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Ethics and Medicine seeks to develop a Christian mind on the complex and fundamental challenges posed to society by the break-up of the Hippocratic consensus and technological advance in medical science.

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Ethics & Medicine (2000) **16:3**, 65–66 0226–688X

C. Ben Mitchell, PhD

An Idea Whose Time Has Come

British philosopher and science writer Colin Tudge has recently said of cloning,

> If people do not get to grips with such research then the new biotechnologies that are beginning to influence our lives so profoundly will forever occupy some esoteric, elevated niche, effectively out of sight. That would be a huge pity, for cultural and political reasons. On the whole, the world at large deploys science and technology with little finesse—we seem to suffer many of their ill effects, without properly reaping many possible benefits—and we will never do better unless people, meaning voters, consumers, and citizens, have a better feel for what is going on. (Ian Wilmut, Keith Campbell, and Colin Tudge, *The Second Creation: The Age of Biological Control by the Scientists who Cloned Dolly* [London: Hodder Headline, 2000].)

One could not agree more with Tudge. The stuff of biotechnological medicine and the bioethics which ought to be related to it should be of interest to everyone because everyone has a stake in the progress of science and its implications for the future of humanity. Too long has bioethics been the realm of so-called experts who wield the jargon with gladiatorial style. Too long has bioethics been the vehicle of making laws which few citizens understand or affirm.

An idea has come to fruition that has the potential to, as Tudge puts it, give people 'a better feel for what is going on'. This summer The Center for Bioethics in the Church (CBC) was formed in Berkeley, California. According to its promotional material, the CBC 'desires to partner with the local church to provide bioethical training, education, and information that is customized to and delivered for the specific needs of each local church'. Toward that end the CBC will offer major conferences, one-day seminars, specific talks, and individual and family consultation.

Why is this project worthy of notice in the pages of this journal? Not the least reason is that several individuals associated with this journal serve as the board of references for the CBC (including Nigel Cameron, John Kilner, and myself). Speaking for the others, we feel some obligation to promote good ideas, and this is a good idea in our estimation.

Furthermore, the person leading this project is a person of integrity and competence. Jennifer Lahl holds degrees both in nursing and bioethics and is fully capable of reaching the goals of her project. Together with her colleagues she will no doubt provide a much-needed resource in that part of the United States.

Perhaps one of the most important reasons to mention the CBC (if not the most important reason) is that one hopes it will encourage imitation. That is to say, this is an idea whose time has come. Churches should consider supporting the establishment of many centres like the Berkeley CBC.

For the last decade especially, bioethics centres have been springing up around the world to serve the needs of a largely academic constituency. If the explosion of biotechnology is teaching us anything it is that bioethics is not the domain of academics alone. Sooner or later everyone of us will have to make decisions about the development, use, or continuance of some new medical technology. It therefore behoves us, out of pure self-interest if nothing else, to 'get to grips' with these technologies. Even more importantly, these technologies will impact the future. Will they enhance the quality of life of future generations or will they be used against those whose quality of life is not deemed to warrant their benefits? Will they remake human beings in the image of the technocrats or will they respect and serve the dignity of human beings made in God's image?

Surely in some measure the answer to these questions will be determined by how well each of us and our children are educated and equipped to assess these technologies. These decisions must not be left to a few technocrats; they belong appropriately to us all.

But why is the CBC aimed at the church? Because the church has a coherent, cohesive worldview which may be brought to bear on these technologies, it makes sense to go to the churches. Because the church has learned through painful lessons the importance of respecting human dignity, it is wise to go to the churches. Because the church is composed of persons who impact and are impacted by these technologies, it is important to go to the churches. Because the church represents a body of individuals who can engage policymakers and those who direct the scientific and medical enterprise, it is prudent to go to the churches.

Another set of reasons why the church needs the CBC is because, while these other reasons may be true, churches have nevertheless been slow to grapple with the issues at the intersection of medicine, technology, and ethics and yet are forced to make decisions which they are ill prepared to make.

For instance, clergy find themselves increasingly asked to counsel families about the use of artificial reproductive technologies. As genetic screening and therapy become more widely available, difficult choices will have to be made. With few exceptions, ministers still have very little training in bioethics. Thus, a resource like the CBC can render a profound educational service right in its own community.

Moreover, physicians, nurses, and other health professionals often find themselves in need of tools for ethical and theological reflection. In partnership with the local

churches, the CBC can assist in equipping those professionals to think Christianly about the practice of medicine.

We wish the Center for Bioethics in the Church well and hope others will follow their example. Those who wish to know more about the center may contact Jennifer Lahl at The Center for Bioethics in the Church, P. O. Box 20760, Oakland, CA 94620, or by email at the cbc@onebox.com. Or, they may visit the centre's website at www.thecbc.org

Ethics & Medicine (2000) **16:3**, 66–68 0226–688X

Clarke D. Forsythe, JD

Can Christians Be Effective in the Public Policy Arena?

Can Christians be effective in the public policy arena? The answer is 'yes', and I think there is a wealth of documentation to support this assertion. One needs only to look at Michigan to see evidence of this fact. Look at what Michigan has done in abortion legislation and what they've done with the abortion rates over the last decade. Look at what they've done about assisted suicide. If you lived or worked in Michigan back in 1990 when Jack Kevorkian started his crusade, there were some very dark days when he was running rampant. There was no political leadership, public opinion seemed to be supporting him, he was laughing in the faces of pro-life people, and he was a media star along with his attorney Jeffrey Feiger. But Christians turned things around slowly. It has taken about nine years, but they have a very effective organization. In fact, it is one of the most powerful and effective state-based organizations in the country and I think the proof is that Kevorkian was finally convicted under a new statute that they passed during those nine years. Christians successfully defeated an initiative to legalize assisted suicide in Michigan, right in Kevorkian's own backyard, defeating that initiative by a margin of 71 to 29 percent. So Michigan is a wonderful example of progress.

Making a difference requires facility with communication. We must know our audience and we must communicate effectively with them. Let's say you are trying to influence the American Bar Association or the American Medical Association or some state-based healthcare organization. Who are they? What do they do? How are they run? What is their mission? What are their purposes? It is important to distinguish those groups from governmental bodies or legislative committees. Testifying before legislative committees requires you to understand the committee, where it's coming from, what rules limit testimony. And, of course, it's also very different from communicating with the public. As Sir Brian Mawhinney has reminded us, the sound bite is here to stay. So communicating with the public is different from communicating with other audiences.

The art of communication assumes some kind of message that raises the question of vision. The label 'pro-life' assumes one message, and one message only, and it's a hard message. 'Don't have an abortion' or 'Abortion is wrong' or 'Assisted suicide is wrong' is the kind of the message we sometimes communicate. But that message is incomplete. It must point to a broader, positive vision that can inspire Americans and others. And even if the message that abortion and assisted suicide are wrong is true, those messages must appeal to, become part of, and adhere to a broader vision. For example, I would suggest that our vision in the cause for life must be a nation where every child is protected in law and welcomed in life; where strong families affirm women in both personal and professional roles; where the law recognizes mutual responsibility of men and women for child-rearing; where a network of services supports and affirms men, women, and families in child-rearing; where no person's life is demeaned by our law and culture as unworthy to be lived because of age, infirmity, or disability; and where every American can claim the right to life acknowledged in our nation's founding documents. That is the broad vision and that must be stated positively.

Perhaps the best examples of portraying that broad vision have been the DeMoss Foundation advertisements. Some of those advertisements were shown on television in Michigan by a coalition opposing assisted suicide, promoting a positive vision of healthcare, and, a positive vision of care for the terminally and chronically ill. You must start with that positive vision and your sound bites have to be part of that positive vision.

So communication is a combination of that positive vision and pragmatic arguments. They complement one another and work together. For example, a number of years ago when abortion clinic shootings and bombings were more prevalent, when they were happening in Boston and other cities, there was a tendency by some pro-life advocates to give the media a mixed message. 'Well, we condemn this, but we also condemn the violence in the clinics.' That's a mixed message. It was one of moral equivalence. It was obscure. It was ambiguous. It was an inadequate and muddled message because it seemed to be justifying the clinic bombings by the violence going on inside the clinic. Given the context of the national media and need for speaking in sound bites, pro-lifers should

have unequivocally separated themselves from what was happening. And the only way you can do that in the media is to unequivocally condemn that violence and separate yourself from it. Those media sound bites in the aftermath of those clinic shootings did not allow a kind of reasoned moral thesis on violence outside the clinic or violence in the clinic. It simply didn't allow for it. We have to be media-wise.

We must address our culture as it is, not as we would like it to be. It's a culture that appeals to and adheres to utilitarian and pragmatic arguments, rather than natural law or specifically Christian arguments. I think, however, that a natural law ethic leads to appropriate utilitarian and pragmatic arguments because when you speak about the natural law—for example, the rule that we should not kill innocent life—you ultimately come to the negative effects of violating that law. So you start from a natural law principle and you come all the way around to talking about the implications of legalizing assisted suicide. What will be the natural outcome of legalizing assisted suicide? What will be the negative impact on the healthcare system, on patients, and on doctor-patient trust. What about the impact on family members and on the delivery of healthcare? Those are all pragmatic arguments which derive from a natural law ethic. And they basically tell Americans the natural consequences of violating that law. They're connected, they're coherent. They're not contradictory.

It's also important to have real empathy for our audience. So many people seem to come from a stance of condemning American culture and the American public as naïve or immoral and you can sense a harshness in their perspective. But it's really necessary for us to show some understanding and some empathy for our audience whoever they might be. When I was giving a talk about assisted suicide to a law school symposium some years ago, one of the speakers got up and started railing against the American Student Nurses Association for supporting assisted suicide and insisted that that just proves the old adage that students know only enough to be dangerous. He began his own speech to a student group with that quote. I started laughing. I couldn't imagine why he would begin a talk to students with such a putdown. He didn't know his audience.

I see our role at Americans United for Life as largely translating natural law into terms the public can understand. Like it or not, those are in largely utilitarian and pragmatic terms. In 1991, we were involved in a campaign in the American Bar Association's (ABA) annual meeting to keep the American Bar Association neutral on the issue of abortion. This was just before the Casey decision in 1992. Our theme was neutrality. Keep the ABA neutral. We weren't arguing that they should become pro-life. We wanted to keep them neutral and prevent them from becoming pro-abortion. Well, I was an ABA member at the time, but I wasn't influential in the ABA. I wasn't an official of the ABA. But our team was led by officials in the ABA. They knew where the skeletons were. They knew how the rules operated. They knew the parliamentary procedures of the ABA. And with that knowledge and our theme of neutrality, we prevailed in 1991. But a year later, in 1992, we lost in San Francisco. They strategically put the ABA convention in San Francisco, they manipulated the rules better than we did, they were able to put more speakers on the agenda than we were, and the ABA left neutrality and adopted a pro-abortion position. We lost because we didn't operate cleverly within the rules of the institution. It wouldn't have taken manipulation of the rules, just an appropriate application of the rules of the institution to have kept the ABA neutral on abortion.

In a democratic public arena, of course, we must deal with the force of public opinion and garner majority support for any policy proposal. We must mount a constant and civil public argument over and over and over again. It must become our constant theme. It must be repetitious, it must be persevering. We can't be screaming at people, we can't be condemning people. It must be a civil public argument. That is what's going to win the day.

It is also necessary to define differences. We must identify and define differences between candidates on policy positions in order to pass legislation in the states or in order to win elections. It is necessary to urge people to make a choice and in order to urge people to make a choice you have to distinguish differences between those two choices. I take heart from Sir Brian Mawhinney's suggestion about praying with political opponents. I think that's wonderful. I think that should be done. But it's no contradiction to leave that prayer meeting and to go out and rail against their position on political issues. There's no contradiction there. That is perfectly within the boundaries of civil discourse. There are some limits on civil discourse but there's no contradiction in praying with political opponents, being friends with political opponents, and in the public realm honestly pointing out why their policies and their positions will yield negative results for American or British society. There's just no contradiction there. We should be honest, straightforward, and convictional without being trite, arrogant, or deceitful.

We must also focus on specific, realistic changes in policy in order to address the bigger issues because debate over specifics—for instance, partial-birth abortion, parental consent or notice, women's right to know legislation, clinic regulation—moves eventually to the broader issue of abortion generally. When you debate the issue of women's right to know, you're basically debating the issue of how much information women should have about abortion. They should have as much information as possible about the nature, risks, and alternatives to abortion. If you focus on informed consent or women's right to know legislation, you're always going back to the broader issue. So debate on specifics moves that broader issue to the fore.

I would like to comment on the question of compromise. Unfortunately, comprise is usually used as an epithet: 'You're compromising'. Anyone who has read the Hanukah story of the Macabbean revolt under Antiacus Epiphanes, knows the imperative to resist compromise on fundamental moral principles. That's what that story is all about. That's what that history is all about. But, sadly, there's been a tendency in the pro-life movement over the last twenty-five years to denigrate the concept of compromise by labelling as compromise many types of important legislation like the ones I've mentioned—informed consent, partial birth abortion, etc.—that seek to limit abortion whenever it's not possible to ban it entirely.

But given the constitutional and political obstacles of Roe v. Wade and Doe v. Bolton, incremental legislation is both morally appropriate and strategically necessary. I think there are important questions to consider about compromise. What is compromise? Is this decision compromise? Is that decision compromise? It is important to think about power, intention, and perception. The whole notion of compromise imagines a group of people meeting in a room and saying, 'Well, you can kill ten babies if we'll save ninety or you can kill forty babies if we'll save sixty,' or something like that. The reality is, for the most part you're fighting against an opposing power and fighting tooth and nail for as much as you can get and you're fighting tooth and nail for majority support. You start out with 30% on this side and 30% on that side and you're arguing with the 40% in the middle and you're trying to get enough of the 40% in the middle to get a majority to pass some legislation and make some progress step-by-step. The intention of such incremental legislation is obviously not to endorse abortion or Roe v. Wade but to limit the evil of abortion and the evil effects of Roe v. Wade.

Political compromise usually has three primary purposes. Some legislation of this type seeks to protect principles like parental authority or informed consent. Some seeks to limit the evil by limiting the number of abortions as much as possible. And some seeks to limit abortion in such a way as to challenge the authority of Roe v. Wade and create appropriate test cases.

Roe v. Wade has power because it has constrained the ability of public officials to prohibit abortion over the last twenty-five years. It may not have any moral authority, but it has political power. Hitler had political power. He may not have had moral authority but he had power enough to kill six million Jews. Stalin may not have had moral authority, but he had power. There's a big difference and you need to distinguish between the two. You can't ignore the power that someone has; and recognizing that power is not the same as acknowledging his or her moral authority. It is not compromising to recognize that power is a fact that you must deal with. There are no secrets about the purposes of incremental legislation. In fact that type of incremental or regulatory legislation has been documented in a book we published in 1987, *Abortion and the Constitution: Reversing Roe v. Wade Through the Courts*. And no informed person could get the impression that that kind of legislation admits any moral authority or endorses abortion. In fact, exactly the opposite is true because that type of legislation is usually condemned by the other side as 'the first step in banning abortion'.

In *Euangelium Vitae*, Pope John Paul has really summarized this whole issue very well. He said, 'When it's not possible to overturn or completely abrogate a pro-abortion law, an elected official whose absolute personal opposition to procured abortion was well-known, could licitly support proposals aimed at limiting the harm done by such a law and lessening its negative consequences at the level of general opinion and public morality. This does not in fact represent an illicit cooperation with an unjust law but rather a legitimate and proper attempt to limit its evil aspects'.

Some of the problems we are experiencing are broadly-based cultural, social, and political problems. Certainly abortion has been deeply engrained in our culture for over twenty-five years. In 1973, abortion on demand was legal in a number of states, but not in all fifty states until the Supreme Court's decision. Fifteen states between 1966 and 1973 legalized abortion to some extent or another. But in 1973, the Supreme Court wiped out all the rules, all the laws on abortion, and legalized it throughout the country in all fifty states. That dramatically changed the situation. However at that time, abortion was not deeply engrained in natural culture. Twenty-five years later, things have changed.

Human cloning, on the other hand, is not a deeply engrained social and political problem because it is still regarded as being in the the realm of science fiction. Whereas probably 80 or 90% of public opinion would ban human cloning, the attitudes towards abortion are very different. So our approach must also be different.

Finally, all of this assumes that we have planned sufficiently to succeed. You have to plan strategically. You have to have a conference or to draft and publicize a statement on stem cells. You have to plan to have a press conference in Washington and get information distributed to those 535 legislative offices. You have to plan to succeed. The better planning you do, counting the costs along the way, the more likely you will be to succeed. And of course you have to have sufficient resources at your disposal. The Christian Legal Society combined with the Center for Bioethics and Human Dignity to distribute that stem cell segment to 535 legislative offices. That took a lot of people. They had to plan that out and had to have the resources. If only two people had turned up that morning they wouldn't have been able to distribute it to those legislative offices. They had to plan to do that and to have the resources to do that. The question is, do you have the capacity to implement the plan you create? Capacity is a question that I must confess has kept me awake many nights over the past ten to fifteen years. It is something I wrestle with every day.

But none of this is going to succeed, without perseverance. The more experience you have in the public policy process the more you realize you have to persevere. People who are new to it may think you just go down to the state legislature with your legislative testimony, go to a committee hearing, and you pass a bill. It doesn't work that way. States like Michigan have had to persevere year after year after year.

William Wilberforce spent his entire parliamentary career in Britain—forty-eight years—fighting first to limit the slave trade, and then to abolish slavery altogether in the empire. At the same time, he was leading a corresponding crusade to change the 'manners'—that was the phrase they used—of England, primarily among the upper classes. He succeeded on both accounts. But he worked for forty-eight years(!), first banning the slave trade, and then banning slavery, and Parliament didn't vote to ban slavery until four days before he died in 1833. He spent his whole life on that issue and he persevered. So this is not for the faint-hearted. I urge you to persevere in your own arena, to persevere in the things you can do. We can change law and culture, but it takes wisdom, faith, and perseverance.

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Ethics & Medicine (2000) **16:3**, 69–72 0226–688X

Jeffrey L. Newswanger, DO

Toward the Relief of Suffering and the Restoration of Person

Relief of suffering has long been an important goal of the medical professions. On the threshold of modern medicine, Hippocrates wrote, 'I will define what I conceive medicine to be. In general terms, it is to do away with the sufferings of the sick, to lessen the violence of their disease'.[1] Throughout the subsequent history of medicine, the relief of suffering continues to be a priority. The 1846 American Medical Association's *First Code of Medical Ethics* reinforced the importance of the physician comforting the sufferer when he cannot cure the disease. 'A physician ought not to abandon a patient because the case is deemed incurable; for his attendance may continue to be highly useful to the patient, and comforting to the relatives around him, even in the last period of a fatal malady, by alleviating pain and other symptoms, and by soothing mental anguish'.[2]

Today, suffering has assumed an even more prominent role in medical thought. There are numerous reasons for this. One reason is that suffering in a medical context may be more common as more people survive their illnesses long enough to enter a chronic phase.[3] In addition, we live in a culture of comfort. An imperative exists to remove all sources of discomfort at any cost.

Certainly, the relief of suffering is a laudable and historic goal. Imprecise thinking as to what suffering is, however, has led to a failure of caregivers to address sufferers' needs appropriately. The combination of this unmet need with imprecise definitions of suffering and our culture's intolerance of anything deemed unpleasant or undignified has resulted in a wrong-headed thought process which justifies the killing of the patient as the 'final solution'.

