starting point for ethical critique, Christian medical ethics has with startling predictability confined its advice to the now repetitious litany of generic cases; artificial reproduction, abortion, genetic manipulation, the 'problem' of medicine in a multi-cultural society, etc. This narrow focus on specific issues is radically different from Tolstoy's focus on life attitude, teamed with his careful notation of the social conditions which exert pressures to internalize un- or anti-Christian presuppositions. Tolstoy was careful to note that Ilyich's *conscious* choices were made with utmost scrupulousness. But Ilyich's downfall stemmed from the multitude of choices he made or the basis of *unconsciously* accepted and unexamined presuppositions.

By noting that Tolstoy's critique began with a wide ranging social critique, I do not wish to deny the importance of examining specific cases. On the contrary, careful consideration of cases is essential for the development of a penetrating understanding of moral problems as they face the moral actor. In the field of medical ethics, clinical experience cannot be overrated. Without seeing the face of ethical problems as they present themselves to those who may have a chance to change medical practice, medical ethicists end up couching their arguments in ways that take no account of practical difficulties. Medical ethics literature is full to bursting with the type of advice that can be given without close observation of the *sitz im leben* of clinical life. The fact remains that the vast majority of medical practitioners and medical researchers have little input or control over the practice of research or codes of practice for the hot-button issues addressed in volume after volume of medical ethics journals.

We cannot simply discard, however, general thought experiment-type ethical deliberation. By thought experiment I mean the presentation of an abstract case (such as the low-birth weight baby with a 50 percent chance of healthy survival) the discussion of factors involved (probabilities, arguments for and against) and a conclusion on the basis of a careful balancing of factors based on a general principle. By filling medical ethics journals with this type of thought experiment-type case, a legitimate niche for Christian thought has both been detected and filled to capacity. But, having done so, Hauerwas' and Lammers' critiques press in on just this point with painful accuracy. They rightly lament that this niche has now been filled, and yet the average medical professional has found the practical tensions of medical society almost untouched.

This shortcoming admitted, it must be argued that Christian medical ethics *has* been successful in at least three major ways.

The Successes of Christian Medical Ethics

1. It cannot be denied that the practice of considering thorny medical issues has had a salutary effect as an intellectual exercise. In filling the thought experiment niche to its capacity, Christian medical ethicists have proved both their interest and zeal for tackling at least the theoretical aspects of the tough problems facing medical practitioners. The literature that has been produced has undoubtedly served as a support for those medical professionals with the time to read, understand, and apply its theoretical insights to their own medical practice. The work of medical ethicists has also proved a boon to those interested lay people and legislators who seek to make wise medical choices. This simple level of analysis is a foundational intellectual step to more complex analyses, and is both necessary and positive
2. A second benefit has been the attraction of Christians, especially Protestants, to the general discipline of Christian ethics. This cannot help but raise the level of thought in Christian ethics at large. An intuitive sense that all is not quiet on the front lines of medicine has led to an explosion of interest in the field,[6] thus attracting Christian minds to the general field of Christian ethics.

This success is a two-edged sword, however, as it has become obvious that this influx of interested parties has not led to a corresponding increase in ground-level observation of the problems as they present themselves to the practitioner. Christian bioethics in general survives on the precious trickle of material coming from

those who are either involved in medicine, or who take the time to shadow the demanding lives of medical professionals. The resulting glut of ivory tower reflection on medical issues validates Lammers' lament that medical professionals remain unaddressed in their day to day practice. Medical professionals are talked at, but not with.

3. The limited nature of these successes has served to reveal a serious weakness in Christian ethics at large. The feeling of ineffectiveness that Hauerwas voices reflects the realization that even having filled the niche which Christian ethics itself defined, it has failed to create the possibility of real social change. This failure makes apparent the tenuous nature of the link between this specialized realm of medical ethics and the whole vision of life which Christianity offers.

The advantage of reaching a dead end is that wrong turns can now be systematically tracked down. Because Christian medical ethics has not offered a holistic view of life, it cannot find the intellectual resources to offer distinctive solutions in the medical sphere. However, the situation is hopeful precisely because by not having solved the problems Christian ethics set out to solve, it is forced to revise its presuppositions. Christian ethics must start again by questioning its adherence to rationalist, liberal, autonomy-based, Hippocratic-do-no-harm, or benefit/burden canons of ethical reason. Without this rethinking its task as it has been conceived is at an end.

Having enumerated the somewhat bittersweet successes of medical ethics, attention to Tolstoy's approach hints that there may yet be a way forward.

Possibilities for New Directions in Christian Medical Ethics

1) A new life for Christian medical ethics will be secured as it changes the scope of the analyses pursued in Christian medical ethics. Tolstoy begins with a refusal to offer the Ilyiches of the world simple prescriptions for their day-to-day professional problems. He begins with a rejection of the foundational values which Ilyich considers important. Simultaneously offered with this rejection is a different way of perceiving the daily choices of life, exposing the pressure to conform in certain ways. If, for instance, we were to apply Tolstoy's point in 'The Death of Ivan Ilyich' to a single tenet applicable to the life of a physician we might say 'no matter what social pressures may present themselves, the tendency to value efficiency over human engagement is to be absolutely avoided.' Tolstoy's insight in that narrative is a powerful way of illuminating day-to-day decisions by pointing out their significance within a whole life. He does this by constant references to the social forces which shape our understanding of what constitutes a valid ethical problem and solution.

He accomplishes this change of scope by using a twofold method. He first develops a critique of the presumptions of polite society and secondly works to illustrate how these presumptions force actors into false dilemmas. The lesson for medical ethicists is that medical ethicists must become astute critics of culture at large, developing critiques of much larger scope. This critique having been formulated, the dilemmas of the individual actor must be analysed in detail, focusing on the temptations that present the moral actor *as they present themselves*. Dietrich Bonhoeffer notes that doing ethics in this way means drawing a distinction between 'ethical' and 'mundane' actions.

> Certainly there is a necessary time and place in human existence for the so-called 'ethical phenomenon', that is to say, the experience of obligation, the conscious and deliberate decision between something which is, on principle, good and something which is, on principle, evil . . . But precisely this proper delimiting of the place and of the time is of crucial importance if one is to prevent a pathological overburdening of life by the ethical, if one is to prevent that abnormal fanaticization and total moralization of life which has as its consequence that those processes of concrete life which are not properly subject to general principles are exposed to constant criticism, fault-finding, admonition, correction and general interference.[7]

Bonhoeffer's point is that discussions of 'ethical problems' and 'decisions' have their time and place, but that most daily decisions are not of this character. This does *not* mean, however, that Christian ethics must discuss each and every daily act in medicine, evaluating them in all their mundinaity, but as he points out, ethical 'decisions' are *always* culminations of mundane patterns of relating.

Taking this view, the new medical ethics must allow broad based social observation to create overarching critiques, which can then be applied not only in medical ethics but in other fields as well. We must develop critiques which help to expose the way institutions are made productive by their participants having internalized certain codes of action.[8] The irony of Hauerwas' recent pessimism is that in his most powerful essays he utilizes large scope Christian critiques of western culture to give startlingly fresh insight into medical practice.[9] Tolstoy, using this type of critique, reveals that the dilemmas posed by culture are often false dilemmas, which are not choices at all within an explicitly Christian frame of reference. I contend that it is these largely false dilemmas that have taken centre stage in the Christian bioethics literature, a problem caused by a narrow scope of moral analysis which accepts the constraints on moral questions imposed by cultural presuppositions.

Once again, Bonhoeffer's incomplete work on ethics clarifies the understanding of ethics at stake here. In his view, vocation is that place where the individual works for the good of the world by acting in support of or in opposition to its systems. After noting that modern institutional systems seem to restrict the freedom of an individual to act, Bonhoeffer acknowledges that it appears that freedom of choice and action to be so restricted in these systems that only the most senior industrialists and politicians can act freely.

> Yet it would be an error if we were to continue to look at the problem from this point of view . . . Even when free responsibility is more or less excluded from a man's vocational and public life, he nevertheless always stands in a responsible relation to other men . . . Where man meets

> man . . . and this includes the encounters of professional life—there arises genuine responsibility, and these responsible relationships cannot be supplanted by any regulation or routine.[10]

My point here is that a Christian medical ethics which does not set itself to the task of asking where medical people can actively influence social systems has only marginal usefulness.

There is a payoff in all this for the project of Christian medical ethics. When ethicists do attempt this task they come much closer to offering ethical analysis which has a possibility of offering true existential liberation to practitioners. By observing the actual dilemmas of practitioners, and attempting to discern the shape of the moral spaces where they are constrained to act by tacit assumptions, medical ethicists can be immensely helpful in pointing out the ways in which the practitioner's seemingly constrained moral action is actually open to revision. This is accomplished by exposing and critiquing the unexamined presuppositions which from the actor's point of view seem to preclude certain actions. It is precisely by leaving these 'blind-spot' moral spaces un-analysed that the momentum of the medical establishment is maintained despite the sound and fury of the Christian medical ethics industry.

The idea can be expressed in more practical terms by listing a few of the avenues of questioning which are suggested by such an approach:

One group of pressing and interlinked questions deal with the beginning of human life.

—How and why is cloning research funded? What larger social presuppositions make this type of research so compelling? On the basis of what socially acceptable presuppositions will the announcement of a human cloning be shrugged off by western society when human cloning is announced?

—What factors press infertile couples to assume that artificial techniques of reproduction are the most practical solution to their problem? What social ethos drives their choices, and can these forces be critiqued from a Christian perspective?

—Is there an intellectual linkage between researchers' high valuation of fetal/embryonic research, the strength of the fertility industry generally, and the increasing pressure to save every 'wanted' infant, no matter how premature and compromised?

—What is the genesis and rationale behind the *institutional* arrangements that simultaneously allow 23-week-old babies to be saved with the highest tech medicine and also aborted? What does the parallel, divergent growth of these institutions suggest about the way that medicine and society are organized to allow antagonistic parties to operate without impediment or contact? Does Christian ethics have a critique of institutions which diffuse such sensitive moral questions by constructing institutional systems which remove from practitioners the opportunity to have moral qualms?

A second group of questions arises from western medicine's relation to the death of the body.

—Why the consistent, persisting resistance of western medicine to investing in research in preventative medicine? Why, and on what grounds, are the more high-profile and expensive research programme being pursued, like organ xenografting, or artificial organ replacement? Is the expenditure of energy and intellect on research by the medical establishment defensible in relation to expenditures on primary care?

—How has the western medicine establishment come to see its focus as research into end stage treatments rather than producing and supporting thoughtful recommendations for social/political change conducive to cultural lifestyle revisions, which might reduce the occurrence of certain life-threatening diseases? Does Christian ethics defend or critique current practice?

A third set of questions revolves around the formation and steering mechanisms of the *culture* of medicine.

—Why do people, and which types of people, choose to enter medicine and medical research? On the basis of their reasons for entering, what can we understand about the choices that face them and the way they will be shaped by these early forces? What can Christian ethics offer as an alternative/challenge to such a demographic group, taking into account their starting presuppositions?

—How effectively are the best insights of the Christian medical ethics industry imparted to medical students at Christian medical schools? Is the form of the literature even conducive to such a project?[11]

Can Christian discussions of economics move beyond rationing? A fifth woefully unexplored wilderness is the economic superstructure of medicine.

—Many of these questions have economic facets: Can multi-million dollar experimental particle accelerators for cancer treatment be defended in a world where good nutrition is not yet globally available? Should this fact even be brought to bear when deciding to embark on a course of medical research? What social and institutional arrangements would keep such questions from being considered in serious discussion, and are these arrangements defensible from a Christian standpoint?

In the sixth and final sphere we find the subject matter of this paper. How does the Christian medical ethics industry think and work, and can its habits and recommendations be defended?

—The most interesting question yet to be answered is this: Why do so few practising medical ethicists have the proximity to the practitioner to observe these problems first hand? What makes it seem perfectly reasonable to offer 'thought experiment' type discussion to whole groups of practitioners whose institutional structures and personal ethos make any real implementation of the insights of these thought experiments highly problematic? What are the forces that have made the large-scope critiques I am suggesting so scarce in medical literature, and is the impact of these forces on the shape of medical ethics defensible from a Christian perspective?

The last question illustrates why this paper is of course itself just such a 'thought experiment' targeted for the medical ethics community, not the majority of medical practitioners. The real work of medical ethics is to search out the empirical facts regarding the above questions, to discover, for instance, why western Christian medical ethicists feel comfortable ignoring larger scope questions. Does it stem from a lack of access to practitioners? A distaste for clinical experience? A lack of time or resources? Medical ethics

cannot shirk gathering this data, either by painstaking literature examination or practical research.

To go beyond the relative usefulness of thought experiments, medical ethics will have to address people where they are, making intelligible the forces, presuppositions and choices facing them. This may at times mean revising the angle of observation of certain ethical problem areas. This may also mean rewording thought experiment type discussions to take into the account the perspective of the practitioner. Finally, the larger framework of the Christian life must be allowed to relativise the place of medicine altogether for the disciple who is prepared to follow Christ (cf. Luke 14:26–35).

2) We must examine this latter idea more closely. The new Christian medical ethics must see medicine as residing within a whole sphere of Christian life. The dead end of Christian medical ethics has revealed that the meta-ethical presuppositions of much of the thought of Christian medical ethics is not significantly different from predominating modes of moral thought. This points up the need for a re-Christianization of ethical methodology. As alluded to in the discussion of the third success in bioethics, the flagging of the bioethics project reveals that a re-Christianization of meta-ethics is essential in providing Christian ethicists with the distinctiveness to produce novel and penetrating insights. This distinctiveness is swallowed whole when Christian ethics accommodates itself to public discourse by confining itself to moral presuppositions which are 'acceptable in public discourse'.

