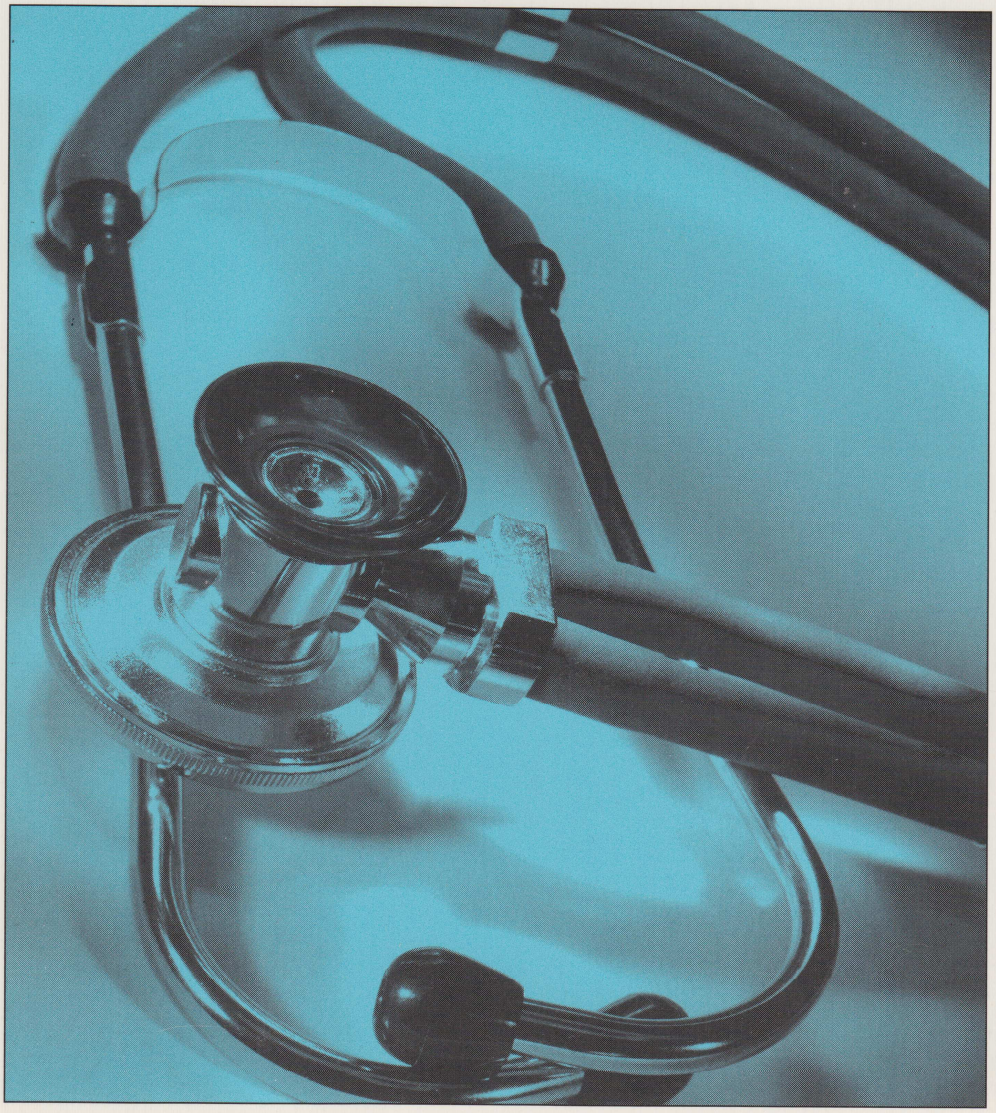
Ethics & Medicine

An International Journal of Bioethics



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LANGUAGE OF THE GENOME

C. BEN MITCHELL, PHD

The recent announcement that scientists have deciphered the human genome is not a threat to a Christian worldview, but another vindication of its coherence. The human genome – the molecular-biological blueprint of the human body – is written in the language of four letters, A, C, T, and G, which represent the amino acids that produce the proteins that ultimately make up our biology. It turns out that the arrangement of these letters in the genome account for things like eye color, hair color, and a host of physical traits. Even the ignominious and ubiquitous condition of male pattern baldness has a genetic link. Furthermore, misspellings in the genome account for as many as 4,000 genetically-linked illnesses. Much to the amazement of the translators of our genetic code, instead of the human genome consisting of 100,000 genes that code for our biological traits, the human blueprint is only around 30,000-50,000 genes in number.

Scientists thought that since the fruit fly possesses between 13,000 and 14,000 genes, in order to account for the incredible differences between a fruit fly and a human, our genome would have to be tens of times larger. Not so. If the measurements are accurate, the human genome is just over twice the size of the fruit fly's. In other words, the language of the genome is much subtler than we thought previously. More nuanced information is contained in fewer sentences, as it were. This ought not surprise us.

The fact that our biology is written in a decipherable language testifies even more brilliantly to a God who speaks. That God created all living things from a relevantly similar blueprint is likewise not surprising. It should not trouble us, then, that the human genome is similar to that of other species. The latest research indicates that chimpanzees share 98.8 percent of our genes, mice share 85-90 percent of our genes and bananas 50 percent of our genes. For people whose worldview includes the affirmation that we were made from the dust of the earth, this hardly comes as unsettling information. To go on to conclude, as evolutionists such as Stephen Jay Gould do, that the similarities between genomes point to Darwinian evolution as the explanation for human existence requires an act of faith that is simply breathtaking. Subtle differences in the language of our genomes results in profound differences between us and other species—and *vive le difference!* The point is, interpreting the information in our cells requires a set of worldview lenses through which to view the information.

A Darwinian sees through Darwinian lenses. The more we understand about our DNA, the more difficult it becomes for naturalistic Darwinism to explain what it sees. So Darwinians often talk about "blind watchmakers" and other oxymorons. Francis Crick, the co-discoverer of the double helical nature of the DNA

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molecule has even declared, "Biologists must constantly keep in mind that what they see is not designed, but rather evolved" (Crick, *What Mad Pursuit,* 1988, p. 138). It is as if reminding themselves of their own dogma will convince them that the evidence for a Designer is a mirage in the desert of scientific explanation. We know, of course, that a Designer leaves fingerprints everywhere and that the God who speaks has, in infinite wisdom, uttered a language which brought all of us into existence. E&M

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GUEST COMMENTARY: BIOETHICS FOR NURSES FROM A FAITH-BASED PERSPECTIVE

JACK HANFORD, THD

Nurses are numerically the largest group of health practitioners in America. Their role is central for bioethics because they occupy the intersection between the physician-patient relationship. Nurses are the key health professionals involved in decisions for organ donation. Likewise, they have increasingly been utilized in genetic counseling.

Gwen Anderson, RN, PhD, of Stanford University is a leader in nursing education. She offers courses on genetic nursing from her website. Anderson describes the learning experience in the following way:

> On my Genetic Nursing Resource web site, I have placed four conceptual models that represent a synthesis of the state of the science and art of social-psychological research in genetic nursing. I have setup this aspect of the web site as an on-line discussion forum so that nurses/students could have a conversation about the utility of these models for practice, research, and education. I have an elaborate set of questions that I think would help students to think about and discuss genetic nursing and the practicality of our current genetic nursing knowledge as well as the gaps and future possible directions . . . BSN students might want to use this web site and on line discussion forum to . . . learn about the state of genetic nursing as a practice, a theoretical and a research activity.
>
> Also on the web site is a 600-item citation list of genetic nursing articles that could be used to create a custom bibliography that could be used to better understand the models and their practical use in nursing practice . . . I'm about to put a redesigned version of this web site in place so it will look like an actual web site. As with the physicians, nurses also struggle with the machines of technology at the bedside and they are the main source of care for the elderly. And even in relation to pastoral care, nurses are working with pastors in a growing movement practicing effective care in the parish setting. (from personal correspondence, 24 May 2000)

Is Nursing a Profession?

Physicians have long been recognized as professionals in the technical sense of the term. Nurses less so. The main challenge for nursing in the 21st century is to establish the integrity and solidarity of their profession. Currently, nurses are viewed as quasi-professionals, somewhat similar to the status of clergy. Nurses

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are perceived as qualifying as one half of a profession because they have a clear and well articulated code of ethics and they fulfill the service or altruistic dimension of authentic professionalism.

In order to meet the model of the American Medical Association and be recognized as a bona fide profession, nursing will have to continue to cultivate professional standards. From about 1900, the AMA has endeavored to unite and standardized their profession by setting forth rigorous demands through higher education. Nurses have not yet taken charge of their profession in the same way and have not yet set forth academic demands similar to those of physicians. Appropriate requirements for nurses are careful selection of students, a standardized degree, and rigorous research. These are necessary to become fully professional.

The stakes for nurses are exceedingly high. Managed care will force nurses (and physicians) into its corporate mold if nurses do not take control of their profession. When managed care relies exclusively on the bottom line, it destroys the needed discretion of and erodes the patient's trust in nurses and doctors. These professional qualities (viz., discretion and trust) must be maintained if quality care is to be delivered. Patients fear that the one who pays the bill will decide the necessary treatment. Actually, patients provide the remuneration by paying the premiums for their insurance coverage. This point must be emphasized to counter the notion that health maintenance organizations and employers are paying the bills. The American public must deal with the fact that the insurance industry not only does not actually pay the bill but takes approximately 25% of the financial resources for its own operation and delivers no healthcare itself. So health professionals need to be encouraged and supported when they assert their distinctive leadership in defining the therapeutic relationship and exercising necessary control within the health system

When I authored a research report about advancing moral reasoning with nursing students, my long-range goal was to contribute toward excellence in clinical practice. Such has always been the mark of the competent professional nurse. Clinical nursing competence includes both technical and ethical aspects. Research suggests that moral and faith development progresses from moral reasoning toward building a bridge between moral thinking and moral action which culminates in professional nursing practice.

Laura Ducket, Muriel Ryden (1994) and James Rest (1994, 1998 p59, 1999) show a .58 correlation between scores on the Defining Issues Test (DIT) and clinical performance. Earlier research by Sheehan (1980) on doctors also supports this finding. The DIT is a multiple-choice test measuring the moral reasoning of the subject who analyzes and determines the most important considerations when thinking through a moral dilemma. A moral dilemma presents a conflict in moral thinking about an issue and about what standards for moral evaluation should be used. The subject's selection of items from the test indicates the developmental level of moral reasoning.

Researchers at the University of Minnesota have identified the steps toward learning ethics that lead to ethical professional practice. They have identified both a strategy and a body of moral knowledge, including who should teach the curriculum, how it should be taught, and how to implement a moral decision in nursing practice. Ethics instruction is integrated into clinical practice and the quality of the clinical practice is evaluated by a clinical professor with a clinical evaluation tool which assesses clinical performance. These measuring instruments are studied to establish their reliability and validity. The results, especially with the DIT, have been so impressive that the nursing school and others are tempted to use the test findings for assisting in the selection of students. Three of four groups of nursing students demonstrated significant advancement in moral reasoning from pre- to post-test on the DIT. This suggests a great deal of empirical progress toward establishing criteria for technical and ethical professional competence.

Significant damage is done to a profession is when it is sold at the cheapest price. For example, when a physician, hospital, or HMO hires the least trained or least educated nurse for the lowest salary, professional excellence is threatened. Most professionals have not been over trained as much as their professional function has not been understood or appreciated.

There are many additional problems that concern the American Nurses Association (ANA) as they seek a foothold on professionalism. Hospital staffing practices are often unsafe because nurses are regularly forced to work long hours, including excessive overtime. New York nurses have protested this staffing issue by picketing. The management of Southside Hospital in New York initially refused to address the staffing problem. Nevertheless, 400 nurses at the Nyack Hospital won their struggle. They created a strong consensus and signed a five-year contract that includes language to ensure safe staffing levels and improvement of working conditions.

The United American Nurses (UAN) organized their National Labor Assembly on June 21, 2000, to prepare nationally for present and future labor disputes. The UAN seeks to provide a strong labor voice for the ANA, develop leadership, assist in bargaining, and further strengthen the UAN. To gain power, they are continuing affiliation talks with the AFL-CIO.

I sincerely hope that all these efforts will succeed, because nurses' claims, especially on safety and staffing, are justified by the principle of justice. From my own painful, even traumatic, experience during three strikes, I have observed that the strike is a limited and questionable strategy as a protest action. To win, such action must gain political support from citizens generally, and many of them will feel hurt by the strike because their own medical care seems threatened. Currently, Americans do not seem to accept the justice claims of nurses and, therefore, do not provide decisive support for nurses involved in labor disputes. The political mood is more negative than positive toward unions and is even more intensely negative toward strikes, especially in health care.

Consequently, the ANA is wise to focus on its development as an authentic profession by increasing demands for education and bona fide academic degrees along with advancing serious research. They have produced research most notably at the University of Minnesota under the outstanding leadership of the late James Rest, showing the correlation between moral reasoning and competent clinical performance. Complementing this research on the ethical dimensions of the profession, nurses are advancing their research also in more technical areas of practice.

Through additional profession-building initiatives, nurses are mounting a major offensive in response to the damaging effects of managed care. The damaging effects on mental health practitioners point toward nurses' own critical response here. In 1994, nurses, predominantly those associated with managed healthcare, organized The American Association of Managed Care Nurses (AAMCN). This professional group is defining standards for managed care nursing, educating nurses with critical thinking skills, and learning specifics about managed care. They produce resources such as *The Journal of Managed Care Medicine* and their new textbook, *A Nurse's Introduction to Managed Care* (2000).

These sources guide and connect two roles in nursing, from direct patient care to administration of nursing practice. The AAMCN plans to inform and impact public policy in support of their mission. State chapters are being established from Florida to Nevada, including a chapter in Washington D.C. Through these efforts, nurses are asserting the power of their professional ethical values to regulate a market which controls managed care. In order to do so, they line up against the bottom line, including exorbitant salaries of CEOs in managed care corporations, as well as the higher profits of such organizations compared to other business groups. Frequently, in opposition to these forces of commodification or commercialism, nurses must make independent professional judgments about a patient's clinical condition from within a therapeutic relationship between a particular nurse, doctor, and patient. This often puts nurses in extraordinarily difficult positions.

Eliot Freidson (1990), a distinguished sociologist of medicine, documents what he calls "The Centrality of Professionalism to Health Care." The nursing professional must be motivated by the quality performance of practice enunciated by the special knowledge of professionals and supported by their own community of solidarity, stimulating the courage to make discretionary judgments for the patient that will create and enhance the patient's trust which is necessary for healing.

Many expert critics of managed care insist that universal health care is the solution to "mangled" health systems. For example, the president of the American Nurses Association, Mary Foley, has offered a proposal for universal coverage for health care. Specifically, she recommends that Medicare become universal. She argues that Medicare is American, is successful, and can be expanded to cover the American population, including parity for coverage of those suffering with mental illness.

Faith-based Nursing and the Example of Judith Shelly

Many nurses embody a faith perspective, including Christian faith. One contemporary representative is Judith Shelly, an RN with a doctor of ministry degree who is director of resources for Nurses Christian Fellowship and editor of the *Journal of Christian Nursing.* Shelly captures the Christian faith perspective in nursing.

The history of Western medicine seems to indicate that the commitment to battle death has been motivated largely by the faith traditions, especially Christian faith. This at first appears paradoxical. Those who believe in life after death are nonetheless committed to fighting it to the finish. That is, Christian conviction accepts both the tragedy of death and that crucifixion precedes the resurrection. Yet, death is viewed as an enemy to be defeated. Thus, dominant metaphors for Western practitioners have been military metaphors such as "to battle death," "to write orders," and "to command younger practitioners in their training and discipline." Florence Nightingale launched nursing on a "military mission."

In contrast, the East has generally accepted death as a passing of the seasons, thus removing the tragic dimension. Consequently, there has been less intense commitment toward aggressive treatment and development of medical institutions in the East.

Elizabeth Kübler-Ross has apparently been influenced by Eastern thought and has impacted nursing in America through her literature on death and dying. Some studies of American nurses have shown a decline in their attitude toward the sanctity of life principle in the sense that this standard symbolized guidance toward fighting death. These trends produce concern that Dr. Ross's influence might create a chasm between nurses and physicians who embody the traditional battle against death.

If this phenomenon is true, then we need to be reminded of our valuable tradition by nurse Shelly (1999, p. 190) who confronts the horror of death. The Bible hints toward a natural death in Genesis 25:8. But Shelly does not accept "natural" as a categorical virtue. Often the natural requires intervention. In fact, intervention is much of what medical and nursing practice do. They intervene before the natural process leads to death and suffering. Death separates us from our loved ones. Christianity teaches us that death is an enemy, though a conquered enemy. This faith perspective on the reality of death is from Christianity. Shelly integrates her faith into her professional practice and this makes a difference in favor of life over death. Her faith and hope in the resurrection can empower her for the demanding and strenuous struggle against disease, pain, and death.