In the following, I will attempt to define suffering more precisely by analysing what suffering is not, and conversely, what it is. Additional insight will be sought from the wisdom of scripture. From this I will extrapolate a suggested concept of what is and is not proper relief of suffering.

Defining Suffering

H.R. Niebuhr said, '. . . suffering is the exhibition of the presence in our existence of that which is not under our control . . .'[4] His profound definition warrants critical thought. Our late twentieth-century western culture is defined by control, comfort, and cleanliness. As a society, we are intolerant of anything that is outside our control. Many laudable advances in the control of inconvenience and discomfort have been made. Suffering nevertheless still exists. If Niebuhr is correct, this should be no surprise. Our influence over that which is out of our control is, by definition, severely limited. Thus, when we attempt to eliminate suffering, we seek an unlikely goal. Proxies for that goal are then established and defined as 'goods'. As we adjust our goals and definitions to maintain our fiction of control, we move further and further from the original reality. In doing so, we also move further from the original beneficence toward the patient. We find ourselves treating numbers and ideas that may have no true correlation with the patient's well being.

Suffering and death are viewed as failure in our technology-based culture. We seek mastery, and when it evades us, we feel anger and remorse. This anger and remorse can quickly turn to frustration and resignation. Both the patient and caregivers begin to contemplate death as a source of relief. To hold this view of suffering, however, is to take too high a view of ourselves, to deny our creatureliness, and to confuse ourselves with God.

What Suffering is Not

First, in our quest for an accurate understanding of suffering, we must understand what suffering is not. Misunderstanding and imprecision abound regarding suffering. In the general population, imprecise terminology is common and expected. Yet, regarding the concept of suffering, perceptions are especially telling. Daily, patients come to my office complaining that they are 'suffering' from a cough, sore throat, or other minor affliction. Although they use the term 'suffering' to describe their malady, they will, if questioned, readily admit that their problem is mild. These patients are not truly suffering at all. This is an example of the hyperbole so common in American English. We 'love' ice cream, 'hate' quiche, and 'die' of embarrassment at the least social impropriety. Although not linguistically inappropriate, this imprecise and colloquial use of the words distorts our thinking about our topic. It suggests that disease and suffering necessarily coexist.

At the same time, patients commonly come who clearly are suffering. They often complain of pain. They may perhaps complain of anxiety, lack of appetite, or insomnia. Yet, these problems, in and of themselves, are rarely severe enough to explain the depth of the patient's misery. Something more is happening to cause the suffering. The assumed correlation between disease and suffering does not exist. Unfortunately, modern scientific medicine no longer has tools to understand non-physiological causes of distress.

Professional use of the term 'suffering' is often no more precise. This is quickly seen in a simple search of medical literature. In a 1982 article, Dr. Eric J. Cassell notes that a search of the medical and social-science literature was of no help in defining the concept of suffering. In general, 'the word "suffering" was most often coupled with the word "pain", as in "pain and suffering".'[5] Almost two decades later, we have seen the expansion of the field of bioethics and the resurgence of attention toward psychosocial issues in medicine. There has been little change, however, in the understanding of suffering. A contemporary Medline search for 'suffering' will reveal a handful of articles dealing with suffering in a holistic sense. Most, however, continue to use 'suffering' as a synonym for 'pain' or 'disability', ignoring non-physical sources of suffering. Even more importantly, this usage ignores the uniqueness of individuals and the values (positive or negative) that they apply to their illness.

Suffering versus Pain

The most common idea associated with the word 'suffering' is that of pain. Certainly pain is an unpleasant sensation that may be closely linked to suffering. Yet, *they are not one and the same.* There are pains, such as the pain of childbirth, which have very little 'suffering' associated with them. The positive meaning of the pain outweighs any threat to the integrity of the person. A very different scenario is seen in the woman labouring to deliver an already dead baby. The pain then becomes an insult far greater in magnitude than would be expected on a mere physiological basis. The pain in this case is salt in the open wound of profound grief.

Suffering versus Disability

Another idea closely linked to suffering is disability. We commonly speak of individuals suffering with a certain handicap. Nevertheless, I have several profoundly disabled patients in my practice who are living proof that disability does not have to bring suffering. They are people who have established an identity independent of their physical problems. Although they must do things differently from most people, this has not robbed them of joy or meaning in life. Some of the happiest people I have ever met have Down's syndrome. There are many who argue that an unborn baby with Down's faces a life so full of suffering as to be not worth living. I have yet to see that sorrow reflected in the face of my Down's syndrome patients. The same is true of elderly patients with dense dementia. Some of them are tormented by agitation and paranoia. However, many are content, joy filled, and unaware that they have a problem. Are these people really suffering? From an external point of view some may think that these people have a poor quality of life. Yet, to justify inducing their death on the basis of their suffering is to impose an external set of very artificial values. Suffering can be defined only on the basis of the individual's subjective experience.

What Suffering Is

Before analysing component parts of suffering, several points must be made. First, it must be understood that suffering is a complex and organic concept. As such, suffering is neither easily nor accurately analysed by an inductive approach. That is to say, suffering, as it is defined here, is much greater than the sum of its component parts. Second, suffering is inherently individual and subjective. Thus each person's experience of suffering will be somewhat different from any set of general descriptors we might define. Third, to suffer is inherently human. We live in a damaged, sin-filled world. This is one of the few scriptural truths that is empirically demonstrable. Every living human has experienced the undeniable presence of evil in the world. It is not possible to exist with self-awareness in this world without experiencing some suffering. Fourth, suffering is uniquely human. We speak of animals suffering. Yet, suffering entails more than simple pain or hardship. It also entails a threat to personhood. Cassell has pointed out that patients do not suffer primarily because they have a disease. Rather, they suffer as a result of perceived threats to their personhood.[6] It is possible to experience great suffering and yet not have a recognizable disease. Suffering entails loss of several key elements of personhood. Understanding these threatened areas of personhood will enable the physician to respond appropriately to suffering.

Suffering and the Loss of Control

A key element of our created nature is agency. That is to say, we have the God granted ability to exert control over our bodies and our environment. One of the delightful things about babies is watching them gradually learn to control their hands and feet. At first, the baby is entirely passive, minimally aware of the world. Gradually, however he or she develops an awareness of things around, the desire to get things that are nearby, and eventually the ability to pursue and obtain what is wanted. As the ability to exert influence over environment is developed, the baby begins to exhibit clearly a unique personality. Control over the body and the environment is an integral component of an intact person. When that control is limited, the person is deeply threatened and suffering is experienced. The suffering of a diseased person can be ameliorated even in the absence of treatment for the disease, if control can be reestablished. Loss of control exists when the pain has mastery over the patient. Control exists when the patient has mastery over the pain. The amount of pain actually experienced in these two situations may be the same. In fact, the patient may tolerate more pain in the second without experiencing suffering. Studies of patient-controlled analgesia illustrate this phenomenon. In this technique, a machine allows the patient to self-administer intravenous narcotics within preset parameters. Numerous studies have shown that patients report significantly less discomfort with the same or less medication when using this modality.[7] The most obvious explanation is that mastery has been given to the patient and thus suffering has been relieved, making the pain tolerable.

Suffering and the Loss of Independence

Loss of independence is related to the loss of control and yet is distinct. This is a complex issue, for none of us is truly independent. Interdependence is essential to health. Yet this interdependence must have boundaries. There are aspects of the self that are inherently private. When these aspects must be exposed to others, great discomfort results. In addition, interdependence and independence must be balanced. Much of the meaning we find in life comes from our ability to contribute to the ebb and flow of our interpersonal network. Those who have both lost the ability to contribute to the network and have become fully dependent on receiving from the network will experience a great loss of meaning in their lives.

Suffering and the Loss of Hope

Vaclav Havel has perceptively observed, 'Hope is not the conviction that something will turn out well, but the conviction that things will make sense regardless of how they turn out'. Human beings require hope for continued existence just as surely as they require oxygen or water. Anyone who has practised medicine has seen patients die for no other reason than a lack of hope. A classic example is the elderly couple whose lives are defined by caring for one another's infirmities. When one dies, the other will rarely live long. To a large degree, our self-worth is founded in the future. What we value in our life is the potential to achieve. When all hope is gone, the person no longer sees any potential to achieve in the future. This is profoundly threatening to personal intactness.

A Scriptural Perspective on Suffering

Up to this point, this has been primarily an argument of logic and philosophy. This type of argument may be of interest to the academician and clinician but of itself it will offer little comfort to the sufferer. An argument limited to that found 'under the sun' cannot fully explain the existence of suffering in this world. Neither can such an argument provide ultimate comfort. Only a knowledge of the truth regarding suffering and its relationship to the human condition can bring peace to the sufferer. The scriptures have much to say regarding suffering. We will briefly explore several illustrative passages.

In Psalm 109 we see the prayer of a suffering man. The psalmist expresses the raw depth of his pain: feelings of hopelessness, aloneness, failure and loss. However, in the midst of this experience, he is able to cling to one last reality, the unfailing presence of God. There is a God who is not silent, who 'stands at the right hand of the needy one'. The sufferer who understands this truth will find great solace even in the face of continued loss. Certainly, the most well known biblical text on suffering is the book of Job. The story of Job provides an example of one who lived a good life, did all the right things and yet suffered greatly. In the story, he cries out for an explanation. His friends try to help him. However, their misconceived concepts of suffering simply cause more pain. Job finds no peace until he looks beyond the empiric universe to something greater than himself. God first reveals himself to Job as the creator sustainer of all things. Until this point Job, like all suffering humanity, has demanded to know why his suffering has come. Cassell suggests that people suffer more when no reason for their illness can be given. We are more comfortable with calamity that is our own fault than with calamity that happens by apparent chance.[8] God answers Job with a series of unanswerable questions. The point is that there is much in life that is unknowable. We exhibit supreme hubris when we demand to be privy to the 'wherefores' of life. The question, then, to ask is not 'why' but 'what'. 'What can be gained?' 'What good remains?' When Job approaches him in humility, God then reveals himself as comforter. The ultimate security of personhood and relief of suffering can be found only as we bow in humility before the Creator. Prolonged suffering will be the destiny of those who refuse to do so.

The meaning in suffering exists primarily in light of the brevity of this life in comparison to eternity. The Greek-Jewish scholar, Paul of Tarsus states this plainly in his powerful theological statement in his letter to the Christians in Rome:

> I consider that our present sufferings are not worth comparing with the glory that will be revealed in us . . . Not only so, but we ourselves, who have the first fruits of the Spirit, groan inwardly as we wait eagerly for our adoption as sons, the redemption of our bodies. For in this hope we were saved. But hope that is seen is no hope at all. Who hopes for what he already has? But if we hope for what we do not yet have, we wait for it patiently.[9]

The complete removal of suffering from our experience will come only when creation is fully redeemed and remade in the new heavens and new earth promised at the end of the age. It is this hope, which allows the believer in Christ to remain joy-filled in the face of pain and loss. We know that even when we have lost control, there is a faithful Friend who remains in absolute control. Even when our independence is shattered, there is one on whom we can depend absolutely. Most importantly, we know that, in the face of hopelessness, we wait eagerly and patiently for the return of the One who is the hope of the world.

The Relief of Suffering

If we are to preserve our humanity, we must find a response to suffering that values the life of the sufferer above the ideal of relieving suffering. In addition, we must find ways to restore and preserve the integrity of the sufferer's person. This entails looking beyond physical impediments to the spiritual reality of a being created in the image of God. Fr. Robert Patterson has written, 'Persons are spiritual beings with worth and dignity independent of their useful qualities. To see a person as less than spiritual is to risk seeing him or her as an object'.[10]

Focus on the spiritual person who is the patient is not easy to fit into modern medical practice. Medical theory has undergone a profound but subtle change in the last century. It has shifted its emphasis from the art of the individual physician to the knowledge of the scientific system.[11] Possession of medical information is now equated with the ability to heal. Since medical information

is available to all, the need for the art of a personal physician has been lost. This shift has resulted in a depersonalized, formulaic method of practice. Practice guidelines and 'best practice' principles have been developed. Proponents suggest that once a physician has made a diagnosis, following established pathways can result in uniformly good outcomes. Although this method adequately addresses diseases, it entirely ignores persons. In the midst of this impersonal milieu, the idea has gained acceptance that any situation which can cause pain or loss is universally undesirable. This idea, combined with imprecise thinking about what suffering is, has translated into acceptance of abortion and assisted suicide as permissible and even obligatory methods of relieving suffering. Both history and logic tell us that the move from these issues to more comprehensive forms of eugenics is an easy one. In this line of thinking, medicine becomes a tool of social development. As Dr. John S. Rolland has warned, 'If we become overly enamored with biologically sculpting the ideal human, and at the same time devalue human life that does not fit more "perfect" criteria, or because [of] illness/disability involves suffering (sic), then we are at grave risk of losing our humanity altogether'.[12]

Thus, what caregivers need in managing suffering is an approach to patient care that preserves a high view of the person who is the patient. Also needed is an appropriately intimate relationship between the suffering patient and the comforting physician. In order to bring restoration to the sufferer, a physician will need to come alongside the person and provide support and direction that goes far beyond the prescription of pharmaceuticals and performance of procedures. Medical practice, based on procedures and pharmaceuticals, allows the physician to treat the ill person from a safe distance without risk of becoming soiled or mired himself. To relieve suffering, we will have to acknowledge that as healers we are also co-sufferers. We cannot enact restoration upon patients at will. Much of the work will have to be done by the patients themselves. As we lay down our white-coated facades and engage the patient person-to-person, we will be empowered to show the patient the way to restoration. A case from my practice will illustrate this point. Shirley (not her real name) is a 50-year-old woman who has diabetes and extensive vascular disease. She developed a poorly healing foot wound, which progressed until the leg was endangered. Her primary doctor referred her to a vascular surgeon in the city, two hours from her home. Over about a year, the surgeon performed progressive amputations; first at the ankle, then below the knee, and finally above the knee as one wound after another failed to heal. On the way home from the hospital after the final amputation, climbing out of the car she fell and landed on the stump, tearing open the surgical incision and badly contaminating it. She returned to the vascular surgeon repeatedly as he attempted to correct the problem. Finally, he told her there was nothing more he could do. She left his care in utter despair. It was at this point that the patient came to me. She appeared profoundly depressed. The wound was badly infected, foul smelling, and horrible to look at. In addition, Shirley had a plethora of other complaints involving almost every part of her body. As I tried to get a handle on the case, I turned our discussion to the psychosocial problems involved. Slowly, she revealed to me that the unpresentableness of the wound caused her great emotional pain. As she sat in her wheelchair, this horrible wound was the first part of her that was presented to those she met. Formerly a fiercely independent person, she suddenly found herself almost entirely dependent on others. In spite of a close, supportive family, Shirley felt abandoned. Working with a local surgeon, we continued aggressive wound care. I instituted intense treatment for the diabetes and taught the patient to control her own disease. In addition, I began working with her to deal with the psychosocial issues of her disease. As Shirley gained the ability to control her body and her disease, the multitude of complaints melted away. Amazingly, the surgical wound also began to heal. The first surgeon had given her appropriate medical care, excellent pain relief, and the neccessary equipment to overcome disability. By ignoring her personhood, however, he had failed to relieve suffering and, therefore, failed to control her disease. My medical care was in no way superior to his. I succeeded because I acknowledged her personhood and addressed the threat to its integrity.

Conclusion

The relief of suffering is a complex process which will be different in each case. As caregivers we will succeed when, mindful of our own personhood, we engage the patient as a person. We all are sufferers at one level or another, in need of the grace of God. Only as the sufferer experiences the presence of the Creator-God as incarnate in the Christ who suffered just as we do, will he or she receive not only peace, but even joy and meaning in his or her suffering.

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Ethics & Medicine (2000) 16:3, 73–75 0226–688X

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Artificial Nutrition and Hydration for Patients in Persistent Vegetative State: Continuing Reflections

The withdrawal of artificial nutrition and hydration from patients in the persistent vegetative state (PVS) remains a controversial ethical issue. Currently, in England and Wales, cases of proposed withdrawal must come before the courts individually. The landmark English ruling was the House of Lords decision in the case of Antony Bland in 1993, which has prompted discussion as to whether nutrition and hydration constitutes medical treatment or is part of the basic care of patients, as well as raising questions about the concepts of futility and the best interests of patients.

In 1991, a working party of the Institute of Medical Ethics opined:

> It is difficult to see how prolonged survival in this non-sentient and undignified state can be in the best interests of the patient. It is particularly distressing for the patient's relatives and friends to have to watch for years the unresponsive shell of a loved one. The economic and social consequences of indefinite treatment of vegetative patients may also mean that the medical and nursing care and resources that they receive, with no prospect of recovery, are denied to other patients who could benefit.[1]

This statement refers to the economic and social consequences of treatment of PVS patients. While these are important, they should not be the basis of life and death decisions for individual patients. This is recognized by the British Medical Association, which has stated, 'Judgements should not be based on the prospect of benefit to others', and, 'Treatment decisions . . . must be based on what is best for that individual and not on avoiding a burden to the family or to society'.[2] In fact, in the Bland case, the Law Lords took no account of these considerations, basing their ruling on the belief that artificial feeding was a medical treatment which could be withdrawn under certain circumstances, and that in the case before them, such withdrawal would be in the best interests of the patient.

Feeding: Treatment or Basic Care?

That feeding by nasogastric or gastrostomy tube is considered medical treatment rather than appropriate care is accepted by responsible bodies of medical opinion in many countries.[3] That opinion has been challenged, however, by the Royal College of Nursing which issued a statement following the Bland case to the effect that 'stopping a patient's food and water was unethical'.[4] Goodhall has argued for nurses to take a more active role in decision making,[5] and this particular issue might have been decided differently had nursing voices been heard. The Christian Medical Fellowship has stated, 'We . . . do believe that more weight should have been given to the opinion of the nursing profession that feeding (even by naso-gastric tube) is always part of the basic care of all patients, except at the very end of their lives'.[6] Keown also has challenged the view that tube feeding constitutes treatment. His rhetorical question, 'What is being treated?' draws attention to the fact that feeding is not treating a specific disease but maintaining life. He argues against the comparison of tube feeding with artificial ventilation, but this is unfortunately the weakest part of his argument with the Bland judgement, since provision of nutrients by tube certainly involves technology, cannot be seen to be entirely 'natural', and may entail significant side-effects.[8] The two interventions are more similar than Keown admits. Therefore it may be conceded that artificial tube feeding can be regarded as medical intervention, and the argument then moves on to the question of the circumstances in which such an intervention would be deemed futile.

Futility and 'Best Interests'

In the case of Tony Bland, continuation of artificial feeding was considered to be futile. In other circumstances, a treatment would be considered futile if it was not achieving the goals for which it was prescribed.[9] The Institute of Medical Ethics Working Party identified the normal purpose of feeding as 'sustaining life and easing the ravages of hunger

and thirst', and considered that in vegetative patients these conditions do not apply, so 'feeding does not benefit the patient'.[10] Patients in PVS may indeed not be experiencing hunger or thirst, but the absence of these experiences does not indicate that nutrition is unnecessary, it means merely that the patient will not eat or drink without help. The primary aim of feeding is the maintenance of life. This is certainly achieved in PVS, so the treatment cannot in itself be regarded as futile.

