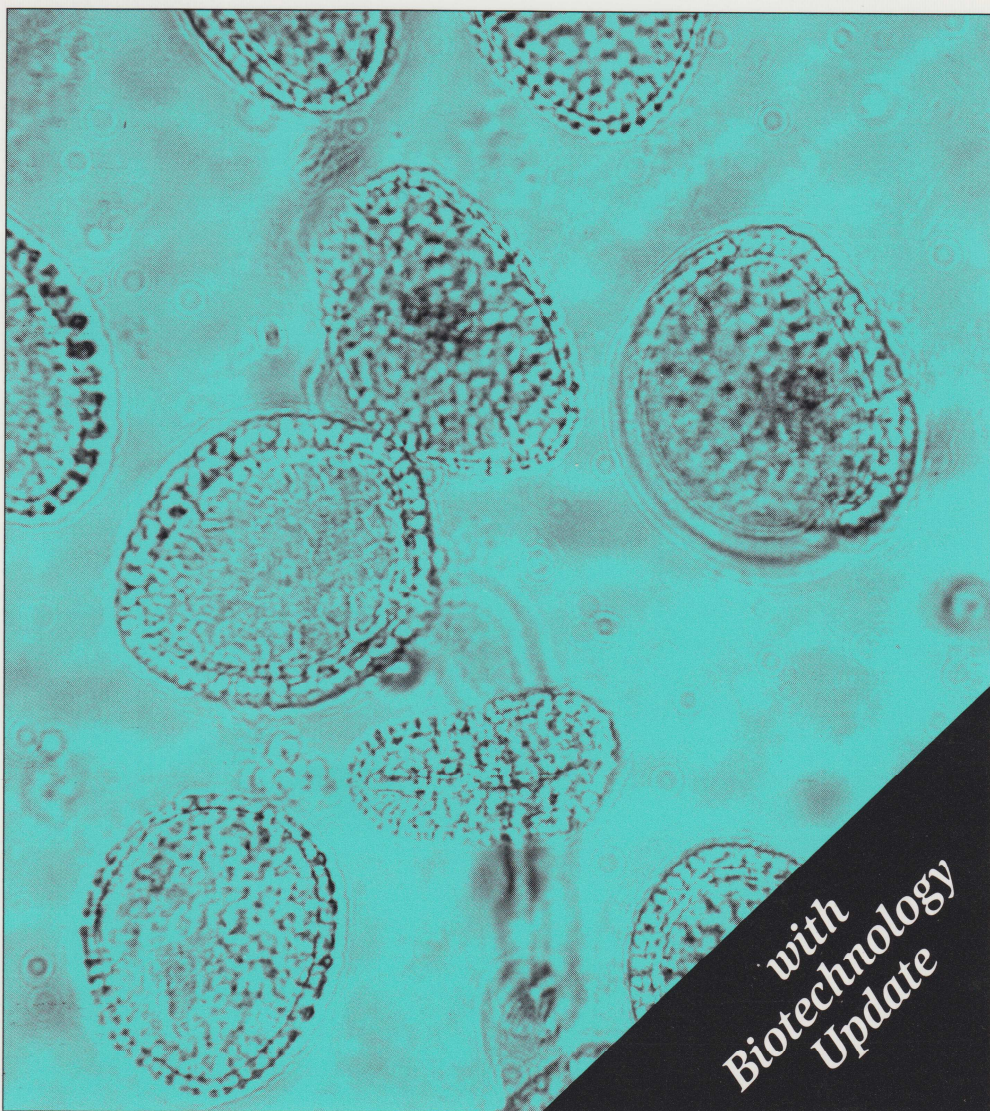


CELEBRATING 20 YEARS

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# Ethics & Medicine

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EDITORIAL

## THE NEW UTOPIANS AND A TRULY HUMAN FUTURE

C. BEN MITCHELL, PHD, EDITOR

Utopianism—the idea that we can enjoy a perfect society of perfect people on a perfect earth—is not new at all. Novelists, playwrights, social engineers, and media moguls have played with the idea for millennia. The new utopians, however, are a breed apart, so to speak. They are what we might call “technopians.” That is, they believe that technology is the key to the perfect society of perfect people on a perfect earth.