By taking on non-Christian moral presuppositions, Christian ethics quickly finds itself in an extremely precarious position. Mirosalv Volf is right to say that Christian ethics exists in a shape or be shaped world.

> In contemporary, de-Christianized, pluralistic, and rapidly changing Western cultures, only those religious groups that make no apologies about their 'difference' will be able to survive and thrive. The strategy of conformation is socially ineffective in the short run (because you cannot shape by parroting) and self-destructive in the long run (because you conform to what you have not helped shape). A good deal of courage in nonconformity is needed to preserve the identity of Christian faith and to insure its lasting social relevance.[12]

As Volf hints, lasting social relevance is not all that is at stake—the viability of Christian thought as a whole rests in the balance. Karl Barth points out that the use of 'publicly acceptable' moral presuppositions ultimately subverts Christian theology altogether:

> . . . the fact has always had to be reckoned with that an independent ethics has always shown at once a tendency to reverse the roles, replacing dogmatics as the basic theological discipline, absorbing dogmatics into itself, transforming it into an ethical system with a Christian foundation, and then penetrating and controlling biblical exegesis and pastoral theology in the same way. Since independent ethical systems are always in the last resort determined by general anthropology, this inevitably means that dogmatics itself and theology as a whole simply becomes applied anthropology.[13]

If Barth is right in his claim that Christian ethics must be thoroughly and self-consciously theological, the Christian medical ethicists must come to terms with an occasional accusation of irrationality or unpracticality from critics. These charges become much more bearable when Christian ethics in general rests secure in having done the hard work of placing medicine within a full-orbed view offered by a thorough understanding of the Christian life. Christian medical ethics must accept the pressing need for christological first principles of ethics, and admit that 'do not harm' simply will not do. The choice can only be between seemingly publicly indefensible first principles and maintaining a faith with any unique content.

Conclusion

To renew Christian medical ethicists' flagging enthusiasm demands a renewed interest in the experience of the medical practitioner. It must find itself deeply concerned with practitioners having to face a possible 'Ilyich experience' just by being part of a medical system in which certain options are systematically excluded, and others urged.

This will demand a change of scope of ethical analysis, while keeping firmly in mind the way in which problems present themselves to the practitioner. Christian medical ethics must develop large-scale critiques which will make sense of the daily pressures which practitioners are subjected to, but may or may not perceive. It does little good to offer solutions to the perceived problems of practitioners if the framework that the problems assume is indefensible when judged in the light of christological first principles.

Likewise, in neglecting to give a full critique of the ethos, presuppositions, and institutions of western society, Christian ethics limits its ability to offer substantively Christian solutions. The evils of modernity are faceless, corporate and banal in practice. If Christian ethics is to say anything distinctive it must move beyond its infatuation with abstract analyses of problems and toward an understanding of the practice of Christian ethics as both a calling and as a unique part of the Christian academic responsibility for offering a full-orbed view of actual Christian existence, which includes the lives of medical practitioners.

In the short term this policy will undoubtedly prove disconcerting to practitioners (like Ilyich) used to instant advice on practical questions. The pressures of time, finances and lives in the balance are so great that they understandably clamour for simple practical resolutions. But if Tolstoy's tale has taught us anything, it is that succumbing to cheap answers at the point of such pressures is the direct route to ruin of the soul. In *both* keeping practitioners in mind, and moving their analysis to a more wide ranging level, Christian medical ethicists must have the courage to take the large detour into meta-ethics which is necessary to lay the groundwork for *workable* practical advice at a future point. This tension is inevitable and ultimately good, but the bewildering sense of lost bearings it creates should not be underestimated. Ultimately, when Christian medical ethics has freed practitioners to see the forces which bear on them, and has exposed unexamined internalized imperatives with the light of Christian faith, the practitioner will have been handed a tool much more far reaching than specific advice for a narrowly conceived medical dilemma.

In the final analysis, medical ethicists themselves are prone to the very formalism which led to the ruin of Ilyich. Christian medical ethics must take place with a wholehearted concern *for* the goods and the freedom of those facing the seductions of the ethos of the age. A Christian church, fighting *for* the world must be prepared to heed 'scarcely detected inclinations' before it can rightly 'fight against what the most highly placed people regarded as good'. To do ethics is necessarily to be concerned with the plight of people, and to offer a door behind which lies true Christian freedom. Christian ethics has filled one niche in this pursuit, but much remains to be done by those with a commitment to love of the neighbour that dares to question the neighbour's presuppositions, and a love of self which attempts the same.

References

1. I am indebted to Agnetta Sutton, Martin Wendte, and Andrew Cameron for helping me to clarify the argument presented here.
2. Stanley Hauerwas, in Allen Verhey Ed., *Religion and Medical Ethics* (Eerdmans, 1996), 80.
3. Ibid., 34.
4. Tolstoy illustrates the physician's temptation to focus on the diagnosis rather than the patient, gives an insightful psychological catalogue of the mental and spiritual experience of terminal disease, and graphically illustrates the anti-euthanasia advocate's contention that a lonely death is worse than death itself. The entire story can be read also as a sustained reflection on the social roles and pressures of the professions.
5. Tolstoy, Leo, *The Death of Ivan Ilyich*, trans. R. Edmonds (Penguin, 1960).
6. Part of the attraction to the field is the perception that medical ethics is on the front lines of the perennially raging 'culture wars'. Thus the fittingness of the military metaphor. Ironically, the pacifist Hauerwas can't give up the metaphor either, playing it up with his camouflage coloured dust cover on the likewise militantly titled *Dispatches from the Front*.
7. Dietrich Bonhoeffer, *Ethics* (Macmillan, 1955), 265.
8. This is the type of critique that Micheal Foucault deploys in his instructive *History of Sexuality*.
9. For example, Hauerwas critiques western attitudes toward the handicapped, and applies his Christian conclusions in penetrating fashion to medicine and society at large in 'Part Three, "Caring" for The Mentally Handicapped,', found in his *Suffering Presence*, (Notre Dame, 1986).
10. Dietrich Bonhoeffer, *Ethics*, (Macmillan, 1955), 251.
11. For one answer to this question see my 'The Coherent Institutional Philosophy, Myth, or Mandate? An Ethnography of Faculty, Worldviews at a Christian University', with Johnny Ramirez in *The Journal of Research in Christian Education*, 5(1) (Spring 1996), 3–32.
12. Miroslav Volf, 'Theology, Meaning and Power', in *The Future of Theology: Feschrift for Jergen Moltmann* (Eerdmans, 1996), 100.
13. Karl Barth, *Church Dogmatics*, 1.2 (T&T Clark, 1956), 782–783

Brian Brock, MA, is presently pursuing doctoral studies at King's College, London, England

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Richard C. Eyer, D.Min.

Is the Code of Ethics of the American Medical Association Ethical?

The American Medical Association was founded in 1847 under the original name of National Medical Association. In part, harbouring less than noble reasons for its creation, it appears to be founded to a large degree on self-interest, *'for the protection of their interests, for the maintenance of their honor and respectability, for the advancement of their knowledge, and the extension of their usefulness'*.[1] The specific intent was aimed at the exclusion of quacks which were understood to be homeopathic doctors and apothecaries. An article in the Journal of the American Medical Association recounts:

> The introductory remarks constantly emphasized quackery and the duty of physicians to stamp it out. 'Physicians, as conservators of the public health are bound to bear emphatic testimony against quackery in all its forms', even when masked as philanthropy or religion . . . *Ministers of the gospel often 'give their countenance, and at times, direct patronage, to medical empirics'*. And Apothecaries, through sale of 'quack medicines and nostrums', often seem allied to 'empirics of every grade and degree of pretension'. The fight against quackery was an important part of medical ethics.[2]

The Code of Ethics of the American Medical Association is an outgrowth of the attempt to maintain control of the practice of medicine. The Code claims to be in the tradition of the Hippocratic Oath, but it has gone much farther than that and is in constant flux. The Code of Ethics has undergone many revisions since the founding of the AMA, changing already in 1903 and more recently in 1996. An editorial for August 5, 1996 in JAMA reports, 'The AMA's Code of Ethics today is a constantly evolving document that serves as a contract between physicians and their patients. Responding to current trends, the code is developing new boundaries for the business of medicine.' This editorial comment in JAMA, although intended as a compliment, raises some red flags regarding the purpose of a code of ethics.

First, that the standard for moral behaviour with reference to the Code of Ethics should change according to

'current trends' makes one wonder whether doctors are expected to abide by the Code or whether the Code is to be adapted to the practices of doctors. If the Code is a standard to live by it seems a strange matter to revise the Code to conform to the behaviour that is obviously beyond the limits set by the Code. The same editorial elaborates, 'the ethics which govern it [AMA] must keep pace with [that] progress'. How interesting that moral behaviour in medicine *should* change and that such change is necessarily seen as 'progress'.

Second, it will not come as any surprise to most that the word 'business' has replaced the word 'profession' in reference to medicine. What is a surprise is that the medical profession should boldly acknowledge the word. It would seem that the same self-interest that founded the AMA in 1847 is alive and well in the 1990s. Lester King MD, writing in JAMA in 1982, reports that physicians at the founding considered themselves a 'superior class' with a 'definite obligation to maintain the honor and dignity, a sort of noblesse oblige that rested on status'. Perhaps it is for this reason that membership in the AMA is declining among young doctors who feel differently about the status of their profession. In spite of this decline in membership and the fact that the AMA represents only half the doctors in America, the Courts continue to recognize the AMA as representative of physicians in America in making judgements on ethical questions in medicine.

In many ways the issue of control seems to have guided the founding and the continuance of the American Medical Association and its Code of Ethics rather than a genuine concern for the moral behaviour of its physicians. The criteria for physician acceptance into the AMA in the early days at times came to rest on his *belief more* than his *educational* level. '. . . the AMA code, ignoring the educational deficiency of many of its members, stressed orthodoxy in medical beliefs'. The political nature of the AMA is inherent in its foundations. It would appear to be a highly politically motivated organization even today as evidenced in its boast that it is the final appeal by the courts in matters of ethical/legal decision-making. If this is true, then the need for 'keeping pace with trends' seems all the more expedient lest the AMA lose status and control for its own political aggrandizement.

Arthur Caplan, writing in JAMA 1995, says, 'Up until 1995 the AMA Code had far more to do with matters of etiquette and professional comportment than with substantive matters of morality.' He claims that it was in 1980 that the first significant revision of the Code appeared identifying the new Principles of Medical Ethics that exceeded the norms that ought to be followed by physicians in private practice 'into the much more murky ethical waters'. Caplan concludes, 'The AMA has grown feisty, ornery, and even courageous.' One's appreciation for the courage of the AMA must depend on one's appreciation of the ethical directions in our culture today. I, for one, do not believe our culture, much less medicine, is headed in a direction that makes ethics anything more than expediency glorified.

In March of 1997 the American Medical Association met in Philadelphia to 'celebrate American medicine' by celebrating the 'common bond that has linked physicians over the year—our professional code of ethics'. The object of celebration was the latest revision of the Council on Ethical and Judicial Affairs (1996–1997 edition), *Code of Medical Ethics: Current Opinions with Annotations*. The 'annotations' are legal judgements establishing the practice. There are no moral judgements throughout the Code. Although the Introduction to the Code contains a disclaimer that ethical and legal may not be equivalent, it is clear that *ethics* for the AMA has, for all practical purposes, become a synonym for *legal*. The Code bears little resemblance to Aristotle's meaning of the word *ethics* as moral character development. In the remainder of this paper I propose to run through some of the more controversial aspects of this Code of Ethics.

The principles of medical ethics identified in the prologue of the Code of Ethics is a general appeal to the physician to provide *competence, honesty, responsibility, respect for patient's rights, continued study, provision of appropriate care, and participation in the* AMA. Although laudable, these Principles are also vague. Most significant is the highlighting of 'patient's rights' as an indicator of the value placed on autonomy. The best illustration of this is found in the first ethical issue taken up in the Code, abortion. It is boldly stated, against Hippocratic tradition, that 'The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion . . .' The ethical justification is cited as the Supreme Court ruling in 1973.

The issue of patient autonomy spreads quickly to the other end of life's spectrum when, five pages later, the issue of end of life decision-making is addressed. Under 'Futile Care' there is an attempt to place limits on patient autonomy when it infringes on the physician's interests. The physician is not obligated to meet all patient demands when, in his judgement, such demands are futile. Denial of treatment on the basis of futility is to be based, not on clearly defined meaning of futility however, but on the general Principles of the Code. In former times of moral conviction this may have worked, but in today's world of economic interests and moral relativity the Code's Principles are an empty guideline.

Human Tissue Research

Under 'Commercial Use of Human Tissue' informed consent, full disclosure of business arrangements, and the sharing of profits with the patient guide the physician's role. Under 'Fetal Tissue Research' full activities are condoned with provisions to safeguard 'the best interests of the fetus'. What this means is not explained. Although there is, from time to time, an attempt at expressing moral concern, moral caution seems to be based more on uncertainty of outcome than on the deontological issue of right and wrong. But this is the state of the art in ethics today and it ought not surprise us to see this appear in a substitute *Hippocratic* Code.

Gene Therapy

As so often happens in the Code of Ethics moral judgement seems to be tentative. This is evident in the section 'Gene Therapy' in which physicians are cautioned provisionally against support for germ line cell therapy. 'Because of the far reaching implications of germ line therapy, it is

appropriate to limit genetic intervention to somatic cells *at this time.*'[3] There is no indication of anything sacred about the make-up of a human being. We simply need to take cautionary measures in altering such make-up. Caution is predicated in *ways and means* to address issues of concern rather than on a substantive understanding of what it means to be human as one created in the image of God; something physicians have tacitly respected in the past. This tendency to delay through merely 'cautionary concerns' reveals a tragic flaw in the Code itself. In order for a Code to have any objective force it cannot be constructed in anticipation of its becoming obsolete. Technologies may change, but morality doesn't. The idea of a Code, which is expected to deteriorate with age as the shock of new possibilities has worn off, is a mockery.