Jennett, who with Plum originally defined the PVS syndrome, has suggested a different definition of futility, i.e., a treatment is futile if it brings no benefit to the patient.[11] This moves the argument on by accepting that feeding is fulfilling its aim of sustaining life, but asserting that the continuation of life is itself not a benefit. In effect, it is not the treatment that is futile, but the life. Those who argue thus are not claiming that the patient is already dead, as in the case of brain stem death, when artificial ventilation, which is not fulfilling its life-sustaining function, is stopped. Indeed, it is admitted that in the case of PVS, 'there is no way to establish that irreversible and complete loss of all neurocortical function has occurred'.[12] Therefore it is argued that the quality of life is the issue at stake. Is that life of such quality that it is 'in the best interests' of the patient to remain alive? Jennett, who argues strongly for the withdrawal of feeding, leans heavily on surveys both of doctors and of medical students which indicate that few would want to be 'kept alive' if in PVS.[13] His argument is, however, somewhat inconsistent. He begins by citing evidence that 'these patients are not capable of experiencing distress or pain, let alone having higher cognitive activity'. Later, however, he refers to 'literally useless lives', and 'lives of poor quality', and quotes a contemporary newspaper article which refers to 'a prolonged and agonised death'.[14] The Institute of Medical Ethics Working Party admitted that in the case of PVS, 'the reasons commonly advanced for assisting death do not apply. Vegetative patients are not suffering. . . . Nor are they terminally ill.'[15] And Sheila McLean, writing in the newsletter of the Voluntary Euthanasia Society of Scotland, says, 'The best interests test is spurious because the nature of the diagnosis itself means that the person in PVS has no interests whatsoever, far less "best" ones.'[16] One might quote Jennett's own words against him: 'It seems to me important also to protect incompetent patients from becoming the victims of third parties pursuing their own agendas.'[17]

The Status of PVS Patients

If PVS patients are not suffering, and the medical treatment of artificial tube feeding is fulfilling its function of sustaining life, the only remaining justification for removing such treatment would be that the patient has lost the right to life. This is the implication of Jennett's use of the term, 'literally useless', and it leads to consideration of the meaning of life itself, and the definition of a person.[18] Christians have traditionally emphasized the sanctity of life. People are made in the image of God, and life is of great value. Moreover, biblical ethics place great emphasis on caring for the weak and disadvantaged.[19] If a PVS patient remains a person in the image of God, and it would seem dangerous to deny that,[20] then he or she remains 'entitled to the ordinary care to which any impaired and vulnerable person is entitled'.[21] Goodhall has helpfully contrasted consequentialist and deontological ethical systems as regards their approach to PVS.[22] The deontologist would see the provision of food and water as moral duties, and their non-provision or withdrawal would be unethical.[23] The consequentialist argument that 'it is difficult, if not impossible, to determine if any benefit is being bestowed on these patients, and the infliction of harm cannot be ruled out',[24] can easily be reversed: It seems probable that no harm is being done to these patients, as they are not suffering, and the possibility of benefit cannot be ruled out.

Persistent or Permanent?

PVS is usually regarded as a permanent state but, since it is a clinical diagnosis, this cannot be stated with certainty. Some have reported degrees of recovery from PVS, but in Jennett's view these should be treated with caution, and in fact strengthen his case for non-treatment, since he regards recovery to some degree of awareness of one's condition as worse than non-sentience.[25] However, Andrews has argued for the application of 'coma arousal programmes',[26] and more recently there has been a suggestion that a brain implant may offer some hope of recovery.[27] Such reports ought, indeed, to be treated cautiously, but they do strengthen the belief that in cases of PVS, life has not yet ended. Although profound disability is a condition in which most people would not like to find themselves, it does not offer justification for ending life.

Conclusion

The persistent vegetative state presents a difficult ethical dilemma. From the Christian standpoint, court decisions allowing the withdrawal of artificial feeding and hydration from patients appear unsafe. Their definition of feeding as medical treatment has been questioned but, even if it is granted, such treatment cannot be found to be futile. Instead, it seems that the life of the patient is itself regarded as futile and therefore able to be ended. Such a view is contrary to the biblical picture of humanity in the image of God and the divine command to care for the weak and disadvantaged in society. As Keown has written, removal and withdrawal of feeding and hydration from PVS patients reflects a 'consequentialist ethic radically inconsistent with the principle of the sanctity of life'.[28] More recent discussion of the issues has provided no evidence to refute that claim; on the contrary, it is possible that public acceptance of the withdrawal of nutrition and hydration from PVS patients has led to the increasing acceptability of a policy of similar withdrawal of treatment from patients with other severe neurological diseases, leading to allegations of 'involuntary euthanasia'.[29] Studies of the ethics of withdrawal of treatment have tended to concentrate on PVS, but their conclusions, particularly in the areas of medical futility and the best interests of patients, might be used to inform a wider debate.

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Ethics & Medicine (2000) **16:3**, 75–79 0226–688X

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Autonomy, Euthanasia, and the Holy Spirit

The concept of autonomy seems ill suited for defining euthanasia practice. The following inferences illustrate the problems of the contemporary use of autonomy: (1) the definition of autonomy has been pushed outside the scope of autonomy's true meaning, (2) autonomy is not an absolute human rights claim but a relative rights claim, and (3) the Christian viewpoint does not support the expanded autonomy definition as proposed by euthanasia activists. While these reasons are not meant to be all inclusive in regard to autonomy they do serve as reasonable starting points to evaluate the question of autonomy's true nature in relation to euthanasia practice and the involvement of the Holy Spirit.

What is Autonomy?

To begin with, the question of definition is crucial in the face of what autonomy is perceived to be. It should also be noted that this definition tends to have significant variance in the areas of law, medicine, and philosophy, thus making any final definition elusive. For purposes of clarity and brevity, a somewhat more restrictive approach will be applied in this article.

The word 'autonomy' can be broken down into two parts: *autos* (self) and *nomos* (rule or law). According to G. Dworkin, a city could claim legal *autonomia* when the citizenry could make their own laws in contrast to being under the control of outsiders and forced to live under adverse foreign justice.[1] For T. Mappes and David DeGrazia, autonomy is based on the capability of a person to choose and perform the following abilities:

1. The ability to formulate appropriate goals, especially long-term goals.
2. The ability to establish priorities among these goals.
3. The ability to determine the best means to achieve chosen goals.
4. The ability to act effectively to realize these goals.
5. The ability to either abandon the chosen goals or modify them if the consequences of using the available means are undesirable or if the means are inadequate.[2]

Thus, for Mappes and DeGrazia, 'an individual is autonomous in this sense only to the extent that he or she

possesses the abilities requisite for effective reasoning and the disposition to exercise those abilities'.[3] Mark Blocher uses a similar paradigm while stating, 'Autonomy is a right that arises only for a rational, moral being capable of understanding that there are actions he or she is not free to choose.'[4] While these definitions are fairly reasonable, they fail to address certain aspects of our humanness. Thus, ethicist Richard Devine raises important questions about autonomy in his book, *Good Care, Painful Choices*. 'A primary value is personal autonomy. But what is the extent of this autonomy? Does my life "belong" to me? Absolutely and utterly? To dispose of as I wish? Or is life rather a gift, over which I am given limited dominion or "stewardship"?'[5]

In the end, autonomy is not only intellectual but also emotional. In Matthew 22:37 and Mark 12:30, Christians are commanded to love God 'with all your heart, and with all your soul, and with all your mind'. Thus the Christian faith requires both the exercise of intellect and emotion. This seems also to provide us with a proper methodology with which to evaluate the role of autonomy in euthanasia. So how do we define autonomy?

> *Autonomy, defined as complete self-rule and sufficiency, is an illusory condition, limited by others, and thus self-refuting, and one which is not justified by our day-to-day experience in either secular or theological realms.*

Is autonomy really illusory? Consider that none of us has complete control over our lives. We wake up to clocks we cannot fabricate ourselves, listen to music we cannot write ourselves, as we dress in clothes we never learned how to craft, and drive to work in cars which defy our ability to repair! We are never truly autonomous from the day we are born, (we require our mothers to bear us), to the day we die, (we require undertakers to bury us). John Hardwig points out the fallacy of autonomy in what he refers to as the 'individualistic fantasy':

> This fantasy leads us to imagine that lives are separate and unconnected, or that they could be so if we chose. If lives were unconnected, things that happened in my life would not or need not affect others. And if others were not (much) affected by my life, I would have no duty to consider the impact of my decisions on others. I would then be free morally to live my life however I please, choosing whatever life and death I prefer for myself. But this is morally obtuse. We are not a race of hermits.[6]

Autonomy: A Relative Rights Claim

Autonomy that is granted cannot be truly autonomous, since someone outside us must be the donor! Our day-to-day experiences confirm the self-refuting nature of autonomy. As bioethicist Mark Foreman points out: 'We are social creatures and one almost never acts in a manner that is completely and totally independent of others or which does not affect the community of which he or she is a part.'[7]

Since the implementation of the Oregon Death with Dignity Act in 1997, healthcare providers now find themselves addressing the practice of assisted suicide that is supported by language sympathetic with patient 'autonomy'. If, however, we apply the truest definition of autonomy, then John Hardwig's question is appropriate: 'But can we really expect health care providers to promote patient autonomy when that means encouraging their patients to sacrifice health, happiness, sometimes even life itself?'[8]

It is obvious that the conclusion to Hardwig's question is 'no'. To ask someone to perform such an act would be immoral. Nevertheless, this is precisely what is being requested with euthanasia. This also brings up a second issue, the question of rights. We will discuss rights more fully when we look at liberty, the twin brother of autonomy.

The idea of autonomy does not extend merely to medical or philosophical applications, but to political ideas as well. Communist leader Fidel Castro said of the suicide of Augusto Sanchez, a man of importance in his government: 'We are deeply sorry for this event, although in accordance with elemental revolutionary principles, we believe this conduct by a revolutionary is unjustifiable and improper . . . We believe that Comrade Martinez could not consciously have committed this act, since every revolutionary knows that he does not have the right to deprive his cause of a life that does not belong to him, and that he can only sacrifice against an enemy.'[9]

Even Castro recognized that all human beings are socially interdependent. The greater good was not served by Sanchez's suicide because a greater good could be found for Cuba by Sanchez's continued life and involvement with others!

In his volume, *The Sensate Culture*, Harold O.J. Brown has noted the fallacy of the autonomy/euthanasia dyad viewed as a right: 'The trend to euthanasia is being facilitated by a curious emphasis on "patient autonomy", which permits the liquidation of the useless or suffering under the pretext of affording each individual the maximum range of choice. Our late sensate society no longer even bothers to ask whether physicians have the right to kill certain patients but assumes that they do and argues only about how and when.'[10]

It is not surprising that supporters of so-called 'autonomous euthanasia' do not dwell on the fact that what they are claiming as a right is actually restricting the autonomy, or liberty, of other individuals. A short overview on liberty-limiting principles is necessary so that this point can be made clearer. Six 'liberty' principles have been identified by Mappes and DeGrazia. They are:

1. The principle of harm—a person's liberty is justifiably restricted to prevent that person from harming others.
2. The principle of offense—a person's liberty is justifiably restricted to prevent that person from offending others.
3. The principle of paternalism—a person's liberty is justifiably restricted to prevent that person from harming him or herself.
4. The concept of extreme paternalism—a person's liberty is justifiably restricted to benefit that person.
5. The principle of legal moralism—a person's liberty is justifiably restricted to prevent that person from acting immorally.
6. The principle of social welfare—a person's liberty is justifiably restricted to benefit others.[11]

After reviewing these principles, it is easy to see that the inclination of self-determination is not toward an absolute right but a relative right, relative to the extent that our rights can and are limited by our interactions with other human beings. The general reason for such restraint is obvious; underlying social values are the standards for most rights determinations.

For example, a man is caught after killing seven people 'for fun'. He is caught, tried, and convicted. He is placed on death row. The man's autonomy has been restricted due to the social nature of his actions. It is wrong to kill other people for fun. He cannot claim an absolute right to killing, as this would circumvent the autonomy of those who would be killed! (A violation of the offence, harm, and legal moralism principles, etc.) Thus, any absolute right to autonomy is founded on an insecure premise. J.P. Salranck has pointed out that '... an individual cannot invoke autonomy to justify an ethical or legal claim to acts such as assisted suicide; rather he must vindicate the underlying value that the autonomous act endeavors to attain'.[12]

There will no doubt be those who say we have a problem assigning what value is the greatest good; and they will be right! But, while what constitutes the greatest good is controversial, the notion that the greatest good can be achieved autonomously seems equally contentious.

Absolute Autonomy is Not Consistent with a Christian Worldview

If God's attributes are accurately identified, (that he is creator, sustainer of the universe, sole source of moral goodness, eternal, infinite, necessary, omniscient, omnipotent and sovereign), then, according to Mark Blocher, '... there is no room for created, finite, mortal beings to be self-sovereign'.[13]

The Holy Spirit who indwells each believer serves as a guide, teacher, and enabler of discernment. Christians, thus, are never autonomous in any aspect of their lives. In actuality, the very idea of Christianity involves submission, an act which cannot be accomplished without someone to whom to submit! Both 2 Corinthians 3:5 and John 15:5 illustrate the fact that believers are dependent upon God, are not themselves sovereign, and are certainly not autonomous.

If autonomy can be inferred at all from the biblical texts, then surely a fair reading of Romans 1:24–28 reveals an example of how this autonomy is expressed.

> 24 Therefore God gave them over in the lusts of their hearts to impurity, that their bodies might be dishonoured among them.
> 25 For they exchanged the truth of God for a lie, and worshipped and served the creature rather than the Creator, who is blessed forever. Amen.
> 26 For this reason God gave them over to degrading passions; for their women exchanged the natural function for that which is unnatural,
> 27 and in the same way also the men abandoned the natural function of the woman and burned in their desire toward one another, men with men committing indecent acts and receiving in their own persons the due penalty of their error.
> 28 And just as they did not see fit to acknowledge God any longer, God gave them over to a depraved mind, to do those things which are not proper,
> 29 being filled with all unrighteousness, wickedness, greed, evil; full of envy, murder, strife, deceit, malice; {they are} gossips,
> 30 slanderers, haters of God, insolent, arrogant, boastful, inventors of evil, disobedient to parents,
> 31 without understanding, untrustworthy, unloving, unmerciful;
> 32 and, although they know the ordinance of God, that those who practise such things are worthy of death, they not only do the same, but also give hearty approval to those who practise them. (NAS)

In Galations 5:17, the apostle also observes that '... the flesh sets its desire against the Spirit, and the Spirit against the flesh; for these are in opposition to each other so that you may not do the things that you please'.

In fact, only God himself is absolutely autonomous (or sovereign). His sovereignty is exercised in relation to his creation. Gilbert Meilaender explains why sovereignty is so important: 'If my life is not simply my possession to dispose of as I see fit, as if the God-relation did not exist, the same is true of the lives of others. I have no authority to act as if I exercised lordship over another's life, and another has no authority to make me lord over his life and death. Hence, Christians should not request or cooperate in either assisted suicide or euthanasia.'[14]

Much of the euthanasia debate has focused on the aspect of suffering and mercy. There is no question that this is the most difficult part of debating euthanasia in some cases. However, suffering, as a category, simply does not suffice as an adequate justification for assisting someone in his or her death. A Christian acquaintance of mine who supports euthanasia told me that in his view euthanasia was allowable and that scripture supported such a stance. He pointed out that Jesus himself had stated in Matthew 23:39, '... You shall love your neighbour as yourself.' He then told me that since he would not wish to suffer a horrible death, that it would be immoral and un-Christian to deny a neighbour's wish to also avoid such an end. If we did not aid our neighbour, we would be unmerciful.

I pointed out to this fellow that we needed to review the passage he quoted more carefully. I shared a passage from J. Kerby Anderson's book, *Moral Dilemmas*. 'Christians are commanded to love others as they love themselves (Matthew 22:39; Ephesians 5:29). Implicit in the command is an assumption of self-love as well as love for others. Suicide, however, is hardly an example of self-love. It is perhaps the clearest example of self-hate.'[15]

In fairness, perhaps Anderson goes too far. A better term than 'self-hate' would be 'infidelity', for suicide selfishly sacrifices our relationship with our Creator by assuming a greater good can be achieved through our autonomous actions rather than through God's sovereign providence. A biblical example can be found in the book of Job where the Devil is allowed to inflict boils upon Job. The first euthanasia advocate was there. In Job 2:9, Job's wife says, 'Do you still hold fast to your integrity? Curse God and die!' She was, in essence, calling Job to be unfaithful to God's sovereignty and pushing Job to be his own master and end his

suffering, something she assumed to be a greater good for Job. Job, however, recognized the problem with this approach and answered appropriately, 'Shall we indeed accept good from God and not accept adversity?' (Job 2:10 NAS)

Suicide is not a clear-cut example of self-hate, but it is an example of infidelity to God. Knowing these facts, I then pursued the matter of euthanasia with my colleague, and I also posed a scenario: What if a child came to you and told you that his life was miserable? School was terrible. He was picked on daily. He claimed he had no friends, little money, and had such severe asthma that he could not participate in sports. The boy then surprised you by asking if you would 'just kill me and put me out of my misery'.

For the most part, my interlocator had no doubts that the destruction of the child would be unwarranted. My next question was very simple. If we love our neighbour as we love ourselves, then shouldn't we show mercy to this child by helping him to end his life?[16] It is a *sincere* request, after all. Shouldn't we honour it? I certainly would not wish this child's circumstances upon me as they sound quite oppressive. The fellow to whom I posed this question shook his head and sighed, 'A child cannot rationally make such a decision.'

The child's life belongs to his parents and family, just as a Christian's life belongs to God. In addition, just as a parent knows better than to accede to a child's demand, so God does not always grant his children what they desire or request. What this child, indeed any person who is in such terrible circumstances requires, is mercy *not death*!

Said Lactantius (c. 240–320 AD) in his work *Epitome*: 'For it was God who placed us in this abode of flesh: it was He who gave us the temporary habitation of the body, that we should inhabit it as long as He pleased. Therefore it is to be considered impious, to wish to depart from it without the command of God. *Therefore violence must not be applied to nature*. He knows how to destroy His own work. And if any one shall apply impious hands to that work, and shall tear asunder the bonds of the divine workmanship, he endeavors to flee from God, whose sentence no one will be able to escape.'[17]

How does this lead us to the Holy Spirit? First, as believers, the Holy Spirit works within our hearts as our guide, (Romans 8:11–16). 'The Spirit himself bears witness with our spirit that we are children of God (v. 16).' Thus, even in our spirit, the Holy Spirit is effective in his work.

As Christians, our character is not to be one of autonomy but one of transcendent involvement and dependence upon our Creator. The Holy Spirit maintains an active role in the direction and formation of that character. God is a triune being with attributes of omniscience, omnipotence, omnipresence, and, of course, sovereignty.[18] Therefore, we cannot exclude the sovereignty of the Holy Spirit over our lives and we must not capitulate to a sub-Christian view of human autonomy.

In 'Euthanasia and Christian Vision' Gilbert Meilaender writes, 'Life is a great good, but not the greatest good (which is fidelity to Christ).'[19] Indeed, our fidelity, our faith in Christ is the greatest good. This good is realized by our interaction with and our submission to God's grace and the guidance of the Holy Spirit. Since God's omnipresence and sovereignty are manifested in part by the Holy Spirit, it would be incorrect to suggest that we are completely 'sovereign' or truly 'autonomous'.

Conclusion

Autonomy is not suitable as a premise for the euthanasia argument. Indeed, the idea is self-refuting and thus serves as a poor basis for promoting euthanasia. Furthermore, we have seen that autonomy is not a supportable concept using a best reading of scripture on the subject.

Death is an unnatural event. It was not present in the beginning of creation and scripture says that it will be abolished at the end of time. Its intrusion into our lives is unavoidable, however, and we must deal with its implications. As Christians, this does not include making death our ally.