The new technopians actually have a name for themselves: Transhumanists. According to the World Transhumanist Association: “Transhumanism (as the term suggests) is a sort of humanism plus. Transhumanists think they can better themselves socially, physically, and mentally by making use of reason, science, and technology. In addition, respect for the rights of the individual and a belief in the power of human ingenuity are important elements of Transhumanism. Transhumanists also repudiate belief in the existence of supernatural powers that guide us. These things together represent the core of our philosophy. The critical and rational approach which transhumanists support is at the service of the desire to improve humankind and humanity in all their facets.” ([www.transhumanism.com](http://www.transhumanism.com))

Again, the idea of improving society through technology is not new. In fact, most of the last century was spent doing just that. What is new, however, is how the Transhumanists intend to improve society. They intend to craft their technopia by merging the human with the machine. Since, as they argue, computer speed and computational power will advance a million fold between now and the year 2050 A.D., artificial intelligence will surpass human intelligence. The only way humans can survive is by merging with machines, according to the Transhumanists. Do the movies *AI* or *Bicentennial Man* come to mind?

Now, before you dismiss the Transhumanists as just another group of space-age wackos, you need to know who some of them are. One of the brains behind the movement is a philosopher at Oxford University, Nick Bostrom. Bostrom’s website ([www.nickbostrom.com](http://www.nickbostrom.com)) sets out his worldview quite clearly. He wants to make better humans through technology.

Another Transhumanist is a professor of cybernetics at the University of Reading in England. Kevin Warwick deserves the distinction(?) of being the first “cyborg.” He wears implanted computer chips in his arm and wrist. The next stage of human evolution, argues Warwick, is the cybernetic age. As Warwick told *Newsweek* in January 2001, “The potential for humans, if we stick to our present physical form, is pretty limited. . . . The opportunity for me to become a cyborg is extremely exciting. I can’t wait to get on with it.” And so he has.

Rodney Brooks, professor of robotics at MIT, believes that through robotics we are reshaping what it means to be human. His recent book *Flesh and Machines* is an exploration of his worldview. For many of the Transhumanists, human beings are merely what AI guru Marvin Minsky has called, “computers made of meat.” So, melding biological computers (the human brain) with silicon brains (computers) seems like a good thing to do.

What do the Transhumanists all have in common? First—to be most charitable—they find the problem of human suffering, limitation, and death to be disconcerting. The technopian vision is of a pain-free, unlimited, eternal humanity. For that vision, we should commend them. But, how to get there? That is the real question.

Secondly—and less charitably—the Transhumanists display what can only be called self-loathing. They are very perturbed by humanity and its finitude. The body and its limitations have become a prison for them and they want to transcend the boundaries of this mortal coil. In their view, Transhumanism offers the greatest freedom.

Thirdly, they are confident—even triumphalistic—evolutionists. Theirs is not the Darwinian evolutionary view of incredibly slow, incremental progress of the fittest of the species. No, this is good old Western pull-ourselves-up-by-our-bootstraps, relatively instant, designer evolution. But, with all of our human frailties, are we going to make ourselves better through technology? Since we are so limited, error-prone, and bounded, we might just destroy ourselves! The problem of self-extinction worries a few of them, especially Nick Bostrom.

The Apostle Paul was a Transhumanist of sorts. He too found the limitations of our fallen humanity bothersome. In 2 Corinthians 4 and 5 he groans about this earthly tabernacle or tent. He longs to be freed from the suffering, the pain, and the finitude. Yet, his hope is not in his own abilities to transcend his humanity, but in God’s power to transform his humanity through redemption. He is confident that this mortality shall put on immortality—that we have a dwelling place not made with human hands, but eternal, and heavenly.

*But we have this treasure in earthen vessels, that the excellency of the power may be of God, and not of us. [8] We are troubled on every side, yet not distressed; we are perplexed, but not in despair; [9] persecuted, but not forsaken; cast down, but not destroyed; [10] always bearing about in the body the dying of the Lord Jesus, that the life also of Jesus might be made manifest in our body. [11] For we which live are always delivered unto death for Jesus’ sake, that the life also of Jesus might be made manifest in our mortal flesh. [12] So then death worketh in us, but life in you. [13] We having the same spirit of faith, according as it is written, I believed, and therefore have I spoken; we also believe, and therefore speak; [14] knowing that he which raised up the Lord Jesus shall raise up us also by Jesus, and shall present us with you. [15] For all things are for your sakes, that the abundant grace might through the thanksgiving of many redound to the glory of God. [16] For which cause we faint not; but though our outward man perish, yet the inward man is renewed day by day. [17] For our light affliction, which is but for a moment, worketh for*