Caplan is amused when he reads of genetic enhancement of human characteristics that, 'genetic manipulation generally should be utilized only for therapeutic purposes. Efforts to enhance "desirable" characteristics through insertion of modified or additional gene, or efforts to "improve" complex human traits—the eugenic development of offspring—are contrary not only to the ethical tradition of medicine, but also to the egalitarian values of society.' Caplan comments, 'Seems to me a professional association that includes among its members cosmetic surgeons, sports medicine experts, and psychoanalysts is going to have a hard time plausibly arguing that improvement and enhancement are goals outside the historical moral ethos of medicine.' In the end, approval of germ line therapy will depend not on moral criteria, but on utilitarian criteria and satisfactory cautionary measures.

Genetic Counselling is also addressed by the Code of Ethics. There is firm insistence that genetic counselling should be required as part of physician protocol. Anticipating physician resistance to this directive on moral grounds the Code says: 'Physicians are *ethically obligated* to counsel prospective parents' and in doing so to 'avoid the imposition of their personal moral values'.[4] It is an example of postmodern authoritarianism that the authors of this Code can demand 'ethical obligations' while *limiting* the physician from acting/speaking from his own ethical/moral perspective. In effect, the physician is obligated to abide by the ethics of the Code which prohibits the Physician from speaking morally.

Continuing in the section Genetic Counselling, there is what amounts to an attempt to de-humanize the child conceived by referring to it not even scientifically as an embryo but as a pre-embryo. This newly designated, politically correct designation is created by those who wish to de-emphasize the accepted understanding of an embryo as the first stage of human development. Traditionally, an embryo is the pre-fetal stage up to three months when the term fetus is used to describe the developing child. But what is a pre-embryo? This is the new politically correct language like 'product of conception' that arises from 'gamete providers' that is meant to de-emphasize the fact that this is, by any other name, a human *child* that has been conceived.

Genetic screening, genetic selection, and abortion are given approval with only cautionary words about patient autonomy and consent. Moreover, credence is given to the validity of allowing 'social policy' to determine the use of genetic screening for such purposes as sex selection, enhancement of characteristics, etc., 'The direction of future genetic screening tests should be determined by well-thought-out and well-coordinated social policy'.[5] Again, social expediency and political correctness seems to be the moral guideline offered by the Code.

In-Vitro Fertilization

The ethical biases of the Code are evidenced in the subject of In-Vitro Fertilization in the words, '*any fertilized* egg that has the *potential* for human life . . .'[6] The emphasis intended here is on the word 'potential', but it is the words 'fertilized' and 'human life' that strike us most at odds with the word potential. Clearly it is not a potential human life once it is fertilized, but a real human life. This is not an unfertilized egg, but a fertilized egg that is described as not yet human life. What species is it if not human? DNA studies have verified the presence of human DNA in the first union of cells. Or is this yet another attempt at deconstructing what it means to be human in order to create a definition that will conform to *whatever we choose to do with these matters we prefer not to think of as human?* Eugenics always has a way of re-defining some as 'non-human' when it comes to re-defining the human race.

'Gamete providers' is the term used in the Code to refer to what we formerly called 'parents'. But according to the Code, we become parents only when we *consent to bear responsibility for the child* we have conceived. How convenient! Now we can excuse 'gamete providers' for abandoning moral responsibilities and the children they conceive so long as they do not consent to take responsibility for them. Although the authors of the Code may not have intended this social outcome, the Courts will surely be guided by it. The Code has contributed to the demise of the family as the basis for all social and political structure,

Although claiming to have rejected eugenics, the Code also proposes it. Under Pre-Embryo Splitting physicians are told, 'Couples might wait until they can discover the mental and physical characteristics of a child before transferring a genetically identical sibling for implantation.'[7] Identifying choices parents might make, the Code continues, '[couples might] sell their frozen pre-embryos (later the Code says, 'the sale of embryos can and should be prohibited) . . . or they might decide to . . . harvest the child's tissue.' Is this a slip of the Freudian tongue when the word 'child' is used or has someone taken 'responsibility for the gametes they provided'?.[7] Has the 'pre-embryo' become a 'child' only because someone wanted it? But if we now are speaking about the possibility of killing one 'child' in order to harvest organs for the use of its sibling is this ethical by anyone's criteria? In confusing nonsense we are given assurances that 'it is not evident that a sibling would have negative psychological or emotional consequences from having acted as an organ or issue donor'. One might amend that statement by adding, 'especially if it costs that donor sibling its life to do so!'

Euthanasia and Assisted Suicide

The issue of euthanasia is addressed in the Code as unacceptable. However, it is defined narrowly enough to enable

us to think of euthanasia only as 'the administration of a lethal agent . . . for the purpose of relieving the patient's intolerable and incurable suffering'. The subject of euthanasia is dispensed with in eighteen lines, one of which reads, '. . . to engage in euthanasia would ultimately cause more harm than good'. Does this imply that it might cause some good in the penultimate sense? Is the implication here that it is not so much a moral issue as it is a practical one. The practical issue, it is pointed out, is that it might confuse the role of the doctor as healer with the role of doctor as killer. Whereas this is a legitimate concern, one wonders whether keeping up with the pace of change in medicine as mentioned earlier in this paper might not cause change in the acceptance of euthanasia if it becomes expedient or is politically correct to do so.

Sexual Misconduct

In a final break with Hippocratic tradition the section, 'Sexual Misconduct in the Practice of Medicine' virtually permits sexual activity once the 'physician-patient relationship' is no longer 'concurrent'.[8] Why is it 'sexual misconduct' to be sexually active with one's patient? Answer, because it may 'detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment . . . and ultimately may be detrimental to the patient's well-being'. It is not unacceptable because it is morally wrong! Sexual activity is permitted if the physician-patient relationship is terminated. It must be assumed here that the doctor-patient relationship is a matter of contract and not of covenant. Covenants are not dissolved, except through faithlessness. But perhaps that is part of the problem. We no longer think of medicine as a covenant profession. We think of it in business terms.

Although it is good to spell out the problematic implications of sexual involvement with a patient, it is also unfortunate that an inevitability seems to be assigned to the possibility of sex between doctor and patient. Promiscuity outside the doctor-patient relationship is no longer a moral issue for the Code even when the physician continues to be a physician to others, if not to the former-patient-partner with whom he has just become sexually active. This must be seen as a sign of hope, for example, by physician psychotherapists who are closer to justifying sexual activity with patients, calling it *therapy* where neither 'confusion of roles', nor 'vulnerability', nor the 'well-being of the patient' is being violated. Morality seems to be a matter of definition, not of moral prohibitions based on absolutes.

Conclusions

The Code of Ethics of the American Medical Association follows the trends of society and has all but abandoned the Hippocratic Tradition. Although there may, on the part of some, be a well-intentioned attempt to define right and wrong and to set limits for physicians to follow, such ethics are built on a distortion of the Kantian notion of autonomy, the perversion of a Kierkegaardian existentialism, and the Machiavellian doctrine of expediency. More importantly, there is a growing credibility-gap between what the AMA now stands for and the Christian physicians who reject a purely utilitarian ethic which justifies itself in the name of 'progress'. Our Lord warned through the apostle Paul that 'in later times some will depart from the faith, giving heed to deceitful spirits and doctrines of demons, through the pretensions of liars whose consciences are seared . . .'[9] If Christian influence continues to decline in a postmodern age, so will the moral system that arose from it. And yet, Christians can address the deeper issues of ethics today with 'meanings' that are absent from the procedural approach to ethics that merely provides 'rights'. Individual physicians in Christian congregations need to be offered a Word of God that builds on the meanings of our life together in Christ. In Christ, we do not look merely for rules and rights to guide us, but we look to the deeper mystery of having the image of God restored in us by grace, through faith. In Christ, we look to the meaning of grace that frees us to live faithfully when ethical dilemmas must be addressed and there are no easy answers. We can, nevertheless, as God's people with a nobler message, be a light in the darkness of medical ethics today.

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Richard C. Eyer, D.Min., is Assistant Professor of Philosophy at Concordia University Wisconsin, USA.

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Robert D. Orr, M.D.

A Clinical Ethics Perspective on Assisted Reproductive Technology

Infertility is a common problem in modem western society, currently affecting 10–15% of marriages in the U.S. Approximately 40% of the time it is the man's problem, and 60% of the time, the difficulty is in the woman's anatomy or physiology. Many social factors have led to an increase in this affliction, including delayed childbearing, the use of contraception, multiple sexual partners, and sexually transmitted diseases. The absence of children from marriage has been exacerbated by the relative dearth of babies available for adoption in the U.S. since the abortion laws were overturned in 1973.

Infertility has always been painful. It was even viewed as a curse in biblical times. Sarah, Rebekah, Rachael, Manoah's wife, Hannah, and the Shunammite woman all suffered psychologically and spiritually because of their barrenness—but they all eventually did bear children, praising God for his miraculous intervention. The pain of infertility continues today. In fact, the pain may be even greater for the modern woman because she has the choice of using assisted reproductive technology (ART). If she chooses to use ART and it does not work, her pain is magnified from yet another disappointment. If she does not have access to ART or chooses not to use it, her pain may be magnified as she sees others who achieve ART success.

There are many methods used to help an infertile couple bear a child, including artificial insemination (from husband or donor), in vitro fertilization (IVF), intra-fallopian transfer, embryo transfer, intra-cytoplasmic sperm injection, and surrogate motherhood. All of the methods have in common the issue of using the gametes (eggs and sperm) from the infertile couple, or the option of using donor sperm, donor eggs, or both.

The technique used for artificial insemination was developed in the 19th century. However, it was not commonly used until the 1960s, and even then it was not talked about very much. ART exploded onto the scene, however, with the 1978 announcement by Drs. Steptoe and Edwards (Cambridge, England) of the birth of Louise Brown, the first person born as a result of successful IVF. Almost lost in the jubilation was the fact that these ART researchers had experienced over 500 failures—over 500 eggs had been successfully fertilized in the lab, but had not resulted in birth.

Since 1978, the ART 'industry' has mushroomed. In the U.S., about 48,000 ovulation cycles were used in 1995 at over 300 infertility centres in attempts to produce a baby. Since ART services are not covered by most health insurances in the U.S., the $10–15,000 cost per IVF cycle must most often be born by the infertile couple. And because IVF is successful only about 20% of the time, it has been estimated that the cost per birth for an ART baby ranges from $44,000–$800,000.[1] ART is big business; business eagerly sought by infertile couples with financial means. Laurie Zoloth-Dorfman, from San Francisco State University, has said that 'ART is an odd mixture of unrestrained desire, the unfettered marketplace, and the seduction of experimental technology'.

Regulation of the Art Industry

Because of the unique features of ART—which separate it from much of the practice of medicine—some have suggested that the ART industry needs to be regulated.[2] There are certainly moral questions raised by many of the techniques used, such as the use of donor gametes, research with embryos, and the financial and societal complications of surrogate motherhood. This alone would be sufficient reason for regulation. But in addition, there is considerable potential for, and unfortunately significant history of, abuses within the industry. Abuses range from false advertising and multiple impregnations from a single donor to breach of contract and misappropriation of eggs.[3]

But how could this industry be regulated? It would be possible to regulate the practice itself, and this has been done in many jurisdictions. Regulation ranges from truth in advertising requirements to the banning of specific procedures, such as surrogate motherhood. Alternatively, some regulatory oversight could be achieved by refusing or limiting payment for specific procedures.

Even if there were societal or professional consensus on the need for regulation, which there is not, who would do the regulating? It could be done locally by the individual clinic or institution, such as by the development of practice protocols, policies, and guidelines. Or it could be done by one or more professional bodies. For example, the American College of Obstetrics and Gynecology (ACOG) develops technical bulletins and opinion statements on many issues, including issues of ART. The American Society of Reproductive Medicine (formly the American Fertility Society) has produced 'Ethical Considerations of ART',[4] and it has joined with the ACOG to establish the National Advisory Board on Ethics in Reproduction (NABER), an

independent public policy organization which also develops position statements. In addition, the Society for Assisted Reproductive Technology (SART) in 1990 developed a registry of ART outcomes which uses standardized methods of measuring programme success rates.

A third option for regulation of ART is by the government. In the U.S., states would probably exert control over practice since it is part of the practice of medicine, and the federal government could exert some regulation by controlling funding. There is quite a spectrum of government regulation of ART in other nations; Germany is the most restrictive, the U.K. is the most tightly regulated, and the Italian government is the most liberal, although the medical profession in Italy has promoted tighter regulation.

Ethical Issues in Art

There is a large variety of ethical issues involved in ART. Some of these involve basic questions, and others are more specific. The basic questions in ART ethics include: Is infertility a disease? Is there a right to reproduce? or to conceive? or to deliver a baby? or to raise a child? What is a family? What is the moral status of individual gametes? of pre-implantation zygotes? of embryos? of the fetus? or even of the father?

While some would claim an unlimited right to reproduce, it is clearly a 'bounded liberty', in that there are obvious limits. There are biological limits, e.g., a woman without a uterus cannot reproduce. There are moral limits, e.g., incest is universally proscribed. There are legal limits, e.g., there are laws against rape and polygamy. There are personal limits, e.g., some individuals refuse to participate in reproduction, even with their spouse. And clearly, there are currently in our society economic limits, e.g., couples living in poverty will probably not have access to ART.

The concept of family and parenthood is clearly a moral concept. While some parents may consider their children to be their possessions, it seems more ethically appropriate to consider parenthood to be a privilege and a responsibility, i.e., a responsibility for rearing, nurturing, teaching, civilizing.