If there is a problem with suffering, the answer certainly does not lie in the extermination of the individual struggling in the midst of such a crisis. It lies in the maximizing of care to dying patients, not in expediting the demise of those needing care. To use autonomy as a foundation for a right to euthanasia and to promote such a right as correct in the light of scripture is a tandem error, as we have already seen.

Finally, the Holy Spirit speaks to us through the scriptures as well as directly to our spirit. We cannot ignore what a best reading of the scriptures has to say on this subject. We also cannot ignore that it is God's omnipresence and sovereignty which make true autonomy such an illusory idea. We are never alone. That is the truth of the Christian way of life. And it is why autonomy as a basis for euthanasia fails from the Christian point of view.

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How Then Should We Die?: California's 'Death With Dignity' Act

Perhaps the greatest challenge facing contemporary culture is that of arriving at a clear and convincing consensus on what constitutes moral surety as well as agreement on what knowledge can serve as an adequate foundation for living the moral life. Our pervasive postmodern cultural drift has left us in a wake of moral and intellectual confusion and chaos. To be sure, ours is a culture that is at once both profoundly complex and ambiguous; a culture in which wholehearted tentativeness is extolled as a virtue. We are so steeped in the rhetoric of tolerance, relativism, and pluralism that we little recognize that morality, rights, and justice require a transcendent referent.

Our generation is lost to the truth that human dignity is anchored by a shared conviction that all human beings are made in the image of God. For this loss our culture is paying dearly, and with it goes the moral fabric and traditions of the public square and its institutions. And of this there may be no plainer example than the process of secularization occurring in medicine.

Having abandoned the reality of divine involvement in the creation and sustenance of human life, contemporary culture now toys with what it means to be human without God. Increasingly popular is the view that whether one possesses dignity or not turns on the question of suffering. In modern parlance it is simply undignified to suffer. Suffering, somehow, is believed to reduce a person to a state that is incompatible with dignity. Therefore, it should come as no surprise that one of the most pressing social issues today involves the effort to legalize physician-assisted suicide-a project based upon the view that people ought to 'die with dignity'.

In California this view is embodied in Assembly Bill 1592, the 'Death with Dignity Act'. Introduced by Assemblywoman Dion Aroner (D-Berkeley/Richmond) on February 26, 1999, Assembly Bill 1592 is intended to establish California as the second state in the nation to legalize physician-assisted suicide.[1] Patterned closely after Oregon's groundbreaking law, the California bill provides for a terminally ill patient to end his or her own life when certain conditions exist.

The purpose of this essay is to review the historical development of California Assembly Bill 1592 (AB1592). An evaluation of both the content of this bill and the process by which it was introduced to the California State Assembly will be offered. The student of bioethics will here find that the usual arguments in support of physician-assisted suicide in the United States, as well as euthanasia in the Netherlands, have been employed in support of AB1592: namely, suffering and autonomy.[2] Given the rather predictable pattern of argument advanced by advocates of physician-assisted suicide and euthanasia, this discussion will prove useful for those who wish to offer an informed and sensitive Christian response to similar legislative efforts in other states and countries.

A Review of the Content of California AB1592

The California 'Death with Dignity Act' authorizes an adult to make a request to end his or her life if: 1) the person meets certain qualifications, 2) the person is determined by his or her attending physician to be suffering from a terminal illness, and 3) the request for lethal assistance is made in conformity with certain procedural instructions. The bill states that the provisions of AB1592 are intended to establish the procedures by which a person may make a request to end '. . . his or her life in a humane and dignified manner'.[3]

The proposed law would provide immunity from civil liability, criminal prosecution, or professional disciplinary action to those participating in good faith compliance with the act. Furthermore, the bill states quite plainly that nothing in its provisions should be construed as permitting lethal injection, mercy killing, or active euthanasia.[4] Moreover, actions taken in accordance with the provisions of the bill would not be construed as constituting suicide or homicide.[5]

Among the general provisions of the bill are the qualifications that the patient must be an adult of 18 years or older; capable of making and communicating health care decisions to his or her health care providers; and that an 'informed' decision to end his or her life has been based upon an appreciation of the facts concerning medical diagnosis, prognosis, options, and risks and benefits of taking the prescribed medication.[6] The 'qualified patient' must also be a resident of California and suffering from a terminal illness. The bill defines 'terminal illness' as an incurable and irreversible disease that has been medically confirmed and will, within a reasonable degree of medical judgement, result in death within six months.[7]

The California bill also includes 'safeguards' that are designed to reduce the chances that the provisions of the law are misapplied, that patients have been assigned an incorrect diagnosis, or that a patient's request to end his or her life is as a result of an emotional or psychological problem. As such, before a patient may be considered as a candidate for physician-assisted suicide, a consulting physician must confirm the medical diagnosis and any symptoms suggestive of a psychological disturbance must be addressed.[8] Furthermore, requests for assistance in dying must be voluntarily expressed in writing and witnessed by at least two individuals, one of whom is a disinterested party to the estate of the patient and uninvolved in his or her care.[9]

In an effort to minimize the chances that a request for death is a consequence of an emotional problem, the attending or consulting physician who is of the opinion that the patient may be suffering from a psychological disturbance will make a referral for counselling. No medication intended to end life would be prescribed to the patient until the person conducting the counselling determines that the patient is not suffering from a psychological disorder, including depression.[10]

Finally, the bill proposes that in order to receive a lethal prescription, patients must make both an oral and a written request for assistance in dying. The verbal request must be reiterated to the attending physician no fewer than 15 days after making the initial oral request, and no fewer than 15 days must elapse between the initial oral request and the provision of a lethal prescription. Furthermore, no fewer than 48 hours must elapse between the patient's written request and the writing of the prescription. The California bills states that a patient may rescind his or her request at any time and in any manner.[11]

A Review of the Process of California AB1592

Reports of AB1592 had been splashed across the headlines of California newspapers before it was introduced before the state legislature in February 1999, and the story headed the evening news on several local television stations. Reports of the bill's first hearing before the State Judiciary Committee, however, passed with little notice—the nation's attention had been diverted and its hearts were heavy. American society was drowning in a maudlin emotion of grief and shock.

At precisely the same hour that the 'Death with Dignity Act' was being heard in the judicial hallways of Sacramento, California, two youths brimming with rage and emptied of compassion were living out their twisted fantasies of fame and revenge by slaughtering innocent life in the school hallways of Littleton, Colorado. And only weeks before the California judiciary hearing, Jack Kevorkian had been convicted of murder for participating in the same conduct that assembly members were now being asked to view as compassionate and empowering.

In a deeply emotional and moving presentation, Assemblywoman Dion Aroner argued that the AB1592 '. . . is about compassion, but more than that, it is about choice. This is about how people spend the last days of their lives.'[12] Perhaps there was not a dry eye in the room when Ms. Aroner finished telling the judiciary subcommittee a story describing the slow and agonizing death of a loved-one. Those in the packed auditorium were clearly moved. Even people who were in sharp disagreement with her proposed bill had difficulty feeling anything but deep sympathy. Yet there was something more etched into the faces of those who filled the room—a vague sense of anxiety about what would happen if they were to find themselves similarly situated. Uncertainty, particularly when it involves death, tends to nourish fear.

The sympathy and fear that had lingered in the air following Ms. Aroner's presentation quickly evaporated and was replaced by joy and celebration when several opponents of the proposed legislation told their stories of loved ones who experienced peace and triumph in the midst of pain and suffering. Suddenly, hope and optimism sparkled in eyes which had been heavy with gloom and despair only moments before. Such is the power of stories; such is the fickleness of the emotions they produce.

Several members of the judiciary committee had been absent during the hearing—occupied by competing legislative commitments. As such, those Assembly members in attendance during the morning hearing registered their votes and the bill was placed 'on call' until that afternoon when their missing colleagues could rejoin the committee. The partial vote was split and early indications suggested that the bill was unlikely to pass out of committee. During the recess that followed the first round of voting, various individuals and interested groups in the audience spilled into the hallways and outside onto the lawn to discuss the perceived leanings of those Assembly members who had not been present for the morning hearing.

Perhaps feeling assured that the bill would not secure the required number of votes necessary to pass, many in the morning audience left the state capitol and only a modest band of interested individuals followed the judiciary committee into their afternoon session. Conspicuously absent from the afternoon session were Assemblywoman Dion Aroner and Assemblywoman Audie Bock (Green Party-Oakland). Ms. Bock had been present for the morning hearing and had voted against the bill. However, she was a newcomer to the Assembly and the hallways were buzzing with speculation that Ms. Aroner had taken Ms. Bock to some secluded area of the capitol and was trying to persuade Ms. Bock to change her vote.

Often overheard was the rumour that Ms. Aroner was using data from a recent Field Poll to convince Ms. Bock that fully 75% of Californians supported the right of an incurably ill patient to request and receive life-ending

medications. On such a view, it was presumed that Ms. Aroner was arguing with the freshman legislator along the following lines:

1. legislators have an obligation to enact the collective will of the people;
2. the majority of Californians are in favour of physician-assisted suicide;
3. therefore, legislators must support AB1592.

Yet others remained fully convinced that the defeat of AB1592 was a foregone conclusion—a mere formality—and that there was little reason for concern.

In the late afternoon, judiciary committee chair, Sheila Kuehl (D-Santa Monica), called for the remaining votes on AB1592. At nearly the same time that the votes were being called, Ms. Aroner and Ms. Bock walked in through a side door and assumed their seats. The remaining Assembly members who were absent from the morning session registered their votes and the bill was defeated on an 8–7 margin. However, before the gavel could be brought down —signalling the end of AB1592—Ms. Bock leaned forward, switched on her microphone, and advised Ms. Kuehl that she wished to change her earlier vote from 'no' to 'yes'. Thus, the bill passed through the Assembly judiciary committee on an 8–7 vote and would move on to the appropriations committee.

The California Assembly Appropriations Committee has been regarded by many as merely a 'rubber stamp stop' for Assembly bills making their way along the judicial road to becoming law. So the assumption was that AB1592 would easily pass through the appropriations hearing and that the next formidable battle would occur when the bill passed from the appropriations committee to the full legislature. Accordingly, few attended the appropriations meeting.

On May 27, 1999, AB1592 was brought before the Assembly Appropriations Committee late in the evening. However, in contrast to what many had suspected, the bill would not be 'rubber stamped'. Rather, Ms. Aroner would have to ask Assembly Speaker Antonio Villaraigosa (D-Los Angeles) to temporarily remove Assemblyman Herb Wesson (D-Culver City) late that evening and replace him with Assemblywoman Hannah-Beth Jackson (D-Santa Barbara). Ms. Jackson was a known supporter of AB1592 and would cast the deciding vote that allowed the bill to move out of the appropriations committee.

When interviewed about his late evening change in Assembly members for the vote on AB1592, the Assembly Speaker said that he had 'made a commitment' to Ms. Aroner to get the bill out of committee.[13] Mr. Wesson would later state that he did not mind being replaced because he would have voted against the bill and that his temporary removal from the committee 'probably made my life easier'.[14]

As for Ms. Aroner, she proudly told reporters that she was very happy with the bill's progress through the legislature. 'I think it's phenomenal. No one ever expected this to get out of its first committee', she said.[15] Nevertheless, Ms. Aroner announced the day following its approval by the appropriations committee that she would wait until the following year before attempting to present AB1592 before the entire state Assembly. 'I don't have the votes. The Legislature's not where the public is, it's really clear', she said.[16] She added that she would take the following months to meet with her fellow legislators in an effort to convince them of the bill's merits.[17]

A Review of the Arguments in Favour of Physician-Assisted Suicide

Disillusionment over the American judicial process is soaring; one needs only to consult election-day participation statistics and measures designed to capture public sentiment concerning our political processes to see that this is so. As if anyone needed additional reasons to become further disenchanted with government politics, the process by which AB1592 has advanced through the California Assembly strains credulity and inflicts further insult on a beleaguered culture that has lost its faith in those who don the mantle of authority in our society. While some proponents of the California 'Death with Dignity Act' stressed that the merits of physician-assisted suicide legislation could be discerned through rational discussion and debate, the manner by which California AB1592 has proceeded belies such an assertion.[18] Rather, the bill's 'success' has been thus far contrived—the product of backroom deal-making and late-night manipulation of Assembly committee composition. To state that the bill's progress has been 'phenomenal' and feign surprised delight concerning its approval in committee hearings is disingenuous at best.

When arguments in favour of AB1592 have been advanced, they assume the usual form. Autonomy (choice) and relief for those who suffer greatly (compassion) are common to all arguments advocating physician-assisted suicide and euthanasia. Typically, choice and compassion are bundled together and presented as though they comprise a single argument in support of assisted death.[19] Constructing her argument this way, Assemblywoman Aroner asserted that: 'A mentally competent person suffering from a terminal illness who is in great pain should have the option of peacefully ending his or her own life.'[20] Indeed, at first sight, this appears as a single reason for allowing physician-assisted suicide. Upon closer examination, however, one notes that this argument is actually comprised of two separate and distinct elements: autonomy and suffering.

The first element is autonomy—the mantra of the latter half of the 20th century. The word autonomy derives from two Greek words: *auto*, meaning self, and *nomos*, meaning law. Strictly construed, the rule of autonomy maintains that each person is a lawgiver to himself or herself. Under such a view, each person has a right to self-determination in decision-making. One hears variations on the theme of autonomy every day: 'This is my life and I can do with it as I please.' 'Who are you to tell me what I can or cannot do with my life?' 'Well, that may be true for you, but it's not true for me.' With respect to the physician-assisted suicide debate, autonomy frequently involves the claim that people ought to be empowered to *choose* both the manner and time of their own death.

Meilaender offers an insightful critique of this assertion when he comments, 'If self-determination [autonomy] is truly so significant that we have a right to help in ending our life, then how can we insist that such help can rightly be

offered only to those who are suffering greatly?'[21] The implications are straightforward. Surely those who do not suffer greatly likewise possess a right to self-determination. Why are we not constrained by the same logic to offer assistance to those seeking death and who are not suffering greatly?

During many years in practice as a clinical psychologist, I counselled numerous people who were experiencing serious emotional, financial, interpersonal, and mental conditions. Truly, their suffering was very real and deeply painful. Occasionally, the one receiving counsel would view his or her situation as hopeless and not perceive that there were viable options for extrication from seemingly unbearable circumstances. At such times, some would voice the intention of bringing life to an end. Depending upon certain clinical factors, mental health professionals are legally, ethically, and professionally bound to preserve the wellbeing and safety of the one making such a threat, including involuntary hospitalization, if necessary. But again, if these people are autonomous, do not they have a right to exercise self-determination?

The language of self-determination and autonomy is based upon the view that each one owns his or her life and may do with it as one pleases. Clearly, this notion is hostile to any Christian understanding of human life. The testimony of the scriptures is consistent throughout—our lives are entrusted to us by the Creator. Life is not to be regarded as our own. The apostle Paul brings this point home with some force when discussing the topic of sexuality purity: 'Flee from sexual immorality. All other sins a man commits are outside his body, but he who sins sexually sins against his own body. Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? *You are not your own; you were bought at a price.* Therefore honour God with your body'.[22] The Christian recognizes that he or she has been bought with a price, we are not our own!

The second element is suffering. As previously mentioned, contemporary culture has embraced the view that suffering is incompatible with human dignity—it is simply undignified to suffer. Hence, suffering must be either adequately controlled or fully eliminated from the human experience of death, and when this is not possible, death is believed preferable to suffering. One strongly suspects that advocates of physician-assisted suicide are confusing pain with suffering, for when asked to provide an example of uncontrolled suffering, advocates of physician-assisted suicide frequently describe a case involving unresolved physical pain.

Clinical vignettes involving 'uncontrolled' pain are proving exceedingly problematic for advocates of physician-assisted suicide. There is a growing consensus among medical professionals that all physical pain can be controlled.[23] Moreover, though stories about the failure of morphine to provide adequate pain relief abound, few advocates of physician-assisted suicide mention the medications Dilaudid (hydromorphone) or Levorphamol—each about five times more effective than morphine. Similarly, little is heard about the medication Fentenyl, a synthetic pain reliever that is about one hundred times more potent than morphine.[24]

If all pain can be controlled by the judicious and adequate administration of powerful pain-relieving medications, the advocate of physician-assisted suicide must alter the form of the argument. Perhaps for this reason, much of the rhetoric involved in more recent discussions of physician-assisted suicide has been marked by the substitution of the term 'suffering' for 'pain'. On such a view, it is argued that society has a moral obligation, based upon compassion, to either relieve or eliminate unbearable suffering.

However, does this change in focus and semantics resolve the problems created by previous arguments for physician-assisted suicide based upon the need to alleviate pain? Meilaender thinks not. He applies the same logic that he employed in his critique of autonomy to the question of suffering. He writes, 'Similarly, if the suffering of others makes so powerful a claim upon us that we should kill them to bring it to an end, it is hard to believe that we ought to restrict such merciful relief only to those who are self-determining, who are competent to request it.'[25] Indeed, the experience of suffering is not restricted to those who are autonomous!

As in other legislative debates concerning the merits of physician-assisted suicide, some California supporters of AB1592 charged the Christian community with reacting to the sufferings of others with cool indifference, or worse, callous disregard. According to the argument, surely God would not want those he loves to suffer—to allow human suffering to continue unchecked is incompatible with any coherent notion of a merciful and gracious God. Accordingly, it is argued, Christians should—among all people—favour safe and legal procedures that would allow a human being to escape the agonizing grip of unbearable suffering. How does the Christian respond?

Human suffering is neither enjoyable nor desirable—the scriptures never suggest otherwise. However, the Christian perspective recognizes that suffering may bring about qualities of character and positive benefits in a person's life not otherwise gained. The apostle Paul writes that the Christian rejoices in sufferings because of the perseverance, character, and hope that it develops in the believer's life.[26] Elsewhere, Paul comments that the Christian's troubles result in an eternal glory and the infusion of Christ's power in the life of the believer.[27]

The apostle Peter encourages his readers with the thought that suffering serves to refine one's faith and prove it genuine. In the process of endurance, the believer makes known the person of Christ, and praise, glory and honour result.[28] And the book of Job provides compelling evidence of how benefits were gained through the process of suffering. To be sure, the presence of suffering in the world comes as a result of the fall, but God can, and does, use suffering to work good into our lives.

Finally, the scriptures provide no indication that escape from suffering is necessarily God's will. Recall that the Lord Jesus Christ, prior to his crucifixion, prayed three times that the cup of suffering he was about to endure be removed from him if it were his Father's will. Thankfully for those who have claimed the grace and forgiveness from sin found only in Christ's shed blood, and who are now forever alive in him, it was not! Can you imagine our lost and hopeless state if God's will is that suffering should always pass from those he loves? Indeed, it was on the basis

of Christ's suffering that grace and forgiveness were extended to those who call upon his name and place their trust in him.

Legislative 'Safeguards' in Physician-Assisted Suicide

For many, the central issues of concern with respect to physician-assisted suicide turn on the potential for tragic and irreversible consequences pursuant to its misapplication. More specifically, the public worries about the accuracy of medical diagnoses and the motives of financially-interested family members as well as cost-conscious hospitals and insurance carriers. The exquisite vulnerability of those who are disabled or elderly is frequently raised as a troubling issue, as is the mental status of patients requesting assistance with dying. Such concerns are not without merit, given that similar problems have haunted the Dutch experience. In an effort to allay these fears, the California 'Death with Dignity Act' contains a number of 'safeguards'.