*us a far more exceeding and eternal weight of glory; [18] while we look not at the things which are seen, but at the things which are not seen: for the things which are seen are temporal; but the things which are not seen are eternal.*

*[5:1] For we know that if our earthly house of this tabernacle were dissolved, we have a building of God, a house not made with hands, eternal in the heavens. [2] For in this we groan, earnestly desiring to be clothed upon with our house which is from heaven: [3] if so be that being clothed we shall not be found naked. [4] For we that are in this tabernacle do groan, being burdened: not for that we would be unclothed, but clothed upon, that mortality might be swallowed up of life. [5] Now he that hath wrought us for the selfsame thing is God, who also hath given unto us the earnest of the Spirit. [6] Therefore we are always confident, knowing that, whilst we are at home in the body, we are absent from the Lord . . . [ESV]*

Much of what the Transhumanists long for is already available to Christians: eternal life, and freedom from pain, suffering, and the burden of a frail body. As usual, however, the Transhumanists—like all of us in our failed attempts to save ourselves—trust in their own power rather than God’s provision for a truly human future with him. **E&M**

## SOME CHRISTIAN RESPONSES TO THE GENETIC REVOLUTION

JULIE P. CLAGUE, MTH, PGCE

'I will praise thee; for I am fearfully and wonderfully made; marvellous are thy works.'

Psalm 139:13-15

On the historic day of the announcement of the completion of the international effort to create a working draft sequence of the human genome (June 26, 2000), President Bill Clinton, flanked by Francis Collins and Craig Venter, the American scientists who led the genome sequencing efforts, remarked:

Without a doubt this is the most important, most wondrous map ever produced by humankind . . . Today we are learning the language in which God created life. We are gaining ever more awe for the complexity, the beauty, the wonder of God's most divine and sacred gift. With this profound new knowledge, humankind is on the verge of gaining immense new power to heal. Genomic science will have a real impact on all our lives, and even more on the lives of our children. It will revolutionise the diagnosis, prevention and treatment of most, if not all, human diseases. In coming years, doctors increasingly will be able to cure diseases like Alzheimer's, Parkinson's, diabetes and cancer by attacking their genetic roots.<sup>1</sup>

It is significant that President Clinton chose to describe the scientific achievement of mapping the genome in rich theological terms. He invoked the *sensus divinitatis* in order to powerfully convey the miracle of life and the inherent value of humankind. Genetics has always had the power to capture the human imagination, prompting recourse to the sort of transcendent language that can express both the truth of individual uniqueness and humanity's collective power to transform itself. The latent potential of the human genome lies in its future promise to medical science. It is beyond dispute that the genetic knowledge gained from sequencing the genome will help humans to understand better how to safeguard health and how to tackle disease. The Clinton speech invoked the narrative of human power over nature in order to outline the considerable medical benefits expected as a consequence of the completion of the Human Genome Project. The immediate value of the sequence data lies in its use to identify disease-causing genes that will eventually lead to the improved diagnosis, prevention, and treatment of a variety of maladies. The long-term goal is the medical treatment of the vast array of disorders that have a genetic component.

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Newly identified biochemical target sites in the body are already emerging as suitable for the pharmaceutical equivalent of precision-bombing. The trial and error involved in the one-size-fits-all approach to prescribing drug therapies should give way to a bespoke tailoring of drug and dosage to the genetic make-up of patients, thereby improving effectiveness and minimising side-effects. Genetic testing for inherited disorders and predisposition will become commonplace, allowing individuals and families to discover whether they or their offspring risk developing disease. In combination with appropriate genetic counselling, this can provide such individuals with the opportunity to minimise risks—for instance, by modifying diet, by taking preventative drugs, or by changing harmful lifestyle patterns—and help them understand, prepare for, and manage diseases for which there is no existing treatment. Those couples that risk passing diseases to their offspring but who wish to have children may be able to utilise the technique of pre-implantation genetic diagnosis as a means of selecting healthy embryos. Ultimately, application of the knowledge gained from the Human Genome Project is expected to transform the practice of medicine, lead to the eradication of many diseases and improve the life expectancy of many. Death will not be put out of business, but he will lose far more poker games.