Leon Kass, in stating his position that infertility is not a disease, notes that the very words used by a society in speaking about having children are revealing of evolving attitudes. In ancient Israel, children were 'begotten', indicating the transmission of life from father to son. The ancient Greeks spoke of genesis or generation of children, indicating a springing forth of new life. Pre-modern Christians spoke of procreation, suggesting that life was given by a Creator. And moderns speak of reproduction, suggesting this act is our own work of creation, comparable to that of a machine.[5]

In addition to these basic conceptual questions, there are many specific questions which are constantly evolving as technology changes. These specific questions focus on the gametes: sources, methods of obtaining, storage, selection/distribution, manipulation, and access.

Sources of Gametes: For some, the need for the male to masturbate in order to obtain semen is a moral issue. For many, the use of donor sperm or donor eggs raises even greater problems. Does this intrusion of a third party into the reproductive process fundamentally change it from procreation? Or does the ability to produce a child with genetic relationship to one of the parents outweigh this problem? Does it make a difference if the gametes are truly donated out of love, or whether they are 'donated' for money?[6] It has been proposed to use eggs from aborted fetuses, or even from an Inca cadaver which had been frozen in a glacier for 500 years.

Gilbert Meilaender believes that the use of donor gametes 'destroys precisely those features that distinguish procreation from reproduction. Lines of kinship are blurred and confused; the child begins to resemble a product of our wills rather than the offspring of our passion; and the presence of a child no longer testifies to and embodies the union of her parents.'[7] In addition to this basic issue, of course, are added concerns about the transmission of disease, accidental (or intentional) use of the wrong person, risk of donation (e.g., the hyperstimulation syndrome in egg donors), and the availability of genetic information. There is also concern that this asymmetrical parenthood may place stress on a marriage. In addition, some adolescents or adults who result from gamete donation go through significant emotional trauma in searching for their 'real' father or mother.

Storage of Gametes and Zygotes: Sperm banks have been developed in which semen can be frozen for later use. One such bank was set up by Nobel laureates so that their, presumably superior, genetics could be passed on. Others have been established for the use of men who must undergo sterilization for cancer therapy, or men who are terminally ill and want their widows to have the option of having a child at a later time.

The fate of unused frozen zygotes is also a moral issue for many. What should be done with frozen zygotes when they are no longer needed (successful ART) or no longer wanted (divorce, death)? Some advocate their destruction. Others believe that each zygote is a unique individual and should be protected and nurtured. There have even been proposals that embryo adoption services be made available so that unused frozen zygotes can be given to infertile couples.

Selection/Distribution of Germinal Material: When multiple gametes are available, the professionals involved in ART must select which one or ones to use. Is it possible, and is it ethically justifiable, to use morphology as a selection criterion, presuming it is a proxy for quality? The number of embryos to implant in each IVF cycle raises questions. The more implanted, the better chance for success, but also the greater the chance of multiple pregnancy which may, in turn, threaten the integrity of all of the new lives.[8] Many programmes restrict the number to 3 or 4. Others will use more and recommend fetal reduction (i.e., abortion of a portion of the pregnancies) if high-order multiple gestation results.

Is it morally justifiable to select sperm or embryos by their sex? While most oppose pre-implantation or prenatal sex selection because of the fear of sex discrimination, is it justified if the goal is to prevent a sex-linked disease or condition (e.g., hemophilia, muscular dystrophy, colour blindness), or to permit sex balance within a family?

Manipulation of germinal material: And, of course, when we are manipulating gametes in order to achieve prgnancy, questions arise about their further manipulation

to treat genetic disease or even for genetic enhancement. It is possible to test an early embryo for some genetic diseases without destroying its integrity, which then allows a decision by the parents about continuation of the pregnancy. It is also theoretically possible, after identification in the embryo, to change the genetics of the somatic cells (i.e., non-germ cells) in some instances to prevent expression of a disease in that individual (e.g., thalassemia). While many are willing to accept this therapeutic genetic manipulation, even more are morally uncomfortable with the idea of changing other genetic characteristics in order to enhance the individual (e.g., increased height or intelligence). And the idea of changing the genetics of the gametes themselves (germ cell) in order to alter permanently the genetic heritage for all time frequently raises concerns of perpetuating lab error, as well as the claim of 'playing God' even when the effort is to eliminate a dread disease.

Access to ART: It is clearly a matter of distributive justice whether ART should be available to all or only to those who can afford it. Should it be a covered health insurance benefit? Should this benefit be mandated for all, or may it be used as a marketing tool for some health plans? Beyond this question of economic access, should ART be available to unmarried individuals or couples? to homosexual individuals or couples? to post-menopausal women?[9]

It is not only ethical questions which have been raised by the new assisted reproductive technologies. Many issues and conflicts have gone to court for legal adjudication, including the 'ownership' of frozen embryos, the identity of proper parents, the enforcement of preconception contracts, the elements of informed consent, and many others.[10]

Ethical Precepts and Principles in Art

It is a truism in secular medical ethics that 'the ability to act does not justify the action'; just because we can do something does not automatically mean that we should do it. This requires ethical analysis of any technology. There are several principles available in secular ethics which can give guidance in this analysis. The principle of non-maleficence requires that we assess ART to ensure that we do no harm. The principle of beneficence requires that we ensure that we are doing good with the use of our available technologies. The principle of fidelity requires that we are faithful to, and do not abandon, an individual patient. The principle of justice requires that we treat like individuals alike. And the principle of autonomy requires that we allow individual patients to make informed choices. This autonomy principle is often said to give rights to patients. We can split those rights into negative rights (the right to be left alone) and positive rights (entitlement). Most ethicists agree that negative rights have a greater claim than positive rights; i.e. while a patient may choose to forego a specific treatment, that does not automatically translate into a right to demand another treatment.

Application of ethical principles to concepts or specific situations is a matter of drawing lines between what is acceptable and what is unacceptable. This idea of drawing lines often raises questions about a 'slippery slope', a concern that if we permit acceptable action A today, that may lead to pressure for permitting unacceptable action B in the future. This is easy to envision in relation to ART. If we accept IVF today, using donor gametes, why not allow surrogate motherhood tomorrow? It is just a minor extension of the technology.

Of equal or even greater concern to the Christian, however, is the question of who is allowed to draw the lines in society? If I believe that a particular application of ART is unacceptable, e.g., a lesbian couple having a child using donor sperm, based on my concept of marriage and family, should my scruples be applied to someone else who has different values? Who sets the standards?

In addition to these secular principles, Christians have several other principles derived from scripture which we should apply to the questions raised by ART. *The sanctity of life*—each individual is a unique creation by God from the moment of conception; casual or callous disregard of the life within the zygote, embryo, or fetus is an affront to him. The *sovereignty of God*—God has ultimate authority. *The fall of humankind*—we live in a sinful state, and God allows us to make choices which fall outside his will. *Dominion*—God has given us authority over some aspects of nature. *Stewardship*—we are, individually and collectively, responsible for how we use our bodies, talents, and resources. *Family structure*—God has ordained the union of one man with one woman for the purpose of procreation. *Adoption*—God has provided for our adoption, and he recognizes the need for adoption to compensate for some results of our living in a fallen world.

Many Christian denominations have developed position statements on ART or on various aspects of ART. There is not unanimity. The longstanding Roman Catholic position has been that the conjugal act has both unitive and procreative meaning, and the two cannot be separated. This conservative position effectively prohibits most ART. Some denominational position statements, such as that of the Seventh Day Adventist Church, focus on the biblical principles involved, giving general guidance without specific proclamations on specific modalities. Others take a definite stand on specific modalities. In Appendix A can be found the position statement of the Christian Medical and Dental Society, a group of about 10,000 evangelical Christian health care professionals. It outlines relevant biblical principles, and categorizes specific modalities into those which they believe are consistent with God's design, those on which they cannot speak with certainty, and those which they believe are inconsistent with God's design.

Conclusion

Currently available technologies used in assisted reproduction raise difficult ethical questions on which there is a spectrum of opinion among secular thinkers, and even a disparity of opinion among conservative Christians. Rapid and nearly unstoppable advances in this field ensure that this will be fertile territory for continued ethical scrutiny.

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Robert D. Orr, M.D., is Director of Clinical Ethics and Associate Professor of Family Medicine at Loma Linda University, Loma Linda, California, USA.

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Steven A. Long, Ph.D.

A Conflict of Interest in Reproductive Medicine

The establishment of a special class of health provider has followed the legalization of abortion in the United States. These women's reproductive health centres (WRHCs) have three defining characteristics, which also distinguish them from traditional women's health care providers.

First, while many of these clinics provide various health care services, such as pap smears, testing for sexually transmitted diseases and cancer screening, these procedures represent an insubstantial part of their services. WRHCs deal nearly exclusively in birth control sales and abortion services. For many clinics, these two activities account for over 90% of clinic income.

Second, this focus allows the WRHC to employ a minimum number of physicians to serve multiple clinics. One WRHC in the State of Iowa, USA, with which I am familiar, has sixteen clinics with only one physician. Disease treatment and surgical procedures (except for elective abortion) are normally not part of patient care so specialized training in women's health care—including OB/Gyn—is rare.

Third, WRHCs assume the role of expert human sexuality educators, soliciting public schools for opportunities for presentations. The content often includes:

- information on the use of birth control and where to obtain it.
- advocating abortion as one solution to a problem pregnancy.
- saying that sex is good when you are ready and responsible.
- detailed information on sexual practices presented to children as young as six.

In this article I will argue that these WRHCs have a conflict of interest. Specifically, a WRHC worker acting as sex educator generates a conflict of interest between obligations to the clinic and the obligations to the health interests of children, parents and the public.

What is Conflict of Interest?

Identifying conflicts of interest is a tricky business. A judge who accepts a bribe from the defendant in an upcoming trial has a clear conflict of interest. Who does she serve? The interest of justice or the interest of the accused? In a real sense, once she accepts the bribe, she is obligated to both (though one obligation has a certain illegitimacy). But what about the practice of elected officials accepting money from special interest groups? Isn't this a clear case of conflict of interest, too? Some people might say 'yes', since the money could sway a vote contrary to the obligation to the electorate. Other people would argue that this is not a true conflict of interest because the amount of money accepted from any one individual is small. In addition, the electorate benefits from the transaction because the funds are used for informational campaigning.

In large part, conflict of interest is determined by particular moral standards, codified into law, about acceptable business practice. Generally a conflict of interest occurs when a person has two or more interests that, if pursued, will have a detrimental or unjustified effect on one of the parties or another individual. And often one of the interests is illegitimate (as in the case of the bribe).

I suggest the following conditions as collectively sufficient to generate a conflict of interest. These requirements help us determine cases of conflict of interest not codified into law and are relatively non-controversial. I will not further argue for their soundness, but merely stipulate them here to provide a starting place for our argument. In these criteria the agent is a participator in a role and the principal is the group, person or interest to which the person is obligated.

1. *The agent must function in two or more roles or be obligated to two or more principals (and a public aspect often exists for at least one role).* Imagine that a politician who has been chosen to oversee a government banking policy committee is also on the board of directors of a large

bank. Our politician has a dual obligation. First, he is obligated to the people he represents; second, he is obligated to the bank and other directors.

2. *The agent's obligations in one role conflict, or potentially conflict, with obligations in one or more other roles.* Suppose our politician is in the position to repeal a banking regulation that would favourably impact bank profits. Suppose also that this regulation protects banking customers from usurious interest rates. In such a situation the legislator has an interest or obligation to benefit his banking associates (as a member of the bank board of directors); yet he also is obligated to the electorate (as a legislator).[1]
3. *There is the potential for the agent to exploit the conflict of interest illegitimately for personal interest (or the conflict manifests itself in unfair or inappropriate acts).* Crucial to establishing a clear case of conflict of interest is the potential for abuse. Would a judge who accepts a bribe be tempted to rule unjustly? Probably, and that is why it is illegal. Would a supervisor be tempted to favour unfairly a subordinate employee who is also a relative? Perhaps, and most companies have policies prohibiting relatives from being in direct supervisor/employee roles; the potential for granting unfair advantage is clear, even with the best intentioned boss. Likewise, it is easy to imagine our banker-politician advocating legislation to improve his own financial standing at the cost of the people. Clearly this is an illegitimate (and possibly illegal) use of power, as is taking a bribe.
4. *Divesting oneself of one or more roles is possible.* Business ethicists draw a distinction between 'conflict of interest' and 'conflicting interests'. The latter arise in situations in which any choice we make is bound to violate one of more of our *unavoidable* obligations. An Ethics 101 classic case crudely illustrates this type of dilemma: Suppose a crazed man with a bloody axe knocks on your door and asks if Uncle Bob is at home. You could be faithful to your moral absolutism responding 'Yes, he's upstairs', but risk facilitating personal harm to Uncle Bob. Or you could lie, violating your ethical standards. In this case you have two legitimate interests: to protect the health and well being of Uncle Bob and to preserve your integrity. Each interest is legitimate, but any choice is bound to violate one interest.

We are confronted with these types of ethical dilemmas (though without such drastic consequences) on a daily basis and there is no moral wrong inherent in having conflicting interests such as these. In contrast, *conflict* of interest involves ethical dilemmas created by one or more roles that can and should be abandoned. In other words, conflicting interests are unavoidable ethical dilemmas, but conflicts of interest are moral wrongs that can be avoided. Our politician has a conflict of interest because the roles he fills are elective. He could refuse to serve on the banking committee or resign his board position. Failure to do so constitutes wrongdoing because failure to divest oneself of the roles that leads to the actualization of a conflict of interest constitutes wrongdoing.

The Case of Women's Reproductive Health Centers

If we apply these four criteria to a WRHC sexuality educator, given the distinctives I have outlined above, a clear case of conflict of interest can be established. The first condition is clearly satisfied for the WRHC worker who conducts sex education classes in the public schools. There is little doubt that the sex educator has a special obligation to children, parents and society. As a clinic representative she has certain obligations to her employer (as any employee has). Thus the WRHC worker has dual obligations.