Shelly also accepts the survey of Christian nurses, 80% of whom ranked compassion as the top characteristic of a good nurse along with competence, faith, integrity, and responsibility. Here we can see why nurses are so often admired, since they are considered to be the conscience of health practitioners.

Notice the word "science" in conscience. The word means "*knowing with;*" that is, to know what is right from universal moral principles and a faith perspective.

Does Faith Contribute to Effective Practice?

Shelly's (1999) faith-based perspective leads toward effective practice because her view of Christian faith includes a moral imperative to serve, just as Florence Nightingale sought to join faith with ethics and service. Shelly's emphasis on compassion can be interpreted as "suffering with" or "feeling with" the patient and using empathy to communicate at a deep level with the patient as person. She stresses that competence must integrate the best science, the most advanced technology, and the most arduous development of specific nursing skills. Her faith is not blind, but is accountable to truth. She does not shy away from power but seeks its source, does critical evaluation, and seeks to discern when power comes from authentic faith. And finally, she counts on results which can be known, understood, and accepted by other capable health professionals in harmony with healing motif in the Bible, especially in the ministry of Jesus.

Conclusion

This essay advocates for faith-based nursing because nurses are the consistent advocates for care of the patient. Suggestions were offered toward embodying this caring into solid professional structures of academic excellence, rigorous research and responsible political action for justice and the integrity of the profession. With a commitment to authentic professionalism combined with a faith perspective, nurses can participate in victory over death, pain, and suffering through effective practice. E&M

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A Stranger in a Land of Strangers: Englehart's Thesis Outlined

STEPHEN N. WILLIAMS, PHD

The traditional Christian account of bioethical decision-making is firmly nested in a spiritual quest: the pursuit of the kingdom of heaven. At the surface, many of the responses may seem similar to those provided by other Christian bioethics, as well as by secular morality. On closer inspection, each of the choices differs from those of a secular bioethics in being explicitly directed by spiritual concerns. The enterprise of ethics and bioethics for the traditional Christian always leads beyond this world to the next. As a consequence, decisions will differ because of the concern to treat the soul and achieve salvation. In comparison with the ethics and bioethics of other Christian religions, traditional Christian ethics and bioethics will also diverge because of different understandings of the nature of moral knowledge and of moral authority. Where among other Christian religions there will be a central reliance on discursive moral rationality or biblical exegesis, instead noetic experience, the role of the spiritual father, and concerns with spiritual, ascetic therapy will be central for traditional Christians.[1]

This passage encapsulates Tristram Engelhardt's message in his new volume on bioethics, *The Foundations of Christian Bioethics.* It is a massive book: at over four hundred broad and well-packed pages, it must be around the 200,000-word mark. It is also quite extraordinarily repetitive, a studied literary device. The word 'homiletical' springs to the Western mind to describe this device, and this is encouraged by the author (p.161), but it might be better sourced in the unhurried and weighty Eastern liturgy, the literary response to a Tradition whose champion in the field of bioethics the author sets out to be.

He opens his account by saying: 'This book is as much about a philosophical puzzle as it is about bioethics. This book is more about a religious quest than it is about a philosophical puzzle' (p. xi). Hence it is not until well over the halfway stage that Engelhardt turns to the treatment of specific bioethical issues. For the first three chapters, we have a critique. Secular bioethics is completely adrift from religious truth. But that is virtually the case for non-traditional Christian bioethics too. So what is 'traditional Christian bioethics'? It is the ethics that is grounded and expressed in the Christianity of the first millennium, preserved in the true Church which is solid with that Christianity, namely the Orthodox Church. 'Orthodox Christianity is often defined as the religion directed in right belief to give right worship to God. More fundamentally, it is the religion that leads to right glory, glory with God the Father' (p. xxi, n.22).[2] 'The Church

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may once have had two lungs, but one developed the cancer of novel beliefs and the development of new doctrines' (p. 391). Cancer set in quite early in the new millennium with the advent of Scholasticism, and Protestantism, as much as Roman Catholicism, is riddled with it. So strongly does the author adhere to Orthodoxy that he refers to non-Orthodox Christianities as 'other Christian religions'. So wholeheartedly does he embrace the Christianity of the first millennium that when, in conclusion, he foretells the restoration of the Christian Empire centred in Texas (restored to include 'Santa Fe, the city of the Holy Faith') the reader may experience a flash of momentary suspicion that the tongue is not at this point firmly lodged in the authorial cheek (p. 394).[3]

The fourth chapter is expository, setting out the theological basis and moral thought of Orthodoxy and the rest of the volume moves in some detail through the gamut of issues in bioethics from life's beginning to its end, and from sexuality to resource allocation. For cultural Westerners this volume is certainly different and for most anyone it is, for one reason or another, quite demanding. It is comprehensive both in its world-view and the scope of its discussion. Many readers will experience sensations reminiscent of those of a cosmonaut whose horizons are expanded by a voyage to an adjacent planet. The author himself prepares us for the book's novelties.

What *is* wrong with the West on this account of things? Well, secular bioethics, rejecting Christian bioethics, is bent in the direction of a liberal cosmopolitanism. That is to be distinguished from libertarian cosmopolitanism. This latter is forced on us by the facts of socio-historical life. Given that we are moral strangers who lack a consensus on moral foundations based on either revelation or reason, we must simply dwell together in society on the principle of consent. Public moral space is only that space in which permission and consent are sought and negotiated. Substantive moral convictions are reserved for private space and libertarian cosmopolitanism allows these to flourish on their own turf. Not so liberal cosmopolitanism. It pushes a value-agenda, which it foists on us all, autonomy in particular. It works off secular schemes of Enlightenment and post-Enlightenment rationality, which allow abortion and homosexuality to be protected by law because they are morally acceptable practices. In libertarian cosmopolitanism, on the other hand, while such practices may be a matter of consent, their moral content is a matter of public neutrality. Despite the fact that immense moral fragmentation is the order of the day, liberal cosmopolitanism persists in the pretence that there are normative values, thus masking moral diversity by the promotion of false consciousness.

Non-traditional (i.e., non-Orthodox) Christianity has lamentably failed. In fact, it has fed secular bioethics, despite the sincerity of many Western Christians in their moral opposition to it. For Western thought cradled and nurtured that fatal progeny, discursive reason. Not only did it allow moral wisdom to be the product of stringent logical deduction in the cause of legalistic rationalism. More fundamentally still, it sought the unity of natural and revealed knowledge, natural and divine law by the improper identification of faith and reason. That is, it

aspired to a single overarching rationality. Secular bioethics just took this ideal and ran with it, but in a direction away from Christianity. It was able to take up the dream of a unified epistemological ideal in the wake of the fragmentation of moralities and religions achieved by the Reformation. Renaissance overtook Reformation, empowered by the medieval synthesis of faith and reason to usher in eventually a uniform pagan rationality.

What is the alternative to the West? The One, unfragmented True Faith. Its norm is first millennial Christianity, its source mystical or (better) noetic experience, the experience of the true and living God. It cannot be directly argued for. Faith and participation are invited or enjoined on us. Its focus is single: salvation. Salvation is otherworldly, attained by holiness, which is our this-worldly vocation. It is wrong to gear bioethical thinking to any other goal than this salvation. To do otherwise would be to abandon religion. Moral reasoning is harnessed to salvific destiny. Certainly, this does not preclude the exercise of reason in logical and conceptual clarification; to the contrary, Engelhardt is very much about this in his treatment of particular bioethical topics. But the criteria of right and wrong action are elucidated by reference to God's saving purposes. In the tradition of first millennial Christianity, this involves holding definite moral convictions about what is right and wrong. The author's conclusions are generally conservative in a sense that substantively identifies them with much conservative Roman Catholic or Protestant bioethics. Yet he constantly insists on keeping his distance. Where the Western frame of mind mires us in tangles of inferential legalisms or exegetical uncertainties, the 'magisterial' spiritual authority of a Basil or a Chrysostom and the contemporary spiritual guidance of an Orthodox priest furnish the insight for what is morally correct for this person here and now.

One courts the charge of dreadful injustice to the author in not reporting his conclusions on the range of bioethical questions with which he deals, but that would mean a catalogue which would not really convey what he is about. As the title and his own description of the work indicate, the author is most interested in telling us how he gets to his conclusions. The nature of the book demands that we attend to it in the light of its avowed preoccupation with religion and philosophy. This journal is not the place to pursue in detailed theological and philosophical terms some of the issues that detain Engelhardt. But we shall try to do justice to the main concerns.

Public Morality and Private Rationality

Direct engagement with the religious convictions expressed in this book is difficult because its premise is the truth of Orthodoxy, its authority is the Tradition and the author disavows the possibility of settling the matter by publicly accessible reason. This last point will be granted by plenty of religious or non-religious people. Protestants will be swift to insist that it is a mistake to ascribe such infallibility to a tradition and communion; that the argument that the Church was the bearer of Scripture and the liturgy its context leads to false conclusions. For the Church from which the Scriptures came confessed the

authority of that product over the institution or communion out of which they were produced, just as Jesus (so some put it), born of Mary, is her Lord. And are we to believe that Basil and Chrysostom, when they grounded their theologies on what Genesis or Matthew or Romans said, sanctioned the view that their own teaching, rather than these texts, *practically* took precedence as the authoritative norm for the Church?[4]

Protestants may be swift . . . but whether or not the line of argument intrinsically favours a traditional Protestant view of authority, it will not normally be persuasive for the Orthodox, who characteristically do not set up the question of Scripture, Tradition and Church as do Protestants. These form a conceptually unified whole in a way that makes it hard, if not impossible, to conceive of a relative subordination of authorities. The liturgy does not just constitute a feature of Orthodoxy; it is its genius, in which the enduring and saving unity of Scripture, Church and Tradition is sustained and grounded in the very being and energies of God, the Holy Trinity.[5] In a West cut off from its past, from worship, from a sense of transcendence, from an impulse towards the sacred or from an objective source of authority, it is not hard to appreciate the attraction of Orthodoxy. To draw bioethics into its world, as Engelhardt does, is to convert the process of decision-making from harried perplexity into hopeful pilgrimage.

As far as explicit statements go, Roman Catholicism is a particular religious target for the author, but only because it is easier to treat it as a unity than it is Protestantism. A specific response is best left for those who (unlike the present writer) have a committed religious interest in defending the distinctive theology, ecclesiology, moral philosophy and spirituality of the Roman Catholic communion. But Westerners might make common cause in challenging at least two features of the historical and theological analysis. The first is that the author makes too much of the community of thinkers in 'discursive reason' which lands Aquinas, Bonaventure and Ockham, Dominicans and Franciscans, for example, in one and the same spiritually leaky craft. A more extended treatment - which only the perverse will request - might profitably weigh the relative contributions of Aquinas' synthesis and Ockham's rejection of it in the formation of modernity. The second is that if 'Disbelief [is] a moral choice not a miscalculation' (p.164), one can hardly trace the continuities of the medieval synthesis and the horrors of the twentieth century as Engelhardt has done. To suggest that Stalin, Mao and Pol Pot are ultimately reaping what the Scholastics have sown is to misunderstand the force of his own point about disbelief as a moral choice. Secular rationalities and accompanying moral horrors are the product of something much deeper than intellectual mistakes in epistemology.[6] But however close all this is to the mark, Roman Catholic, Protestant and secular will not want the matter of discursive reason to rest there and will want to attend further to the question of libertarian and liberal cosmopolitanisms.

Engelhardt apparently holds that libertarian cosmopolitanism is coherent if not desirable. Short of imposing one's morality, which liberal cosmopolitans do and which traditional Christians will not, how else can one carry on social life?

However, there is a snag here. A huge proportion of those involved in consensual arrangements are non-consenting parties: foetuses that may be aborted; embryos that feature in surrogacy contracts. Engelhardt believes that they have the moral right not to be subject to arrangements that secularists promote. But in giving public moral primacy to consent, he effectively yields the palm to his secular foes. Their consent is sufficient to allow them to treat non-consenting parties in the way that they do. But why should the inability of an embryo to give or to withhold consent make it subject to the decision of others simply because they do consent? Why should Engelhardt not aim at what he says liberal cosmopolitans aim at, namely the enshrining of values in law and public policy, in this case the outlawing of abortion or surrogacy arrangements that are based just on consent?

His answer would be this: we have no public basis on which to do what liberal cosmopolitans (unwarrantedly) do; we just have a private basis on which to judge actions moral or immoral. However, de facto, embryos are treated without their consent on the basis of *somebody's* values being imposed on them. Imposition is writ into the fabric of a society and world which contain embryos, infants, the mentally challenged and the incapacitated elderly. If society consisted of consenting adults, Engelhardt might be right to abide by libertarian cosmopolitanism. But the agonistic reality of social life in our pluralistic society, composed only in part of consenting adults, undermines his form of acquiescence in this pluralism. Why should a secularist's freedom to make surrogacy or abortion arrangements on the basis of permission and consent override my defence of the right to life or to standard nurture in the biologically maternal womb, of non-consenting parties?

Engelhardt seems to think that the principle of consent in the public square could only be replaced if we could rely on discursive reason to secure moral claims. That endeavour will never succeed, doomed by the manifest absence of any standard rationality, let alone guilty of religious error in exploring such a route. The candour of his initial descriptives–a (philosophical) 'puzzle' and (religious) 'quest'—suggest that he feels driven into his position not by a truculent celebration of the internalist nature of all rationalities, but by an open acknowledgement that such is a fact of life. But is it really impossible to steer a course between the Scylla of belief in a humanly common rationality and the Charybdis of adherence to purely internalist criteria for rationality?

Certainly, there are limits to intellectual persuasion. Certainly, there is no neutral, presuppositionless reason common to all competent adults. But Christians who examine the ground of their own faith must affirm that it pivots on the resurrection of Jesus from the dead. This is neither presented in Scripture as an uninterpreted fact, nor portrayed without the background of a specific tradition of religious experience, nor promulgated as a rationally accessible datum to be reached by a uniform logically demonstrative track from any point in space, time or culture. Nonetheless, it is a this-worldly event, with empirical data relevant to its verification and falsification, religious conviction being dependent on

its veracity. In its widest connection–with the whole person of Jesus and the existence of a Creator of the universe–it forms the point from which a whole worldview is established and reality illuminated, as far as it can be. Within this context, we outline a rationality in relation to sexuality and the embryo, euthanasia and death, nature and nurture, cosmology and history. Without triumphalism or naïveté, omniscience or incorrigibility, the Christian is entitled to ask why this rationality may not be persuasive and which one is more so. Since something or someone will publicly prevail, one is bound to ask it publicly, however futile such a question seems in a society of moral strangers exhibiting divergent epistemic commitments. The West may have got plenty wrong in its concept of rationality and deployment of reason. Yet the instinct that led faith to seek understanding is suppressed at our peril. This Engelhardt does, in important respects. But how are his principles applied?

Bioethics and Faith

A reviewer of Tristram Engelhardt's book is almost bound to suffer defeat at two points. Firstly, one cannot give an account of the wealth of reflection on bioethical particulars, including on the relevant tenets of fundamental sexual ethics. Secondly, one cannot convey the atmosphere of the volume, increasingly pervasive as it progresses, in which the reader breathes the air of holy mystery that engulfs a practice of charitable realism. While bioethics is certainly rooted in firm and uncompromising principles, the author systematically distinguishes them from their Western counterparts. They are rooted in a personal relationship with God, not in impersonal natural law. They eschew the linguistic garb of 'rights', 'virtues' or 'goods' in favour of what enhances holiness, relationship with God, salvation. Their goal is therapeutic and their structure non-juridical. Consequently, the expert is the spiritual director not the academic thinker.[7]

Perhaps the most striking feature of the account is the 'either-or' directed on behalf of noetic (experiential) truth against reason. For example 'one should resist the temptation to ground prohibitions against murder or abortion in supposed general moral principles such as the principle of the sanctity of life, rather than in the pursuit of God' (p.209). Such false grounding provides an entree for misguided reason. Ascription of personhood to the conceptus is avoided because the Tradition does not make quite that move and the only other way of making it would be via some sort of philosophical and/or biological account of matters, which gives authority to reason.[8] Or if, as we must, we insist on making heterosexual relations the norm for sexual ethics, morally rejecting homosexuality or bestiality, any appeal to what is natural in the light of reason is invalid.