Inevitably, this rapidly expanding branch of medicine is bringing with it complex and various ethical questions. There are concerns over the distressful effects of disclosure of adverse health information to patients about diseases for which no treatment is available, and the role such knowledge might play in their life choices. Issues of confidentiality are raised when patients are provided with information about a genetic disorder that also affects the well-being or interests of third parties. Are there circumstances in which there might be a duty to disclose information to family members, or to insurance providers, or to employers? As the power to predict, prevent, treat, and cure disease increases one might expect subtle shifts in cultural attitudes to health, disease, and death. New genetic knowledge gained could be misused to discriminate against or stigmatise certain individuals or social groups unfairly. As genetic therapies gradually become available, consideration will have to be given to whether it is appropriate to use public funds to correct certain sorts of disorder: which count as medical and which count as enhancement? To what extent is germ line gene therapy justifiable, in which future generations inherit the genetic modification? Will such changes to the genome exert as-yet-unknown harmful long-term effects on populations? And, given that biotechnology and pharmaceutical companies have to invest huge sums of money in the research and development of new drugs and treatments, how might an equitable balance be struck between providing incentives to and protecting the interests of commercial investors through copyright and patent laws, while at the same time ensuring that there is both healthy competition, and that the benefits of research are made widely available to patients at a fair price?

The moral questions that have emerged as a result of the genetic revolution have been and continue to be the subject of important and legitimate public scrutiny, and have given rise to extensive scholarly discussion within biomedical ethics and related disciplines for over thirty years. Indeed, the proliferation of concerns created by new genetic knowledge and technologies has given rise to a whole new sub-discipline of ethics, which could be termed 'genomortality',



incorporating the social, economic, and political as well as the biological and personal realms. Perhaps it is no coincidence that the modern academic discipline of bioethics began to establish itself (in the 1950s and 1960s) at the same time that the field of human genetics first promised to transform the human condition.

In any case, it is noteworthy that Christian writers were the first to respond to the moral dimensions of the genetic revolution. The first documented religious response to genetics was Pope Pius XII's Address to the First International Symposium of Genetic Medicine in September 1953, less than five months after Crick and Watson presented their double-helix model of DNA to the world. With the atrocities of the Second World War still at the forefront of the collective consciousness, the Pope described 'racialism' and 'eugenic sterilization' as 'contrary to morality'. However, invoking the common good of humanity, he found no reason to disapprove of the beneficial aims of genetics:

Genetics has not merely a theoretical interest; it is eminently practical as well. It aims at contributing towards the good of individuals and of the community—towards the common good . . . The fundamental tendency of genetics and eugenics is to influence the transmission of hereditary factors in order to promote what is good and eliminate what is injurious. This fundamental tendency is irreproachable from the moral viewpoint . . . The practical aims being pursued by genetics are noble and worthy of recognition and encouragement.<sup>2</sup>

Thirty years later, Pope John Paul II, in his Address to the World Medical Association, employed the same line of moral argumentation to justify genetic medicine:

A strictly therapeutic intervention, having the objective of healing various maladies—such as those stemming from chromosomic deficiencies—will be considered in principle as desirable, providing that it tends to real promotion of the personal well-being of man, without harming his integrity or worsening his life conditions. Such intervention actually falls within the logic of the Christian moral tradition . . . And since, in the order of medical values, life is man's supreme and most radical good, there is need for a fundamental principle: first prevent any damage, then seek and pursue the good.<sup>3</sup>

John Paul reiterated this basic position in 1995. He acknowledged that 'the biomedical sciences are currently experiencing a period of rapid and marvellous growth, especially with regard to new discoveries in the area of genetics'. In this regard, scientific research must respect personal dignity and support human life, but must also endeavour 'to promote the true good of human beings as individuals and as a community. This happens when efforts are made to eliminate the causes of disease by putting real prevention into practice, or whenever more effective therapies are sought for the treatment of serious illnesses'.<sup>4</sup>