First, AB1592 requires that the patient requesting physician-assisted suicide make a voluntary and informed decision based upon an understanding of his or her diagnosis, prognosis, and treatment options. The bill states that the patient must be suffering from a terminal illness diagnosed by his or her attending physician and confirmed by a second consulting physician. This 'safeguard' is intended to protect against misdiagnosis and to ensure that, within a reasonable degree of medical judgement, the patient has no longer than six months to live.

On the surface, this 'safeguard' makes considerable sense. The public is now quite aware that autopsies revealed that most of Jack Kervorkian's clients were not terminally ill and that some of his clients showed no anatomical evidence of physical disease. Accordingly, a second opinion regarding terminal illness seems imperative.

However, research indicates that medical prognostication is more art than science. In one study, patients receiving a terminal diagnosis (i.e., death will probably occur within six months) were followed over the course of their care. Depending on the type of diagnosis assigned, some 20–35% of the patients studied were still alive after six months. Even more startling was the finding that between 12–20% of these 'terminally ill' patients were still alive after one year![29] These statistics did not change when a second opinion was obtained.

Within scientific disciplines, including the social sciences, such error rates are viewed as excessive. Generally, a 1–5% margin of uncontrolled variance is considered acceptable, in contrast to the 20–35% figure reported for medical prognostic accuracy involving terminal illness. In short, the medical profession is simply not able to reliably diagnose terminal illness within a reasonable degree of certainty.

Second, AB1592 allows attending or consulting physicians to refer a patient seeking assistance with dying to a mental health professional if, in the opinion of the physician, the patient may be suffering from an emotional or psychological problem that may interfere with his or her exercise of sound judgement. On the surface, this 'safeguard,' likewise, seems quite reasonable. However, a couple of points serve to illustrate the problems with this 'safeguard'.

Research studies have consistently affirmed that most general practice physicians are unable to discern even the most common forms of psychiatric problems in medical and hospital patients.[30] In one study, fully 80% of general practice physicians were unable to identify the hallmark signs and symptoms of clinical depression.[31] Clearly, the ability of general practice physicians to detect the presence of possible emotional or psychological disturbance is wanting.

In some circles it has been suggested that the problem of unrecognized psychiatric disturbances among those seeking death is resolved by requiring all candidates for physician-assisted suicide to undergo a psychiatric or psychological evaluation. However, such a proposal does not settle the issue. The dying person is teeming with emotions. The one facing death struggles against an undercurrent of alternating disbelief and hope, itself superimposed against a backdrop of terror, rage, anguish and surrender. The psychological pendulum in the mind of the dying swings between the extremes of denial on the one end, and acceptance on the other. For days or even weeks, the dying person may present to loved ones and medical staff a seemingly quiet and resigned acceptance of his or her own death. However, the pendulum frequently swings again and the dying person can express unrealistic thoughts about leaving the hospital or making plans for travel following discharge.[32]

The matrix of the mind is exceedingly complex—much more so when confronted with the prospect of impending death. A 'decision' for physician-assisted suicide might be made while the dying person is in a mental state characterized by a temporary acquiescence to death's summons, and, thus, merely reflect the patient's transient state of acceptance. And should the patient undergo a psychological evaluation during such times, the emotional turmoil churning under the surface of a reposeful air may escape notice.

Furthermore, what is to prevent a physician favouring physician-assisted suicide from making a referral to a psychiatrist or psychologist known by the physician to be similarly predisposed to a patient's right to choose? These forms of professional alliance are common and should a referral occur under this scheme, the mental health evaluation may be conducted with a view toward political expediency, rather than in response to honest inquiry or medical necessity. Mental health workers frequently rely on primary care physicians for their referrals, and the politics involved in these relationships should not be ignored. The competition for mental health referrals is frequently quite keen and, as a result, some are unwittingly (or otherwise) ensnared by a confirmatory bias—the tendency to provide the expected feedback in hopes of winning favour with the referring physician and encouraging future referrals.

Many physicians desire honest, straightforward, and competent information from their consultants—even if the consultant's opinions differ sharply from those of the referring physician. Unfortunately, this is not always the case and the consultant who disagrees with the referring physician's subjective clinical impressions may find his or her telephone referral line strangely quiet.

This problem is not merely theoretical. Frequently, physicians and attorneys will refer to psychologists and psychiatrists whom they believe will provide a desired opinion. These types of referrals regularly occur in civil, family and criminal law applications of behavioural medicine where a specific mental health professional is retained due to his or her reputation for being pro-defence or pro-plaintiff.[33] Referred to as 'hired guns', these mental health professionals make their living by offering predictable and biased reports favourable to the cause of the one who has retained them. Clearly, mandating mental health evaluations for some or all candidates for physician-assisted suicide is not the 'safeguard' it purports to be.

This review suggests that the proposed 'safeguards' in AB1592 are unable to resolve the fears they seek to assuage. The medical profession has yet to develop prognostic capabilities that are sufficient for the purpose intended in the 'Death with Dignity Act'. And the difficulty experienced by most general-practice physicians in identifying patients suffering from emotional or psychological disturbances, coupled with the professional alliances and political climate in which referrals are frequently made, renders the mental health 'safeguard' problematic.

Towards a Christian Response

If the Christian community is to gain traction in resisting the intellectual and moral decline of our culture, we will need to become more thoughtful and perceptive of the postmodern worldview that surrounds us. Efforts to legalize physician-assisted suicide fail to acknowledge the biblical worldview concerning human dignity, suffering, death, and the afterlife. Furthermore, the scriptures consistently affirm that it is God, not humans themselves, who is in control of life and death.[34] The Christian worldview insists that this is not our life to do with as we please.[35] Rather, life is to be viewed as a gift that is received and lived moment by moment from the gracious hand of God.[36] This view forbids any notion that we may take our own life, let alone the life of another.

Given postmodernism's misplaced emphasis on utilitarianism and autonomy, it should come as no surprise that much of the discussion concerning physician-assisted suicide—along with the entire array of emerging bioethical tensions in our society—begins at the wrong end of the questions involved. For example, it has long remained a fixity within the western Hippocratic medical tradition that the physician should, *Primum non nocere*—'First of all, do no harm'. Cameron has described how American medicine has largely spurned this Hippocratic maxim over the past twenty-five years following the landmark January 1973 Supreme Court decision, Roe v. Wade.[37]

Today, our culture begins at the opposite end of the issue. As Assemblywoman Aroner stated in support of AB1592, 'This measure is about compassion and choice.'[38] In evidence of how far our culture has slipped in such a brief period of time, Brown invites us to consider the following: 'Our late sensate society no longer even bothers to ask *whether* physicians have the right to kill certain patients but assumes that they do and argues only about how and when.'[39]

The bioethical agenda in our society has allowed the proverbial camel to poke its nose under the tent. Several questions naturally follow from the discussions in California concerning AB1592: How much more ought we to allow? Will this lead to euthanasia? What affect would the Americans with Disabilities Act have upon this proposed bill which seeks to secure a right for some that would not be available to all?

For example, if a patient was unable to self-administer the lethal medication due to physical or mental incapacity, does not the ADA require that such individuals be afforded the same rights and privileges as everyone else in society? It would seem that the lethal dosage would need to be administered to physically and mentally disabled people by a second party. This would constitute euthanasia and would rapidly move us from 'allowing death,' to 'causing death'. This represents far more than a subtle shift in semantics—it represents a seismic shift in culture. For once we become comfortable with the idea of 'causing' someone's death, where do we go from there?

John Brooke, president of Americans for Death with Dignity, has stated forthrightly that those of religious conviction do not have the right to thrust their morality through legislative action upon those who do not embrace the same beliefs. This argument is receiving increased play in discussions related to AB1592. But is it not true that *all* laws are a reflection of the moral consensus of the constituency that they govern? Indeed, laws are the embodiment of a culture's morality. The argument that one ought not, or cannot, legislate morality is absurd. All laws are moral laws. Laws instruct us concerning what we ought to do or ought not to do. Questions or issues that involve any semblance of *ought* are inherently moral. The question is not whether one has the right to introduce his or her morality into law, but rather, whose morals the law will reflect.

Furthermore, all questions of morality may be evaluated from either a secular or religious perspective. It is not at all clear why only religious perspectives should be barred from shaping the public square while secular views are touted as the 'neutral' or default setting to which our culture must dial its moral bearings and begin its discussions of contemporary issues. Why is it that only the religious paradigm must be held in contempt by our society and excluded from shaping the moral contours of legislative initiatives, including the California 'Death with Dignity Act'?

As Cameron has ably demonstrated, western medicine locates its roots in the Hippocratic Oath—one of the earliest documents adopted by the church with its original pagan content recast in light of first century Christian monotheism.[40] Medicine has been practised since then as an inherently moral art grounded upon the ethical commitments that early Christian revelation affords. On this view, it seems very odd to suggest that those of religious faith should not bring their values and morals to bear on our society's decision whether or not to redirect the future of medicine and legalize physician-assisted suicide.

A far more appropriate question is to challenge proponents of AB1592, and similar bills, to describe the values and morals that are so powerful as to justify tearing the practice of western medicine from its historical Christian foundation. Arguably, medicine's Christian roots ought to

be preserved and serve as the default setting that informs and directs its practice. Quite properly, it seems that the proponents of physician-assisted suicide ought to assume the burden of proof in their efforts to advance AB1592, given that their proposal signals a marked departure from medicine's historical foundations and is totally inconsistent with its moral character.

Finally, when did it become good medical practice to eliminate suffering by eliminating the sufferer? Brown rightly observes that Hippocrates never spoke of 'ending suffering', rather, he spoke only of healing.[41] Brown adds, 'If Hippocrates had been concerned primarily with ending suffering, he would have prescribed rather than prohibited deadly drugs. Instead, he made a categorical distinction between healing and killing, and while he acknowledged that healing is often impossible, he rigorously rejected killing.'[42]

Any notion of killing those who have entrusted their lives into the hands of the healer is unacceptable.

Conclusion

Contemporary culture stands in desperate need of hearing explicit instructions as to how to go about making moral choices, and the Christian church stands in desperate need of faithfully promoting a worldview that captures its convictions. In the bright glare of the postmodern mindset, all traditions seem to fade away. But the world still seeks for that which will provide an adequate foundation for living the virtuous life.

Should our culture fail to hear and heed an informed and sensitive Christian response to its unbridled quest to reformulate the nature of humanity, the consequences might well prove devastating. Christians have much to do and the hour is late. As Colson has observed, 'The truth is that Americans are losing their moral recognition of the universal dignity of human life.'[43] California Assembly Bill 1592 is yet further evidence that this is true.

The church needs to cease from its blind insistence that the issues of bioethics are merely political, legislative, or social in nature. Rather, we need to recognize that the issues of bioethics—including physician-assisted suicide—intersect the very heart and message of the Christian faith. Indeed, the emerging bioethical tensions and agendas are insidiously redefining what it means to be human—a concept so fundamental to our theology. And if this is so, then the issues of bioethics may well represent the central cultural phenomena that the Christian cannot afford to ignore.

The lyrics were penned over thirty years ago, but it is hard to imagine a more timely commentary on our contemporary cultural malaise:

From the canyons of the mind,
We wander on and stumble blind,
Wade through the often tangled maze
Of starless nights and sunless days,
Hoping for some kind of clue—
A road to lead us to the truth.
But who will answer?

Is our hope in walnut shells
Worn 'round the neck with temple bells'?
Or deep within some cloistered walls
Where hooded figures pray in shawls?
Or high above some dusty shelves,
Or in the stars,
Or in ourselves.
Who will answer?

If the soul is darkened
By a fear it cannot name,
If the mind is baffled
When the rules don't fit the game,
Who will answer?
Who will answer?
Who will answer?[44]

The Christian church has been charged with a mandate to answer the call and to push back against a culture that is pushing very hard against it. The California experience with physician-assisted suicide will probably not be the final project for those who would seek to secularize further the public square and its institutions. The arguments and processes described in this chapter will probably be recapitulated in another place at another time.

If the church is to make a difference, she will need to be ready to rise up and speak. Indeed, the subject matter of bioethics is of compelling interest and the problems are certainly worthy of considered reflection. But more importantly, we need to be involved in making a difference because the moral aim of our Christian faith is so important to the quality of the society in which we live, and the eternal destiny of those with whom we share our lives.

References

1. California Assembly Bill 1592, 'The Death with Dignity Act,' may be accessed online at www.leginfo.ca.gov
2. To be sure, there are differences between the American and Dutch perspectives on what constitutes ethical end-of-life care. In the Netherlands, physicians may directly and intentionally end a dying patient's life if certain 'safeguards' and requirements are met. Should government-approved procedures be followed and faithfully reported, Dutch physicians may be excused from criminal prosecution. Such activity constitutes euthanasia, given that the physician administers the lethal medication to the patient. In the United States, physicians are not permitted to directly and intentionally end a patient's life. Rather, AB1592 and similar bills that have been introduced around the country, seek to legalize physician-assisted suicide. Under conditions of physician-assisted suicide, physicians are allowed to provide lethal medications to the patient. However, in contrast to euthanasia, the patient must self-administer this prescription. Advocates of euthanasia in the Netherlands frequently charge that Americans do not understand the Dutch experience and that the arguments in favour of euthanasia in the Netherlands are wholly different from those advanced by Americans in support of physician-assisted suicide. However, the arguments for both euthanasia and physician-assisted suicide are the same; namely, autonomy and suffering. The difference lies in the Dutch emphasis upon the physician's *duty* to end suffering, whereas Americans tend to place greater emphasis upon the patient's *right* to choose the manner and time of his or her own death. For more on the Dutch experience, see David C. Thomasma, Thomasine Kimbrough-Kushner, Gerrit K. Kimsma, and Chris Ciesielski-Carlucci, ed. *Asking to Die: Inside the Dutch Debate About Euthanasia* (Dordrecht, The Netherlands: Kluwer Academic Publishers, 1998).
3. California Legislature 1999–2000 Regular Session, Assembly Bill 1592 (February 26, 1999), 1.
4. Ibid., 2. Mercy killing refers to the belief that human beings ought to be

released from pain and suffering, and that there exist circumstances under which such release may be attained only through death. On such a view, the killing of a person is viewed as an act of mercy. Active euthanasia refers to the commission of an act by a second party that brings about the intentional death of another person. Active euthanasia is frequently accomplished through the administration of a lethal injection.
5. Ibid.
6. Ibid., 3–4.
7. Ibid., 4.
8. Ibid.
9. Ibid., 4–5.
10. Ibid., 6.
11. Ibid., 7.
12. *The Sacramento Bee* (April 21, 1999), A1.
13. *The Sacramento Bee* (May 29, 1999), A3.
14. Ibid.
15. Ibid.
16. Ibid.
17. Ibid.
18. In introducing the 'Death with Dignity Act,' Assemblywoman Aroner said, 'I think we're beginning the discussion [concerning the merits of physician-assisted suicide].' John Brooke, president of Americans for Death with Dignity stated that physician-assisted suicide '. . . is the wave of the future. Physician-assisted suicide is going to be more common.' He added that it was time for California to resume debate over the idea of legalizing physician-assisted suicide. *The Oakland Tribune* (March 6, 1999), A12.
19. Gilbert Meilaender has made a similar observation and comments on this his volume, *Bioethics: A Primer for Christians* (Grand Rapids, Mich.: Eerdmans Publishing, 1996), 62.
20. *The Oakland Tribune* (March 6, 1999), 1.
21. Meilaender, *Bioethics*, 63.
22. 1 Cor. 6:18–20, NIV. Italics added.
23. For example see, Robert L. Sassone, *How to Protect Your Loved Ones From Pain* (Stafford, Virginia: American Life League, 1995), 11–12
24. Ibid., 5.
25. Meilaender, *Bioethics*, 63.
26. Rom. 5:3–5.
27. 2 Cor. 4:17 12:10.
28. 1 Pet. 1:6–9.
29. *The Boston Globe* (May 12, 1997), Sec. A, passim.
30. Reference forthcoming.
31. Reference forthcoming.
32. I wish to express my appreciation to Edwin Shneidman, PhD who, as my instructor in Clinical Thanatology while I was a student at UCLA, contributed greatly to my understanding of the inner world of the dying person. My discussion concerning the psychological dynamics of death bear his fingerprints.
33. See, Robert W. Evans, 'The Use of "Independent Medical Examinations" in Forensic Neuropsychology,' *American Journal of Forensic Psychology* 4 (1992), 3–14.
34. For example, Job 14:5; Eccl. 3:2; and, James 4:13–15.
35. Jer. 10:23
36. Ps. 139:1–16 serves as a striking illustration of this truth.
37. See, Nigel M. deS. Cameron, *The New Medicine: Life and Death After Hippocrates* (Wheaton, Ill.: Crossway Books, 1992).
38. *The Oakland Tribune* (March 6, 1999), 1. The reader will notice that Assemblywoman Aroner here states the two central elements we have just considered in this chapter and common to all arguments for physician-assisted suicide and euthanasia; namely, compassion (suffering) and choice (autonomy).
39. Harold O.J. Brown, *The Sensate Culture* (Dallas, Tex.: Word Publishing, 1996), 201.
40. Cameron, *The New Medicine.*
41. Brown, *The Sensate Culture*, 201.
42. Ibid.
43. Chuck Colson, *Christianity Today Magazine* (November 16, 1998), 104
44. L. El Aute and Sheila Aute, 'Who Will Answer?', *Ediciones Musicales, BMG*, Ariola S.A., (1967).

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Hope, Healing, and Justice in the Abortion Debate

Throughout the last 26 years, abortion has remained the most controversial topic since emancipation. Both proponents and opponents continue to debate the issue. One hears from feminists, conservatives, and 'family planning' agencies. One hears from organized religion, legislators, and ethicists. Rarely though does one hear from those whom the issue effects directly, the women seeking abortion, or those who have experienced it. In a less politicized climate, we would be sought out for our opinions, our descriptions, and our thoughts regarding how to make a horrid situation bearable. Nevertheless, we are ignored. The paradox is that abortion is allegedly about us, the women in crisis, our needs, our safety, our health. The reality is that abortion has its own cache, it is separated from the real world, protected by the very controversy it engenders. Those who presume to legislate any facet of the procedure are accused of wishing to block a woman from access to her 'constitutional rights'. Those who support abortion rights in the cause of feminism or reproductive freedom, actually protect the practice of abortion rather than the person experiencing abortion. Women injured either physically or emotionally by abortion are seen as necessary causalities in the fight for equality by abortion supporters. Some detractors of abortion rights seem to hold our needs a distant second to those of the unborn. It is time that we spoke for ourselves, and had a voice in this debate.

'Legal abortion protects women's health'[1] is the proclamation of Planned Parenthood's website on abortion. This would give one the impression that abortion is a woman's health issue. This assumption does not stand up to scrutiny. Another assertion from the same website is, 'A woman is more than a fetus'.[2] This is a statement with

which few can argue initially. A woman weighs more than a fetus. A woman is taller than a fetus. A woman is older than a fetus. One entity does not have less (or more) value than the other. On reflection, however, does this mean that to support one entity, one must diminish the personhood of the other? In addition, this statement implies that the health of the woman is of paramount importance, superseding everything and everyone else. Planned Parenthood's website also states, 'At the most basic level, the abortion issue is not really about abortion. It is about the value of women in society . . . (anti-abortion leaders) oppose most ideas and programs which can help women achieve equality and freedom . . . They think that the abortion option gives too much freedom.'[3] Predictably, Planned Parenthood (the world's largest abortion provider) also claims that 'Thousands of American women died. Thousands more were maimed' before the legalization of abortion.[4]

Pro-life groups on the other hand, have been instrumental in recognizing, and defining Post-abortion Syndrome. National Right to Life played a large role in publicizing Dr. Joel Brind's research on the link between abortion and breast cancer. Several pro-life groups provide at least referrals for, if not onsite, post abortion counselling. Yet, sometimes their rhetoric about their concern for the woman in crisis and the unborn child being equal does not come through clearly. Fears of 'legitimizing abortion' get in the way of protecting women not only from unwanted abortions, but also from the very real dangers of abortion. Some well-meaning pro-life people may unintentionally cause women in crisis pregnancies to feel less valued.