The second condition is satisfied as well. There is a potential conflict of obligation in at least two areas—in the promotion of clinic products or services and in the discouragement of teen sexual activity. The first area of conflict is not unique to WRHCs in the medical field. We see this same type of conflict when a physician is part owner in an independent testing lab to which he refers patients. Here the fiduciary obligation to the patient and market or financial obligations of the physician potentially conflict. Ordering a multitude of tests provides the opportunity for lucrative income, but may not be in the best interests of the patient.

The WRHC educator is in a similar position when promoting birth control and abortion in a high school context. With the title 'sex-education expert' comes tremendous responsibility and obligation to teens, teachers, parents and the public. But one may also reasonably claim that the educator has a special obligation to the WRHC's financial interests, as any employee would. So the prospect of a clinic sex-educator recommending products or services that the clinic provides is problematic, because we are never quite sure whose interests are being served. This conflict of obligation for the physician/testing facility owner and the WRHC sex educator is magnified by the vulnerability of the client—an ill patient or an impressionable minor are in a poor position to discern the correctness of the recommendation. Each will probably trust the 'expert' judgement.

The second area of potential conflict of obligation concerns the discouragement of teen sexual activity. Two distinct and well-recognized philosophies of sexuality education exist in the public schools. One emphasizes abstinence until marriage as socially responsible and in the best interests of the child—and claims success in reducing teen sexual activity. The second equates responsible sexual behaviour with 'readiness' and advocates the use of birth control—and claims success in increasing condom usage, but not in decreasing sexual activity. The efficacy of each of these two approaches is hotly debated (and we haven't the space to pursue that issue here). For the sake of our argument, though, it doesn't really matter. If *any* educational approach reduces teen sexual activity—whether abstinence based or not—then there is a potential conflict of obligation for the WRHC sex educator. I take it that a decrease in teen sexual activity is desirable, since there would be corresponding reduction in teen illness, unplanned pregnancy and other undesirable social consequences. So working to decrease teen sexual activity is arguably an obligation for a sex educator in the public schools. But one may also reasonably claim that the clinic

representative has an obligation to promote the self-interests of the clinic, namely, to add to the client base of the clinic. And this can be achieved only by finding new currently sexually active women or encouraging more abstainers to become sexually active.

The unique distinctives of the WRHC create this conflict for the sex educator; the sexually abstinent rarely need birth control or abortions. So the WRHC sexuality educator has two choices: teach in such a way to potentially reduce the number of sexually active clinic clients, or avoid instruction that might reduce teen sexual activity and potentially increase the clinic client base. Since the sexuality educator cannot encourage abstinence without potentially decreasing the clinic client base, and therefore clinic income, and since the clinic educator is also obligated to the clinic, the obligations of the role of sex educator conflict with the obligations of the role of WRHC employee.

Once a conflict of obligation has been established, the next question is, 'Is there a potential for abuse of roles?' The third condition specifies this abuse as personal financial gain, unfair or inappropriate acts. It is reasonable to assume that sexuality educators can and do change behaviour. In fact, the project of comprehensive sexuality education in the public schools is premised upon the idea that behaviour can be modified (i.e. If we teach about disease and condom usage, kids will curtail dangerous behaviours). Since the sexuality educator can change behaviour, the potential for abuse is obvious. Certain behaviours benefit the WRHC financially; others do not. What would keep a sex educator from pursuing a course of education that increases the level of teen sexual activity? Several former clinic operators have stated that this was exactly their method of operation. As one WRHC clinic director put it, 'We knew that if we could teach about sexual practices, condoms and other forms of birth control in the early grade school years, they would become sexually active. And when they wanted birth control, or needed an abortion, they would come to us.'[2]

Notice that I am not claiming that every, or even most, WRHC sexuality educators do this. All I am saying is that the potential for abuse exists—and that is all I need to establish. Note too that I need not establish bad motives on the part of the sexuality educator. Conflict of interest sometimes involves intention, but more often concerns the potential for abuse of the role. If the potential exists—no matter how noble the person—there is a conflict of interest.

The last criterion for conflict of interest is that it is possible to give up one or more of the roles. Clearly WRHC employees need not be sexuality educators. If she is convinced that this is her calling she could resign at the clinic and pursue her interest through some other health provider or agency. Clearly, then, there is sufficient reason to believe that WRHC sexuality educators have a conflict of interest.

A Critical Objection

Now someone might argue that health education—even sex education—is a normal and acceptable part of medical practice, and as such, violates no standard of what is appropriate or fair. Hence no conflict of interest exists. After all, other medical providers conduct health education in their area of specialization. For example, the cancer unit at the local hospital may host seminars on breast cancer detection and risk reduction. This type of education is a common practice for medical providers. Yet, to my knowledge, no one has argued that the cancer unit educators have a conflict of interest. This is the case, even though the cancer unit may benefit financially from the practice, let's say, by selling more breast X-rays. Far from being inappropriate, many people believe that the hospital is obligated to teach about these issues. Since the WRHC's field of specialization is sexual health, why couldn't the WRHC offer similar public education—sex education—without conflict of interest?

In part, we have already answered this question. The key point is that the potential for abuse (the third condition described above) exists for the WRHC in a way that it does not for the traditional medical provider. Two key differences between the WRHC and traditional medical providers defuse the comparison between them:

1. Traditional medical providers treat illness or injury; the WRHC provides services for a form of behaviour.

The fact that WRHCs service a form of behaviour affects the application of basic ethical principles shared (presumably) by all medical providers. Let's assume that health care workers have and feel a duty to increase health, and will do nothing intentionally to cause illness of injury.[3] This ethical inclination prevents the breast cancer educator from doing anything to increase the risk of the disease (and increase the number of clients). In fact, health education governed by this ethical inclination will almost always reduce the client base, because people are encouraged to avoid risk factors.

In contrast, this ethical inclination to promote wellness is not sufficient to keep a WRHC worker from illegitimately encouraging sexual activity, since sexual behaviour is not a disease. At best this ethical inclination may cause the educator to encourage 'safer sex' or 'responsible sex'.

And there is little doubt that this message can only financially benefit the WRHC through the sale of birth control and a potential increase in teen sexual activity.[4] Thus the ethical inclination to promote wellness is not sufficient to prevent abuses by WRHC workers.

The fact that WRHCs service a behaviour can also make a difference in the way new clients are generated. Traditional medical providers can do little to increase the incidence of illness or injury. At best, then, they can increase the number of clients by encouraging the already ill to seek treatment. In contrast, WRHCs can increase the number of women needing their services by increasing the number of sexually active women through sex education. As I have already argued, sexuality education can affect behaviour. So the sex educator can generate clients in a way that a breast cancer educator never could. In fact, if a breast cancer educator could and did increase client base by increasing the number of women with the disease, public outcry would be great. Yet this is exactly the type of abuse we find with WRHC employees also adopting the role of sexuality educator.

2. Traditional medical providers offer a much broader range of services than the typical WRHC.

The potential for abuse for the WRHC sex educator is multiplied when one considers that the clinic would not

exist (at least in its present form) without sexually active clients. Any significant increase or decrease in sexual activity among women in general—or even a subgroup, such as teenagers—is likely to affect clinic income since they serve the sexually active almost without exception. Even if a traditional medical provider could increase incidence of disease or injury, the financial impact on the business would be minor since their range of services is typically much greater than the WRHC.

Notice that I am not arguing that the WRHC has no legitimate interest to market their services. I will grant that health providers have a legitimate interest in marketing their services (even non-profit hospitals have a bottom-line of income that must be maintained). I will also grant that health education can and should be part of the total health care services of a medical provider. Ultimately, the real question is not whether the health education benefits the medical provider by increasing the client base; the central issue is whether or not the health education in question has significant potential for abuse. And that I have established in the case of WRHCs.

The bottom line is that organizations that stand to benefit so greatly from sexually active teens should not be teen sexuality educators. As Joseph Margolis points out, 'Where a community recognizes a substantial conflict of interest arising within a relationship of explicit roles, it is reasonable to forbid the relationship to be occupied'.[5] Such should be the resolution of this conflict. We would not permit a large cigarette manufacturer to lead a teen anti-smoking campaign in the public schools. Neither should we allow WRHCs to run public teen sex-education programmes. To do so is to put the worker in a position of conflict of interest and the students at risk.

References

1. Note that the legislation in question is a realization of an existing conflict of interest. The dual roles, not the legislation, create the conflict of interest.
2. From a private conversation with Carol Everett.
3. I acknowledge that some crazed individuals do harm patients, and that others may act from less than altruistic motives. Still I believe that the promotion of wellness is the ethical norm for health care workers.
4. This is confirmed by the WRHC's penchant for comprehensive sex education over a true abstinence approach.
5. Joseph Margolis. 'Conflict of Interest and Conflicting Interests', in *Ethical Theory and Business*, Tom L. Beauchamp and Norman E. Bowie, eds. (Englewood Cliffs, NJ: Prentice-Hall, Inc.), p. 369.

Steven Long is currently Director of the Spring Arbor College, Metro-Detroit Center, Dearborn, Michigan, USA, where he also serves as Assistant Professor of philosophy.

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Agneta Sutton, M.Phil.

Is the Human Embryo Our Neighbour?

'It was you who created my inmost self and put me together in my mother's womb' (Psalm 139). The Psalmist wrote this long before *in vitro* fertilization was thought of and long before the advent of cloning. However, the line just quoted, raises a number of questions concerning the status of the early human embryo, among them the question of whether the human embryo created in vitro is more than research material. It raises the question of whether the embryo—whatever its provenance—can be described as a human being before it has embedded itself in the lining of the maternal womb or before it has developed the so-called primitive streak. It raises the question of whether the early human embryo is our neighbour. More generally, it raises the question of the grounds on which human life deserves special respect.

Let us assume for a moment that it is incorrect to talk about a new human being or a new human life before implantation or before the development of the primitive streak—or before some other stage in the development of the embryo or fetus. On that kind of assumption, many of the objections raised against IVF and cloning for research purposes are irrelevant. If human life begins only at or after implantation or the development of the primitive streak or later, then the fact that the creation of embryos *in vitro* means that many human embryos will waste and perish is of no moral importance. If the early embryo is but a blob of tissue, then research involving the destruction of the early embryo is morally unproblematic. If (after the one-cell stage) there is a crucial cut-off point in the embryological life-process, such as implantation or the development of the primitive streak, at which human life begins, then there is no reason to object to the creation of embryos by cloning in order to produce various types of tissue for human repair by tissue transplantation—at least, provided the technique does not involve the annihilation of embryos developed beyond a certain stage.

Indeed, it would be very convenient for scientists engaged in embryo research and others interested in the development of cloning techniques for the purpose of tissue transplantation, if it were possible to come up with a convincing argument for saying that human life begins only at the primitive-streak stage or when the embryo has

truly embedded itself in the maternal womb and begun to receive sustenance from the same. But to throw the ball back into the court of those who would maintain that human life begins only at implantation or at the time of the appearance of the primitive streak or at some other stage or process in the life of the developing embryo: What grounds can they possibly have for making such a claim?

To start with implantation, if that is when human life begins, then the early embryo conceived in the womb is no more a human being than the embryo created outside the womb. But how could a process such as implantation relating to the environment and the source of sustenance of the embryo constitute a criterion on the basis of which to decide whether we are speaking of human life or not? Of course, implantation is an important stage in the life process of the embryo. It is certain that the embryo needs to embed itself in the lining of the maternal womb to receive nourishment. Likewise, the nine-month fetus needs to leave the restricted space of the maternal body to breath and receive new types of nourishment to continue on its life-journey. We all need a proper environment in which to thrive. We all need proper nourishment. The times of implantation and birth are important times marking changes of environment and nourishment needed for early human life to continue on life's journey. However, neither of them marks times of coming alive or becoming human.

The argument that the embryo is unable to continue living unless it implants itself in a womb is not a reason for denying that it is a human being. None of us can live without nourishment and without a proper environment. We need oxygen to breath. We need liquid and food. We can sustain only a certain amount of heat or cold and so on. The situation of the embryo ready for implanting, but denied a womb in which to do so, is similar to that of a starving person locked out in the cold and not allowed to enter indoors to keep and receive food. The person who is locked out in the cold is a human being even if he or she is not able to live to see another day. Likewise the human embryo locked out of the womb is just as much a human embryo as the one who is allowed in to grow and develop.

Nor does the development of the primitive streak signify the beginning of human life. There is only one significant cut-off point at the beginning of the life-process, namely the creation of a zygote, a one-cell entity ready to initiate cell division with a view to embryological development. I would not argue, however, that this cut-off point can necessarily be pin-pointed to a discreet moment. It is, however, certain—because it is tautological—that the human embryo—whatever its provenance—is an entity of human origin. Its humanity cannot be denied. Equally, dividing cells are clearly alive. And if we are speaking about human cells which are dividing in unison in a goal-directed manner so as together to become an entity able to implant itself in a maternal womb and pursue the path of embryological development, then we are talking about a human being in the early phase of life. The entity we are talking about may exist in a Petri-dish in the laboratory, it may float down the fallopian tube in the maternal body, it may not yet have developed a primitive streak, but it is a human being.

Before cloning was on the agenda, I used to argue that human life begins at fertilization. Today I would say that it begins with the creation of a zygote, a one-cell entity of human origin, which possesses a double set of chromosomes and the capacity to commence cell-division and start embryological development oriented towards the making of a child. And when I speak of the capacity for this kind of development, I mean that the entity will or would develop into a child and eventually a mature human being, provided it is in a hospitable environment, is receiving adequate sustenance and is not prevented by disease, accident or deliberate human intervention from growing. Nobody can deny that all of us may succumb to disease, suffer an accident or be deliberately killed at any stage in life. This applies to the child, the teenager, the middle-aged person and the old. It does not make any one of us any less human. The fact that the embryo may be prevented by disease or other misfortunes from developing any further, does not alter its human status. In particular, as regards the situation of the embryo that has not yet reached the primitive-streak stage and is prevented from doing so by human intervention, it is not unlike that of the fetus that is being aborted and prevented from being born. It would be irrational to deny that the aborted fetus was a fetus or a fetal human being. Likewise, it would be irrational to deny that the pre-primitive streak human embryo is a human embryo proper.