This positive attitude towards genetics may surprise those who are inclined to view Roman Catholicism as the Church that likes to say 'No'. It is true that there are a number of interventions that are considered illicit in official Roman Catholic

teaching, but which gain widespread approval within all other mainstream Christian denominations. Examples include: direct sterilisation, artificial contraception, artificial insemination by husband (AIH), *in vitro* fertilisation (IVF), abortion to save a woman's life, and non-therapeutic embryo research. The last two cases are deemed to constitute direct attacks on innocent human life, and are condemned on this basis. In the other cases, the chief ground for Catholic disapproval is the sense that the action constitutes a dehumanising intervention into the God-given natural order. More specifically, it is said to do so by separating the procreative and unitive meanings of sex from their proper locus in the conjugal bonding of man and woman. By contrast, in the case of genetic interventions, the underlying Catholic attitude is more positive. These sorts of interventions into nature, provided that they respect human rights, are justified because of their humanising contribution to the common good. Similar teleological arguments lead to Catholic approval in principle (i.e., provided the risks are not great) of xenotransplantation<sup>5</sup> and the use of adult stem cells for diseased and damaged tissue replacement.<sup>6</sup>

Prescinding from discussion of the so-called 'inseparability principle' in Catholic natural law ethics (a topic that has been subjected to exhaustive scrutiny for several decades), it is clear that there are two different attitudes to 'nature' and what is 'natural' at work in these moral teachings. They can be considered as two basic outlooks or world-views that often characterise Christian (and non-Christian) responses to medical interventions.<sup>7</sup> The first describes certain sorts of actions as unnatural and therefore immoral because they interfere with the given order, the structure of which constitutes either a 'design classic' that cannot be improved upon by human manipulation, or a finely-tuned organism that will be knocked out of kilter by human tampering. To interfere disrupts the way things should be and frequently leads to harmful consequences. The second approach takes a more optimistic view of humankind's ability to apply God-given intelligence to the task of transforming and humanising the world. Pius XII appealed to this line of argument in order to justify the use of anaesthetics and analgesics in the medical treatment of pain: 'Man preserves, even after the Fall, the right of dominating the forces of Nature, of using them in his service, and of employing the resources so offered to him to avoid or suppress physical suffering.'<sup>8</sup> The same fundamental attitude to humanity's place in God's creation is at work in papal approval of genetic medicine. It goes without saying that the Catholic Church would reject the suggestion that this line of argument could fruitfully be applied to those medical interventions already identified that are ruled out by appeal to natural law. By contrast, it is precisely the application of such logic that has led to their approval by the rest of mainstream Christianity. In summary, though the Catholic Church rules out some medical interventions on the basis of their supposed unnaturalness, it approves of genetic interventions that respect human rights on the basis of their beneficial contribution to both individuals and society.

Two Protestant theologians, instrumental in founding the discipline of bioethics and early influential writers on genetics, were the Episcopalian Joseph Fletcher and the Methodist Paul Ramsey. Their writings now appear somewhat dated, and both frequently had recourse to rhetorical overkill stylistically. However, the underlying theological visions that inspired these writers remain of

interest. Joseph Fletcher was an exponent of the view of the human being as in essence ‘a maker and a selector and a designer’<sup>9</sup>, who acts morally when he or she controls the genetic slings and arrows of outrageous fortune, but his conclusions were extreme and his consequentialist argumentation notoriously weak:

Not to control, not to weigh one thing against another, would be subhuman . . . It used to be that we had no way of knowing which couples were carrying a common gene defect or which pregnancies were positive for it. But now we *can* know; we have lost that excuse for taking genetic risks . . . Screening by one means or another is the obvious way to fulfill our obligation to potential children, as well as to the community which has to suffer when defectives are born.<sup>10</sup>

In his essay ‘Ethical Aspects of Genetic Controls’, Fletcher goes so far as to suggest that laboratory reproduction is more human than sexual intercourse on the basis that: ‘the more rationally contrived and deliberate anything is, the more human it is’.<sup>11</sup> In contrast to what Linda Woodhead describes as the ‘masters of the universe’ approach to genetic interventions that is represented in almost parodic form by Fletcher,<sup>12</sup> Paul Ramsey rejected any optimistic confidence concerning humankind’s ability to intervene wisely into the created order. Thus, in somewhat purple prose, Ramsey poses the rhetorical question:

‘. . . are we then to say that man is let loose here [on earth] with the proper task of disassembling his own “courses of action,” making himself and his species wholly plastic to ingenious scientific interventions and alterations? . . . it follows that thereafter human nature has to be wrought by Predestinators in the Decanting and Conditioning Rooms of the East London Hatchery and in commercial firms bearing the name ‘Genetic Laboratories, Inc.’ in all our metropolitan centres.’<sup>13</sup>