Those who want to join Engelhardt in insisting that spiritual obedience is the beginning and the heart of wisdom, and that it is in God and not in Reason that wisdom lies, may still baulk at the refusal to grant reason a more positive role than he does. I may be (a) generally opposed to abortion on account of my religious faith. But within its perspective, I may (b) see the world in terms of natural kinds of things with pertinent natural rights and this reinforces conclusions

about the status and relevant treatment of the human embryo. Further (c), being informed (like Engelhardt) on rudiments of science, I find that what is conceived is genetically complete from the moment of conception. Why should I not then appeal to the significance of (b) and (c) for a rational account of the morality of embryo treatment? I grant the fact of conflicting rationalities and my conclusions are not dependent on the detailed reasoning I adopt. Nevertheless, I shall urge others who do not share my presuppositions to attend considerately to my reasoning.[9]

Quite apart from reservations Engelhardt would have on the particular theological convictions that might emerge in this example, he would refuse to foreclose, by such intellective procedures, what the Tradition studiously does not. Here, we who are non-Orthodox, will have a straight disagreement on the matter of authority in religion. On Engelhardt's interpretation, on some matters, the faithful need simply to be informed of what the Spirit has said in Church and Tradition. But on other matters specific discernment is needed. Should I seek artificial insemination by my husband as long as his semen is produced in the context of marital intimacy? Should stored gametes be used for reproduction, within marriage? Is it allowable to use tissues and organs from aborted foetuses? Should I select the sex of my child? Should I undergo an abortion if my life is threatened by continued pregnancy? Should I take medication that prevents a zygote from implanting? When should treatment be withheld or withdrawn when that will allow death to take its course? When is dissimulation justified in the context of health-care provision? The answers to these questions are situational. They must be directed to the salvation of the soul of the person involved. The expert in such matters is the spiritual father, not the academic reasoner.

The broad approach adopted here has some commendable features. Starting with seeing the whole business of bioethics in the light of God's goals and purpose, Engelhardt warns us very effectively against fundamental attitudes like the idolisation of health and making the maximisation of temporal satisfaction our goal. All this rightly leads him to emphasise what is best ad hominem and not just what is right *per se*.[10] And that certainly demands judgement, intuition and discernment of the kind that cannot be established by, reduced to or netted in a rigid conceptuality. But aside from the quarrel we might have with the structure of his moral theology, on issues of sin and penitence, the argument suffers yet again from excessive suspicion towards reason on account of its frequently excessive pretensions in the past and in the present.[11] Banishment is not the only alternative to tyranny. Engelhardt needs to explore more thoroughly a range of ways of potentially deploying reason, including the possibility of framing its operations within the bounds of revelation in a way that does not limit its persuasive power a priori to an intellectual and spiritual community of like-minded people.

I have hammered away at the question of rationality because the author's programme is so driven by his views on this and his arguments best approached by attending to them. His Orthodoxy, in the terms presented, one either accepts or rejects. His bioethical beliefs are subject to individual discussion, *seriatim*. But

on reason, in an attempt to let Christianity be Christianity, he is promoting an unhelpful more than a valid sectarianism.[12] In this journal, it is appropriate to conclude on this point with reference to his criticisms of a former editor, Nigel Cameron. 'It is remarkable' says Engelhardt 'how the commitment to broad consensus and moral rationalism can lead even Christian thinkers to celebrate a medical-moral tradition independent of the truth of Christianity...Aside from the view that apparently locates Christian bioethical concerns in terms of medicine rather than medicine in terms of Christianity, there is a failure to explore how it could be that the Hippocratic paganism he endorses turns out to be so congenial to a Christian account of medicine' (p.67, n.121). Engelhardt is referring to Cameron's thesis on the fusion of Hippocratic and Christian concerns. It is not germane to consider all the principal aspects of that thesis right here. But, in terms of theological foundations for bioethics, I believe Cameron to be basically on solid grounds and Engelhardt on dangerous ones:

1. All truth in God's world is God's truth. It does not have to be embedded in the true comprehensive account of matters to qualify as truth. Nor are tenets maintained outside a Christian scheme of things *ipso facto* stripped of a meaning that coheres and overlaps with the Christian meaning of things, even though meaning and truth outside Christianity are transformed when its light falls on them.
2. Detecting a Christian-Hippocratic tradition where the latter component predates the former does not entail locating Christian biomedical concerns in terms of medicine rather than medicine in terms of Christianity. As Cameron never gets close to doing so, Engelhardt can only say what he says on a doctrinaire assumption that anything Christianity is deemed to share so fundamentally with an alternative tradition, a tradition of 'moral rationalism', must be shared on the basis of that tradition, not on the basis of Christianity. The assumption is unwarranted.
3. Why should any puzzlement attend the congeniality of Hippocratic paganism to a Christian account of medicine? Matthew's celebration of the presence of the Magi would not have turned into increasing bewilderment or consternation in proportion to the congeniality of their tenets with those of the Jews. One should have rejoiced to find Hippocrates in their number. Christ was not born under the star of reason. But if God should choose to guide, here and there, by such a star, we should not fear that the star, and not the presence in the cradle, thereby becomes the object of worship. With Engelhardt, in laying out foundations for bioethics, we should eschew dilution and Christian compromise, false confidence in the flesh, frail forgetfulness that we contend against principalities and powers. And reason may not be the brightest of colours. Nor is it unflecked by unsightly hues. But at least let us not just see red when we see reason. E&M

References

1. H.T.Engelhardt Jr., *The Foundations of Christian Bioethics* (Lisse/Abingdon/Exton Pa./Tokyo: Swets & Zeitlinger, 2000, ISBN: 902651557X, $39.95) p.323f.

2. It can also be called 'Orthodox Catholicism', which is 'that of the Orthodox Church, the ancient Roman Church whose bishops assemble presided over by the Bishop of New Rome, the Ecumenical Patriarch of Constantinople' (p.xxi, n.20).

3. For thoroughness of adherence, note the following. 'The Orthodox Church gives special weight to the homilies of St.John Chrysostom on St.Paul, for it knows that St.Paul's guidance of St.John is verified not only by the Tradition, but by the relic of St.John Chrysostom's skull and incorrupt ear into which St.Paul spoke, preserved to this day in the monastery of Vatopaidi on Mount Athos' (p.215, n.28).

4. On p.xvi Engelhardt asserts that '[i]f Scripture is at the core of theology, its authoritative claims will be deconstructed through text-critical and sociohistorical reassessments of the Scriptures, thus rendering it congenial to the assumptions of our age'. On the following page he goes so far as to say this is volume 'celebrates the great gift of the Scriptures but recognises that they are not essential to Christianity'. However, he considerably modifies this position in his pivotal fourth chapter.

5. 'The Liturgy frames the sociology of knowledge for a Christian bioethics' (p.189).

6. Actually, one might question Engelhardt's characterisation of twentieth century evils in terms of secular moralities anyway, despite his appeal to Merleau-Ponty (p.23, 28f). Perhaps that he denies that the intellectual mistakes of Scholastics and post-Scholastics were characteristically made in good faith. But even if he affirms a frequently 'good faith' (i.e., sound intention, central to his own account of morality), accounts of modernity still need to sort out the whole business of why people do what they do with ideas, and the way the logic of ideas get worked out in history.

7. 'Claims of bioethical knowledge should be tested by moral experts who have acquired such discernment and who need not be educated' (p.172). '...Experience of God is a necessary condition for the possibility of a traditional Christian bioethics. It is also a sufficient condition' (p.181).

8. This ultimately includes the drawing of inferences from Scripture.

9. However, I am not making a thoroughgoing commitment here to this method of moral reasoning.

10. In one respect, Engelhardt denies that anything is right per se, for that formulation betrays the subjection to natural law to which the West has been enslaved. But I have put it this way rather than omitting the word 'just' in my sentence above so that the impression is not conveyed that Engelhardt advocates a situationism subject to no stateable principle at all save the principle of love.

11. Orthodox priests in their capacity as spiritual directors may sanction actions that are not ideal, in that they may fall short of the norms for behaviour embedded in the divinely-given natural order, just as long as the actors mourn their complicity in what is ambiguous and fallen and are prepared to do penance if prescribed. Certainly we should be sensitive to the contaminations of an evil in the heart and in an order that ever surrounds us. But the pneumatology is defective here. It can not be a structural feature of the religious life that the Spirit who dwells within us prompts actions for which we must then do penance. If the author is not quite saying this, it remains that a spiritual director should discourage action that will be necessarily accompanied by penitential mourning. But in the cause of brevity, I risk a dogmatic interpretation of the author on this point.

12. I mean this in principle, quite apart from what one believes about Orthodoxy.

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The Position of Nurses in the New Dutch Euthanasia Bill: A Report of Legal and Political Developments

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Editor's Note: On April 10, 2001, The Netherlands became the first democratic nation to legalize euthanasia. According to press reports, the 75-seat Senate voted 46-28 in favor of the new law permitting active, voluntary euthanasia. Even though the following article was written prior to the passage of the law, it's content and argument remains intensely relevant.

Introduction

In the autumn of 2000, opposing views on euthanasia and physician-assisted suicide clearly came to light when members of the Second Chamber of the Dutch Parliament discussed the new euthanasia Bill, titled 'Review Procedures For The Termination Of Life On Request And Assisted Suicide'. Meanwhile, this Bill has been approved by the Second Chamber but must still be approved by the First Chamber before it becomes an Act. The debate in the First Chamber is expected to proceed April 10, 2001.

Of course, these opposing views also exist among physicians and nurses. They often give rise to polemics and sometimes even to conflicts on the work floor as well. For Christian nurses, these debates revolve around genuine dilemmas, such as: what do I do with my beliefs when confronted with a request for euthanasia?; what are my rights and duties when I refuse to grant a request?; how far can I be forced to cooperate?; and the like. To a certain extent, of course, they share these dilemmas with non-Christians.

In the Netherlands, individuals and nursing associations of Protestant stripe have a large stake in these issues. Among them are Febe (Reformed Union of Health Care Workers), Hospital Christian Fellowship – The Netherlands, the Reformed Social Association (GMV) and the Reformed Social Union (RMU). To be sure, the secular nursing union NU '91 (the largest Dutch nurses' association), studies these issues as well, particularly with regard to the legal position of nurses in euthanasia. That is why a collaborative Febe and HCF-N task force, 'Ethics and Law in Nursing and Care' (WERVV), has contacted this union before the public and political debates to make policymakers and politicians aware of the importance of adequate legal protection of nurses confronted with euthanasia situations. This will be discussed later in this article.

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By explaining some terminology, focusing on the position of nurses in the new bill, addressing the initiative of the aforementioned nurses' associations, and discussing the government's response to this initiative, we hope to provide some insight into what the Dutch practice of health care will be when the new euthanasia bill comes into force.

Euthanasia and the Law

Dutch juridical literature defines euthanasia as follows: 'Euthanasia is the intentional termination of a patient's life by someone else on request of that patient' (definition by the State Committee on Euthanasia, 1985). Note that euthanasia is always defined in the Netherlands as voluntary active euthanasia, contrary to international use of the word.

Simply put, ending someone's life is a crime in The Netherlands. According to the penal code, section 293, 'He who takes the life of a person on his/her explicit and serious desire is punished by imprisonment of at most 12 years or a fine of the fifth category (= hfl. 100.000,--).' However, according to a ruling by the highest court of law in The Netherlands, the Supreme Court, a physician who has performed euthanasia will not be punished if he can successfully claim to have been subject of circumstances beyond his control. More precisely, the situation must be one of a conflict of duties, namely the duty to alleviate suffering and the duty to preserve life. This *force majeure*, or emergency situation, must be apparent from the circumstances, which are formulated for legal review as 'requirements of careful practice'. In the present situation, the physician must be able to successfully appeal to force majeure to attain impunity. In the new 'Review Procedures' Bill, these requirements of careful practice are laid down legally, purposing that the physician who complies with the requirements no longer needs to appeal to *force majeure*, but can claim impunity directly: not because he was in a case of emergency, but because he acted according to the requirements in the law. In effect, carefully practiced euthanasia and physician-assisted suicide are legalized in this Bill.

These requirements of careful practice entail that the physician:

a. must be convinced there was a voluntary and well-considered request from the patient;
b. must be convinced that the patient's suffering was without prospect and unbearable;
c. must have informed the patient of the situation he was in and on his prospects;
d. must have come to the conclusion together with the patient that there was no other reasonable solution for the patient's situation;
e. must have consulted at least one other independent physician, who has seen the patient and formed an opinion on the requirements in items a-d; and
f. must have carried out the euthanasia in a medically careful way.

The physician must then follow a certain reporting procedure, including a report of his actions. The reporting procedure is to prove that the physician has complied with the requirements of careful practice.

The performance of euthanasia is restricted to physicians. That is why anyone who carries out euthanasia while not being a physician will be prosecuted in every case, even if he/she has met the requirements of careful practice. This, for instance, happened to a nurse in 1995, when she carried out euthanasia of her own accord on a befriended AIDS patient who requested her to do so. Although a physician was present and had even supplied the means, this did not prevent the nurse from being sentenced. The regional Leeuwarden Court found the nurse guilty, albeit without imposing punishment. The physician had to answer before the medical disciplinary court.

Euthanasia, furthermore, is defined by the intention or goal to end a patient's life. To be distinguished from euthanasia and hence not punishable, then, are situations where intention and aim of medical decisions are not to end someone's life even if the final result is the same, meaning that the patient dies sooner than would have been the case if the decision had not been made. If the intention of the medical decision was to avoid the pointless prolonging of the dying process, or to respect the right of inviolability of the person and his body, or to alleviate suffering with proportional medication, then there is no intent of killing and no legal liability. Therefore, euthanasia is to be distinguished from

- Withholding or not starting a treatment that is futile from a medical point of view (with a shortening of life as a side effect).
- Withholding or not starting treatment when the patient refuses it (with a shortening of life as a side effect).
- Raising doses of pain medication (with a shortening of life as a side effect).

In short, if any of these measures are taken without the intent to end the patient's life, then it is not considered euthanasia. When the intention is to end the patient's life (which is sometimes hard to distinguish), either by commission or omission, it is in effect euthanasia. If the patient has not requested it, it is intentionally ending life without an explicit request from the patient (involuntary euthanasia), which remains a violation of the penal code.

Reporting Procedures

In this latter case, too, the physician must follow the reporting procedure. When the physician does not follow the required reporting procedure and, contrary to the facts, issues a natural death certificate, he is guilty of the crime of 'issuing a false medical certificate' (Art. 228 of the Penal Code). The Dutch Cabinet has decided, then, to lay down two new reporting procedures, one for reporting euthanasia and physician-assisted suicide, and one for reporting the termination of a patient's life without a request.

The reporting procedure for euthanasia implies that physicians must report their actions in ending a life to the municipal coroner by means of a questionnaire, after which a regional review committee – consisting of a physician, an ethicist and a lawyer – judge whether the physician has complied with the care requirements. Only if the review committee reaches a negative judgment will this be reported to the Public Prosecutor (according to the Bill), so that he can take legal action against the physician. If the committee's verdict is positive, this procedure is closed. However, the Public Prosecutor is still entitled to start an independent investigation if a penal act is suspect.

Lastly, the Bill also deals with written euthanasia requests or 'living wills'. The physician may comply with these written wills, containing a request for euthanasia, unless he has valid reasons not to do so. It may be, for example, that medical science has produced an acceptable alternative for the patient's condition after the will was made. It may also be that the statement is not clear enough for the physician as a guideline. The physician is never obliged to meet the request. When he does meet it, he must comply with the requirements of careful practice. Whenever possible, the physician and the patient need to discuss the euthanasia request, so that both know where they stand.

The Legal Position of the Nurse

As we saw, the Dutch Supreme Court has described euthanasia as an act strictly limited to the physician, on the condition that he complies with the requirements for careful practice. That is why euthanasia is an act which cannot be handed down to someone who is not a physician. This implies, as stated earlier, that nurses or other non-physicians will be legally prosecuted if they should perform euthanasia.

The question that follows is: may nurses or others ever assist a physician in the performance of euthanasia? Bearing in mind that euthanasia is still a crime, the answer is negative: complicity to penal acts is also a crime. When the physician performs euthanasia, someone who cooperates can be punishable (a) as principal perpetrator in the second degree (if he/she has as large a part in the euthanasia as the physician, Penal Code, art. 47), or (b) as an accomplice (when he/she has only a limited part in the euthanasia, for example when he/she only filled the syringe with a lethal medication).

In any case, nurses can always take recourse to a claim of conscientious objections if they refuse to cooperate in a case of euthanasia. In the Collective Labour Agreements for Hospitals 1999-2000, it says that serious conscientious objections to whatever task or order are sufficient for a health care worker to rightfully refuse cooperation in those. When a nurse does cooperate in a case of euthanasia, she will go free only if the physician goes free. This can be the case when the physician who carried out the euthanasia has complied with the requirements for careful practice.