As to the many arguments which have been advanced in order to show that we cannot speak of individual human life before the primitive streak stage, none of them is valid. It has been argued that until the appearance of the primitive streak, the embryo might twin and that this proves that it is absurd to speak of individual life before then. Later it was admitted that the time-limit for twinning was probably a week earlier. Be that as it may, it does not really matter. For even the embryo that is to twin is a living human embryo, a living human being. That it might asexually give life to another like itself does not mean that it is not human life and not a human being. Another argument that does not hold water is the one to the effect that only some of the cells in the early embryo go on to become the fetus, while other cells develop into placental and other supportive tissue. The placental tissue is part of the organism growing within the womb. That some of the tissue is discarded at birth does not change this. Fetus and placental and other supportive tissue grow in unison in a goal-directed manner, and so as an integrated whole, that is a single organism. The arguments for denying human status to the pre-primitive streak human embryo are as feeble as the ones advanced in support of the claim that the pre-implantation embryo is but a blob of tissue, and thus quite different from the post-implantation embryo.

However, it is my contention that the question of when human life begins is not really what worries scientists and others willing to exploit embryonic human life for research purposes and for the production of human tissue for transplantation purposes. I suspect rather that those who are producing arguments to justify embryo research, on the ground that the embryo is not a human being, are doing so for opportunistic reasons. I suspect that they do so in order to convince the world that embryo research and the destruction of embryonic human life is unproblematic from a moral point of view, although they know that they are talking about nascent human life.

In other words, I am suggesting that for them as for us the basic question is: How much respect should we afford

the early human embryo, be it created ex or in utero? Arguments referring to processes or stages such as implantation or the primitive-streak stage are resorted to in order to deny that the early human embryo deserves to be protected from harm. But, from a moral perspective, these are arbitrary cut-off points in the embryological development. Human life deserves the same respect and protection at all stages of life. There is no morally relevant difference between a pre-primitive streak embryo and a post-primitive streak embryo—whatever its provenance. Likewise, there is no morally relevant difference between a pre-implantation and a post-implantation embryo—whatever its provenance. Indeed, there is no morally relevant difference between the fetus and the infant, nor between the infant and the teenager, and so on. Old and young deserve the same respect. Why?

For us Christians—and, indeed for all the people of the Bible—the answer is that human dignity and worth derives from our relationship with God. We read in the Book of Genesis:

> God said, 'Let us make man in our own image, in the likeness of ourselves, and let them be masters of the fish of the sea, the birds of heaven, the cattle, all the wild beasts and all the reptiles that crawl upon the earth.'
>
> God created man in the image of himself, in the image of God he created him, male and female he created them.
>
> God blessed them, saying to them 'Be fruitful, multiply, fill the earth and conquer it. Be masters of the fish of the sea, the birds of heaven, and all living animals on the earth' (Gen. 1:26–28).

Created in the image of God, the human being has a special relationship with God, conferring a special dignity on him or her. Created as master over the rest of creation the human being also has special responsibilities before God. Indeed, as a relational being created for a personal relationship with God and as master of the rest of creation, the human being is a covenant partner of God himself. On a Christian understanding, then, it is as relational beings, created in the image of our triune God and for union with God, that we human beings possess a special dignity. On a Christian understanding, it is because we human beings are created as relational beings in the image of the triune God and for union with the triune God that we are created for union and communion with our neighbour and so, should love and respect our neighbour and treat all human life as sacred.

On the basis of biblical revelation, we know that the human being is special compared with the other animals and the rest of creation and that it is made for personal communion. In Genesis 2:18, we read that 'it is not good that man (male) should be alone' and that for this reason God saw it fit to make 'a helper fit for him'. As John Paul explained at some length in his Wednesday lectures delivered between 29 September 1979 and 26 March 1980 ('Original Unity of man and Woman' in *The Theology of the Body*, published by Pauline Books and Media, Boston, 1997), the passage has two implications, one concerning man's uniqueness compared with the rest of creation, the other concerning the male-female relationship. The first is illustrated, in the book of Genesis, by the fact that God asked man to name the animals (cf., Gen. 2:19), which shows that the human being is superior to and the master of the animals. And the second is revealed by Adam's (the male's) joy at the sight of woman. That is to say, the latter connotes man's longing for a helper fit for him, another being like himself, yet unlike himself, and complementary to himself. It refers to our union-seeking nature in the image of the triune God. It points not only to human longing for human communion but to a seed of longing for union with God, a seed sown by God himself when he created us human beings as man and woman. Implicit in this account of the creation of man and woman, is the understanding that the human being is the only being whom God has made for himself and so has chosen as his covenant partner. It is as the only creature capable of a personal relationship with God that the human being is chosen as covenant partner of God.

According to this understanding, what makes us human beings unique and confers a special value on human life is our likeness to God as relational beings and our covenant relationship with him. It follows that human life is sacred at all stages. At no stage is human life more sacred or less sacred than at any other. 'Relationality' is not a trait that we develop at any particular stage. Created for personal relationships with God and neighbour, each one of us, all of us, are, from the beginning to the end of life, created as such. Human life, then, is sacred from the time it begins. The 'relationality' of which I am talking is not bestowed upon us by other human beings—though it should be respected by other human beings. Our 'relationality', in the image of the triune God, is bestowed upon us by God. It does not depend on whether we are accepted within the community or on how we are being treated by other human beings. In particular, the 'relationality' of the human embryo does not depend on its provenance. It does not depend on whether the embryo is created inside or outside the womb. The human embryo—whatever its provenance—possesses from the very beginning the same human dignity as the rest of us, and so deserves to be protected from harm just like the rest of us.

Having linked the concept of our 'relationality' in the image of God with that of covenant partner of God, I have pointed to our responsibility before God for the created world, including human life. As the only earthly creature capable of personal relationships, relationships which require intentional and self-conscious choice and action and recognition of other persons as persons, the human being is the only earthly creature who may consciously seek God or turn away from him, who may accept or reject the divine order of things. The human being is the only earthly creature who may seek out other persons for personal relationships. And it is because we humans are the only earthly creatures who have responsibilities before God and before other human beings, that we human beings are the only earthly creatures who have moral responsibilities.

As covenant partners of God and masters of all the living animals on the earth, including ourselves and our offspring, we are accountable—morally accountable—before God and neighbour for what we do to ourselves, to others and to the rest of the created world. The created world is not for us to dispose of in any manner at all. It is for us to

care for it, till the earth and love our neighbour. This is the will of God. And because 'relationality' in the *Imago Dei* is not a trait that we develop at any particular stage of life, even the early embryo is our neighbour. The early embryo is a member of the human family. It is one of us. It may not yet be able to relate to us, but we ought and should relate to it. The fact that many among us do not relate to the early embryo or to the fetus or to the old and senile, is an expression of alienation from God and neighbour; it is a sign of our fallen nature. It is a sign of our limited vision. More precisely, it is a sign and result of a dualistic understanding of the physical human person.

The dualist view colouring so many of our assumptions concerning human life may trace its origins to a Platonist idealism and to a Manichean vision of the material world, as one severed from a nobler spiritual world. Part of its genealogy may be found in the Cartesian division of body and mind, according to which the body is, as it were, inhabited and piloted by the real person of the mind. Partly, the dualist view of the human being may be traced also to the Boethian definition of a person as an individual substance with a rational nature. Implicit in all these accounts of personhood is an understanding of the human person as consisting of two separate parts, a material part and a mental/spiritual part. And this understanding which severs the body from the mind and/or the soul or spiritual self, fosters an alienating attitude towards early embryonic life, towards the severely brain-damaged, towards the old and senile and anyone who fails to display what we regard as typical personal characteristics such as rationality or self-awareness.

By contrast, a relational and holistic view of the human being fosters an inclusive attitude. On a Christian and Trinitarian view of ourselves as relational creatures, our 'relationality' is the expression of our spirituality. For it is as relational beings that we can be approached by and reach out to God, and through the grace of the Spirit relate to him, as children of Christ or members of the community of Christians. And on a holistic view of ourselves as body and spirit in one, we are both embodied and spiritual beings at once. In terms of a holistic understanding, if there is a human body, there is a human being, however undeveloped he or she may be. The body may not be fully developed or it may be in decline, and our mental capacity for union and communion may not yet be developed or it may have been lost, nevertheless, on the relational and holistic understanding of humanhood—according to which we are created as individuals for union and communion with God and neighbour—even those who have not yet developed rational characteristics, as well as those among us who have lost them, may and should be embraced by the welcoming love of our neighbours and be included in the human family.

Christ's dialogue with the Pharisees about marriage and divorce (cf. Mt. 19 and Mk. 10.) is revelatory in regard to the relational nature of the human being and our likeness to God as relational beings. That is to say, Christ's words 'For your hardness of heart Moses allowed you to divorce your wives, but from the beginning it was not so' (Mt 19:7), show that from the beginning God intended the spousal relationship between man and woman both to reflect the image and likeness of the loving Triune relationship and of God's faithful covenant with mankind—the main witness to which is the faithful relationship between Christ and the Church, as Paul tells us in his post-Pascal Letter to the Ephesians (cf. Eph. 5). Referring to the book of Genesis, and the beginning, Christ speaks about the indissolubility of marriage and refers to man and woman united in marriage as one flesh. Telling us that husband and wife are one, he tells us that it is in union and communion that we humans become whole. He tells us that a truly nuptial union is a union in the image of the Trinitarian union—and that our eschatological end is union with God. Pointing to the dual, male and female, embodiment of humankind and to the spousal union, Christ reveals anew our union-seeking nature and points the way to our perfection as beings in union and communion with God and neighbour. Also, as Paul explains in the letter to the Romans when writing about the redemption of the body, Christ's redeeming love is directed at man as body and spirit in one (cf. Rom. 8). On the relational and holistic understanding of the human being revealed in the Scriptures, our likeness to God, our salvation in Christ and our eschatological end are not qualities that we acquire at any particular stage in life in the way that we acquire rationality or some other characteristic typical of mature and sane human beings. On a Christian, relational and holistic understanding of the human being as created in the Trinitarian image, fallen and redeemed for union with God, human life deserves to be respected and protected at all stages of life from beginning to end.

Agneta Sutton is head of research at the Centre for Bioethics and Public Policy, London, England.

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Appendix A: Reproductive Technology

Preamble

The family is the basic social unit as designed by God. It is formed as a man and woman make an exclusive marital commitment for love, companionship, intimacy, and spiritual union. As a result of their physical union, children may be added to the family.

Children are a gift and responsibility from God to the

family. Parents are entrusted with providing and modeling love, nurture, protection and spiritual training. The inability to have children need not diminish the fullness of the family.

Infertile couples may choose adoption or seek medical care when they desire children. Adoption emulates God's adoption of us as spiritual children. Some reproductive technologies are an appropriate exercise of mankind's God-given creativity.

Certain reproductive technologies may present direct and indirect dangers to the family. As technology permits further divergence from normal physiologic reproduction, it increasingly leads to perplexing moral dilemmas. Not every technological procedure may be morally justified.

The principles which can guide the development and implementation of reproductive technologies include the following: First, conception resulting from the union of a wife's egg and her husband's sperm in the biblical design. Second, individual human life begins at conception; therefore God intends for us to protect it. Third, God holds us morally responsible for our genetic offspring.

Statement

CMDS approves the following procedures as consistent with God's design for the family:

Education about fertilization
Medical treatment (e.g., ovulation-inducing drugs)
Surgical intervention (e.g., for anatomic abnormalities hindering fertility) Artificial insemination by husband (AIH)
Adoption
In-Vitro fertilization (IVF) with husband's sperm and wife's egg, with subsequent: a. Transfer to uterus (Embryo replacement) b. Zygote intrafallopian transfer (ZIFT) Gamete intrafallopian transfer (GIFT)—Husband's sperm and wife's egg—Cryopreservation of sperm or egg

CMDS cannot speak with certainty about the place of the following procedures in God's design for the family:

- Artificial insemination by donor (AID)
- *In-Vitro* fertilization (donor egg or donor sperm)
- Gamete Intrafallopian Transfer (donor egg or donor sperm)
- Zygote Intrafallopian Transfer (donor egg or donor sperm)

  Reason: While there is no clear biblical support for the concept of the introduction of a third party, there is strong biblical support for the ideal of a family as defined in the preamble of this statement.
- Cryopreservation of embryos with specific safeguards*

  Reason: Cryopreservation raises the possibility of embryo destruction and preservation of excessive embryos.

CMDS opposes the following procedures as inconsistent with God's design for the family:

- Selective abortion for embryo reduction or sex selection
- Surrogate mother procedures
- Transfer of excessive numbers of embryos to a recipient mother
- Uterine lavage for embryo transfer
- Discarding of-embryos
- Non-therapeutic experimentation with embryos

Conclusion

CMDS affirms the need for continued moral scrutiny of our developing reproductive technology as it impacts the family. We recognize that as physicians we must use our creative capacity within the limits of God's design. Couples who suffer from infertility should be encouraged to seek pastoral guidance and counsel, as well as to pray for God's wisdom in the use of these technologies.

In this statement embryo refers to the conceptus from the moment of fertilization. We do not differentiate between the new term 'pre-embryo' and embryo.