It is time for the women who have been most intimately acquainted with abortion to have a voice in this debate. Women feel forced into a decision, injured by abortion, or betrayed. It is time that the families of such women have a voice, to give witness to their experiences. We are in our infancy, not quite formed, and still finding our voice. We call ourselves Women for Hope and Justice (WHJ). The group is comprised of women, and their loved ones, who have survived the abortion experience. We are the women who have 'been there, done that, and hated it'. We are medical professionals who have treated abortion injuries. We are attorneys who attempt to seek justice for injured women. We are people who care about women. WHJ held its first national conference last year in St. Louis Missouri, as 'Women at Risk'. A name change was necessary, slowing our formation. Over the last twelve months we have hammered out bylaws and sought to organize ourselves. WHJ is an emerging national coalition of women and their families who either have been pressured into unwanted abortions by others; mistreated by abortion practitioners or abortion counsellors; deprived of information relevant to making an informed decision; injured physically, psychologically, and/or emotionally; or denied legal recourse to seek compensation for injuries inflicted upon us by substandard abortion practitioners.

Women are pressured into unwanted abortions daily. This is quite a paradox when one remembers that abortion is promoted as the ultimate expression of women's autonomy. Again, to cite Planned Parenthood: 'Many hard battles have been fought to win political and economic equality for women. These gains will not be worth much if reproductive choice is denied. . . . At the most basic level, the abortion issue is not really about abortion. It is about the value of women in society.'[5] Research by David Reardon of the Elliot Institute indicates that 53% of the women surveyed felt forced by others to have their abortions. Sixty-four percent of the aborted women responding also felt forced by circumstances to abort. Only 25% chose their abortion freely, without any coercion.[6] Frederica Matthewes-Green found that 89% of women abort for social reasons.[7] It is difficult to understand how *any* equality for women can be sustained if a woman feels compelled to abort, especially if she is aborting her pregnancy while she violates her conscience. It is a double violation. Are these statistics imaginary? Are those of us who have experienced abortion just trying to validate our 'choice' and join a society of victims? The answer is a resounding *no!* If anything, we are hesitant to admit that we allowed others to force us into a decision which is promoted as 'being between a woman and her doctor'. We all like to view ourselves as intelligent and competent individuals. In fact, it is the trauma of feeling forced to act against our conscience, which lays the groundwork for later problems. An example or two can be taken from the past year's news stories.

In Tampa, Florida, a law school graduate pleaded guilty to charges that he threatened to distribute a video of his former girlfriend having sex with him unless she agreed to an abortion.[8] In Richmond, Virginia, a woman accepted a $25,000 settlement to cease her lawsuit against Emergency Shelter Inc., which alleged that (employees of the local shelter for homeless women and their children forced her to have an abortion at the threat of being evicted.)[9] A lawsuit filed in Oregon was settled for $385,000 against two high school employees and the mother of the girl's boyfriend. The case was ended when investigators ultimately concluded that Carr, a high school employee, had coerced her into having an abortion, by threatening to turn her in for sex abuse of her high school boyfriend. Lea Huber was taken to get an abortion she later said that she never wanted.[10] These two examples indicate how abortion can be used as a tool against women. These examples also point out the need for legislation to protect women from unwanted abortions, and incompetent abortion providers. Model legislation provided by the Elliot Institute (a copy of the model is located at www.afterabortion.org) seeks to reduce the occurrence of unwanted abortions. This model supports the enactment of tougher laws that would protect minors and women from being coerced into abortions that are contrary to their maternal desires or moral beliefs. This model requires the abortion practitioner to screen their clients for coercion. Every other medical practitioner takes the time to ensure his/her patient is voluntarily consenting to an elective procedure, and is otherwise open to liability. Women with problem pregnancies deserve as much consideration. The model places full responsibility on the abortion practitioner to make sure this is the woman's choice. The woman is the person who determines if this standard was met satisfactorily, not the abortionist. Women for Hope and Justice supports this approach.

Elective surgeries, such as abortion, are always discussed and evaluated in the light of each patient's individual needs. It is part of the doctor patient relationship. Uta Landry, of the National Abortion Federation, concurs: 'The

majority of legal abortions are not performed as a result of a medical indication. They are considered an elective procedure. Such a procedure implies choice . . .'[11] The issue appears still to be *whose* choice the abortion is. An abortionist, who is allegedly acting in the best interests of his patient, is ethically bound to make sure this decision is that patient's decision. A coerced abortion may make the abortionist an unwilling accomplice in covering up a crime. What better way to avoid the discovery of sexual abuse than to eradicate the evidence? Even Planned Parenthood's written materials seem to agree, 'Abortion is not always the best solution to an unwanted pregnancy. You have to decide for yourself if abortion is your best choice. . . . Your counselor will describe the abortion procedure and try to make sure that you are not being pressured into having an abortion by your husband, partner, family or friends.'[12] The webpage goes on to acknowledge grudgingly that 'serious, long term emotional problems after abortion are more likely if having an abortion is related to serious problems in a relationship or other life disturbing events'.[13] That appears to be a tacit definition of coercion. If Planned Parenthood acknowledges the problem, however grudgingly, then it behoves the abortion practitioner to deal with it. A frequent response from abortion advocates regarding this aspect of the proposal is that there is no need for that to be legislated since Planned Parenthood already follows the practice.[14] My response is that *if all* Planned Parenthood abortion facilities are screening their clients for coercion, that is wonderful; however, not all abortion facilities are Planned Parenthood affiliates, and it is vital that all abortion clinics provide the highest level of care possible. The only way to make sure this is accomplished is to place these requirements into law.

Abortion advocates are not the only guilty parties when minimizing the coercion present in the abortion decision. Anti-abortion advocates sometimes have a hard time accepting that 'these women' are not making real choices. Admittedly, it is difficult to get past the rhetoric of the pro-abortion side and see the real picture. Abortion makes women extremely vulnerable. The pressure is to 'get rid of the problem'. Abortion is promoted as safe, simple, and *your constitutional right*. Women are frequently forced to choose between their child and a relationship with a loved one. Pro-lifers have an image of being unforgiving, and of no help at all. Many schools have policies, which forbid pregnant unmarried girls from continuing their education. Some workplaces are hostile to pregnant women. WHJ is aware of the pressures brought to bear on women in crisis. Most of us have been there. We do not want pity, we want justice. We seek to create a more healing environment. Some pro-life advocates may believe that this approach validates the abortion decision, or somehow might threaten or diminish their determination to protect the unborn child. Nothing in this proposal takes a stand, either way, on the morality of abortion. This proposal is woman centred.

Other aspects of the model bill deal with accountability. Currently the abortionist is accountable only to herself. The Centers for Disease Control itself admits that abortion deaths are under recorded. It also acknowledges that 10% of aborted women experience immediate, short-term complications requiring medical treatment. Joel Brind effectively documented the connection between abortion and breast cancer.[15] Thomas Strahan has compiled a long list of professional journal articles, which document the physical risks of abortion.[16] We believe that women have a right to have this information *before* they make a choice.

The strategy is based, surprisingly enough, on *Roe v. Wade*. *Roe* was successfully argued on the basis of a presumed conflict of interest between the woman and her child. The woman's rights, according to the Supreme Court, superseded the child's. This approach emphasizes an impasse between a woman's rights and an abortionist's rights. The woman's rights should take precedence over the abortionist's rights. Surprisingly, the Supreme Court agrees with this stance. The court has found that abortion has serious health risks.[17] *Casey* describes abortion as a 'medical liberty which women have a protected liberty to seek because of their unique health needs'.[18] The responsibility for determining the need for an abortion, considering each patient as a unique individual, rests with the physician. Abortionists are, by court decision, accountable. The model stresses this little considered point, and enforces the accountability that every other physician in the land has to his or her patients. A woman has the legal right to seek an abortion. She may request one, but just as a patient cannot demand that a gall bladder be removed, she cannot demand an abortion if the physician does not feel it is in her best interest. Therefore should the woman have later problems, or in fact is forced into her abortion, the abortionist is liable.

Abortion clinics are self-regulated. The legal justification for this is the right of privacy and physician autonomy. Few clinics have emergency equipment, or admission arrangements in the event of serious complications. Payment is required first which is a formidable form of coercion. Staff counsellors are unlicensed. Counselling is rarely done on an individual basis; rather it is done in a group setting, where the pressure to 'go with the programme' is intense. Post-abortion monitoring lasts for a half hour at the longest. Most complications take longer to appear, notably, uterine atony.[19] Women are given a list of instructions, and told if there are any problems to go to an emergency room—not to return to the clinic. After an abortion at their facilities 'The [Planned Parenthood] clinic will give you written instructions for after-care and a 24-hour emergency phone number to use if complications arise'.[20] However, many women report that there were no instructions given.[21]

Abortion still carries its own burden of shame, guilt, and the need for secrecy. Women are hesitant to make the trip to the emergency room due to the fear of discovery or the fear of expense. Their shame is intensified when they are told even the abortion facility, with its friendly, helpful, staff is not willing to stand by them if complications occur, complications for which the facility itself is responsible.

What if the worst happens? What happens if a uterus is punctured or any one of a number of immediate complications occurs? Does not sound medical practice dictate that an abortion clinic, like other outpatient surgical centres, has emergency equipment, trained staff, and hospital admitting privileges? The textbook for abortion providers lists emergency equipment, including oxygen, Ambu bags, Laryngoscope, and Endotracheal tubes as some of the

'basic emergency equipment necessary for a small abortion practice on the first trimester outpatient laminaria/local anesthesia model'.[22] This would seem to indicate that the standard of care is to have basic emergency equipment, with people trained to respond. This standard is frequently not met. For example, Lou Ann Herron hemorrhaged to death as the abortionist ate his lunch. The paramedics were not called immediately, although an assistant from an affiliated abortion facility was, even though a hospital was across the street. The abortionist was notified of the bleeding an hour and a half after the abortion. Three hours after the bleeding was noted, the abortion clinic supervisor refused to call emergency personnel, without paging the abortionist first. When help arrived, the woman was dead. Dr. Nancy Dickey, president of the AMA said, 'Five or six or seven years ago, you never heard about it [cases of injury]. Now you see them once a year or so. When you ask these district attorneys about it, they say somebody has to hold these people accountable.'[23]

In contrast to a standard pre-op visit, women are not evaluated for any risk factors or health concerns. Abortion counsellors are trained to 'sell' abortions, not to evaluate or assist a woman to address the options and evaluate her emotions. Risks are greatly minimized. Despite the standard of care, which stresses that physicians are obligated to assess risk factors, abortionists do not care to establish or follow such a standard. The risk factors for abortion include uterine abnormalities, multiple gestation, cardiovascular disease, renal disease, asthma, epilepsy, diabetes, venereal infections, intoxication, obesity, and other health conditions.[24] The literature agrees that there are emotional risk factors, the disparity lies within their frequency. These risks include, conflicting maternal desires, moral ambivalence, feeling pressured, feeling the decision is not hers, prior emotional problems, immaturity, low self image, poor coping skills, a history of abuse or emotional trauma, etc.[25] Thus the Elliot Institute model is well within the established standard of care for outpatient procedures, particularly abortion. Requiring an abortionist to screen his patients is clearly reasonable. If the abortionist does not perform the screening, he is liable. If the abortionist identified these risks and proceeded, he is guilty of malpractice. Therefore the burden of proving that the 'treatment' provided to his 'patient' was in her best interests, lies with the abortionist. The proposed intervention does not rely on the patient to volunteer her risk factors. This is the standard in other medical/surgical situations. The abortionist, just like his physician counterpart, must assess his patient to ensure she is capable of making this decision. Uta Landry identified 'symptoms' which indicate poor decision making.[26] This standard is also described in *Obstetrical Decision-Making*

The Elliot Institute model defines a State Abortion Information Depository (SAID) to 'assist physicians in providing full disclosure, and to provide citizens with a central clearing house for information regarding relevant to decisions regarding abortion'.[27] The Department of Public Health would be required to establish and maintain a thoroughly indexed depository of all documents and material which citizens believe are relevant to making an informed abortion decision. . . . The SAID shall maintain at least one copy of each edition of any document submitted by outside agencies regarding:

1. Known or claimed adverse effects of abortion
2. Predisposing risk factors to post-abortion sequelea.
3. Alternative management techniques for crisis pregnancies.
4. Any other information which would be relevant to a reasonable patient or to the standard of care offered by abortion providers.

Copies of any document filed in the Federal Abortion Information Depository shall be available for public inspection.[28] The purpose of the depository is to establish the standards for full disclosure. Anyone who believes abortion has risks or can provide safer alternatives can deposit information and data, which should be available for consideration by patients seeking abortion. The legal presumption will be that abortionists are familiar with the materials in the SAID. If the clinic is sued, the clinic-prepared brochure can be compared to the contents of the SAID. The jury would make the decision whether there is anything in the SAID, which a reasonable patient would have found relevant to her decision but that was not disclosed. If so, the plaintiff has made her case.[29] Items to be included in the Depository include fetal growth and development information and statistical data on risks taken from professional journals. Thomas Strahan has compiled a fully documented list of complications and risks of abortion taken from professional publications. As there is no agreed upon body of research, these materials are crucial for making an informed choice. One would expect the most ardent advocate of 'choice' to agree this is a reasonable proposal. However, recent court cases indicate that the same individuals, who say a woman has a right to choose and advocate autonomy for woman, vehemently oppose such information. For example, three women who had abortions in New Jersey are having to sue the state for the right to sue the practitioners who aborted their unborn children. The women say the abortion practitioners did not obtain their fully informed consent before the abortions.[30]

Another issue addressed in the model is the disparity between public health requirements for outpatient clinics, which *do not* perform abortions, and those that do. Michigan is trying to pass a bill, which ensures merely that basic public health, and safety requirements (regarding things such as the width of hallways, etc.) are followed by abortion clinics. These are laws which other public facilities must follow. The clinics are fighting the legislation, arguing that this is a back door attempt to close clinics and make the abortion decision burdensome.[31] A similar case is under litigation in Louisiana.[32] Such litigation begs the question; just *who* is being protected?

It is markedly apparent that the abortion industry views women with contempt. For years we have heard the slogan, 'Safe and Legal'. Abortion may be legal, but it never will be safe, especially under the current regime which keeps abortion providers in a protective bubble. There have been many news stories about abortionists reusing disposable equipment, injuring their patients, and aiding those who are forcing women to abort. Abortion is about money, not women. Once we acknowledge that, and work towards taking the abortion procedure out of its protective bubble, we will see a significant change in abortion. *The Protection from High Risk and Coerced Abortion Act* has been

introduced in Mississippi by Jackson Right to Life. Bob Marshal introduced it in Virginia, and Al Salvi introduced it in Illinois. Colorado is also working on a ballot initiative. A two-sentence referenda that we would like to see placed on ballots in the states says, 'Women have a civil right to full disclosure of all the information that a reasonable patient may consider relevant to a decision to refuse a recommendation for abortion. The state may not limit a woman's right to recover damages from any injury which may have resulted from an abortion.'

Obviously, this approach is new, and can be somewhat threatening to both sides of the issue. It took time to get a hearing from some pro-life groups, most of which are now very enthused and hopeful. Pro-abortion activist groups are frightened by this. But the majority of those who hold pro-abortion views, because they believe in 'choice', are at least willing to listen. Most people are deeply ambivalent about abortion, and would support this approach. We have even compiled a list of frequently asked questions in order to explain our position clearly. One of the most frequent is, 'Won't this increase the number of abortions if clinics are clean and abortionists are competent, and abortions are no longer dangerous?' My response is, 'Abortion can never be rendered completely safe. The issue is one of the levels of care offered to women, not the abortion rate. Yet, even assuming that raising the level of care and accountability of abortion providers would increase the abortion rate, wouldn't this make Planned Parenthood willing to join us? If abortion is as safe as the industry claims, then nothing will change, aside from incompetent abortion providers being held accountable for their actions. If abortion is indeed a risk to women, then the women themselves will be capable of weighing the risks and benefits of the procedure, which is only appropriate. If abortion is a health risk, why are we pushing women into risking their health? If the fall out of such legislation is a drop in the abortion rate, or the limited availability of abortion, it just indicates how dangerous the current situation is for women. The stated goal for legalizing abortion was women's health. If this is true, then regardless of the impact of abortion on the providers, this legislation is necessary for all concerned. However, the abortion industry has long promoted its safety record, so therefore, should have no objections.' The expectation is that the abortion rate will dramatically drop, if the procedure is as dangerous as it appears to be.

Fortunately, in our judicial system there is a mechanism that can make the abortion industry accountable. But this system must be corrected to remove the artificial protections from full liability enjoyed by the abortion industry. This model will do just that. Making the industry accountable, will certainly impact the way abortions are performed and marketed. It will impact the number of abortions performed. It has been very difficult to get the Pandora's Box of abortion shut. However, we can protect women in crisis, and through them, their children with this proposed legislation. This is not to say the efforts of groups more focused on the unborn child should be dismissed. There is always hope that the hearts and minds of Americans can be changed; but until that time, this approach will save lives and protect women. It is possible that through education more hearts and minds will change, just as they were impacted by the discussion on Partial Birth Abortion. Common ground between the two sides is possible. Both sides do care about women, for the most part. Avoiding the rhetoric and changing the context of the discussion will not only give aborted women a fair hearing, but give witness to the fact that Christians offer hope and healing, and most importantly, the Healer himself.

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Book Reviews

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Valuing People
Gareth Jones
Paternoster Press, Carlisle, 1999

Many Christians will find this an uncomfortable book because it offers no neat conclusions. Nevertheless, it is essential reading for anyone who is involved, either as a teacher or practitioner, with issues at either end of the human life-span. It covers most of the main ethical problems facing the medical profession today, including the genetic revolution, cloning, and clinical problems such as Alzheimer's disease and the persistent vegetative state; but it deals predominantly with the status of the human embryo, IVF, abortion and the severely deformed neonate.

The author is an anatomist—Professor and Head of the Department of Anatomy and Structural Biology at the University of Otago, Dunedin, New Zealand. He is committed Christian, who takes a high view of the authority of Scripture. An appreciable proportion of this book is taken up with a consideration of Passages in the Bible relevent to the bio-ethical issues with which he deals. He rightly states that on many of the matter of current bio-ethical interest such as IVF and cloning, the Bible is silent; and in such cases we need to search for moral values that accord with the general thrust of biblical teaching.

In considering the status of the embryo an fetus, he focuses on the controversial passage in Exodus 21, verses 22–25, dealing with injury to a woman leading to miscarriage; which seems to imply that the life of the offspring is less important than that of the mother. He also considers the implications of Jesus' incarnation, and of John the Baptist's leaping into his mother's womb on the occasion of a visit from our Lord's mother. He notes the references to ante-natal life in Psalm 139 and Jeremiah 1 and concludes that although the adult can look back and see God's care for him or her during embryonic and fetal life, the Bible has nothing to say about embryos which survive only for a few days.