'Cooperation by nurses' might mean any of the following:

- Cooperation in planning and preparing euthanasia,
- Cooperation in filling a hypodermic syringe, preparing or changing a perfusor or the infusion system with a lethal drug
- Carrying out euthanasia autonomously after being ordered to do so by the physician.

Nurses who give a lethal injection or operate the infusion system are liable to be punished because they are responsible for accepting the task of carrying out the act themselves. That is why the nurse can be held responsible by the judge, just as the physician for his part. In practice, the legal investigation focuses mainly on the physician's doings. But in principle, it does not rule out that the nurse must be able to account for her part in such cases.

We may conclude that nurses – even without claiming conscientious objections – are fully justified in refusing to assist in the performance of euthanasia. After all, it is still acting against the law –whereto nobody can be obliged. In practice, however, it seems that the expectations and legal position of nurses are not as clear as they should be. Unfortunately, nurses themselves are partly responsible for this, because they simply do cooperate in euthanasia. But surely their superiors, the physicians involved, and last but not least the lack of clarity from the Cabinet, who to a certain extent accept cooperation on euthanasia by nurses, are responsible as well.

Associations and Interest Groups for Nurses

Nursing organizations fundamentally rejecting euthanasia and rendering assistance to self-inflicted death as well as those not taking that position, at the very least agree on the following points. (a) Nurses should be involved in the documentation of a request for euthanasia and the resulting decision making process, and (b) nurses' legal position deserves a better regulation and protection. Naturally, the underlying motives differ for these organizations. Partly, these organizations also differ in the way they flesh out and put forward their points of view.

To prevent any unwelcome involvement of nurses in termination of life by health professionals, those nurses' organizations which fundamentally reject euthanasia (i.e. Febe, HCF-NL, GMV and RMU), have pleaded with political parties for inclusion in the Bill of at least the following section: 'No person can be obliged to give a treatment aimed at terminating a patient's life, or to cooperate in any such treatment.' A similar section pertaining to abortion was at the time included in the Abortion Act (Art. 20).

The Febe and HCF-NL task force, WERVV, has also proposed to the political parties to include an article in the Bill requiring the physician to consult nurses, on the basis of their expertise, concerning the patient's request and the possible alternatives. They have also proposed to adopt a section in the Bill forbidding the

physician to deputize non-physicians to terminate a patient's life. As far as the reporting procedure is concerned, this task force finally proposed that the physician should hand the nurse's report to the Coroner beside his own.

For the WERVV task force, it was gratifying that the Reformed parliamentary parties SGP, GPV and RPF were prepared to include those proposals in some form in amendments to the Bill. As far as the large, secular nurses' union NU '91 is concerned, WERVV found a sympathetic ear for the first of the proposed additions to the Bill with regard to nurses ('Nobody is obliged . . .' etc.). They are also willing to press for inclusion of such a section in the Bill. Regrettably, this organization takes the stand that nurses must be able to cooperate on euthanasia under certain conditions, provided that they are well informed and their legal position is well protected. Equally regrettable is their stand that, when a patient specifically requests this, nurses must be able to carry out euthanasia, but only when a physician is present. These stands are based on the idea, now prevalent in the Netherlands, that euthanasia could be the last part of good terminal care.

The Responsible Ministers' Response

The Ministers involved, Mrs Borst (Health, Welfare and Sports) and Mr Korthals (Justice), gave a most disappointing and debatable response to the nurses' organizations' work, however. Mrs Borst has always been of the opinion that nurses must not be involved in the performance of euthanasia, because for them there are no impunity grounds. By 'performance' she meant acts concerning the patient directly, like inserting or turning on an infusion, or injecting a lethal drug. These are medical acts a nurse really should refuse, even if the physician insists. In that case the nurse should complain to his/her superiors. While this seems a rather sympathetic stand to pro-life nurses at first glance, several problems arise.

Take the tasks nurses perform in preparation to a medical intervention, like filling a syringe. These may be carried out by nurses, according to the Minister. But why? Because nurses usually are much more skilled in these things than physicians and hence nurses may do them just for safety reasons! Then why should they also refrain from administering the injection, if that is safer? The Minister did not give any juridical basis for her stand on preparing acts. She referred to the Minister of Justice on this point. But Mr Korthals never provided any basis for a decent regulation either.

Minister Borst ignored the issue that nurses could refuse to cooperate in euthanasia because it is a violation of the law. She merely pointed to their right to refuse to complete certain tasks when they give rise to conscientious objections. The Minister did support the idea of nurses writing an independent report of the proceedings surrounding a case of euthanasia for the regional review committee. But she found it unnecessary to include a regulation for this in the Bill. According to the Minister the review committee could also ask the nurse to file a report on his or her own initiative.

Really hard to accept for the nurses' associations just mentioned was the fact that Mrs Borst repeatedly suspended her position on nurses and euthanasia by simply referring to a survey of nurses' actual involvement in the practice of euthanasia, to be initiated by the Department of Health in 2001. In doing so, the Minister gave the impression that she wanted to let clarity on the legal position of nurses depend on this survey's results. For the nurses' associations, this was particularly wry, as they had been asking for such a survey for years without this being granted.

For this reason, the nurses union, NU '91, urged the Minister on behalf of the general assembly of all Dutch nurses' organizations, AVVV (which is also the official conversation partner of Mrs Borst when nursing is concerned), to keep her from suspending a decent regulation for nurses. The claim was that the time is right for the Minister to regulate the legal position of nurses. In addition, NU '91 and AVVV also frankly declared themselves in favor of a legal duty for physicians to consult nurses in case of a request for euthanasia. Lastly, they pleaded for the inclusion of the section 'No person is obliged to provide a treatment to a patient which is aimed at ending his/her life, or to cooperate on such a treatment.' To date, there has been no answer.

In spite of our worries about future legislation of euthanasia, to conclude, we are very grateful for the increased awareness and support of non-Christian political parties and nursing organizations in The Netherlands regarding this issue. We hope and pray that this may still have a positive effect on the new legislation coming into force later this year and, moreover, on the survey initiated by the Department of Health into the involvement of nurses in euthanasia. E&M

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A Critique of the Clinical Examples for the APA's "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice"[1]

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In April, 1990, the American Psychiatric Association (APA) published "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice" (hereafter "Guidelines") after having been approved by the APA Assembly and Board of Trustees in 1989.[2] Since then there have been few published considerations of the Guidelines, though their publication has been hailed as a "significant event,"[3] beginning as they do with the precept that "psychiatrists should maintain respect for their patients' beliefs. . .".[2] Howsepian published a conceptual critique of the Guidelines in 1997, also noting "the paucity of subsequent psychiatric publications which interact with [the Guidelines]".[2] Indeed, a Medline search uncovered no additional articles dealing exclusively with the Guidelines. Given the perceived significance of the Guidelines this is surprising.

Along with the Guidelines themselves, the Appendix to the Guidelines has received scant attention. In the Appendix, the APA Committee on Religion and Psychiatry (hereafter "the Committee") offers four examples intended to "illustrate the kinds of problems that may arise when strong beliefs are interjected into clinical practice."[2] This paper examines these four examples. Presumably in providing these examples, the Committee believes that the Guidelines can fruitfully inform our approach to such problematic situations. However, close examination reveals that while the examples describe apparent conflicts, they are too vague to illustrate the application of the Guidelines. In part this is due to the conceptual flaws in the Guidelines themselves noted by Howsepian.[4] However, there are problems with the examples as well. The purpose of this paper is to demonstrate that while the examples indeed portray situations in which conflicts apparently arise, they fail to clearly delineate the ethical issue at stake. Further, by using examples portraying stark conflicts, the Committee presents the erroneously simplified view that real life situations can be readily divided into those within the purview of psychiatric formulation and practice, and those outside that domain. Using the words of the Guidelines themselves, the polarized examples superficially suggest that it should be relatively easy for psychiatrists to "maintain respect for their patients' beliefs," while remaining true to accepted psychiatric "diagnostic concepts or therapeutic practice."[2]

Ethics & Medicine, 17:2 (2001):93-98.

The concerns of psychiatry and religion, however, are not always so distinct, nor is either immune from the influence of the other. George Carey, Archbishop of Canterbury, in an address to the Royal College of Psychiatrists and the Association of European Psychiatrists, comments that psychiatry and religion "share a concern for many of the same things."[5] He elaborates, quoting from Bill Fulford's book *Psychiatry and Religion*, that "Religion and Psychiatry occupy the same country. A landscape of meaning, significance, guilt, belief, values, vision, suffering and healing."[5] Joseph English, past President of the APA, has recounted his warm and gracious meeting with Pope John Paul in which the Pope noted that psychiatric practice "brings [psychiatrists] to the threshold of the human mystery. It involves a sensitivity to the often tangled workings of the human mind and heart, and an openness to the ultimate concerns which give meaning to people's lives."[6]

The psychiatric literature acknowledges its debt to religion and ideologies. Aaron Beck et al. in the introduction to their seminal *Cognitive Therapy of Depression,* trace the philosophical origins of cognitive therapy to Seneca, Epictitus and Marcus Aurelius, as well as to "eastern philosophies" such as Taoism and Buddhism.[7] More recently, Linehan has invoked and modified Eastern spiritual training in the development of "mindfulness skills" - skills which are considered essential to her dialectical behavioral treatment.[8] Presumably psychiatry is richer for these infusions of thought from outside "accepted therapeutic practice."[2] At a more radical level, religion has been noted to be more therapeutic for some patients than accepted practice. Arthur Lazarus reports discovering this when he encountered a former patient with borderline personality disorder who, "appeared to benefit more from commitment to religion than to medical psychotherapy."[8]

With such complexities in mind, each of the four case examples from the Appendix is presented below followed by commentary. Citations from the Guidelines themselves are followed by references, in parentheses, to the particular section of the Guidelines cited.

Case 1

A psychiatrist began treating a homosexual man for depression. The initial focus of treatment was on the patient's depression, as the patient did not seek treatment for his sexual orientation. After the depression lifted, the issue of homosexuality became more prominent in the therapy. Only after considerable therapeutic investment on the patient's part did the therapist indicate that he regarded the patient's sexual orientation to be sinful.

Superficially, this case appears straightforward. It deals with seemingly mutually exclusive views of homosexuality: the therapist's religious view that it is sinful, and the APA's that it is not a mental disorder,[10] and presumably also not sinful. Note that the vignette does not tell us what the patient's view is, nor does it allege that there was an attempt by the psychiatrist to impose his belief on the

patient, or whether the psychiatrist's belief affected the conduct of the therapy. We may guess that the Committee wants us to think that the psychiatrist failed to "maintain respect for [his] patient's beliefs" (I) and that he offered religious concepts ("sinful") as "substitute[s] for accepted diagnostic concepts or therapeutic practice" (IIB) but this is hardly demonstrated in this case.

The point of this case is unclear. While it does introduce a *situation* in which conflict might arise, the example fails to fully delineate the nature of the *conflicts themselves.* Hence, we are left to guess what the Committee would have this religious therapist do. Should the therapist not allow the therapy to drift to the topic of homosexuality? Should he have disclosed his beliefs about homosexuality before the patient made "considerable therapeutic investment", or should he have kept his beliefs about homosexuality to himself? Is the Committee suggesting that this therapist's views on homosexuality bar him from practicing psychiatry?

Each of these possibilities raises concern. Perhaps because this case deals with a high profile issue such as homosexuality and the apparent violation is by a religious person, this case seems much clearer than it is. However, there are many other areas with the potential for conflict between the patient's and the therapist's beliefs. Does the case seem as clear with modification of some of the particulars of the case?

A psychiatrist began treating a devoutly Catholic woman for depression. The initial focus of treatment was on the patient's depression, but when the patient became pregnant during the course of treatment the issue of her ambivalence about the pregnancy became more prominent. Only after considerable therapeutic investment on the patient's part did the therapist indicate that he regarded abortion to be a viable way of dealing with her ambivalence.

In this reworking of the case, it is now the patient who embraces a religious view which conflicts with the therapist's views. While the reworking is not a perfect mirror image of the original, it raises some of the same questions. Should the therapist not have allowed the pregnancy to become a topic of discussion? Should the therapist not have disclosed his beliefs at all, or should they have been disclosed before the patient made "considerable therapeutic investment?"

Case 2

A devoutly religious psychiatrist pressed a severely depressed nonreligious patient to engage with her in prayer at a time of initial therapeutic encounter. The patient had not anticipated a religious component to the therapy and was not accustomed to religious practice. She was quite troubled to find herself drawn into it and her symptoms were aggravated.

This case also seems straightforward on first reading. However, this case illustrates a distressing tendency in the examples to use strongly charged language, in this case, "pressed." Such language obscures the ethical issues. Are we dealing with the ethics of a possible conflict between religious commitments and

psychiatric practice, or are we dealing with the ethics of bad technique? Adverse outcomes may come from pressing anything, and since the adverse outcome seems intended to persuade us that an ethical violation occurred, the use of the word "press" becomes important. Consider: "a nonreligious psychiatrist pressed a severely depressed patient to enter psychoanalytic psychotherapy. The patient had not expected an analytic component to the therapy, and she was quite troubled to find herself drawn into it, aggravating her symptoms."

Of course, an application of accepted practice short of "pressing" may also trouble patients, resulting in an aggravation of symptoms. Presumably we are supposed to believe that this psychiatrist runs afoul of the Guidelines through her imposition of her religious beliefs (II) and by her substitution of such beliefs for "accepted...therapeutic practice (IIB)." It is not clear, however, whether the prayer is truly offered as a "substitute" for accepted therapeutic practice, nor whether there would be a violation if the prayer was offered but not imposed. Offering is not the "imposing" forbidden by the Guidelines (II).

The first two cases concern themselves with issues popularly identified with the so-called Christian Right: prayer and homosexuality. If it appears thus far that the Committee is intent on patients being protected from the zealous Christian Right, the Committee now appears to offer counterbalancing cases.

Case 3

A group of radical socialist psychiatrists conducted a medical clinic dedicated to implementing their ideologic system. They explained to a series of troubled patients that the source of their symptoms lay primarily in their political plight and pressed them into participating in a political campaign without informed consideration of alternative therapy.

It is unlikely that many psychiatrists will see themselves in this example. While there appear to be enough psychiatrists in this country identifying themselves as "Christian" to attract study,[11,12] "radical socialist psychiatrists" are probably very few in number. The term "pressed" appears again, raising the question whether this is primarily an issue of technique or one of conflict between religion and psychiatry per se. Apart from the matter of "pressing," the ethical violation appears to lie in the failure to inform the patient about alternative therapies, i.e. offering religious "concepts or ritual...as a substitute for accepted diagnostic concepts or therapeutic practice." (IIB) Would the case have been less problematic had the patient been informed of alternatives? Consider Case 2 above in light of this question:

A psychiatrist who is a devotee of New Age beliefs and practices operated a clinic dedicated to helping people function better through awakening their spiritual interests. She invites a depressed patient to meditate with her and to carry a quartz crystal to channel healing energy, but only after delineating alternative therapies including medication, cognitive behavioral treatment, and interpersonal psychotherapy.

Here the patient is not "pressed" and was informed of well-accepted alternatives. Would this psychiatrist be violating the Guidelines? Or would these "radical socialist psychiatrists" violate the Guidelines if they invited participation in political campaigns and provided informed consent of alternative therapies?

Case 4

A psychiatrist provided interpretations to a devoutly religious man. In doing this, however, she denigrated his long-standing religious commitments as foolishly neurotic. Because of the intensity of the therapeutic relationship, the interpretations caused great distress and appeared related to a subsequent suicide attempt.

As with other cases, there is a superficial plausibility to this case, but once again the language poses problems: "denigrated" and "foolishly neurotic" A psychiatrist denigrating anything of import to a patient, whether religious beliefs or stamp collecting, should make us wince. The case can serve as a reminder that the theories underlying some accepted psychiatric practices may leave little room for religious beliefs in their understanding of what constitutes optimal mental functioning. This failure to leave room may become the basis for discounting or even denigrating a patient's beliefs, as in this case. However, what should a therapist do when her formulation of a case is at variance with the patient's religious views? Short of denigrating, what options are available? What does the Committee think this therapist should have done?

The Committee has provided readers with four stark cases to accompany the Guidelines. The cases pit a clearly "religious, antireligious or ideologic therapist" (II) against a foil who shares none of these beliefs. While they outline broad areas of conflict, the precise issue or question at stake is usually ill defined. Consequently they do not help us to see clearly how to apply the Guidelines and we are left to guess at the solutions to these challenging cases.