Ramsey believed the technological age was one ‘in which “progressives” are in the saddle and ride mankind—ahead if not forward.’<sup>14</sup> Instead of Fletcher’s ‘bend nature to human purposes’ approach, Ramsey’s appeal was to the inherent wisdom of God’s created order and God’s ultimate control of history. The manufacturing of progeny pays disrespect to God’s design and intentionality: ‘Men ought not to play God before they learn to be men, and after they have learned to be men they will not play God.’<sup>15</sup> As Gordon Dunstan observed, Ramsey’s attitude to medical research was ‘a literally protestant “thus far and no further”’.<sup>16</sup> His objection to the supposed severing of procreation from its context in conjugal love in IVF gained support from a deontological appeal to the Scriptural theme of covenantal fidelity based on readings of the prologue of John’s Gospel and Ephesians 5.<sup>17</sup> However, Ramsey’s deep pessimism regarding fallen humankind’s capacity to act morally extended also to a sense of impending disaster: many proposals for ‘man’s radical self-modification and control of his evolutionary future . . . must simply be described as a project for the suicide of the species’.<sup>18</sup> Ramsey believed that humanity’s attempts to play God are likely to unleash a Pandora’s box of uncontrollable forces. Thus, his deontological-sounding theological appeals function to give support to what are ultimately

consequentialist concerns.<sup>19</sup> Nevertheless, despite his pessimistic predictions of humankind's fate, it was Ramsey's teleological argumentation based on the promotion of human benefit that shaped his response to genetics and allowed him—along with Fletcher—to approve of certain interventions such as genetic screening:

Should the practice of such medical genetics become feasible at some time in the future, it will raise no moral questions at all—or at least none that are not already present in the practice of medicine generally . . . [Although] The science of genetics (and medical practice based on it) would be obliged both to be fully informed of the facts and to have a reasonable and well-examined expectation of doing more good than harm by eliminating the genetic defect in question . . . In making genetic decisions to be effected by morally acceptable means, the benefits expected from a given course of action must be weighed against any risk (or loss of good) incurred.<sup>20</sup>

These writings, Catholic and Protestant, represent two recurring tendencies in Christian approaches to genetic intervention based on differing visions of the legitimate scope of human interaction with the world. For instance, a typically Protestant 'created order' approach in the tradition of Paul Ramsey is found in Oliver O'Donovan's *Begotten Or Made?*<sup>21</sup> Karl Rahner's positive Catholic theological anthropology informed his interventionist approach to nature in the early essay 'Experiment: Man'.<sup>22</sup> His later essay 'The Problem of Genetic Manipulation' is less naively optimistic.<sup>23</sup>

Nevertheless, despite these differing approaches, most Christians remain open to the new genetic possibilities because of their positive contribution to human wellbeing. Theological colourings are often applied to these outline sketches of nature in order to enrich the vision. Oliver O'Donovan reminds Christians of the need to 'confess their faith in the providence of God as the ruling power of history'.<sup>24</sup> Humans show respect for God's dominion through attentive obedience to the immanent laws of creation.<sup>25</sup> Positive attitudes to technological intervention into nature are expressed through the theological idea of humans as free co-creators with God, participating in the work of bringing the earth to fulfilment. This theme is invoked by the Protestant theologian, Ronald Cole-Turner, who argues that humans restore creation and act as participants in redemption when they use medicine to overcome genetic defects.<sup>26</sup> More frequently, the language of humans as stewards or viceroys is employed to impart the idea of humanity's ongoing responsibility to care for and maintain God's creation. The notion of stewardship performs a useful mediating role between the non-interference 'natural order' and interventionist 'masters of the universe' approaches. The stewardship theme is usefully deployed in a Church of Scotland report on the use of genetically modified animals, and it functions as a means of placing limits on the extent to which humans can exploit their fellow creatures.<sup>27</sup>