The author's perception that a high proportion of the products of conception are doomed to early extinction casts its shadow over much of the book. In his view 'The wastage of embryonic life through spontaneous abortion is of catastrophic proportions, and this questions the dignity of the early stages of human existence.' He deals at length with the subject of personhood—while expressing the wish that such consideration might have been avoided. He believes it to be inescapable that, although all human beings are created in the image of God, some must be regarded as having greater value than others in practice. He does not think we have any ground for arguing that very early embryos are morally equivalent to adults. He adopts a 'gradualist' position, regarding the embryo as a 'potential person'; a human being who in the normal course of development will 'image God'. He illustrates this discrimination between the relative values of adult and embryonic life by analogy with oaks and acorns, many of which will never progress to becoming trees.

This does not mean that the author disregards the value of the earlier stages of antenatal life. Indeed, he expresses 'horror' at the current high abortion rate. On the other hand, he would accept that if the good of the mother would best be served by the destruction of her fetus, this should not be prohibited. Nor does he rule out the use of 'wasted' embryos (or fetuses) for any research which carries a prospect of helping women to have more successful pregnancies.

In the same way, he does not oppose the use of fetal brain tissue to attempt to improve the condition of patients with Parkinson's disease. On the other hand, he would rule out the deliberate production of embryos for use in research programmes.

Professor Jones takes seriously God's command to mankind to exercise dominion over his creation and care for it wisely. Although Christians are bound to be more pessimistic than others in regard to human fallibility and selfishness, he does not believe we should allow this pessimism to colour our attitude to all scientific endeavour. Much of it has, in fact, been pioneered by believers, and has enormously enriched human life. (Where would we be without anaesthesia?) The author insists that the Christian has a duty to search for the truth with honesty and humility and to beware of dogmatism. Choices cannot be avoided, and equally honest and humble Christians will continue to reach different conclusions

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Called to Care. A Christian Theology of Nursing
Judith Allen Shelly & Arlene B. Miller
InterVarsity Press, 1999

Written by two well-known writers on Christian nursing, both of them nurses with a theological training, this book offers a mature synthesis of years of reflection and teaching with focus on the grounds, contents, and limits of an authentically Christian stance in the theory and practice of nursing care. I know of no other book of this kind. Hence 'nurses who call themselves Christians and are trying to think through the implication of that commitment in their professional lives' (p. 7), are well advised to take note of this well-written book. Be they practising nurses or teachers this book has something to tell them.

The aim of the book is 'to demonstrate the subtle ways in which our Christian world-view can shift to other paradigms as we move from one concept to another' (p. 8). The starting point is the conviction that nurses 'cannot separate their professional roles from their profession of faith' (p. 8) or that 'Christian faith is the very heart of nursing theory and practice' (p. 7). Assessing current developments and trends in nursing, this book, then, develops a Christian perspective on nursing and reflection on the theoretical as well as practical ramifications of this approach.

The authors develop their accounts in terms of world-views, on the one hand, and in terms of the so-called nursing meta-paradigm, on the other. That is to say, they distinguish between modern, postmodern, and biblical world-views; and they also work with four concepts central to most nursing theories. These are that of a person, the environment, health, and nursing. Thus, they create a 'matrix' that allows them to explore theologically relevant developments in nursing.

By speaking in terms of world-views, they are, however, merely seeking to find answers to the question of what is right and wrong. Rather, just as their previous book was cast in terms of values and eventually culminated in an argument for the importance of Christian virtues for nursing, here they eventually turn to the pivotal role of the nurse's character. Indeed, one would expect them to cast their next book unashamedly in terms of virtue and character, since these two concepts seem to be what they are homing in on.

To the mind of those not accustomed to such a candidly Christian approach as this to nursing, this book may look like an attempt by nurses 'to get it right' theologically. Moreover, some may feel that the book offers too much by way of theological statements and too little by way of philosophical analysis. Furthermore. Shelly's and Miller's approach 'from the inside' sometimes leads them to make statements which seem to presuppose that the reader is both a Christian and a nurse, such as in their definition of nursing. It runs: 'Nursing is a ministry of compassionate care for the whole person, in response to God's grace, which aims to foster optimum health (shalom) and bring comfort in suffering and death' (p. 57, 212).

This said, all in all, this book is a worthwhile read for Christian nurses, in clinical practice, in education, and in the academe. It will also be worthwhile for pastors, theologians, and other Christians with an interest in care-related professions

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Christians and Bioethics
Edited by Fraser Watts
SPCK 2000

This is a collection of succint, well written and perceptive contributions based on a series of lectures given at the church of St Edward King and Martyr, Cambridge, in 1999. As with all anthologies, each individual contribution stands on its own so there is no single overview. Despite this and the small size of the book, there is good coverage of the whole subject. The Christian view of bioethics is referred to at various points—but not clearly set out as a separate statement.

Fraser Watts, who edits the book and is a Starbridge Lecturer in Theology and Natural Sciences in the University of Cambridge provides the opening contribution, which gives an excellent overview of bioethics. He rightly says that Christian ethics arises out of the dialogue between basic principles an rational examination of likely consequences—although he fails to define what the basic principles are. The 'slippery slope' argument is mentioned but then avoided. Instead he deals with specific aspects of bioethics. Interfering with or modifying *Nature* is acceptable—and any question of man 'playing God' is dismissed as showing an anthropomorphic view of God. Under the sub heading of *Persons* he states that bioethical issues should not be narrowed to a matter of rights but does not supply an alternative view. In the *The Christian Approach* section he makes the case for Stewardship of God's creation and suggests that the criterion of acceptability in ethical questions is whether a proposed action is consistent with God's creative purposes. Arguments based on this view are weak and flawed because of the fact that we live in a fallen world means that mankind's motivation inevitably includes self-interest and pride. This spiritual question can be avoided in a secular treatise on the subject but should be addressed in a discussion that purports to have a Christian view. He stops short at God's creative purposes and makes no reference to redemption at all. Milton understood much better, and far more profoundly, that nature was fallen and needed God's immense plan of redemption. If the fall, man's sin, and redemption through Christ's death are not included in a Christian view of ethics this compromises the very heart of Christianity and any thesis based on it risks being a parody of the truth. This does not mean that it has to be stated explicitly but should be a presupposition underlying the discussion. Can utilitarian arguments be used in support of spiritual truth or, should we make sure that our stand on ethical questions is based on a biblical, pre-Hume view, with the moral imperative seen as part of rational analysis?

The other contributors are—John Polkinghorn on cloning, Derek Burke on the genetic engineering of food, Michael Rees on transplantation ethics, Tim Appleton on reproductive medicine and Michael Langford on assisted suicide.

John Polkinghorn succinctly and clearly distinguishes between reproductive and therapeutic cloning. He points out that reproductive cloning, which produced 'Dolly' the sheep, is not legal in humans. Use of human embryos up to 14 days to grow specific cell lines is permitted under the Human Fertilisation Embryology Act. Michael Rees, who is a transplant surgeon, extends the discussion to include the use of animal embryos as vehicles for growing human organs. The deliberate creation of anencephalic embryos, i.e. without brains, to provide specific organs is not really discussed and objections are regarded as being due to the 'yuk' factor. He does however, end by calling on the reader to face these ethical questions on the basis of absolute truth in relation to the worth of the human soul. The post-modern world view is rejected as basis for finding adequate answers since such a view holds truth to be relative. In this connection it is interesting that the Warnock report took what is acceptable to society as the criterion for what should be permitted rather than any absolute values.

The contribution from Rev Dr Tim Appleton, an independent fertility counsellor, gives a good review of the background to the setting up of the Human Fertilization and Embryology Authority—from the first IVF baby in 1978 to the Warnock report in 1984 and the various attempts to introduce legislation to ban embryo research that followed. The writer was teaching cell biology at Cambridge when he and Dr Edwards became involved in the ethical questions thrown up by the IVF programme at the Bourn Hall clinic. He quotes the case of a couple who had successful implantation of an embryo and were then faced with the question of whether to allow the remaining 24 frozen embryos to die. In fact they were used at a hospital in Manchester. It is stated that there are 500,000 frozen embryos in storage worldwide and 9,000 at the Bourne Hill clinic alone.

Professor Michael Langford writes on Euthanasia and Assisted Suicide and he makes some useful distinctions. The difference between them is essentially between killing and allowing to die, although the end result is the same. His final conclusion is that neither should be legalized. The sections on 'The moral question' and the 'Christian perspective' are very good. He distinguishes between a specifically Christian view and grounds for making decisions that are based on universal principles.

Genetic engineering of food is discussed by Derek Burke, at one time Chairman of the Advisory Committee on Novel Foods and Processes, which is placed inbetween the chapters on Cloning and Transplantation for some reason. Although he is clearly in favour of genetic modification of food, given adequate safeguards, the reasons for it are not clearly stated. In common with many who are in favour of genetic engineering, he accepts the commercial arguments for it and does not show how it will in fact relieve world hunger. On the positive side he calls for greater sensitivity by scientists to the public opinion and warns against the 'aggressive determinism' of some biologists.

Overall it is very good that this series of lecture was held and published for the benefit of a wider audience. It would have been fascinating to have heard the discussion that followed the lectures.

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Revelation and Reconciliation.
A Window on Modernity
Stephen N. Williams
Cambridge,: Cambridge University Press, 1995
ISBN 0-521-48494-4, 180pp, paperback, £12.99

The path to 'modernity' in western culture, in particular the atheism which so often characterizes it, is often said to originate in developments in epistemology (the philosophy of knowledge) which began during the Enlightenment of the seventeenth and eighteenth centuries and continued to unfold right up to the present day. In this ground-breaking study, Stephen Williams, currently Professor of Theology at Union Theological College in Belfast, challenges the fashionable concentration on epistemology and offers an alternative view of the origins of modernity. In the process he interacts with and critiques such writers as Lesslie Newbigin and Colin Gunton who have stressed the role of epistemology in producing modern atheism.

Without denying that epistemology has played a role in the genealogy of modernity, Williams contends that a more fruitful way of understanding these cultural changes is through attention to the issues of sin and reconciliation which are central to the Christian faith. In the opening chapter, for example, Williams considers the place of Descartes and Montaigne in the epistemological developments of the Enlightenment and offers Pascal as the examplar of an alternative perspective on the religious crisis of the period which sees soteriology (the doctrine of salvation) and anthropology (the doctrine of humanity) as the crucial issues.

In the following chapters Williams seeks to establish that the reluctance of philosophers and, increasingly, of theologians to face up to and accept the need for humanity to be reconciled to God through Jesus Christ in fact provides a more convincing explanation of the spiritual problems endemic to modernity. Whilst writers such as Newbigin and Gunton see epistemology as lying at the root of contemporary rejection of Christianity, Williams believes that a denial of the need for reconciliation is fundamental. He defends his thesis in chapters which provide careful, detailed examination of John Locke (a key Enlightenment thinker), Fredrich Nietzsche (crucial to the development of modern atheism and Don Cupitt (a leading radical theologian of the present day), together with a consideration of Karl Barth's description of the development of modern theology. He concludes with an examination of 'Revelation in History' and a postscript considers some more recent writing by Colin Gunton.

It can be said that Williams has made a strong case for ascribing a much greater role to soteriological and anthropological issues in understanding modernity. He is careful to state that he is not dismissing epistemological considerations entirely, and in that sense his book is not proclaiming a sweeping revolution in our understanding of the Enlightenment, but he succeeds in demonstrating that the currently accepted view is gravely deficient in important respects. This is a book for those who already have a grounding in philosophy and theology; beginners will struggle with Williams' detailed expositions of major thinkers. It is nevertheless

an important study for anyone who wishes to come to grips with the cultural milieu in which ethics must be formulated in the twenty-first century.

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Families Following Assisted Conception: What Do We Tell Our Child?
Alexina M McWhinnie
University of Dundee 1996
ISBN 1 873 153 23 6, 50pp, £7.50

This book is especially directed at couples who are thinking of using or have used, donor insemination (DI) or IVF with or without egg donation. But it no less relevant for those providing fertility treatment or counselling. It is based on discussions with people who have experienced fertility problems, sought medical advice for infertility or who have become parents following fertility treatment.

The focal question is whether or not to tell children resulting from fertility treatment how they entered the world. In particular, should parents who have availed themselves of egg or sperm donation tell their children about it, and if so when? Of course, the answers given to these questions depend partly on social attitudes. Overall, people are more open now than in the past, yet many tend to remain silent about these kinds of issues.

Take the case of donor insemination. It has been quietly practised since the last century in fee-paying clinics or in clinics run by voluntary organisations. The first NHS clinics were set up in the late 1970s; and from then on donor insemination has been provided as a 'medical treatment' for male infertility. But it has always been surrounded by secrecy, and the children have been registered at birth as being born within marriage. With the 1990 Human fertilisation and Embryology Act (HFE) the practice became legally regulated and the anonymity of donors was legally assured. Of course, the new law made a big difference insomuch as clinics now had to be licensed and donors had to be tested and their details recorded by the Human Fertilisation and Embryology Authority (HFEA). But although donors are granted anonymity, times have changed since the beginning of the century. In the past couples were advised to tell nobody, but today couples are often counselled to be open with their children and with relatives.

Dr McWhinnie herself is clearly in favour of openness. Yet she admits that none of the DI parents she has met have been open about the treatment. But secrecy, she says, can easily lead to conflict situations. To illustrate her point she says that doctors and hospitals, for example, routinely asks questions such as: 'Is there anyone in the family . . . ?'

So why do people keep DI secret? The answer, Dr McWhinnie says, is complex. Partly, people believe that is nobody else's business. Many experience shame and, even guilt. Others fear that their relatives would discriminate against the children if they knew. Often parents fear that the child would love them less, if he or she knew. And, unless parents are open from the start, it becomes more and more difficult to tell the child and relatives and friends.

There is a whole chapter in the book advising parents on how to tell their children that they were conceived by means of DI. And there is another chapter relating conversations between parents and DI children and little incidents that have taken place. This is just to show the reader what kinds of conversation or situation may arise in the case of DI children. Some of the children involved knew the true facts, some raised unexpected questions, while others happened to find out about their origins by accident.

However, the case of DI parents is not unique, Dr McWhinnie says. On the whole they are faced with very much the same kind of situation as parents of adopted children, though there is one big difference. Adopted children have the right to find out about their genetic origins when they reached adulthood. Donor children have no such right—at least not in Britain. However there are countries in which DI children do have this right, among them Germany and Sweden and, two years from now, the Netherlands.

While most of the book concerns DI families, towards the end there are a few pages about families created by IVF, with or without donated gamates. Parents who had used donation were found to be in the same situation as DI parents whereas parents who had used IVF without donation, had no real difficulties in telling their children—without going into too much detail—that they had received a bit of medical assistance in achieving pregnancy. The author had neither encountered couples who had children created from frozen embryos, nor met couples involved in surrogacy arrangements.

This is short informative book which can be warmly recommended to anyone contemplating DI or IVF as well as to doctors, nurses and counsellors working in fertility clinics.

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New Ethics for the Public's Health
Dan E. Beauchamp, and Bonnie Steinbock, Editors
New York, NY: Oxford University Press, 1999
ISBN 0-19-512438-3, 382 pp., hardback $67.50

The stated purpose of the editors of this volume is to 'stimulate students and scholars alike to think about the public's health in a new way, as an issue that requires political and philosophical analysis' (p. x). This book could be used by philosophers teaching bioethics courses, but it is primarily directed at those active in the fields of public health, public policy, and social welfare, and is also intended for use in medical schools.

The essays in this book deal with a diverse range of topics. In Part I, the ethics of public health are considered, with a special emphasis on the impact of taking a population perspective on public health issues. Part II deals with public health from a community perspective, in which health risks are seen as problems held in common and affecting the entire community. The essays in Part III deal with contemporary challenges to the public's health: alcohol, tobacco, drugs, injury and violence, AIDS and newly emergent diseases (such as the hantavirus), and issues related to justice and health care. The book's final section contains essays which address certain issues arising from the use of new reproductive technologies and genetic screening, testing, and therapy.

The public health perspective contains a consequentialist ethical component, in that it seeks to foster human welfare and allay human misery, with a view towards factual evidence. This approach is also limited by deontological considerations in that it includes a respect for persons and the rights they possess. Public health is also communitarian, as it is concerned with reducing disease and promoting the health of the population, which is a shared communal value. As a communal approach, it is focused on certain institutions and policies, rather than on relationships between individuals. The public health perspective encourages collective action through policy, regulation, and the building of new institutions to solve public health problems. This hopefully leads to the community being brought closer together, with connections between its members being reaffirmed and strengthened.

In 'Community: The Neglected Tradition of Public Health', Dan E. Beauchamp explains more fully the communal aspect of public health and argues that the health and safety of people is not just a matter of individual interests, but rather is something held in common and pursued together as a community. Rather than relying on Mill's harm principle to justify paternalistic health policy, Beauchamp maintains that it should be justified primarily by 'creating, extending, or strengthening the practices of public health—and the collective goods principle that underlies it' (p. 66). For example, regarding seat belt legislation, the slogan 'The life you save may be your own' exemplifies an individualistic perspective. From a more communitarian perspective, this slogan becomes 'The lives we save together might include your own'. The end being pursued is not merely the avoidance of harm to oneself and/or others, but the collective good of public health.

Elizabeth Heitman provides an interesting application of the public health perspective in 'Infertility As a Public Health Problem: Why Assisted Reproductive Technologies Are Not the Answer'. Heitman argues that expensive high-tech treatments for infertility are ineffective when one has the entire population in view, and suggests that community-oriented health policies would be more effective for segments of the population who do not have access to such interventions. Such an approach to infertility requires that we engage in significant research on both the biological and cultural factors that are relevant to infertility. Our efforts should focus on the prevention of infertility and ought to take place at four different levels. First, *educational campaigns* on sexual and reproductive health aimed at men and women would help to prevent infertility. Second, Heitman urges increased *access to preventive health services*, including an emphasis on the protection of fertility when discussing the prevention of STDs in the community. Related to this is *access to both the diagnosis and treatment of STDs* which cause infertility. Finally, *ongoing evaluation and research* must occur which focuses on understanding which strategies are working and why.

Heitman believes that this type of approach will help prevent infertility, and is preferable to the use of assisted reproductive technologies which by their cost can effectively keep many of the less affluent of our population from having any hope of overcoming infertility.

The public health approach helps surface new and useful insights as one reflects on both the ethics and the politics of important issues relevant to the health of communities. I commend this book to the reader interested in considering bioethics issues from a somewhat different perspective than the individualistic viewpoint that is more commonly offered.

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Genetic Engineering: A Christian Response
Timothy J. Demy and Gary P. Stewart, Editors
Grand Rapids, MI: Kregel Publications, 1999
ISBN 0-8254-2357-0, 320 pp., hardback $20.99

Genetic Engineering: A Christian Response is a comprehensive overview of current bioethics issues in genetics. It provides critical information on exactly what the problems are and how Christians should respond to these biblically in a society which maintains a very different worldview from that described in Scripture. Scientists, ethicists, and lay people alike will benefit from thinking through the issues put forth in this book.

The first section of this book, 'Genetic Engineering and Society', deals with the importance of genetic research and its place in society. Issues such as human cloning, embryo manipulation, patenting of genes, eugenics, and human rights are presented in the context of the Christian worldview. Chapter 1 of this section, entitled 'Joy in the Journey' is an interview with the director of the Human Genome Project, Francis Collins, who is a renowned scientist as well as a sincere Christian. Collins does a very thorough job of dissipating undue fears related to genetic research as well as providing a good Christian response to this research. This chapter is a good general introduction to this type of book. The next chapters in this section then deal more specifically with societal issues related to genetic research. In the chapter entitled 'Genetic Engineering: Bane or Blessing?' C. Ben Mitchell thoughtfully explores how Scripture should shape the Christian's view of genetic ethics. He applies these scriptural concepts to issues of prenatal screening and abortion, as well as confidentiality and discrimination in relation to genetic testing. In this section, Frank Young has also written an excellent chapter entitled 'Worldviews in Conflict' in which he discusses how the Christian and secular worldviews differ in regard to human cloning and embryo manipulation.