The Committee may object that the examples were merely intended to "illustrate the kinds of problems that may arise when strong beliefs are interjected into a clinical practice"[2] and were not intended to illustrate the outworking of the application of the Guidelines. If this were the objection, it is worrisome to note that these examples were ones, among others, "addressed to the committee."[2] Hopefully, this critique has demonstrated that the Guidelines do not appear to be an adequate response to such examples, in part because the examples are not clear ones. It is surprising that the Committee "concurred that many psychiatrists take these issues and their solutions [emphasis mine] to be self-evident."[2]

This critique should not be regarded, however, as a blanket denunciation of the Guidelines or the examples. Rather, it is intended to stimulate further reflection upon the boundaries between psychiatry and religion in general, and upon these Guidelines in particular. A robust discussion of these cases and this critique would be welcomed. E&M

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EXIT RAMP

WILLIAM P. CHESHIRE, MD

If lost in County Rockingham,
A North Carolina mystery
Distorts one northbound exit ramp
Which enters highway two-twenty.

Don't lessen your pressure on your brake
Or leave your car unoccupied,
For gravity reversed may make
Your unattended auto slide –

Uphill – defying Newton's law!
Bewildered witnesses to this
Will ask, by what strange twist or flaw
Do opposite directions switch?

From slip to creep, from roll to rush,
The car let loose will plummet thus
On slopes too steep for eyes to trust.
Without true bearings, fall we must.

Which way is up? Which way is best?
Confusion frames experience.
Whilst heavens rotate East to West,
Surrounding landscape orients.

Our sense of vertical depends
On how the mountains shape this scene;
An optical illusion bends
Perspectives once erect to lean.

When looming mountains lift our view
To north horizon upward nudged,
Inclining frames of reference skew;
A level path we cannot judge.

So how much more should we, therefore,
Rely on valid moral points
Of reference when we first explore
Requests oddly for death by choice?

The road that medicine could take
Toward doctor-assisted suicide
Would be a terrible mistake
Against which now we must decide.

The Dutch have demonstrated well
The slippery slope along which we
Proceed once doctors cannot tell
A lethal dose from therapy.

Hippocrates would question how
The Dutch with systematic ease
Give euthanasia and allow
Not only treatment of disease,

But also ending lives of pain
And suffering that will not relent.
'Tis death they offer as "humane,"
At times without informed consent.

Kevorkian and Humphrey claim,
That aiding suicide is kind.
It eases economic drain
And puts the sick outside our mind.

If suicide is good, they say,
For present suffering's relief,
Then why not offer it today
To those anticipating grief?

And if a noble benefit
Is gained by choking respiration
Then why withhold from those unfit
To voice their fatal last petition?

Such killing fast degenerates,
Despite concern for patients' best,
Into a plot that terminates
Without explicit prerequest.

And exercise of "right to die,"
If done with regularity,
Would drive the expectation high
That suicide is one's duty.

Ethics & Medicine, 17:2 (2001):99-102.

The notion of a right to die
In reason finds approval nil,
From such a harsh judicial lie
Would obligate doctors to kill.

Authority once granted makes
The next step that much easier still.
Removal of restrictions takes
Us further down a murderous hill.

As ethical constraints give way,
Down go the lowly euthanists.
Headlong they plunge, their morals stray
Into a bleak, black, deep abyss –

Yet they insist – that up the slope
Of progress marches suicide
Unleashed. Through fallacy's false hope
And pride they claim compassion's side.

Here, too, the opposite is true;
"Compassion" means "to suffer with,"
And not abandon patients to
Asphyxiation, harm, or death.

The long disorienting climb
To suicide's elusive crest
Has ended at no peak sublime,
But in the depths of wickedness.

No shadows tip topography
On slopes of medical demise,
But rather flawed theology
Leads to unsavory compromise.

The one firm reference point of truth,
Is where God's precious blood was poured:
Grand vertical straight azimuth,
The cross of Jesus Christ the Lord.

His cross establishes the sign
That orients the soul to see,
His outstretched arms the level line
Of horizontal certainty.

In weakness Jesus came into
This hurtling world like us to live.
Intense heart-rending pain He knew,
The God who suffers and forgives.

His Words, the Bible, testify
That in due time death will arrive.
Believe in Him, although you die,
And He will raise you up alive!

He is the truth, the life, the way,
His counsel light that guides our feet.
To follow Him from day to day,
Keeps our path smooth, our peace complete.

Trust in the Lord, in Him abide,
And He will keep you in His grip;
Steep slopes make seem to make you slide,
But He will never let you slip.

His Sermon on the Mount reveals
A slippery slope one should beware,
For anger multiplies in zeal:
The root of murder thus laid bare.

One cannot capture dignity
By sheer autonomy's command,
But mercy and humility
Through Christians lending hand,

Will love the sick and suffering
As God so loved the world – that He
Did give His only Son to bring
Salvation overflowingly.

Now crouching at our doorstep waits
The gospel that claims death as well,
And it desires nor hesitates
To send hospitals straight to progress.

Commentary

Life's mysteries often emerge in ordinary places and must be discerned from a particular perspective. One lonely rural highway access ramp in North Carolina is such a place. On this exit ramp, a car left in neutral gear will roll apparently uphill. The optical illusion results from the way the surrounding foothills slope gently upward toward the north, so that one's orientation to the true horizontal, perpendicular to gravity, shifts slightly.

Few vertical clues such as buildings or tall trees are available. A mile to the north, Cedar Mountain enhances the deceptive sloping effect by seeming to lift the horizon. One's overall sense of levelness thus slants by approximately one degree, which is enough to make one feel off balance when turning while walking.

Although the highway access ramp also leans uphill to the north, its true slope is only one-half of a degree. The dominant slope of the surrounding landscape overwhelms one's judgment of the position of the ramp, making it appear to slope one-half degree in the opposite direction. To an observer standing anywhere on the hill, the car that seems to be rolling uphill is, in fact, rolling downhill.

If one's orientation through the senses can be so easily deceived by geography, then one's ethics can surely suffer disorientation by failing to heed valid moral reference points and instead setting one's compass by surrounding cultural slants. This analogy is relevant to the issue of physician-assisted suicide, because opponents invoke slippery slope arguments of progressively broader applications and abuses.

The Dutch, for example, who do not prosecute physicians for performing assisted suicide or euthanasia, have begun to accept such "treatment" as appropriate for some suffering individuals who simply anticipate the future symptoms expected from illness,[1] and in some cases even for those who are not physically ill.[2]

A 1991 Dutch government study documented 14,691 cases in a single year in which medical actions were taken or omitted with the intent of ending patients' lives without their expressed permission. Of those deaths, 1000 were subjected to outright euthanasia, 4941 received morphine in doses in excess of what was needed to control pain with an intent to end life, and life-prolonging treatment was removed or withheld in 8750 with the intent to end life. Chillingly, a significant proportion of the patients receiving "involuntary euthanasia" had complete mental capability yet were not consulted in decisions resulting in their deaths.[3] Dutch physician Van der Maas, sidestepping the term "involuntary euthanasia," speaks of "life terminated without explicit request."[4]

Americans have witnessed media coverage of the controversial "mercy" killing pathologist Dr. Jack Kevorkian, who is now serving a prison term for homicide. American bookstores have sold millions of copies of Derek Humphrey's suicide instruction manual, *Final Exit*.[5]

In "Exit Ramp," highway slopes and assisted suicide converge. The poem argues that not only does assisted suicide falter along a logical slippery slope, but also that some of its proponents are proceeding along that slope in a direction opposite to what they think. What may seem good according to an ethical frame of reference slated by mortal wisdom can, in fact, be evil as measured by God's just and absolute standard.

Ethicists disagree as to where we are along the moral slope and in what direction we are headed. Kenneth Cauthen argues, in the *Ethics of Assisted Death:*

> I think that the analogy of the slippery slope is basically wrong. We are not at the top of a hill so that the slightest nudge of the boulder will start it downward into an abyss. It feels more like we are near the bottom of a steep incline trying to push a boulder upward a few inches.[6]

The cross of Christ marks the true vertical, and his outstretched arms the true horizontal. Christ's life, death and resurrection are the guideposts that orient us along the slopes of life as we journey toward eternity. The Christian response to requests for suicide should not be abandonment to death, but assistance in life. This includes treating pain and depression and compassionately responding to emotional and spiritual needs. This includes affirming the value of the suffering individual and seeking meaning in the midst of suffering. E&M

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RESPONSE TO JOEL GOODNOUGH MD, "REDUX: IS THE ORAL CONTRACEPTIVE PILL AN ABORTIFACIENT?"

Editor's Note: The controversy surrounding the question of the oral contraceptive pill's abortifacient properties continues. Ethics & Medicine *is delighted to have a role in hosting this on-going dialogue.*

The two articles and response below would normally be included in a "letters to the editor" section; however, since E&M *does not have a regular letters section (though, if sufficient readers wrote in, we would gladly add one) and since these responses are so lengthy, we include them below in this special section.*

JOHN WILKS, B. PHARM MPS

In the Spring issue of *Ethics and Medicine,* Dr Joel Goodnough provided readers with an in-depth critique of Randy Alcorn's text *Does the Birth Control Pill Cause Abortion?*[3] He canvassed many issues, including putative breakthrough ovulation rates whilst on the pill, the pill's claimed impact on implantation, its influence on the frequency of ectopic pregnancy and an extended discourse centred on Alcorn's assertion that the pill has an abortifacient capacity. This last point flowed into a discussion of the merits of reclassification of the pill. Dr Goodnough concluded that Alcorn was wrong in much of his data analysis, and therefore wrong in deducing that the birth control pill can reasonably be said to act against implantation. As a consequence, Dr Goodnough concluded that Alcorn was in error for suggesting the pill had an abortifacient capacity.

In presenting his counter arguments, Dr Goodnough took strong exception to the interpretation placed upon a paper by Letterie,[2] referenced by Alcorn in his text. My involvement in this debate has occurred because I had also cited the same work in my Ethics and Medicine paper in January 2000,[3] and am also heavily criticised by Dr Goodnough for apparently committing the same misdemeanour as Alcorn.

I consider that Dr Goodnough has misunderstood the purpose and point of the Letterie paper I cited, and consequently, has misrepresented, albeit unwittingly, the argument I – and therefore Alcorn – was advancing. Further, I take the view that Dr Goodnough has used dated references to support his position, relying on papers which do not properly reflect our current knowledge of the process of implantation. As well, I am concerned that Dr Goodnough has chosen only one paper I referenced on the topic of breakthrough ovulation, yet in my original work I referenced three.

These errors and omissions require correction.

To begin, Dr Goodnough finds it "particularly distressing" that Alcorn (and I) should draw conclusions from studies "even though one would be hard pressed to find actual support for the point within the context of the study"(p.38). Dr Goodnough signatures his concern by criticising my (and Alcorn's) use of a paper from Letterie. This study reported a breakthrough ovulation rate of 30% when a new formulation of the pill was tested. Dr Goodnough asks: "Now, why would Wilks even mention this study in his discussion on the effect of missed pills on ovulation?" (p.38). He suggested that this formulation of the pill is a non-sense formulation, disconnected from normal pill use, and hence tangential to the core of the debate over breakthrough (or escape) ovulation. And his reason? Because this formulation requires a woman to start the tablets a week into her cycle, take a combined oestrogen/progesterone tablet for the first part of the cycle, then switch to a progesterone-only pill during the latter part of her cycle.

This conclusion by Dr Goodnough contains two substantial misunderstandings. First, Dr Goodnough does not inform the reader that this hormonal approach to birth control, rather than being an extreme example of atypical pill use, was actually a clinical trial by a researcher who was testing a "novel" approach to birth control, intended to determine if a "restricted regimen may offer both an effective method of contraception and a means of further reducing both estrogen and progestin content per cycle and the possible short and long term adverse side effects of these hormones." [4]

I had placed my use of this paper within the overall topic of the effect of missed pill tablets, the consequence this omission might have on breakthrough ovulation and the subsequent possibility of conception. Hence my use, and Alcorn's, was contextually valid. I was reporting on a style of the pill that is a forthcoming product currently under evaluation, and certainly not, as Dr Goodnough suggested, only "representative of a woman totally misusing the OCP (oral contraceptive pill)." [5]

But Dr Goodnough might reply that this new formulation is not currently used, and on this point he would be right. So, does my point, and hence Alcorn's, now deflate? No, because in my Ethics and Medicine paper I also cited works by Van der Vange (1986) and Grimes (1994), the former briefly and the latter extensively. Both researchers demonstrated that in motivated, healthy women, taking contemporary formulations, and faithfully adhering to the normal procedure of daily ingestion, breakthrough ovulation occurs. My citation of these two works, but Dr Goodnough's omission of the same constitute my second concern with his criticism of my and Alcorn's publications.

As the work by Van der Vange and Grimes has demonstrated, breakthrough ovulation is not necessarily associated with "errors" made by the woman, or attributable to reduced absorption due to illness, or concurrent medication use. His suggestion that particular events such as these are the usual explanation for escape ovulation does not accord with the research. (p.39). Yet surely the occurrence of breakthrough ovulation during proper pill use is the key to this bioeth-

Alcorn had recommended this change in description, noting that the hormones in the pill lower the level of a crucial molecule known as an integrin, which normally binds the embryo to the endometrium so as to facilitate implantation. Dr Goodnough does not agree that a diminished integrin level is necessarily proof positive of an abortifacient capability because "no references are cited" by Alcorn (p.39). But there is good reason for this apparent omission by Alcorn – researchers consider it unethical to investigate the structure of the endometrium whilst an embryo seeks to implant. Therefore, in my view, Dr Goodnough's argument is invalid.

Is Alcorn isolated in his advocacy of a change in description of the pill from "contraceptive" to "abortifacient"? No. Embryologists such as Moore and Persaud, authors of *The Developing Human–Clinically Orientated Embryology* (6th ed, W.B. Saunders Company, 1998)[8] and Ralf Rahwan, Emeritus Professor of Pharmacology and Toxicology, Ohio State University, support a change in title based upon the recognised capacity of the pill to interference with implantation.[9] Note that, in the citation from Moore and Persaud, they are speaking about the medication known as the "morning–after" pill. Since the "morning-after" pill, or more correctly, the post-coital abortifacient pill (PCAP) has mechanisms of action in common with the daily pill, it is acceptable, in my view, to apply Moore and Persaud's definition to the daily birth control pill. Both medications employ the same hormones, though the PCAP is administered at an excessive "body-shock" dose.[10]

Equally unsound is Dr Goodnough's dismissal of Alcorn's statement that the pill will negate implantation because of changes to the endometrium. Dr Goodnough labels Alcorn's assertion "speculative" (p.39). The doctor is wrong.

We know that there is an optimum level of endometrial thickness necessary for successful implantation. In 1996, Issacs reported that an endometrial thickness of at least 10mm or more, around the time of ovulation, "defined 91% of conception cycles."[11] That same year, Spandorfer noted that 97% of abnormal pregnancies, defined as Fallopian tube lodgement or spontaneous abortion, had endometrial thickness of 8mm or less.[12] Shoham reported in 1991 that no pregnancies were reported in an ovulation induction program "when the endometrial thickness was less than or equal to 7mm."[13]

These results have been obtained from IVF studies, and whilst the message apropos endometrial thickness is relevant to this debate, the drugs used are not. We still need to know what happens to the structure of the endometrium when the pill is taken.

Addressing this specific point was a research paper by Rabe (1997) who studied subjects who took the triphasic levonorgestrel/ethinylestradiol formulation of the pill. Women in this research project failed to develop a median endometrial thickness in excess of 6mm[14] yet they had the highest percentage of follicular cysts with a diameter greater than 20mm.[15] Follicles of this size are "thought to be associated with increased risk of escape-ovulation."[16]

The importance of these events is clear; follicles of a pre-ovulatory size can develop in women taking the pill daily, but endometrial thickness has been shown to be underdeveloped. In the event of follicle rupture, release of an 'ovum', and fertilization/conception, implantation of a human embryo would be greatly hampered. Rabe confirms this very point: "... the occurrence of pregnancy would be unlikely because accessory contraceptive mechanisms such as cervical hostility and endometrial suppression are usually in effect." [17]

Dr Goodnough also relied upon Fallopian tube implantation to argue that embryonic implantation is a robust event, resistant to suspected damage to the endometrium induced by the pill. Therefore the pill cannot act as an abortifacient. But again, he is incorrect in his central premise. Embryonic Fallopian tube implantation occurs because Fallopian tube tissue has the same integrin expression and window of implantation timeframe as the endometrium.[18] Implantation is not akin to two pieces of Velcro randomly touching and sticking.