The selection of writings presented here comprises only a tiny fraction of the Christian responses to genetics. They have been chosen in order to indicate the pervasiveness of the two main overarching narratives of nature that inform Christian judgements on any number of scientific and technological innovations that call for moral evaluation. Yet, they also show that Christians of all hues tend

to greet genetic medicine favourably, while acknowledging both its challenges and the proper limits of medical research in terms of respect for human rights. In other words, Christians, on the whole, believe that the promised benefits create an overwhelming case for the further development of genetic medicine. This is not to say that Christians might not also perceive a role for themselves in witnessing to an alternative set of values and priorities to those of either the 'herd' or the 'superman', thereby challenging prevailing societal norms about normality and perfectibility that infect the popular consciousness on genetics. Neither is it to exclude the important insights and traditional wisdom that Christians can bring to bear on the life experiences of suffering and death, and the offering of hope, compassion, companionship and so on—thus providing a more sober and less materialistic appreciation of the medical goals of longevity, preservation of life, and quality of life. **E&M**

## References

- 1 Verbatim transcript from BBC website, 26 June, 2000, 'Scientists crack human code' ([http://news.bbc.co.uk/1/hi/english/sci/tech/newsid\\_805000/805803.stm](http://news.bbc.co.uk/1/hi/english/sci/tech/newsid_805000/805803.stm)).
- 2 Pius XII, 'Moral Aspects of Genetics', *Address to the First International Symposium of Genetic Medicine*, Sept. 7, 1953 (*Acta Apostolicae Sedis* 44 [1953], 605).
- 3 John Paul II, 'The Ethics of Genetic Manipulation', *Address to the World Medical Association*, Oct. 29, 1983 (*Acta Apostolicae Sedis* 76 [1984], 389-402).
- 4 John Paul II, *Address to the Pontifical Academy for Life*, Nov. 20, 1995 (*Acta Apostolicae Sedis* 88 [1996], 668-71).
- 5 cf John Paul II, *Address to the 18th International Congress on Organ Transplants*, Aug. 29, 2000, n.7 (*Acta Apostolicae Sedis* 92 [2000], 822-26); Pius XII, *Address to the Italian Association of Cornea Donors and to Clinical Oculists and Legal Medical Practitioners*, May 14, 1956 (*Acta Apostolicae Sedis* 48 [1956]).
- 6 cf John Paul II, *Address to the 18th International Congress on Organ Transplants*, Aug. 29, 2000, n.8 (*Acta Apostolicae Sedis* 92 [2000], 822-26); Pontifical Academy for Life, *Declaration on the Production and the Scientific and Therapeutic Use of Human Embryonic Stem Cells*, Aug. 25, 2000, n.5.
- 7 For an excellent discussion of these contrasting attitudes to nature see Linda Woodhead, 'Human Genetics: A Theological Response' in I. Torrance, ed., *Bio-Ethics for the New Millennium* (Edinburgh: Saint Andrew Press, 2000) (on behalf of the Church of Scotland Board of Social Responsibility), pp. 82-96.
- 8 Pius XII, *Allocution on the Relief of Pain*, Feb. 24, 1957, n. 13 (*Acta Apostolicae Sedis* 49 [1957], 135).
- 9 J. Fletcher, 'Ethical Aspects of Genetic Controls: Designed Genetic Changes In Man', *New England Journal of Medicine*, Vol. 285, No. 14, Sept. 30, 1971, pp. 776-83, p. 780.
- 10 J. Fletcher, *The Ethics of Genetic Control: Ending Reproductive Roulette* (New York: Prometheus, 1988), pp. 159-60, 181 (first published by New York: Doubleday, 1974).
- 11 'Ethical Aspects of Genetic Controls: Designed Genetic Changes In Man', p. 780.
- 12 L. Woodhead, 'Human Genetics: A Theological Response', p. 83.
- 13 P. Ramsey, 'Shall We "Reproduce?" II. Rejoinders and Future Forecast', *Journal of the American Medical Association*, Vol. 220, No. 11, June 12, 1972, pp. 1480-5, p. 1484.
- 14 P. Ramsey, *Fabricated Man: The Ethics of Genetic Control* (New Haven: Yale University Press, 1970), p. 55.