*Guidelines for Cryopreservation of Embryos:

1. Cryopreservation of embryos should be done with the sole intent of future transfer to the genetic mother.
2. Embryos should be produced from the husband's sperm and the wife's eggs.
3. A limited number of embryos should be produced to eliminate cryopreservation of excessive numbers of embryos.
4. There should be preagreement on the part of the couple that if the wife becomes pregnant, all remaining frozen embryos will be transferred back into her at future times of her choice.
5. There should also be preagreement that in a situation in which the embryos cannot be transferred to the wife (e.g., where the wife dies or has a hysterectomy) they will be adopted by another couple who desire to have a child for themselves by having the embryos transferred to the adoptive mother.

Approved by the CMDS House of Delegates May 3, 1990. Toronto, Canada, Passed with a vote 4 of 63 in favor, 1 opposed

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Book Reviews

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Unriddling Our Times: Reflections on the Gathering Cultural Crisis
Os Guinness, Ed.
Grand Rapids, MI; Baker, 1999
ISBN 0-8010-5981-X, 141 pp, paperback $8.99

'If ever a generation needed a prophetic word', writes Os Guinness, 'it is ours' (p. 9). There is a gathering crisis in American society, he believes, which is rooted in the country's cultural order—the church, the family, the educational system, the arts and media. While prosperity seems to increase as never before (creating a society of rampant materialism), the gap between rich and poor widens. The ideology of postmodernism blunts the notion of truth and affects (among others) the educational, medical, and legal systems. A pluralistic society finds itself awash in an ocean of aimless spirituality in which the Christian church finds itself marginalized, ignored, or worse: 'the response of the religious right to the crisis is as much a problem as a solution . . .' (p. 9). The media increasingly portrays Christians as enemies of a tolerant society. And the list could go on.

Unriddling Our Times is not so much a book of answers as a call to reflection. There can be no Christian response to the forces at work in society unless Christians as a whole are to see, study, and understand those forces; to remember the lessons of history; and to recover the vision of Christianity as the only answer to the problems facing the world.

Part One discusses the 'unheeded messenger'—people whose words of warning were ignored, only for their message to be vindicated by the passage of time. Think of Jeremiah, Winston Churchill, and others. '. . . our own generation seems heedless of such warnings . . .' Guinness writes (p. 19). The foundations upon which America was founded have been eroded; personal autonomy has become the 'gold standard' for behaviour, and 'truth' has become relative and emptied of meaning. Guinness's brief essay on the need for modern prophets is followed by an extended extract from Nazi-resister Reinhold Schneider, whose 1937 novel *Las Casas Before Charles V*, while ostensibly about Spanish atrocities in the New World, was a hidden denunciation of Nazi activity against the Jews. Spanish priest Bartolomé de Las Casas has the courage to stand before the emperor and speak the truth of the evils he has witnessed. Who will do the same in modern society?

Part Two discusses the erosion of truth and the need to recapture it—because truth is 'essential to resist manipulation' and 'essential as a basis for freedom and fulfillment' (pp. 66, 67). Truth matters, and we redefine it or relativise it to our peril. As a demonstration of the power of truth, the remainder of Part Two is a portrait of Aleksandr Solzhenitsyn and his quest to reveal the true state of affairs of the Soviet Union.

Part Three is perhaps the most disturbing of all. How have the changes in the cultural underpinnings of society affected the people in it? Shirley Jackson's famous story 'The Lottery' is reprinted, followed by an essay by professor Kay Haugaard, who has taught the story in classes for years. Her 1997 essay concludes, 'No one in the whole class of more than twenty ostensibly intelligent individuals would go out on a limb and take a stand against human sacrifice . . .' (p. 141). In the final analysis, when all truth has been relativised and no one is in possession of moral absolutes and capable of judging, nothing—and no-one—is safe. No culture is superior to any other. Human life is of less value than 'tolerance' of other cultural-belief systems.

Where do these changes leave America? In a 'storm corridor', Guinness says. 'For Christians to take refuge in the coward's comfort of being right posthumously is for us to "miss our moment",' and there is no mistaking what Jesus thought of that. Responsible 'unriddling of the signs of the times is an urgent requirement of our day' (p. 12).

Guinness is no scare-monger; he freely admits that crises may build up only to pass away without disaster. *Unriddling Our Times* is thus a book to provoke thought; to encourage Christians to educate themselves about their faith and to re-embrace the foundations of that faith; and to understand at a deep level how the world differs. Most important of all, Guinness calls us to speak the truth to our world—whether it wants to hear that truth or not.

ANDREW M. SEDDON M.D.
Staff Physician
Deaconess Billings Clinic
Billings, Montana, USA

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Children's Rights Re-Visioned: Philosophical Readings
Rosalind Ekman Ladd, Editor
Belmont, CA: Wadsworth Publishing Company, 1996
ISBN 0-534-23532-8, 214 pp., paperback $29.95

This text is, overall, an excellent work in the field of human rights. Ladd has properly identified some of the most significant recently published philosophical articles written by top scholars from differing perspectives, and the resulting volume delivers a thorough treatment of key issues germane to children's rights. Indeed, the issues discussed were certainly important —ranging from parental rights to education and health care—and it is in virtue of this fact that the book is essential to all scholars specializing in human rights, particularly to those whose focus concerns the nuclear family.

The volume is divided into five major sections. The first section is Ladd's introduction, which includes a good, albeit brief, discussion of philosophical concepts necessary for understanding the assumptions which drive the arguments of the articles in each section. Particularly helpful was Ladd's condensed taxonomy of rights and duties, as well as the overview of J.S. Mill's theory of political liberalism in which Ladd furnishes a summary of Mill's principle of individual sovereignty within the broader context of his utilitarianism.

The second section is devoted to the analysis of theoretical issues which are more specific to children's rights. In 'The Philosopher's Child', Judith Hughes considers why society generally disallows children the same rights as it affords to adults. She maintains that society does not acknowledge children as autonomous persons in the hope that they will be protected from being burdened with the responsibility of their own decisions. Onora O'Neill, in 'Children's Rights and Children's Lives' rejects rights language with respect to children, and holds that focusing on the obligations adults have to children allows for a more complete and accurate account of the duties which apply to everyone in terms of the proper treatment of children. This section concludes with Martha Minow's 'Rights for the Next Generation: A Feminist Approach to Children's Rights'. Minow seeks to replace rights language with a feminist analysis in order to implement changes in the juvenile court system which in turn would strengthen children's relationships with parents and community instead of encouraging adversarial family relationships.

Section three discusses issues related to children in their family contexts, including the moral basis of parental authority, state intervention into families' privacy, and the question of whether children are entitled to make moral claims against members of their own family. In 'The Right to Found a Family' John Harris asks whether everyone has a right to bear and raise children in light of the prevalence of child abuse. He speculatively concludes that this question can be answered only by giving thorough consideration to the probable fate of future children. Peter Vallentyne and Morry Lipson argue in 'Equal Opportunity and the Family' that those holding to Mill's version of liberalism should reject family autonomy, given the likelihood that children will not develop essential life skills unless the state interferes in order to ensure equal opportunity for all children.

In 'Does a Child Have a Right to a Certain Identity?' Anita L. Allen argues that transracial adoption should be permitted on the basis that children do not have a right to a particular racial identity. David Archard's 'Child Abuse: Parental Rights and the Interests of the Child' questions those who hold a presumption of family privacy, since those are the conditions which allow child abuse to go undiscovered. Finally, in her essay 'Rights-talk Will Not Sort Out Child-Abuse: Comment on Archard', Mary Midgeley

levels a critique of Archard's narrow focus on parents' rights and suggests an examination of the practical context which raises questions about child abuse.

Section four canvasses issues related to rights in education, with Brenda Almond's 'Education and Liberty: Public Provision and Private Choice' favouring parents as being ultimately in control of the nature and scope of children's education. By contrast, Laura Purdy's 'Schooling' promotes a restriction on unlimited parental rights regarding this issue, since education based on such a system may unnecessarily narrow children's education. The section concludes with Hugh LaFollette's article 'Freedom of Religion and Children' in which he argues, in cases of conflict between parents and the state on the issue of religious beliefs, against parents' rights since (on LaFollette's view) the child is harmed by the parents' unjust censoring of educational content.

The fifth section is devoted to children and health care issues. Edwin Forman and Rosalind Ekman Ladd offer a summary of the traditional arguments for and against parents, children, and doctors as decision makers in their article 'Making Decisions—Whose Choice?', while Dan W. Brock, in his essay 'Children's Competence for Health Care Decision Making', defends the parents' role in medical decision making on the basis that parents have an interest in deciding for their children. The book concludes with Ferdinand Schoeman's article 'Parental Discretion and Children's Rights: Background and Implications for Medical Decision-Making', where Schoeman defends parental rights, based on the assumption that families are characterized by intimate relationships which are not exemplified in state agencies.

While this work is essential to scholars and professionals whose focus is children's rights, its value for the medical and bioethical community is more limited. The provocative section on health care decision making is well worth reading, although it is too short and not as thorough compared to other sections in the volume.

JOHN D. BASIE, M.A.
Erskine Theological Seminary
Due West, South Carolina, USA

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The Complete Book of Baby & Child Care
Paul C. Reiser and Focus on the Family
Wheaton, IL: Tyndale, 1997
ISBN 0-8423-0889-X, 855 pp., hardback $34.99

The Complete Book of Baby and Child Care, published by Focus on the Family, is overall a comprehensive, readable, easy to use and practical reference. It addresses clearly the major issues of parenting, from late pregnancy until adolescence.

We approached this book from two angles: personally, as new parents of a six-month old son, and professionally, as a child and adolescent psychiatrist and a family practitioner.

On a practical level, this is a very thorough and detailed book. Its section on the first three months of life is one of the best we've read for a basic, reasonable approach to the challenges of becoming a parent. It covers the concrete responsibilities for feeding, clothing, and cleaning infants, the assorted equipment needed, and an assessment of medical illness. The authors are to be especially applauded for a thorough and favourable section on breastfeeding. Throughout the book are reasoned, balanced discussions of the facts of a child's physical, mental, and emotional development, as well as the evolving role of the parent. It is very factual, and easily approachable.

In general, the focus is on a broad scope of tried and true aspects of parenting. Controversial areas are either just mentioned or avoided altogether. This may be reassuring to new parents, but perhaps frustrating for those looking for a specific 'Focus on the Family' method of handling issues. Although scripture is occasionally quoted, this text is largely a secular one.

An inherent difficulty for any book trying to be both accessible and complete is that the relatively simple level of the book's language limits the depth and maturity of the subject matter. The authors do find a middle ground, but a closer look will find compromises on both sides of an issue. Although this is a good general reference, parents facing many challenges will probably look for additional help.

We both felt that the section on discipline was extremely thoughtful and appeared to be based on biblical principles (although not always cited directly) and sound learning theory. We especially liked the presentation of how clear, fair, and consistent limit-setting is a necessity for normal development of children. We did find a few areas lacking. Beginning with the introduction, and especially when addressing discipline, positive reinforcement and parent's caring love should be emphasized as much as the importance of the mechanics of administering behavioural measures.

The section on spanking is remarkably brief for an area that is so controversial. Although the authors are to be admired for attempting to provide some limits and guidelines for spanking we disagree as to its presentation as 'a tool that can be useful in certain circumstances.' We would prefer 'a tool that can be misused in many circumstances.' We find the section a bit too encouraging, complete with instructions. Especially disturbing is the statement that a spanking should 'bring on some tears.' Alternatives to spanking are well established as effective, and so we viewed the section on spanking as both limited and not sufficiently based on empirical evidence. We recognize this may be too much to ask from a general overview, but we would hold that the potential for misuse here is great enough to justify additional material. We suspected that as physicians we might be insisting on too much research documentation, but we have found that as parents, we are even more so. Statements on corporal punishment are more suitable in a book committed to explaining the basics of behavioural management, and seem out of place in a general discussion of parenting basics. Too much controversy lies just under the surface to tackle this subject lightly.

From a practical perspective, the book is very easy to use—either read straight through or used as a topical reference. The text is written clearly and in relatively simple language, and the graphics are appropriate (the only exception being an atlas of dermatological conditions that stumped even two physicians from making a clinical extrapolation). Dr. James Dobson has written the forward; a board of physicians wrote the body of the book, and the editors are to be commended for the seamless, clear writing style.

From a medical aspect this is an excellent book. Its information is accurate, and with the rare exceptions noted above, clearly and appropriately stated. Dr. Howard Hendricks said it best: 'God gave us children to keep us close to Him.' Emotionally, as new parents, we have found this to be true, and the reassurance in this text reinforced that thought. This book is an excellent addition to the resources now available to a community of seekers and believers who need reliable basic guidance to parenting. We will not hesitate to recommend it as a basic parenting reference in our practices, and we are certain to continue to refer to it as our son grows older.

ANGEL HEREDIA, M.D.
Child and Adolescent Psychiatry
Wheaton, Illinois, USA

ELIZABETH HEREDIA, M.D.
Family Practice
Wheaton, Illinois, USA

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The Ethics of the Ordinary in Healthcare: Concepts and Cases
John Abbott Worthley
Chicago, IL: Health Administration Press, 1997
ISBN 1-56793-056-5, 332 pp, paperback $50.00

John Worthley has written a healthcare ethics textbook which differs from many others. I have just finished using it in a course I teach for registered nurses completing their bachelor's degree at a secular institution. They found that it set out excellently both the practical relevance and practical difficulty of ethics. It does this in two ways.

First, it is written from a healthcare administration perspective. Given the criticism some clinicians make of some administrative decisions, the students were intrigued to see how Worthley recognizes and struggles with the ethical issues inherent to such decisions. Worthley describes many administrative issues and concerns that a clinician might not be aware of, thus helping to show the reasons for at least some of these decisions.