Alcorn also suggested that the combined pill might increase Fallopian tube contractions, hastening embryo transport to the extent that the embryo arrives prematurely at the surface of an under-prepared endometrium and, subsequently, fails to implant. Again, this would qualify the pill as an abortifacient. Dr Goodnough disagreed with Alcorn's proposition and cited a 1994 paper by Dr Speroff to refute Alcorn. Dr Speroff advised that "perfect synchrony (between embryo arrival and endometrial maturation) is not required." (p.42)

Both Dr Goodnough and Speroff are mistaken. Space precludes a detailed refutation so I refer the reader to my previous paper on this matter for a comprehensive presentation, and merely mention that contemporary researchers consider it mandatory that bio-chemical communication takes place between the embryo and the maternal endometrium prior to implantation. This precise, structured maternal/embryo communication has been varyingly referred to as "a signalling system",[19] embryonic "dialogue",[20] "molecular communication"[21] and "cross-talk."[22] Piccinni has summarised the complexities of the pre-implantation process as requiring "exquisite dialogue"[23] between the human embryo (at the blastocyst stage), and the maternal endometrium.

Finally we approach what I consider to be a most unpleasant aspect in Dr Goodnough's paper: his apparent embracing of relativistic morality. He says: " In prescribing the oral contraceptive, some women (viz., one in 100,000) and perhaps some embryos will die. It is a matter of degree of risk" (p.44).

How does one respond to this statement? Initially it should be pointed out that Dr Goodnough appears to foresee only two "alternatives" for husband and wife: the pill or pregnancy, and if a few unborn children's lives are the trade-off factor this is seemingly acceptable. Apparently the solution to the "who lives" question is answered on the basis of risk/benefit analysis.

Dr Goodnough also sought to defend his views by suggesting that the Principle of Double Effect validated the use of the pill. His advocacy of this posi-

tion is erroneous because the foreseen 'bad' effect of the pill – that some embryos might die – is a fully avoidable consequence: husband and wife need only to practice one of the many methods of natural birth regulation.

For those wishing to assuage any technological interventions into this area of marriage, the Billings method, proven to be as reliable as the pill, and safer for both mother and unborn child, is an excellent option, as is the sympto-thermal method. Other couples may choose to avail themselves of new technologies, such as ovulation monitors, now within the price range of many. These are reliable options, which create no hazards for an embryo "unexpectedly conceived", because these methods do not interfere with endometrial development, embryo/endometrial implantation factors, or Fallopian tube movements. Yet Dr Goodnough does not mention these in his discourse on the justified marital use of the pill.

This is unfortunate because an endearing feature of these methods is they are fully "Christ-like" actions on at least three points. These non-drug approaches do not violate the tenant "Thou shalt not kill"; they maintain what God has joined together in marital intercourse (the unitative, pleasurable and procreative dimensions); and, they do not lead married couples into a form of Onanism, wherein the unitative, pleasurable and procreative characteristics are separated (Gen: 38; 8-10).

In my scientific opinion, Dr Goodnough has erred substantially and frequently in his critique of Randy Alcorn's book. He has misinterpreted some key reports, omitted others, and seemingly been unaware of many. The end result is that the ancient dictum "first do no harm" takes a battering. E&M

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WILLIAM F. COLLITON, JR, MD

I am writing to rebut Joel E. Goodnough's "Redux: Is the Oral Contraceptive Pill an Abortifacient?"[1] It is particularly distressing that Dr. Goodnough's thinking is inconsistent and always reflects his enthusiasm for the estrogen/progesterone combination birth control pill (BCP). The start of his reference 3 reads: "I follow the position of the American College of Ob-Gyn (ACOG) in defining the beginning of pregnancy as the time of implantation." Dr. Goodnough pledges allegiance to the ACOG's inane definition of pregnancy which declares that a healthy woman obtaining non-contraceptive coitus at her peak fertile period with a healthy man and as a result has a tiny baby girl or tiny baby boy traversing her fallopian tube on her/his way to the endometrial cavity isn't pregnant. That is obviously a ludicrous proposition. The same endnote comments: "This confusion of terms can be used to mask moral issues." This was the purpose of the ACOG in changing the definition (circa 1970) that has traditionally been defined as "being with child". The ACOG definition makes the IUD, BCP's, POP'S (progesterone-only pills), and so-called "emergency contraception" (morning-after pills) non-abortifacients. If the woman isn't pregnant, why does she need this last treatment? Dr. Goodnough concludes the footnote as follows: "I will continue to use the term abortion to describe the loss of the embryo both prior to and after implantation." But he can't have it both ways. Either it's the ACOG or the truth.

On p.39, without citation, Dr. Goodnough claims an estimated 70% pregnancy loss in healthy women not on BCP's. While I am not ready to accept this high pregnancy loss in healthy women, it is ludicrous to suggest that implantation in a BCP induced atrophic endometrium would match that of the lush, glycogen rich, God-prepared endometrium found in normal cycling women. Dr. Goodnough always stresses correct use of the BCP. This is wishful thinking when Planned Parenthood and its allies are pushing this mode of contraception on teenagers. Besides, every experienced obstetrician has delivered a baby for a patient who will swear that she was taking her newer low-dose pills faithfully and in the prescribed fashion when she conceived. This chain of events is called a "pill pregnancy."

On p. 44 Dr. Goodnough states, "A medication that is used to prevent conception is not an abortifacient even if it sometimes causes abortion." This is pure semantic gymnastics. *Gould's Medical Dictionary* (5th Edition) defines abortifacient as follows: "(1) causing abortion (2) a drug or agent inducing expulsion of the fetus." From the moral perspective, it matters not how often the loss of totally innocent life occurs, only that it does occur. The doctor also overlooks a fundamental truth: that the BCP and abortion are both anti-life. This truth in no way equates the moral evil contained in these actions. To articulate this proposition more fully, the BCP and all contraceptive actions posited with or remote from coitus are designed to thwart the reproductive good obviously contained in intercourse and placed there by our Creator. Induced abortion ends a totally innocent life already conceived. On p. 45 Dr. Goodnough adds: "Yet, the preponderance of evidence suggests that prescribing estrogen to menopausal women does not sub-

stantially increase the risk of breast cancer." He then states: "future studies could show that estrogen clearly causes breast cancer." The future is now. Chris Kahlenborn, an Ohio internist, has written a book entitled *Breast Cancer: Its Link to Abortion and the Birth Control Pill,*[2] filled with evidence suggesting that it is exogenous estrogen that has caused the doubling of the incidence of that disease in the last 5 decades. More recently, an AP article reported that a government scientific advisory committee has recommended that the chemical estrogen be added to the list of cancer-causing agents.[3] We can be grateful that Dr. Goodnough supports fully informed consent for patients, as does Randy Alcorn.

Later (p. 48) the doctor states: "In fact, based on more recent studies, it appears that the OCP, when taken correctly, approaches 100% effectiveness in preventing ovulation" (no citation provided). Dr. Don Gambrell, a renowned gynecological endocrinologist who agrees with Dr. Goodnough on the issue at hand, has noted a 14% incidence of breakthrough ovulation in patients on the 50 microgram pill.[4] He and a group of pro-life Ob/Gyns supporting the non-abortifacient nature of the BCP, noted that our literature documents a 3-5% (some say as high as 9%) incidence of "pill pregnancies" on the low dose pills.[5] This is proof positive of, at a minimum, a like incidence of breakthrough ovulation. How many more conceptions occurred and were lost to an Iatrogenic BCP-induced abortion because of an unfavorable endometrial pattern? That is unknown. However, it has been known for several decades that this scenario occurs; it is, in fact, demonstrated in an epilogue to an article entitled "The Birth Control Pill: Is It An Abortifacient And Contraceptive? Believe It! The Answer Is Yes":

> Ever since becoming involved in [the abortifacient] debate in the first months of 1988, I have been curious about why the discoverers of the birth control pill (BCP), from the earliest days of their work described three mechanisms of action for their products; inhibition of ovulation, thickening of the cervical mucous (both contraceptive actions), and endometrial changes making implantation unlikely (an abortifacient action). Did they have animal or human studies to prove this? Our confreres of the opposing view suggested that they did not. This third mode of action, they suggested, was merely a marketing ploy to insure women of the complete effectiveness of the BCP.5 In October, 1999 I had the privilege of meeting Elora J. Weringer, Ph.D., a biologist with connections to the Pfizer Company. I inquired of her the location of the early studies of Gregory Pincus, D.Sc. and John Rock, M.D. She referred me to the Worcester Foundation for Experimental Biology, located in the city of the same name in Massachusetts. Several long distance calls to that fair city indicated that the Foundation had broken up into several different disciplines, and that none of the librarians whom I contacted had any information about the location of Dr. Pincus' early studies. Subsequent to that point, the Holy Spirit entered the scene. Via an e-mail originating from Janet E. Smith, a philosopher at the University of Dallas, I received a copy of an article which appeared in the New York Times (June 25, 2000). It was written by Barbara Seaman and entitled "The Pill and I: 40 Years On, the Relationship Remains Wary." The Pill was the brainchild of Margaret Sanger, the founder of Planned Parenthood and an unconquerable

fighter for women's rights. In circa 1950 she was introduced to Gregory Pincus, a reproductive scientist. She raised approximately $150,000, mostly from her friend, Katherine McCormick, an heiress to a farm-machinery fortune. She urged Pincus to get started on a universal contraceptive. Twenty years earlier researchers had established that hormones could prevent ovulation in rabbits and other species. Mrs. Seaman notes that Dr. Pincus was interested in a progesterone-only pill because he was wary of estrogen, as it was already understood to increase cancer risks. She adds: "But there is a problem with progesterone-only contraceptives: they produce irregular and unpredictable spotting, or conversely, a complete absence of menstruation." She labels this "menstrual chaos". Pincus eventually put estrogen back into the BCP. How did Mrs. Seaman learn all this? She has made a study of Dr. Pincus' papers which are now housed in the Library of Congress. She notes: "They comprise approximately 44,000 items, filling 213 containers on 85.2 feet of shelf space. They reveal an awesome scientific and entrepreneurial brinkmanship, and make one wonder why Pincus didn't burn the evidence."

It is sordid. Read Barbara Seaman's article. I won't trouble you with the details. Her article informed me that the object of my search was a 20-minute subway ride from my home with no downtown parking problems. Gregory Pincus was the steroid guru of his day and was internationally acclaimed. I reviewed only 4 boxes (#'s 93,107,142, and 145), but the contents were most revealing.

With regard to the issue of the abortifacient nature of the BCP, the following correspondence is enlightening. It is a letter from Albert Segaloff, M.D., dated September 4. 1964. He must have been an editor for Steroids, an international journal. He writes: "Dear Goody, I am enclosing your manuscript on 'Further Studies on Implantation Inhibitors.' I want to thank you for submitting this most fascinating paper on a very interesting series of compounds to Steroids." The opening paragraph of this paper co-authored by Upendra K. Banik and J. Jacques of the Worcester Foundation for Experimental Biology and the College de France reads: "Twenty-three compounds injected on day I or days I through 3 of pregnancy in rats have been tested as possible inhibitors of implantation. Among them eight have proven active at total doses of 1.5 mg per rat or less. Administration of some of the active compounds by gavage has also led to implantation inhibition. The group of compounds found to be active were also the most potent in uterotrophic assay in immature mice. Among them a highly active compound, A-nor-androstane-2a, 17a-diethyny-2b, 17b-diol (V) has been examined in detail. It appears to act primarily by causing expulsion from Fallopian tubes and uterus of the free, pre-implantation ova (sic), and was ineffective in the usual sterilizing dose in terminating implanted embryos."

In 1965 in the World Health Organization Technical Report Series No. 303 appeared an article titled "Mechanism Of Action Of Sex Hormones And Analogous Substances: Report of a WHO Scientific Group." On page 17, paragraph 5.1 reads: "Both the steroid hormones and the synthetic analogues, when used during long periods, have effects on the reproductive tract that need evaluation. In the normal female, endogenous hormones are secreted cyclicly (sic), involving the interrelated rise and fall of oestrogen and gesto-

gen; this seems to be a protective mechanism of considerable significance. If there is continuous exposure to even low doses of oestrogens, either endogenous or exogenous, pathological effects are produced, the endometrium becoming hyperplastic. On the other hand, if progestogens and gestogens are given continuously at even low levels, amenorrhea and sterility result, with regression of the endometrium to a thin layer having scant if any secretory activity." This finding has been known for a long time.

In Dr. Pincus' files was a paper by Professor L. T. Samuels, a temporary member of the WHO Scientific Group. On page 5 of his paper we note: "Excess oestrogens can interfere with either fertilization, blastocyst formation, or implantation, depending on the time after ovulation when the high level occurs." And later on the same page he adds: "The retention and rate of development of the blastocyst in utero has long been known to be progesterone-dependent. Oestrogens inhibit the blastocyst stimulating effect of progesterone. It is, of course, well known that excess oestrogens prevent implantation, just as they prevent gestogen-induced deciduorna formation in experimental animals." I found several other references verifying these findings, but sufficient to clinch the long-known fact of the abortifacient nature of sex steroids under certain circumstances is another letter from Victor A. Drill, M.D., Director of Biological Research for G.D. Searle & Co. It is dated July 14. 1954 and addressed to Dr. Pincus. On page 2, one finds this paragraph: "We will not send any compounds for anti-ovulatory or anti-implantation tests this month. If you need any for the following month, this, of course, will be indicated on your list of requested numbers of compounds."[6] E&M

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RESPONSE BY JOEL E. GOODNOUGH, MD

I would like to thank Mr. Wilks for his response to my article. The purpose of my article was to critically evaluate Mr. Alcorn's book, since his writings are appearing in churches and Christian bookstores, and there are very few other writings available to a mainstream audience on the subject.

I reviewed the studies that he referenced in order to determine the quality of his work. My article was not meant to be an in-depth comprehensive study on the entire issue. I am not a research scientist but rather just a physician who is seeking information and attempting to apply it to my practice. Mr. Wilks is therefore correct when stating that I omitted some studies, but I considered those I did include sufficient to show that Mr. Alcorn's conclusions on the OCP are suspect.

Mr. Wilks has concerns about my comments directed at his use of the Letterie study. If one reads carefully, it can be seen that I did indeed point out to the reader that the purpose of the study "was to determine if other formulations of pills would be effective at preventing ovulation." Mr. Wilks, however, says that he used this study as an example of the consequences of missed pills. His is an inappropriate use of a study that was designed to answer a different question and not at all typical of a woman who misses one or two pills.

Mr. Wilks feels that I was too limited in my discussion on the endometrium and that the studies I used were "dated", being from 1981, 1989, 1994, 1996, and 1997. He then goes on to cite a study from 1980 as being particularly damaging to my arguments. The issue of the receptivity of the endometrium in an ovulatory cycle on the OCP is complex and not yet resolved.

Mr. Wilks continues the argument about ovulation rates. I do not think that it is necessary to repeat the information contained in my article that showed a difference between ovarian activity and rise in serum progesterone on the OCP versus actual ovulation. I cited five studies in my article that showed the OCP to be 100% effective at preventing ovulation, even when some pills are missed. One of these studies referenced three other studies showing the same conclusions. The problem of failure arises primarily when a woman forgets to start her pills on time and goes longer than seven days without taking a pill. It seems to me that this is an area where we can focus our efforts while the research on the endometrium continues.

I agree with Mr. Wilks when he says that the pill has a precarious hold on ovulation. There is, after all, a 3% pregnancy rate on the OCP. But this can be improved through proper use and with new formulations that shorten the pill-free interval, thereby lessening the consequence of error. In addition, there in now a monthly injectible combined estrogen-progesterone formulation that is very successful at preventing ovulation, primarily because a woman does not have to remember to start her pills each month.

I was prepared for criticism, but surprised by Mr. Wilks' impression that I am embracing moral relativism. The fact that it is wrong to intentionally kill an

innocent human being is a moral absolute. The problem lies in the determination of whether embryos are dying at all, infrequently, or frequently as a result of our intentions to prevent fertilization. If they are dying frequently, it is too high of a cost to pay. If they are dying infrequently, a risk versus benefit analysis is appropriate, just as it is for any other medication or activity that involves unintended risk to human life.

I would also like to thank Dr. Colliton for his comments. I agree with him completely as to the moral status of the embryo, regardless of how one defines pregnancy. I will let the theologians decide on the issue of the OCP thwarting the reproductive good contained in intercourse, placed there by our Creator. I disagree with him on the issue of estrogen and breast cancer, but the purpose of my inclusion of this in my article was simply to illustrate the decision making process of risks versus benefits that a physician has to go through on a daily basis.

BOOK REVIEWS

Called to Care: A Christian Theology of Nursing
Judith Allen Shelly and Arlene B. Miller
Downers Grove, IL: InterVarsity Press, 1999
ISBN 0-8308-1598-8, 288 pp., paperback $19.99

Judith Allen Shelly, director of resources for Nurses Christian Fellowship and editor of the *Journal of Christian Nursing,* and Arlene Miller, associate professor of nursing at Messiah College, have undertaken an important and neglected project in this book. They consider the theological foundations for nursing. Christian nurses and all who are concerned with the implications of Christian faith for health care will welcome their effort.