The second section of this book, 'Genetic Engineering and the Family', addresses several issues, including artificial reproduction, prenatal testing, genetic counselling, and the costs associated with raising versus aborting Down's Syndrome babies. Chapter 11, entitled 'The Least that a Parent Can Do' is a thought-provoking discussion of genetic testing in relation to what parents do with the information gained. This chapter addresses the justifications for genetic abortions, and how society has come to view personhood and to assign values to lives based on their ability to perform or interact as a valuable member of society. The author of this chapter, Brock L. Eide, clearly discusses the problems of justifying genetic abortions from a Christian worldview. He explains that all humans have value because they are created in God's image which by definition makes them valuable members of society as a whole.

More specifically, then, Thomas E. Elkins and Douglas Brown, in 'The Cost of Choice' deal with the cost analysis of testing and then either aborting or raising a Down's Syndrome baby. This chapter addresses the false beliefs of society concerning the value of a person with Down's Syndrome, as well as pointing out the misleading cost analysis which has been shown to favour testing and abortion due to the immense 'burden on society' of keeping and raising a Down's baby. They point out that the cost analysis has never been in the context of any other cost analysis, such as how much it costs society to raise and educate a successful professional.

The final section of this book, entitled 'Genetic Engineering and the Individual' begins with a clear discussion of the biblical view of humanity and how this relates to genetic research. Chapters 17 and 18 are both very well written chapters on human cloning. Chapter 17 gives the history and definition of human cloning as well as dealing with some ethical issues regarding this technology. Chapter 18 deals further with ethical issues related to human cloning, and the pros and cons of using this type of technology. The final chapter deals with the appropriate use of genetic technology in keeping with the biblical view of God's sovereignty. Sonya Merrill ends the last chapter by pointing out that 'No technology that God has allowed humanity to develop is intended to provoke a reliance on ourselves'. We 'must initially rely on the eternal mercy of our compassionate God while we evaluate and use wisely the technologies he has allowed us to create'.

This book is highly recommended for anyone who wants to know more about genetic ethics from a Christian perspective.

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* Institutional affiliation is given for identification only. This review does not reflect the views of the National Cancer Institute.

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Unholy Madness: The Church's Surrender to Psychiatry
Seth Farber
Downers Grove IL: InterVarsity Press, 1999
ISBN 0-8308-1939-8, 162 pp., paper $12.99

Seth Farber was, for many years, a practising psychotherapist with a doctorate in psychology—as such, he has seen the world of psychiatry from the inside. The conclusions he has reached are not complimentary to the profession. They can be summarized in two broad statements. First: '. . . the mental health system [is] a rival religion, a crude form of idolatry inimical to the dissemination of the Christian faith . . .' (p. 12). Second (echoing Thomas Szasz): 'mental illnesses do not exist' (p. 18).

Farber believes that psychiatry is a system built on scanty (if any) clinical evidence, which employs toxic drugs of minimal (if any) benefit, which uses treatments (such as electroshock) that are unproven and frequently harmful, which manufactures disorders that do not exist (such as attention deficit disorder), and which exists solely to perpetuate itself and provide a living for its practitioners. He relies heavily on the work of Thomas Szasz and R.D. Laing, as well as other critics of psychiatry. Psychiatry, in his view, is nothing but a house of cards, founded on an untenable worldview . . . yet is a system to which both society and the church have yielded, essentially separating mental health from spiritual and physical, and allowing the psychiatric profession full rein over mental health.

Once people receive the label of 'mental illness', Farber asserts, they become locked into a system that not only cannot cure them, but reduces them to a permanent level of low functioning and degraded social status. If the illness does not ensure their victimization, the treatment will. Mental patients become relegated to the fringes of society. The church for its part has failed these outcasts, because it has adopted a Constantinian view of society and an Augustinian view of humanity.

Whether or not one wishes to accept Farber's critique at every point, he undoubtedly raises issues of great seriousness. If the mental health system is failing the patients entrusted to its care, then both the medical profession and the church need to speak up on their behalf. However, his conclusions are likely to provoke controversy.

Take, for example, his agreement with Thomas Szasz that because the mind is immaterial, it cannot have mental illness. This is asserted but not demonstrated. Could we say then that on the same basis spiritual disease also does not exist? Unless we adopt a position of strict mind/body dualism, our minds depend for their proper functioning on a physical substrate—the brain. There is little recognition in Farber's book of this close connection. Even though the precise nature of the mind/brain interface remains maddeningly unclear (despite the reams of literature devoted to the topic) there can be no arguing the effects that illness, disease, toxins, and injury have on the brain and the mind. (We should also not adopt the other pole of a strict reductionism that reduces our minds to mere movements of biochemicals.) Farber rejects the idea that mental illnesses are brain diseases (p. 96).

Part of the difficulty may be that Farber does not make it clear that he appears to distinguish 'mental illness' from other conditions that are well associated with physical pathology. That is, the 'mental illness' to which he refers (which he calls 'madness' and the psychiatric profession calls 'schizophrenia') should not be classified with other conditions (one would assume depression, Alzheimer's dementia etc.) that have a defined organic basis. However, the recent sequencing of Chromosome 22, which may contain genes linked to schizophrenia, may undercut Farber's distinction. There may be a physical basis for schizophrenia.

Although Farber prefers the term 'madness', he fails to define it. While we may each have our own notion of what 'madness' means, it would

be helpful to know what Farber means. He appears to equate 'mental illness' (madness) with spiritual illness and reduces them to a difficulty in dealing with relationships and problems of life. As such, he apparently (p. 63) says that 'madness' may be normal, or an alternate normality, or even more sane than sanity. (At such moments, he seems to be embracing a postmodernist mindset.) 'Madness' may be a crisis point where a person's growth comes into conflict with modern secular culture. It requires a spiritual cure rather than a psychiatric one.

While it would be hard to disagree with his conclusion that our world needs more active churches and Christians, and fewer psychiatrists, Farber fails to prove his point about 'madness'. If 'madness' is purely a spiritual crisis, why do medications sometimes help? What about people—including Christians—who have functioned at a high level, and then suffered psychotic breaks? Are 'problems of living' really equivalent to 'madness'? Is the woman who comes into my office concerned that the 'shadow people' are after her, or the man who asserts that doctors at a prestigious clinic replaced his eye with a miniature camera so the CIA can spy on him (both true cases), suffering only from an 'adjustment problem'—a 'resolving crisis' that can be cured by being 'incorporated into a church' (p. 109)? Where is the evidence that 'normal' people became 'mad' before being 'reborn'? Becoming 'mad' does not appear to be a prerequisite for spiritual rebirth in either a biblical sense, or in the experience of the vast majority of Christians. Many people become Christians without experiencing any grave (or mind-threatening) crisis.

Farber's arguments about church and culture—while valid regarding society—don't seem to address the issue of madness. Discussions of church and state politics don't tie in well with issues of mental health. There may be much validity in his assertion that the church has allied itself deeply and erroneously with the mental health system, but can we really equate a 'schizophrenic' episode with 'a manifestation of the readiness of the individual to assume a new spiritual identity' (p. 129)? By all means the church needs to—must—reach out to persons in mental health crisis. We need to incorporate them into our communities of faith. We need to show them the transforming power of Christ. As a medical community and individual physicians we must first do no harm . . . and if the psychiatric field is harming patients then we must provide alternatives.

Farber provides an important critique of psychiatry and a cannot-be-ignored call to Christians to reach out to the mentally ill. Yet much work needs to be done on the underlying basis of mental illness, and Farber's view of mental illness (at least as presented in this book) contains too many flaws and grey areas to be accepted as a norm. While Farber's book is thought-provoking, it is flawed and lacking in certain areas. More efforts in this field by Christians with psychiatric, theological, and philosophical training would be welcome.

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Character Counts: Leadership Qualities in Washington, Wilberforce, Lincoln, and Solzhenitsyn
Os Guiness, Editor
Grand Rapids, MI: Baker Books, 1999
ISBN 0-8010-5824-4, 160 pp., paperback $8.99

As the tenure of America's first post-modern president draws to a close, his baleful legacy of symbolism over substance, verbal manipulation over straightforward truth-telling, and self-aggrandizement over self-sacrifice moves toward full-flower. While the rise of relativism and cynicism by no means began with Bill Clinton, it has found in his character a very visible—and therefore culturally influential—venue. Thus, as Os Guiness observes, today '[C]haracter in leadership has been replaced by image, truth by power and plausibility, and confession and moral changes by spin control and image makeovers' (p. 9).

This crisis in character should compel the nation's urgent attention, Guiness says, because it is absolutely central to effective, vital and virtuous leadership. Yet, the issue is missing in action in American public life. Guiness presents six general reasons for our cultural silence on character: the rigid secularity of contemporary liberalism; the personal hypocrisy of some high-profile 'character crusaders'; our social infatuation with power; the exaltation of style and image; the largely closed nature of the few remaining institutional bastions of character, like the military; and human nature's perverse fascination with evil and the audacity of those among us who transgress moral norms.

The unique contribution of this volume is that it finds the solution to both our lack of interest in contemplating character and the worsening decay of the American character itself in inspirational biography; reflection on lives of significance which developed and manifested outstanding character. This is a literary strategy that serves Guiness well, not least because recent comprehensive cultural polemics abound, notable among them Guiness's own *The American Hour* (New York: Free Press, 1993), Lynne V. Cheney's *Telling the Truth* (New York: Simon & Schuster, 1995), and Robert H. Bork's *Slouching Towards Gomorrah* (New York: HarperCollins, 1996). But the use of the biographical genre succeeds also because, as Guiness alludes, it bears a special power, drawing readers into its dramatic intersection of the personal, philosophical, and historical. Further, the featured quartet selected by Guiness are men whose humanity emphatically displays the virtues and traits that Guiness wishes to bring to our attention.

Essays by Alonzo McDonald and Paul Boller Jr. on George Washington begin the book, and show that Washington's fierce commitment to religious liberty and freedom of conscience animated much of his military and political leadership. In the context of today's hardboiled cynicism it seems quaint to say, but Washington was a man of high principle, and Guiness's essayists make that fact abundantly apparent. What is more, McDonald's essay does a fine job of arguing that the hand of Providence guided Washington's early life—much of it spent literally in the wilderness—preparing him for the years of rugged generalship he was to endure while leading the revolutionary army.

Two essays on English abolitionist William Wilberforce by J. Douglas Holladay and John Pollack passionately make the case that the perseverance and charisma of one man can change the course of cultures. Wilberforce's two life-goals—to end English participation in slavery and to reform England's 'manners' (moral culture)—were tasks of such enormity that the sickly and homely Wilberforce could not have hoped to ever accomplish them, were it not for his conviction that it was work to which God had called him. Holladay and Pollack effectively show that it was Wilberforce's intense Christian faith that powered his decades-long social work, and in the process they illustrate a cogent philosophy of Christian social action and political involvement.

The section on Lincoln, composed of another essay by McDonald and Elton Trueblood's classic meditation 'Theologian of American Anguish' focuses on the 16th president's personal maturation through tragedy; not just the losses and hellish gore of the civil war (producing one million casualties over four years), but also his personal angst (he lost two sons to illness, including one while in office in 1863). Emerging from the crucible of suffering was Lincoln's powerful faith in Providence, and a practical theology of striking sophistication. This theology found its fullest expression in Lincoln's famous second inaugural address, reprinted in this volume.

Guiness's exhibition of leadership concludes with a work by McDonald limning the spiritual psychology of once-exiled Soviet dissident Aleksandr Solzhenitsyn. From his life as a Soviet political 'criminal' to his personally transformative struggle with cancer, Solzhenitsyn champions a humanism and simple piety that he demonstrates can empower one man to stand up against totalitarian institutions.

This readable volume is an excellent discussion tool for management or church retreats, as well as a useful text for courses in both political and religious studies.

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Human Rights and Human Wrongs: Major Issues for a New Century
John Stott
Grand Rapids, MI: Baker, 1999
ISBN 0-8010-6094-X, 192 pp., paper $14.99

This book represents the third edition of a work originally published in 1984 and revised in 1990, as a contribution to the recovery of the social conscience of evangelical Christians. Stott writes, he says, as 'a person who lays no claim to infallibility, who is anxious to go on increasing his Christian integrity over against the pressures of a largely secular society, and who to that end is continuously seeking fresh light from scripture' (p. 12). As such, he writes both to encourage lay Christians as well as those who have expertise in certain fields (such as politics, economics etc) to make contributions to social and ethical issues confronting the world. Stott has selected certain sections of the previous edition ('Decisive Issues Facing Christians Today') and revised them for the current

edition. (The other sections have been incorporated into a separate volume, *Our Social and Sexual Revolution*.)

In Part One, Stott begins with an overview of Christian social involvement through the centuries, distinguishing between politics, social service, and social action. He bases Christian social responsibility on five doctrines: fuller doctrines of God, humans, Christ, salvation, and the church. He asserts that involvement in the major social issues of our day is a legitimate Christian concern.

Many of these issues are quite complex, and are subjects upon which Christians have different opinions. It is important, therefore, for Christians to be able to think clearly about these issues, especially in a society torn between competing and conflicting worldviews—premodern, modern, and post-modern. Stott lists four gifts of God that encourage us in clear thinking: our minds, the Bible, the Holy Spirit, and the Christian community.

In order to influence the world, however, the issue of pluralism must be confronted. How can Christians relate to a world composed of many competing religions and worldviews? This should not be done by imposition, Stott asserts, nor should Christians retreat from the world in apathetic laissez-faire. Rather, the opportunity exists for Christians to engage in a process of persuasion. Christians can make a difference in the world, indeed are called to do so, as salt and light to society.

Part Two details some specific issues that face the Christian community. The first is that of war. War has been part of human existence for millennia, evolving ever more destructive weapons. Now, the nations of the world possess nuclear arsenals that pose a threat to the very existence of life on earth. Even conventional weapons—landmines, for example—create an ongoing loss of life in many countries. Stott examines the different Christian responses to war—total pacifism, the just war tradition, and relative or nuclear pacifism. The difficult issue of nuclear disarmament comes in for extended discussion.

Issues of the environment will undoubtedly become more pressing in the new century. The Christian faith has come under fire for promoting attitudes that contribute to destruction of the environment. Stott points out, however, that a true commitment to biblical Christianity encourages an attitude of respect and care for the environment. Such concern needs to be exercised on individual, corporate, national, and international levels. For humanity to survive on earth, our attitude needs to be one of stewardship, not domination.

Inequality between nations poses another threat to life on earth. Great inequality exists between developed nations and third world countries. Immense wealth contrasts with extreme poverty. While some nations bask in prosperity, others languish under crippling debt. Once again, this is an issue with personal, national, and international consequences. How we live as individuals dictates how we live as a nation, and hence how we relate to the less-developed nations of the world. Stott concurs with the concept of Jubilee—that debts of the world's poorest nations be forgiven. This has not only international implications, but individual—free from the burden of debt, poor countries can turn to ameliorating the poverty, disease, and malnutrition that afflict much of their populations.

The last chapter deals with issues of human rights, of dignity, equality and responsibility. The twentieth century has a long list of abuses for which to account. Will it be any different in the next century? People are persecuted on the bases of nationality, ethnicity, religion, and sex. Only if, as Christianity asserts, people are created in the image of God, will abuses of human rights cease.

Stott's intention in this book is not to provide answers, but to encourage Christians with expertise in various fields to contribute their voices to the ongoing discussions and debates in the world's arenas. This book is a useful primer for those interested in whether and how Christians should be involved in social issues. Perhaps because it was adapted from a larger work, *Human Rights and Human Wrongs* has a somewhat incomplete feel—a concluding, summary chapter would have helped. Although the book's cover claims that a study guide (as in the prior edition) is included, it was apparently not inserted in this revision.

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How to Arrive at a Considered Opinion: A Method of Analyzing Moral Issues in the Public Debates
Kenneth J. Zanca
Lanham, MD: University Press of America, 1997
ISBN 0-7618-0774-8, 106 pp., paperback $24.00

This short book is very much a how-to manual for addressing ethical issues. It provides a very useful way to approach any topic in ethics with a view to systematically arriving at a well-informed conclusion. I have used Zanca's method to give undergraduate students in their first ethics course a strategy with which to approach their term paper. The book itself would be a very useful supplement for a graduate level course, or for anyone seeking to do a thorough examination of an ethical topic.

Zanca's approach involves four steps, which make up the first four chapters of the book. Each chapter is composed of a few pages of explanation, followed by an extensive bibliography of related resources, including internet sites. Apart from his overall method, these bibliographies give important direction for those seeking reliable information on ethical issues. However, this information is also going to make the book less useful as time goes by and resources change. However, Zanca has provided an important listing of primary resource material for the beginning student. In the chapter of the book, Zanca applies his methodology to a particular issue: whether capital punishment is moral.

Zanca's first step is to define the moral issue. Here, the goal is to understand the most common concepts and terms used in addressing the topic of concern. Zanca recommends searching for concise definitions at this point, for which he recommends using dictionaries, and gives a list of his pick of the best. During this stage of data collection, Zanca recommends collecting relevant factual data. How many people are involved with the practice, or believe it is ethical or not? What reasons do surveys give? Is the trend increasing or decreasing? At the end of this stage, a general understanding of the issue should be apparent, along with its significance, and any factual or survey data related to it.

The second step is to study the issue's history. Zanca explains the importance of understanding the history behind a controversial issue, something my students always need to be reminded of. This is a key step in understanding why different people have such different views on this issue. Zanca believes that while history does not justify a practice, nor the need to change it, it is essential to understand why the debate has arisen.

The third step is covered in the most substantive chapter in the book. Zanca first encourages people to examine their own feelings and reactions to an issue. While many people today go only this far, Zanca is very clear that a gut reaction (or moral intuition) is not enough. He makes a strong, concise case against moral relativism. He then explains the origin (and importance) of moral philosophy, and gives thumb-nail sketches of the major ethical theories. For each, he gives a one-paragraph summary, a few examples of how they would be applied, and the major criticisms raised against each. Obviously, this can be only very superficial, yet I find this is enough to help students to start to think in terms of how they make their ethical decisions, and what some of the weaknesses in those approaches are. In Zanca's overall methodology, this step encourages people to look at an ethical issue from a variety of perspectives.

At this point, I find that students are ready to conclude that there is no way to decide which of these approaches gives a better answer. Zanca's fourth step is how he decides between alternatives. For him, justice is the deciding factor, which for him means choosing the option that causes less harm to others by violating fewer of their rights. He then summarizes how this leads to greater clarity on the issues, and ultimately leaves someone having to decide which conclusion fits better with their overall value system. 'In following this method, you have no guarantee that your position is "right", just that it is thoughtful, studied, rational and fair-minded. If nothing else, you have won clarity on the issues where, before, confusion and vagueness reigned' (p. 60).

In his last chapter, Zanca very clearly applies his method to the question of capital punishment. He thoroughly describes all the issues, and how different ethical theories have addressed them. In the end, he weighs the strengths and weaknesses of the arguments, and gives his own position. Whether you agree with him or not, he has made it very clear why he believes what he does. In many cases, this is all we can do for our students: demonstrate clear, fair thinking, and explain what values led us to our conclusions. As a teaching tool to assist with this, I highly recommend Zanca's book.

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