The second, and more intriguing, distinctive of this book is its focus. As the title states, this book is about the ethics of the ordinary. Topics such as euthanasia, abortion and genetic manipulation are put aside, and instead Worthley focuses on more mundane issues. He wrote the book because 'a significant aspect of healthcare —for many of us its most significant aspect —has been largely ignored . . . That aspect is the daily, ordinary routine of healthcare delivery and the power wielded throughout that routine by healthcare professionals—doctors, nurses, managers, clinicians' (p. vii). He coins the term 'microethics' to distinguish these issues from the life and death issues of 'macroethics'. He addresses 'little things', such as how providers get back at 'uncooperative' patients; such as how colleagues are shunned when they upset the routine; such as how far we're willing to go with creative fudging on expense reports; such as how keeping people waiting for hours is an ethical issue.

The students in my class kept saying such things as, 'That goes on all the time at my work. I never thought about it being ethical.' Worthley kept putting his finger on issues that hurt! His underlying assumption was that before tackling macroethics, we have to deal with microethics. 'For if we are not ethically mature with the "little" things, how can we presume to be so with the big things?' (p. 38).

Worthley develops his book around the need to see three sides of an issue: power, values, and control. The power issues were the convicting ones. He describes lucidly how much power healthcare professionals have over patients and colleagues. Rather than use a case with an overtly obnoxious person, he develops one with a caring person who doesn't realize how powerfully her actions affect others. His focus is on 'the bad things that we good people do' (p. 61).

The values section is not original, although he develops the importance of seeing conflict as an opportunity to discover one's own values and become more mature. The problem, for Worthley, is that some healthcare professionals don't know what their values are, but act upon them anyway. The control section deals with the legal restraints placed upon behaviour, and the subtle ways people (and institutions) sometimes get around them.

Worthley's last chapters are very practical for developing ethical reflection skills, and seeing how to use different decision-making models. Here, Worthley limits himself to describing various approaches, and does not elaborate on what he sees as the best resolution. This book's strength is in raising people's consciousness of how values and ethics impact everyday healthcare, not in suggesting solutions.

Each chapter has a set pattern. Worthley introduces the topic and describes how this material fits in with his model. He then gives a reprinted article to elaborate on each section. These articles come from the healthcare administration literature, and many were fascinating and insightful. However, there were also a few whose relevance to the overall theme of the book was difficult to see. Each chapter concluded with a long, elaborate case study, including discussion questions. These dealt with everyday situations in which most of the students could envision themselves participating. These greatly helped to stimulate many classroom discussions.

Christians in healthcare must address the big issues, but we should also be looking at everyday issues. These provide opportunities to demonstrate the values important to us. This book is excellent in raising the issues, but then someone needs to propose what values are more likely to provide better resolutions. Very few in the bioethics community seem to be dealing with the ethics of the ordinary. This is an important opportunity for Christians to consider how our Christianity makes a practical difference in healthcare, and if it doesn't, what is wrong. This book is well worth reflecting on, and is an excellent tool for classroom use.

DÓNAL P. O'MATHÚNA, Ph.D.
Professor of Bioethics & Chemistry
Mount Carmel College of Nursing
Columbus, Ohio, USA

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Religion in the Public Square: The Place of Religious Convictions in Political Debate (Point/Counterpoint)
Robert Audi & Nicholas Wolterstorff
New York & London: Rowman & Littlefield Publishers, 1997
ISBN 0-8476-8341-9; × + 180 pp, hardcover $52.50; paperback $16.95

What is the role of specifically Christian concerns in public ethical and political debate? How should Christians address their ethical arguments when outside church walls, in hospital rounds, boardrooms, and public meetings of various sorts? Readers of this journal will recognize these issues as some of the most important questions we must face as we attempt to offer biblical perspectives on bioethical issues in contemporary society. Most will also recognize the names of the two prominent Christian philosophers who address this issue in the present volume. Robert Audi is Charles J. Mach Distinguished Professor at the University of Nebraska, and Nicholas Wolterstorff is Noah Porter Professor of Philosophical Theology at Yale University and Divinity School. They are among the most prominent philosophers in the broader world of philosophy and in the more specialised world of Christian philosophy.

The book's two main aims are to present reasoned statements of the two most important views on the topic today, and then to allow each representative to critique the other. This goes on against the backdrop of such cases as abortion, school prayer, and other issues. Audi presents the first position, the *liberal* view, the perspective that holds that the public square must be neutral. This view, arguably the 'orthodox' position in contemporary social philosophy, holds that Christians and other persons of faith must offer their moral perspectives in ways that can in principle find support by people of other or no faith identities. Audi endorses two principles. The first is a *principle of secular rationale*, that one has 'a prima facie obligation not to advocate or support any law or public policy that restricts human conduct unless one has and is willing to offer, adequate secular reason for this advocacy or support' (p. 25). The second is *a principle of secular motivation*. Like the first principle, it restricts the conditions under which one may advocate restrictive laws or policies to those in which one 'is sufficiently motivated by (normatively) adequate secular reason' (p. 29). That is, one must be able to make a secular moral case that would itself, even if religious motivations were to drop out, be adequate to motivate one's action. In short, Audi argues that the public square is to be kept neutral of religious or anti-religious faith allegiances, and that only secular moral reason should be allowed to function in promoting policy.

Again, Audi as a Christian philosopher is endorsing what might be called the 'orthodox' or traditional position among ethicists in the liberal tradition. The motivation for this view seems to be that religious arguments are dangerous, threatening to undermine the prospects for rational moral consensus in society. Christian philosopher Robert Merrihew Adams, while not holding this view, explains it as follows:

> One of the objections often raised against religious theories in ethics is that in a religiously pluralistic society they will be divisive, undermining the common, or shared morality on which society depends for its health. We would be better served, objectors suggest, by a purely secular ethical theory on which all could agree. (in G. Outka and J. Reeder, *Prospects for a Common Morality*, Princeton U. Press, 1992)

As but one example of the dominance of this view in contemporary ethics and bioethics, consider the recent bioethics text in which Aaron Ridley writes that religious concerns need to be 'sidestepped' in any attempt at meaningful ethical discussion. While philosophical ethics is 'a constructive approach to ethics', the 'religious approach [is] certain to produce a breakdown in communication and then a standoff'. The role of religion in philosophical ethical debate is to 'try to discover or to describe ethical principles which speak to, and which can be used by, people of any religious persuasion, or of none. We attempt to find a common language which will allow ethical problems to be addressed from a variety of perspectives' (*Beginning Bioethics*, St. Martin's Press, 1996).

Nicholas Wolterstorff, however, refuses to accept the limitations placed on believers by secular liberalism, not least because he does not believe that there is any plausible ethical foundation in society upon which we can all agree. Since there is no agreed-upon common set of moral convictions and procedures, it is unfair to exclude religious convictions in favour of secular ones. Wolterstorff argues that the state should be impartial, but not neutral, regarding religion; religious perspectives are allowed to be brought into public ethical discussion, but the state should not favour one faith over another, not even the 'faith' of secularism. For Wolterstorff, believers cannot be asked to ignore their faith commitments when making moral judgements: 'It belongs to the religious convictions of a good many religious people in our society that they ought to base their decisions concerning fundamental issues of justice on their religious convictions.' Wolterstorff presents a powerful challenge to the dominant view of bioethics, reflecting the recent trends in philosophical ethics that are sceptical of secular reason's ability to arrive at substantive moral conclusions.

Anyone wanting a deeper understanding of the philosophical issues at stake in the debate between liberal neutrality and faith-based morality needs to study this book carefully.

DAVID FLETCHER, Ph.D.
Philosophy Department, Wheaton College
Wheaton, Illinois, USA

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Science, Life, and Christian Belief: A Survey of Contemporary Issues
Malcolm A. Jeeves & R. J. Berry
Grand Rapids, MI: Baker and Leicester, UK: InterVarsity, 1998
ISBN 0-8010-2226-6, 305 pp, paper $19.99

The progress of science has left us inhabiting a vastly different universe from that of our ancestors. Scientifically, we understand far more than Christian believers of the past. Each day, it seems, brings another new insight into the structure of the universe, the nature of life, what it means to be human, and what the future may hold. In the face of this explosion of knowledge,

some people have chosen to adhere even more closely to biblical and theological interpretations of the universe; at the other extreme, some have jettisoned traditional Christian interpretations altogether, embracing ideas and forms of worship totally foreign to what has been considered 'orthodox' Christianity. Others attempt to find a position somewhere in between, faithful to the substance of Christian belief, but open to new views of the nature of the universe and its inhabitants.

This is the position taken by Jeeves and Berry in *Science, Life, and Christian Belief*, a revised and expanded version of their much earlier (1969) volume *The Scientific Enterprise and Christian Faith*. Both are practising scientists, well-qualified to address the issues under discussion: Jeeves is honorary research professor at the University of St. Andrews and president of the Royal Society of Edinburgh, while Berry is professor of genetics at University College, London. Both have previously contributed substantially to the ongoing dialogue between science and Christian faith.

Their position is clear from the outset: they seek to write as 'working research scientists enthusiastic about their science and what it has to offer humankind, and who seek to live as committed Christians' (p. 12). They note ongoing changes in theological interpretation and public understanding of science, and 'tried to include these recent changes within a coherent picture of a Universe created and upheld by a God who seeks to make himself known. We fully accept the revelation of God in his written and living Word; the problem in every generation is to interpret this revelation in a consistent way' (p. 12). Science and theology are not antagonists, but complementary ways of looking at the universe. This may seem to be an obvious point, but to significant numbers of people it isn't: for some, science has invalidated traditional religious belief, and those who cling to Christian beliefs are outmoded or just plain foolish. The number of Christian scientists and those in all walks of life conversant with the science/religion interface show that this is not true. It is perfectly possible (even mandatory) to evidence a Christian faith that takes full account of how the universe is.

Jeeves and Berry begin with discussions of Hebrew-Christian and Greek influences on the rise of modern science, the laws of nature, the scientific enterprise, and the nature of scientific explanation. From here, the discussion moves on to the nature of God, the origin of the universe, and models of God's action in the world. Creation and evolution are compared and contrasted (although one could wish for more discussion of the theological implications of living in an evolutionary universe). Then, the focus narrows to humanity—what is human nature in the biblical sense, and how does it compare to what science tells us? What role do our genes play in forming the people we are? How are our brains, minds, and behaviour interlinked? How do we relate to creation—to the world we inhabit? How should Christians treat this planet earth? The final chapter looks towards the future. The authors conclude, 'God points us to himself. Science points us beyond its limits. Reason can answer only some of our questions. Our need is not more science, better reason or great faith; it is faith in a great God' (p. 254).

The authors' intent is to write a book accessible to both scientists and non-scientists. In general, they succeed, although the non-scientifically literate reader may find some sections heavy going. Jeeves and Berry present an even-handed discussion of issues, relating different opinions and showing where they stand and agree or disagree. In many cases we simply don't have the final answers to the questions science and theology raise; at times we have to be content with uncertainty (and to be free to disagree with each other).

It would be impossible to cover every issue in depth in a book of this length, and so *Science, Life, and Christian Belief* should be considered an overview. An extensive bibliography provides avenues for further reading.

The Christian faith is not outdated fantasy; it is totally relevant. As Jeeves and Berry point out, the insights gained from Scripture are as essential for understanding the cosmos as the latest scientific discovery. While science may point us towards God, it is in his word—written and living—that we come to know him. While I personally would have liked to see more emphasis on the Resurrection (as in the writings of John Polkinghorne, who emphasizes the Resurrection as the ultimate hope for the universe and humanity), Jeeves' and Berry's book is nevertheless an excellent and lucid explanation of a number of wide-ranging issues with which modern Christians need to be conversant.

ANDREW M. SEDDON, M.D.
Deaconess Billings Clinic
Billings, Montana, USA

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'Blind Alley Beliefs'
David Cook, new edition, Inter Varsity Press 1997

If you have ever heard David Cook speak you will want to read this book—if not you should read it. It is, of course, a presumption to write a review of the work of such a well known figure in the field of ethics and society and the book stands quite secure on it's own merits. At least it may bring the book to the attention of those who only know of Dr. Cook through his talks and broad casts. The most famous and enduring is 'The Moral Maze' (The book of the same title is available—SPCK 1983)

This book is a masterly analysis of the philosophical, social and religious forces that have moulded our present society and brought about the current situation with the separation of morality and ethics. It shows the validity of Christianity in providing a consistent basis for morality in today's world, as against other philosophical and religious systems that compete for our attention. The clear analysis of our post-modernist society gives an excellent basis for understanding today's ethical dilemmas—in which the modern sceptic 'is not sure of anything except that he or she is sure that you cannot be sure' (to quote from one of Dr Cook's talks). He points out how reality is replaced by image and subjective reactions replace the truth.

It is not at all a negative book, however, and there is a strong affirmation of the validity of the Christian belief with a challenge to be sure of our relationship to God through Christ. Throughout the book the strengths and deficiencies of each system of belief are set out with doughty arguments that show how none of them adequately answers the fundamental needs of the individual and society. Discussion of each different belief system is followed by a section on the Christian response to it. It is made quite clear that we need to understand how each one is deficient in meeting the needs of individuals and society and how the Christian answer applies.

There is a foreword by Michael Green followed by a short section titled 'Don't be defensive'—a challenging exhortation to Christians to stand up for their beliefs and the gospel. The next chapter on Postmodernism is the longest and portrays the plight of today's society very well. This is followed by chapters on Existentialism, Humanism, Marxism and Communism, Scientific Materialism and Anarchism—which includes a section on apologetics. It would have been helpful to have had an analysis of Christianity on the same basis as other belief systems—to show that it can stand up to critical review. Part of Dr. Cooks unique style is to pose questions and leave the reader to work out the answers. I found that this gave a sense of incompleteness despite the insights and understanding afforded by the questions that he asks. On the other hand it compels the readers to think through the issues for themselves. The other world religions are not dealt with except in passing. Overall this book is a remarkably concise survey, and penetrating analysis, of the 'blind alley beliefs' that have been influential in shaping the morality, ethics and beliefs of the world today.

DR. P.K. BUXTON F.R.C.P.
Dunfermline, Fife