In the first three chapters, the authors provide an overview of their project. They define Christian nursing as 'a ministry of compassionate care for the whole person, in response to God's grace toward a sinful world, which aims to foster optimum health (shalom) and bring comfort in suffering and death for anyone in need' (p. 18, and revisited several times, for example, pp. 212, 225). This definition seems too broad, and not specific enough to the particular care that nursing provides, but it surely provides a context within which to consider nursing as a Christian vocation and ministry. The authors quickly survey the history of nursing, and they compare a biblical worldview for nursing with modern (Enlightenment) and post-modern paradigms for nursing. In subsequent chapters they develop further the implications of Christian theology for our understanding of the person (chapters 4-6), the environment (chapters 7-9), health (chapters 10-12) and nursing practice (chapters 13-16). They consistently compare and contrast the implications of a Christian worldview with the implications of modern and post-modern worldviews.

The book has a number of strengths, among which we would note this first: that it is readable without being shallow, and sometimes profound without becoming inaccessible. Those who are just beginning to reflect about the implications of the Christian faith for nursing practice will be able to understand and follow it, and those who have been thinking about these issues for some time will find it useful and challenging. One of the authors of this review is a nursing student in the Hope-Calvin nursing program; the other is a theologian who has been thinking about health care ethics for three decades; and we both appreciated the book very much and learned a great deal from it.

A second strength of the book is its attention to real life vignettes taken from the experience of the authors (and their colleagues). These serve to keep the book -- and the theology surveyed in the book -- connected to the experience of nurses. Occasionally these vignettes, however, are neglected after being used to introduce a topic or a chapter. One notable example of this neglect was the story of an order not to treat a child born with anencephaly. It was used to introduce Chapter 4 but then ignored. The vignette seemed to suggest both that the child should be regarded as the image of God and that care for such a child required an effort to keep the child alive as long as possible, but the authors did not return to the vignette or give a compelling argument for the claims suggested.

A third strength is the focus on the vocation to care. It is often easy to get caught up in the procedures, the medications that need to be given, the labs that need to be taken, the assessments that need to be documented, and the charting that needs to be completed. Then the patient can become merely that shadow behind these tasks. Shelley and Miller retrieve theological resources that can remind us to care, to attend to the patient. Joined to this focus on the vocation to care is the book's attention to suffering, another of its strengths. Caring for the sufferer means sometimes silent presence, sometimes conversation about meaning, reconstructing identity and values and sometimes action to remedy the suffering (pp. 183-184).

Another strength is that the book connects the notion of health to the creative and redemptive purpose of God. It connects health to shalom, to peace and justice, the wholeness of God's blessing. The weakness that attends this strength, however, is that health becomes too broad a concept. Shelley and Miller complain about the broadness of the WHO definition of health (p. 165), and they are aware that 'the concept of shalom is too broad' (p. 167), but they do not clarify a narrower concept of health. They are to be commended for the attempt to put health in this larger context of God's cause, but they fail to distinguish this part of God's cause from the whole in a helpful way.

Yet another strength of the book was its attention to spiritual care of patients. There is much good and useful advice in chapter 5 on this topic, joined with a healthy suspicion of New Age nursing with its 'energy-based therapies' (p. 96). There is later, in chapter eleven, a good and useful discussion of how patients who are members of other cultures and religious communities might interpret their suffering. Here the point seems to be a generous one, namely, that in order to help patients deal with their suffering you have to start where they are. In practice, however, the point seems not always to be applied so generously. The authors, for example, are suspicious of 'prayer to other gods' (p. 96). One might wonder whether there is one God or many; one might ask whether the patient can do worse than to name the one God wrongly. We would like to ask the authors for some further clarification here.

Similarly, the authors reject 'manipulative proselytizing' and commend 'simply sharing the good news of Jesus Christ' (p. 185; see also p. 230). But the reader is left wondering how to discern the difference and whether patients might sometimes experience 'simply sharing the good news' as 'manipulative proselytizing.' We seem left with the difference being in the motive of the nurse -- and with the suspicion that there must be more to it than that.

This book has many strengths. It can confirm the vocation of students to nursing as a form of discipleship, and it can remind theologians of the power and significance of familiar concepts. It is a book whose project and purpose we commend heartily, but it is not without weaknesses. It will have served its purpose well if it prompts a continuing conversation about the theological foundations for nursing.

Renee Lick *Student, Hope-Calvin nursing program* and
Allen Verhey, PhD, *Blekkink Professor of Religion, Hope College, Holland, Michigan, USA*

The Bible and Healing: A Medical and Theological Commentary
John Wilkinson
Edinburgh: Handsel Press and Grand Rapids, MI: Eerdmans, 1998.
ISBN 0-8028-3826-X, 350 pp., hardcover $25.00

John Wilkinson is both a physician and biblical scholar who has been a medical missionary in Africa and a consultant physician in Scotland. *The Bible and Healing* completely revises and expands his earlier *Health and Healing: Studies in New Testament Principles and Practice* (Handsel Press, 1980). Chapters have been added to examine healing in the Old Testament and the history of the church, while the section on healing in the gospels has been greatly expanded. Wilkinson's biblical scholarship is evident throughout the book. He remains focused exclusively on developing biblical understandings for health, disease and healing.

Wilkinson examines every Greek and Hebrew word used in relation to these concepts. He concludes that the biblical view of health is multi-faceted, in keeping with the currently popular view of holistic health. However, Wilkinson shows how biblical health is intimately intertwined with one's relationship with God. He summarizes that 'any adequate definition of human health and wholeness can only be in terms of the life and perfection of God who created human beings for fellowship with himself and whose will it is that they should share and enjoy the same life and perfection as his own' (p. 26). Health involves proper functioning of the body, mind, and emotions, but also the development of godly character and a deep relationship with God.

Wilkinson's medical training is apparent in his examination of the diseases and healings of both the Old and New Testaments. His eye for detail and thoroughness sometimes make for laborious reading. But these chapters are filled with medical information, which brings a sense of reality of the biblical passages. This serves, in a unique way, to further authenticate the biblical accounts themselves. These are not legendary stories of mythical sickness and healing; they are true-to-life accounts of human struggles with specific illnesses, and of the healing miracles visited upon God's people. For anyone seeking to study all that the Bible has to say on health and healing, this book is an essential and indispensable resource.

Wilkinson gives three of Jesus' healing miracles a chapter each: the epileptic boy (Matthew 17:14-21 and parallels), the bent woman (Luke 13:10-17), and the man born blind (John 9:1-41). These chapters blend Wilkinson's biblical and medical knowledge to give unique commentaries on these accounts. He adds historical medical information to give interesting insights into the likely outcomes for these people if Jesus had not healed them.

From the gospels, Wilkinson moves on to the epistles. He spends three chapters examining Paul's thorn in the flesh (2 Corinthians 12:7-10). Again, his thoroughness comes forth as he reviews the many theories concerning the identity of Paul's thorn in the flesh. The value of all this, however, may be questioned given the speculative nature of most of these proposals, and the inconclusiveness of this discussion. However, Wilkinson's third chapter on this passage more than makes up for the delay in reaching it. This chapter addresses the implications of this passage, and is filled with insight. He concludes: 'The Bible is concerned with the primary causes of events and usually ignores the secondary ones, while modern secular thinking usually remains satisfied with information about the secondary causes and does not enquire about the primary ones' (p. 232). While focused on our physical health, or a physical cure, we have a tendency to forget the inner spiritual healing God seeks in all our lives.

The section on the epistles concludes with two chapters on the James 5 account of praying for healing and anointing with oil. Wilkinson ends the book with relatively short reviews of healing ministries in the history of the Church and in the modern Church. He concludes that the Church remains called to a ministry of healing. However, cultural changes since the New Testament times require careful discernment as to exactly how this should be carried out. The Church has a unique role with prayer, Scripture and the laying on of hands. But this must be balanced with the use of 'medical means.' Wilkinson laments the way the Church has at times neglected this healing ministry: 'This ministry includes all methods of healing, both physical and spiritual, medical and non-medical, for all true healing comes from God' (p. 294). Christians who want to find their role in any form of healing should read this book. It will prepare them well to discern 'true healing' from the false healing available in the world.

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Notes From a Narrow Ridge: Religion and Bioethics.
D.S. Davis, L. Zoloth
Hagerstown, Maryland: University Publishing Group 1999
ISBN 1-5557-2052-8, 288pp., paperback $24.95

"What do you think of this discussion?" I asked a colleague while leaving a workshop at the conference of the International Association of Bioethics in London last year. "They don't take religion into account at all. They don't seem to realise that for most people in the world religion is very important", my colleague retorted. In the course of the following discussion, I found out that he was an Egyptian professional and a Muslim. For him, religion is essential for dealing with bioethical issues. I answered the same was true for me, a Christian. For me it was interesting to realise that on certain points I felt I had more in common with this colleague from a completely different country, culture and religion than with many secular bio-ethicist from our western culture.

This experience provides an interesting illustration of the tension between religion and bioethics as an academic discipline. (Bioethics in clinical practise is in general probably closer to religion, since for many people religion does play a role in their decision making and in the way they experience disease and immanent death).

This volume deals with this tension in a very fruitful way. It is a compilation of fourteen chapters, introduced by one of the editors and concluded by the other. The authors are representatives of various branches of Christianity and of the Jewish religion. Different aspects of the relation between religion and bioethics, which is conceived as a narrow ridge in a mountainous landscape, are discussed.

Following the introduction, D.S. Davis presents the four goals that scholars of religious ethics should keep in mind when talking to clinicians:

(1) explain the role and function of religious beliefs in the lives of individuals and in the culture as a whole,

(2) explain how a specific religion wrestles with moral issues and describe its teaching,

(3) describe what real people actually believe and how they act act

(4) employ their expertise in a helpful and honest manner (like all scholars).

In this chapter the author points out that scholars of religious ethics, when asked to present their religion's view on a certain issue, generally present the official teachings of their religion. They do not say that many of the adherents do not follow their religion's official teachings, e.g. Jews which respect to abortion, Catholics which respect to contraception. This may give an uninformed clinician a completely distorted picture of the way that religion functions in practise.

Two other authors explicitly take up this point of the difference between the official teachings of religion and the conducts of its believers. R.M. Green points out that religions not only have explicit teachings on specific issues, like abortion and euthanasia, but they also have what he calls 'a bioethical sensibility'. By this he means 'the pattern of religiously informed believes, attitudes and valuations that guide choice and conduct with respect to bioethical issues'. As an example he mentions the matricentric focus of Jewish thinking about reproductive matters that softens the explicit condemnation of abortion in (orthodox) Jewish teaching. L. Zoloth reasons that Davis's presentation of the dichotomy between official teachings and actual living of many believers of a religion is too simplistic. With respect to Jewish religion, she points out that Jewish teaching is far more divers than sometimes appears to be the case in presentations of Jewish scholars. In the Talmudic tradition there has always been a lively discussion on almost every position. On the other hand, she also asserts that the sociological observation that a large proportion of those who are Jews do not follow the teachings of orthodox Jewish religion may also be an indication that many Jews do not practise their religion. Zoloth further emphasises the prophetic and critical role of religion towards the mainstream bioethical approache, which tends to accept an unrealistic concept of autonomy and a technology driven medicine.

C.S. Campbell refutes a few of the critiques offered by philosophical bioethics to religious arguments and perspectives. He goes on to describe the role religious studies can play in bioethics. He distinguishes between several contexts of doing bioethics: education, the clinic, institutional committees, specific communities, the community at large and public policy. The author illustrates that in the various contexts religious traditions embody communities of resistance and independent sources of meaning that can make a significant contribution to the bioethical debate.

J.F. Childress writes on the role of religious convictions in the debate about public policies toward human cloning, in which he was involved as a member of the National Bioethics Advisory Board which was asked an opinion on this issue.

A number of authors critically discuss the pretension of neutrality and rationality of mainstream liberal bioethics that tends to deny a legitimate place for religious bioethics in the public arena. Religious bioethics would be either irrelevant for those who do not belong to that religious community or would involve an imposition of one's own believes on other people. The authors rightly point out that this liberal position also has its own presuppositions, its believes. This is very clearly summed up in the title of the chapter by D.B. Sulmasy: 'Every ethos implies a mythos'. Sulmasy demonstrates this by indicating the myth behind the bioethical thinking of some leading bioethicists in the United States, namely H. Tristam Engelhardt, Jr., R. Veatch, D. Brock and D. Callahan. L.J. O' Connell and M.E. Marty, who also describe this misconception among secular bioethicists also indicate that, in their opinion, a new climate of more mutual understanding is developing.

H. Tristam Engelhardt Jr. argues that, in our pluralist Western societies, religious ethics is regarded as a special genre of philosophical bioethics. It either tends to be domesticated by secular bioethics, losing its specific religious content, or it becomes a branch of descriptive ethics focussing on the way religious people engage in the bioethical debate. In the former case, it falls pray to the fundamental problem of secular moral philosophical reason, namely that it can only take a normative substantial view by begging the question. Because a specific moral position requires a foundational choice that cannot be argued in a rational discursive way. Any moral position needs to found itself in a radical claim of a normative revelation. The author argues that religious bioethics should reconsider the possibility of developing a bioethics that makes such radical claim.

Dolores L. Christie discusses the contribution of practitioners of religion by considering three different roles: the believer, the theologian and the scholar of religion. All three can shape their contributions better, according to the author.

Thomas A. Shannon points out that, though bioethics owes a lot to theologians and religious scholars, the role of philosophy has become predominate, at least in the United States. However, the philosophical analytical approach, putting a lot of emphasis on four principles, has certainly helped to clear certain issues with respect to individual rights and interests. But it has given too little attention to social issues and to the importance of communities. In this respect religion can add value to the bioethical debate. The author elaborates this for the issues of physician-assisted-death and a just healthcare system. The treatment of the latter is quite American in its scope, but as such contains important lessons in view of the Americanising tendencies in some healthcare systems in Europe.

The modern myth of individual choice is also identified by Stephan E. Lammers, especially in the United States. He argues that, at least, in the experience of disease, choice is an inadequate metaphor. He further criticises the split between public and rational, on the one hand, and private and a-rational, on the other, in which the medical discourse belongs to the public and religion to the private sphere. Those who defend this split seem to forget that it is itself based on a particular view of life and will view. He also points out that the concentration of mainstream bioethics on individual rights, as well as the interest that it has in mainstream medical discourse, are probably reasons why bioethicists have hardly engaged in a debate on the unjust healthcare system in the US. Religion might provide a good basis for a more critical approach of the present healthcare system.

I find this a very valuable book, even for Europeans, although its scope is rather American. Several authors criticise the overemphasis on autonomy and choice in mainstream bioethics in the United States and the relative lack of engagement on the part of bioethicists in issues of social justice in health care. The same criticism is often heard from European bioethicists. The field of bioethics in Europe is probably more evenly distributed among different currents of philosophical and ethical thinking. In addition, to the analytical principle-based approach, predominant in the Anglo-Saxon world, there are the more hermeneutical approach to ethics, the approach that starts from human right documents and the personalistic approach, to mention some of the main currents.

I hope this book will not only be read by people who are doing bioethics from a religious perspective, but also by the representatives of mainstream secular bioethics. This might further a mature and fruitful exchange of visions, ideas and approaches to the betterment of field of bioethics.

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How the News Makes Us Dumb: The Death of Wisdom in an Information Society
C. John Sommerville
Downers Grove, IL: InterVarsity Press, 1999
ISBN 0-8308-2203-8, 156 pp., paperback $10.99

The basic theme of this concise and penetrating critique of the American news industry is a great paradox: although the volume of information and the immediacy of its availability are increasing, we, as a culture, are actually becoming less knowledgeable about current events and their significance.

Unlike many previous media criticisms, Sommerville's work does not find the basic problem of news today in the industry's liberal bias (though it is true), or in the industry's secular relativism (though that is also a reality). Instead, he uniquely locates our news media malady in the essential nature of the news itself: its dailiness. This problem of periodicity is Sommerville's focus, and with a sharp analytical eye he unfolds its baleful implications for our culture.

Most fundamentally, the information industry has created a 'debilitating news consciousness' (p. 11) within us, which exalts change and crisis as the defining aspects of our personal and social experience. The economics of daily publication require this. Helpful answers to human problems and truly wise, enduring insights must be actively withheld, since a satisfied and enlightened readership is unlikely to feel the need to be 'in touch' everyday. The result is a manic public mind that genuinely knows very little. Sommerville, writes, 'The more successful [the news'] answers, the less we will have to revisit the question again. . . . There is not extended thinking in news reports because it takes too much time to explain something. We find statements rather than arguments, and this has a serious effect on our minds. If news constitutes all of our reading, we fall into the habit of thinking that opinions are the same as thoughts. The news alludes to a debate but can only show us a clash of opinions' (pp. 43-44).

Sommerville includes sections offering keen observations on the distortions the nature of the news visits on politics and government, but it is in the areas of science and religion that his analyses seem most original. With respect to the former, dailiness of the news requires journalists to hype new discoveries, search for surprises and herald alleged trends, especially if they contravene tradition and convention. This excites interest, but at the expense of attention to the real business of scientific investigation, which is far too plodding and dry to cover before the next news cycle dawns tomorrow. Thus, science is dumbed down, and the merits of actual evidence are seldom a topic of news coverage. Correlations become definitive, not merely suggestive; results conclusive rather than indicative.

Religion, also, gets short shrift in the acontextual, truncated daily world of news. Sommerville asserts a spiritual opposition between news and religion, as they inhabit opposite poles of human experience, the daily versus the eternal. 'News is only aware of change,' he writes, 'while religion tries to concentrate on the eternal, even within change.' (p. 50). Daily news is not just unreflective, it is anti-reflective. The religious foundations of absolute realities, featuring the Absolute himself, are naturally anathema to daily news, which cannot abide settled matters, and still survive commercially. Writes Sommerville, 'Tomorrow must have a new edition, and that edition must suggest that there is a new world out there. So what has always seemed reasonable, natural or good must be challenged not just now and then but constantly' (p. 53). Consequently, religion usually makes the news only when it has behaved badly, thus the regular focus on corrupt ministers, fanatical cults, religious wars and intra-church conflict.

By way of solution to our news affliction, Sommerville recommends nothing less than ignoring the daily news, and supplanting the addiction to 24 hour 'information' with introspection, historical study and renewed involvement in one's family and community life. The result will be nothing less than the humanising of both our society and us.

How the News Makes Us Dumb is a bold and scathing sociology of news, and will be useful to anyone pondering how the information industry impacts American culture.

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The Medical Legacy of Moses Maimonides
Fred Rosner
Hoboken, NJ: KTAV Publishing, 1998
ISBN 0-88125-573-4, 308 pp., hardback $29.50

It's not saying much to claim that the term 'Renaissance Man' is not only overused but also misapplied today. It would be remiss, however, to let modern foibles mar such a wonderful and useful appellation. Certainly deserving of the title, Moses ben Maimon (known as Maimonides in English) was born a Spanish Jew in 1135. As Maimonides scholar Fred Rosner points out, Maimonides almost found life's knowledge too easy, 'master[ing] nearly everything known in the fields of theology, mathematics, law, philosophy, astronomy, ethics and, of course, medicine' (p. 17). This text focuses on Maimonides the physician and, like the 'Prince of Physicians' himself, the work is tightly organised, timely and accessible.

Of particular interest in our greying society is Maimonides' advice to the elderly. As is the case with the very best of medieval medical knowledge, some of the advice wears better than others. When Maimonides opines on the specifics of bleeding the patient, one can only be grateful about how far the healing arts have come. But, there are instances when Maimonides' advice on geriatric care makes sound sense. His advocacy of smaller, more frequent meals, his acknowledgement that many elderly cannot tolerate milk well (i.e., in modern language they're 'lactose intolerant') rings true and his advice that the elderly consume foods that will 'soften the stool' is equivalent to prescribed diets today that are high in bulk and fibre (pp. 109-10).

However, it is Maimonides' insistence that the elderly practice some form of exercise that is typical of the classical genius of the man. His insistence that the elderly adopt walking as a primary form of exercise sounds very much like the usual low-impact prescription given today. But it was not all that long ago that medical 'science' advocated little or no exercise for the elderly; such erroneous advice stemming from either ignorance of geriatrics, or fear of injury, or both. Now, the literature is unanimous: our need for regular exercise remains strong and constant as we age.

Rosner has done an excellent job of portraying the genius of Maimonides without lapsing into fawning platitudes. He is also correct in his connecting the early Hebrew roots of preventive medicine from Jewish Biblical and Talmudic sources through Maimonides and beyond. Thus, in large measure, Maimonides anticipated much of the modern criticism of modern medicine—that it exists only to cure the symptoms of the illness, never the root cause—and strove to analyse why patients were manifesting the symptoms they had. Such a stress insures that Maimonides will always be much more than 'merely' a historical source—rather he points to a living tradition that bridges the gulf between empty theory and rootless application. Rosner obviously senses this, and his treatment deserves a place in any serious collection of medical/historical works. It's a good read.

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The Thomas Lynch Undertaking: Life Studies from the Dismal Trade
Thomas Lynch
New York and London: Penguin Books, 1998
ISBN 0-14-02-76238, 224 pp., hardcover $18.40

Handbook for Mortals: Guidance for People Facing Serious Illness
Joanne Lynn, Joan Harrold, and The Center To Improve Care Of The Dying
New York and Oxford: Oxford University Press, 1999
ISBN 0-19-511662-3, 242 pp., hardcover $25.00

Of all the books I've read in recent years, one of the wisest and most helpful happens to be about death and care for the dead (not the dying). Thomas Lynch of Milford, Michigan is a poet and an undertaker. In his collection of essays *The Undertaking: Life Studies from the Dismal Trade*, Lynch brings the poet's eye and pen to the discussion of how we do treat the dead, how we should treat the dead, and what that means for those of us who live. If Jessica Mitford destroyed a great deal of confidence in the 'dismal trade,' Thomas Lynch's essays are restorative. Lynch's book is both playful and profound. He appears equally at ease in proposing the creation of 'golfatoriums,' at which one might take care of the dead and ruin a good walk at the same time, as well as in discussing the sorrow of cleaning up after suicides. His discussion of Dr. Jack Kevorkian and physician-assisted suicide in his essay 'Uncle Eddie, Inc.' is unconventional and brilliant.

Less profound, but no less valuable, is Joanne Lynn and Joan Harrold's Handbook for Mortals. This is, indeed, a handbook; there is no pretence at sustained reflection. Instead, Lynn and Harrold provide in easily accessible form a wealth of information to help individuals and families think through an impending death. Much of the material included is what a competent counsellor or social worker might provide. Advice is proffered about how to think about illness and how to deal emotionally with illness and one's foreseeable death. Practical advice on helping one's family discuss medical decisions, finding help, and discussing care with one's physician is abundant, including a thick chapter listing additional sources of information (all being U.S. listings).

Most valuable is the correction the book provides to much misinformation and ignorance about controlling pain. As the book mentions, much of the public support for physician-assisted suicide dissipates when individuals are made aware of palliative care resources. And one sensible objection to physician-assisted suicide is that we are less likely to devote resources to improving pain control if physician-assisted suicide is an easy and economical option. There's a great deal of work that needs yet to be done in informing the public of the palliative care resources available to patients and this book makes an excellent beginning. Lynn and Harrold also provide helpful information about particular illnesses as well as about family events at both sides of death.

The book provides no detailed ethical arguments. Some readers of this journal will think Lynn and Harrold's acceptance of forgoing artificial nutrition and hydration far too easy and, perhaps, cavalier. While I do not disagree with the substance of their position, I, too, would appreciate their being a bit more circumspect with respect to artificial nutrition and hydration. In an attempt to be even-handed, the book briefly presents arguments for and against physician-assisted suicide but, ultimately, avoids the hard moral debates with the assumption that readers will want to obey the law and that for some time into the future the law will continue to prohibit physician-assisted suicide, with the exception of Oregon.

Neither book is overtly religious, nor dismissive of religious faith. Lynch, we gather, is something of a Catholic. At any rate, his sensibilities seem Catholic, although his piety is not. His expressions of faith appear as affection for a good, though somewhat dotty, elderly aunt. *Handbook for Mortals* is mindful of the comfort of religion and the importance of faith and religious ritual for those who suffer. As such, readers are frequently reminded of the resources of a faith community for the dying and their families.

Handbook for Mortals is intended to appear reader-friendly. The book is peppered with quotations and black and white photographs, thus giving the book something of the appearance of a scrapbook. Astonishingly, for a book so concerned about appearance and for a book by such a quality publisher, chapter 11, 'Forgoing Medical Treatment', concludes mid-paragraph, mid-sentence. Nevertheless, the book is warmly commended as a helpful and deeply humane practical guide for individuals and families facing serious illness. But if you've money enough for just one book, *The Undertaking* might be the wiser, if less practical, purchase.

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The Right to Die Debate: A Documentary History
Marjorie C. Zucker, Editor
Westport, CT: Greenwood Press, 1999
ISBN 0-313-30522-6, 297 pp., hardcover $49.95

Marjorie Zucker has put together an impressive assortment of primary documents relative to the right-to-die debate. Recognizing the critical and complicated nature of this debate, she includes legal documents, government reports, personal testimonies, and religious statements. Her goal is to give a balanced treatment of the arguments concerning people making their own decisions relative to both the timing and method of their own death. A helpful discussion on the historical development of views and definitions of death (primarily in the United States) introduces the book while a brief explanatory note introduces each document. Intentionally developed for 'the research needs of highschool and college students' (p. xxi), the book provides a wide range of documents that outline the history of this debate.

Part I sketches the historical development of medicine. It shows the evolution in the Western understanding of, and response to, death and dying which is a brilliant way to frame the debate historically. Likewise, Parts II and III outline the euthanasia debate up to 1965, providing an indispensable background for comprehending the state of the debate today. They reveal a general opposition to legalizing euthanasia as well has highlighted the strenuous objections from different segments of society. They chronicle the opinions of the medical, legal and religious communities showing that the general opinion to that point was against euthanasia.

The last section of the book (pp. 223-297), which is on assisted suicide and euthanasia, seems the least objective in spite of reassurances from Zucker that, although the work was supported by Choice In Dying, Inc. (former the Euthanasia Society), this organization 'neither advocates for or against physician-assisted suicide' (p. xxiii). Zucker does, fortunately, make the point that withholding and withdrawing treatment 'must be distinguished from assisted suicide because the action is based on the right to be free of unwanted treatment even if this results in death' (p. 223). In fact, she highlights this point by including the Supreme Court's ruling on the difference between 'refusing lifesaving medical treatment and assisted suicide' (p. 289) as being neither irrational nor arbitrary.

The concern, however, about objectively presenting both sides in this last section comes not only from what is said, but what is not said. For example, the discussion of palliative care as a real possibility for the terminally ill appeared somewhat anaemic and limited. Furthermore, the personal testimonies and essays presented in this section seemed to lean in the direction of euthanasia as a compassionate response to those faced with a terminal and particularly difficult illness. Unfortunately, a distinctively Christian view of compassion for the dying appears not to have received equal representation. The discussion of Jack Kevorkian, while not giving support for the practice, fails to present equal space to a dissenting opinion. This is true even in the introductory notes to that group of documents (pp. 234-6).

Another example comes with Zucker's inclusion of an article by James Rachels in which he protests that the distinction between active and passive euthanasia rests on 'a distinction

The theme of Dworkin and Frey's argument is patient autonomy. 'Control over our own lives is one of the most important goods we enjoy . . . it is our life, and how we live it and what we make of it is up to us' (p. 17). They use this belief as the basis for their statement that 'such patients seek to continue to exercise control over their lives, now in the form of bringing about their deaths' (p. 17). The philosophical views of Dworkin and Frey reminded me of the quote by R. C. Sproul; 'We still grasp for autonomy, refusing to have God rule over us' (*Playing God,* Grand Rapids, MI: Baker Books, 1997, p. 54).

Sissela Bok's argument against the legalisation of PAS and AVE begins by questioning whether autonomy is best, 'rather than leaving matters to divine will or to Providence' (p. 84). Bok's first chapter describes the various perspectives in current society related to both PAS and AVE. Her last three chapters deal with the specific issues of suicide, euthanasia, and PAS.

Bok relies on classical philosophers' views, as well as on later historical views to discuss the issue of suicide. Although she compares very nicely both sides of this debate in the historical context, Bok never reveals her position on the matter.

On euthanasia, however, Bok states very clearly the dangers that would be involved in legalising such practices. To argue her position, she uses cases, such as the Netherlands, where despite laws that require the reporting of euthanasia cases, 'over half of the cases are not reported' and among reported cases 'several of the criteria have been found to be violated with some frequency' (p. 124). In '0.7 percent . . . of deaths . . . patients put to death had not been competent to give consent . . . Many were comatose or demented. Euthanasia was also . . . carried out on severely disabled babies' (p. 124). Bok's arguments give clear evidence of the danger of the 'slippery slope', for which Dworkin and Frey claim no evidence exists.

Finally, Bok ties the arguments together in a discussion of PAS. This chapter dealt with the differences between suicide and PAS, and the idea that a physician helping a patient commit suicide 'crosses the line to euthanasia' (p. 130). Bok discusses the physician's role in treatment and relief of suffering in a therapeutic manner, and finally defines three senses in which the word 'treatment' is actually used. The 'moral sense concerns how well or badly we treat others and ourselves. . . .' (p. 138). Bok argues that at the very least, 'medical treatment should never be so construed as to go against the basic moral precepts of how human beings should treat one another' (p. 139).

This book did a good job of educating the reader on both sides of the debate on PAS and AVE. I would recommend this book to anyone interested in learning more about these issues.

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Suicide: A Christian Response
Timothy J. Demy and Gary P. Stewart, Editors
Grand Rapids, MI: Kregel Publications, 1998
ISBN 0-8254-2355-4, 490 pp., hardcover $24.99

'The right to kill oneself or to be killed - who would have ever thought that this country, which has made life the most livable in the world, would now be involved in a controversy over whether life is productive or not and therefore livable?' (p. 21). This is the question posed by editors Timothy Demy and Gary Stewart to begin Suicide: A Christian Response. Whether we should have thought of it or not is a moot point. The controversy is here, and a Christian response is desperately needed. With Jack Kevorkian practising euthanasia with impunity (until videotaping himself for television broadcast and gaining a conviction for murder), the suicide initiative in Oregon, and various court cases, we may be excused for thinking that our society has embraced death as a suitable alternative to life in many situations.

Carl F.H. Henry writes, 'We live in a moment in history when many people, in the Western world at least, seem more deeply concerned over how they will die than over how they ought to live' (p. 17). This focus on the time and means of death has led not to an increased appreciation for life, but rather the opposite - a trend towards the devaluation of life, both by those who feel that certain people are living a life devoid of meaningful existence, and also by those who decide not to cling to a life they feel has become unbearable. The issues of euthanasia and suicide are intertwined.

How should Christians approach the issue of suicide? There is no Eleventh Commandment that states unequivocally: 'Thou shalt not commit suicide', or 'thou shalt not seek death at thine own hand or that of another'. Consequently, there is diversity of opinion amongst Christians as to the legitimacy (or not) of both suicide and various forms of euthanasia. This volume, *Suicide: A Christian Response,* provides a response from an evangelical Christian position.

The authors include physicians, lawyers, philosophers, theologians, pastors, and lay-people (there are thirty-five authors). All have a common perspective reflected in the book's subtitle: 'Critical considerations for choosing life'. Even so, there remain differences between authors in terms of definitions of different types of euthanasia and the extent to which they would go in delineating the extent of euthanasia practices. All, however, respect life as a gift from, and possession of, God. And all have a high respect for the teachings of scripture.

The book is divided into five sections. 'Legal and medical reflections' discusses recent court judgements and the perspectives of physicians and nurses. 'Philosophical reflections' discusses the history of suicide, the problem of theodicy, and moral issues. 'Theological reflections' examines suicide in Jewish history (Masada) as well as martyrdom among early Christians and debunks the idea that early Christians actively desired suicide. 'Biblical reflections' looks at the few suicide cases recorded in the Bible, and studies perspectives from the Old Testament, Wisdom literature, Pauline theology, and Jesus' parable of the good Samaritan, as well as a welcome examination of the literary approach of the biblical narratives (an appreciation of the literary forms of the Bible is not often considered in books dealing with ethical/moral issues). The final section, 'pastoral and personal reflections' demonstrates the profound effects suicide has on the family and friends left behind.

The editors aim at a comprehensive treatment of the issues of suicide and euthanasia, and succeed, to a large extent. Perhaps inevitably, in a book with multiple authors, there is an element of overlap. Also, some sections are more readable than others, and some may appeal more to different readers than others. (Physicians may find the legal sections hard going, for example). I suspect that *Suicide* will appeal primarily to professionals of one sort or another - be they doctors, lawyers, counsellors, pastors. It is not a mass-market, easy-reading book. It is, however, a very worthwhile resource for those involved closely in the suicide/euthanasia debates. Many issues and perspectives just have not been 'thought-through' by the average Christian in

the street, and it is up to those in positions of influence to use that influence wisely, in a manner consistent with scriptural teaching and Christian worldviews. *Suicide: A Christian Response* is an excellent, in-depth evaluation of this most important issue. Death comes to us all. But let it be in God's hands, not those of others.

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