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- 15 *Fabricated Man*, p. 138.
- 16 G. Dunstan, *The Artifice of Ethics* (London: SCM, 1974), p. 60.
- 17 *Fabricated Man*, pp. 32-9.
- 18 *Fabricated Man*, p. 159.
- 19 cf *Fabricated Man*, pp. 52-9.
- 20 *Fabricated Man*, pp. 44-5, 57-8.
- 21 O. O'Donovan, *Begotten Or Made?*, (Oxford: Clarendon, 1994).
- 22 K. Rahner, 'Experiment: Man', *Theology Digest*, Feb. 1968, pp. 57-69 (the essay was first delivered in September 1965).
- 23 K. Rahner, 'The Problem of Genetic Manipulation', *Theological Investigations*, Vol. 9 (New York: Crossroad, 1972), pp. 244-52.
- 24 *Begotten Or Made?*, p. 13.
- 25 *Begotten Or Made?*, p. 5.
- 26 R. Cole-Turner. *The New Genesis: Theology and the Genetic Revolution* (Louisville, Kentucky: Westminster/John Knox Press, 1993).
- 27 Society, Religion and Technology Project, 'GM Animals, Humans and the Future of Genetics', Appendix V, *Board of National Mission Deliverance to the General Assembly of the Church of Scotland*, May 2001, para. 2.

# TWIGS OF TEREBINTH: THE ETHICAL ORIGINS OF THE HOSPITAL IN THE JUDEO-CHRISTIAN TRADITION

WILLIAM P. CHESHIRE, MD

Of all earthly institutions, the hospital most closely measures both the scientific attainment and the compassion of a society. Our world has been blessed with children's hospitals, cancer hospitals, mission hospitals, community and university hospitals, as well as countless general hospitals structured around religious and secular administrations. Most citizens of developed nations have access to tertiary care hospitals, which represent the very crown of medical achievement. In these multispecialty centers rigorous education combines with innovative research, as altruistic men and women skillfully apply cutting-edge technology to the care of patients in the ongoing fight against disease.

For all their diversity, these hospitals share a common ethical origin. Although sickness has been with us since the days of Genesis 3, hospitals emerged much later. Why did hospitals appear at a particular time in history? What were the values and beliefs of the people who originated them? What did they know that previous generations and other cultures had not understood? What motivated such tangible expressions of caring that would inspire the pattern for a lasting institution of healing? The answers to these questions should interest anyone today who visits the modern hospital, whether to provide or to receive health care.

## **All Who Are Weary and Burdened**

William J. Mayo asserted in 1926 that "The hospital should be a refuge to which the sick might go for relief as they went before our Savior, their distress the only condition of admittance, not their social or financial status, race, or creed."<sup>1</sup> Though charity is as indispensable as technical competence, Dr. Mayo thought it essential to emphasize the greater virtue of charity, which does not reject sickness as shameful, but rather treats the suffering person preferentially. He did not consider the context of a secular institution to be incompatible with acknowledging what has been, for so many caregivers, the source of this ethical principle of charity in the life and person of that gentle healer from Nazareth. These words of Dr. Mayo point directly to the moral cornerstone heeded by so many of medicine's builders, who for inspiration have lifted their eyes from the scalpel to the Great Physician, Jesus Christ. In the hearts of those who walk with Jesus awakens a grateful passion to follow the biblical mandate essential to the health professions—to love one's neighbor (Gen 18:4-5; Lev 19:18, 34; Luke 10:27-37; John 13:34; Gal 6:10; Heb 13:1-2, 1 John 3:11).

That the first hospitals were Christian is a conspicuous mark upon the landscape of history.<sup>2,3,4</sup> This landscape is rich, to be sure, with medical discoveries and healing traditions from diverse civilizations, including the Greeks, the Arabs, the Chinese, the Hindus, and the Native Americans, to name just a few. These cultures even produced some healing temples, spas, and clinics. But the record of antiquity prior to and apart from the influence of Christianity is astonishingly blank when it comes to the hospital as we know it. The hospital is no less than a refuge wherein a community of people share a commitment to the consistent and organized provision of medical, surgical, and nursing care for the healing of anyone who comes who is sick.

The emergence of hospitals during the first few centuries of the Christian era testifies to the earnestness and, if the reader will accept it, also the validity of the conviction of their founders that Jesus of Nazareth, descendent of Abraham and David, the wounded healer of Isaiah 53, assuredly was the long-awaited Messiah of Israel. Acts of healing saturate the Gospel narratives, which proclaim that in Jesus the kingdom of God has at last broken in upon our hurting world (Matt 11:5, Luke 10:9). His kingdom holds the promise of fullness of life (John 10:10) and the certain hope of the restoration of all things (Matt 17:11, Acts 3:21, 1 Pet 5:10). To the sick Jesus offers profound encouragement through his assurance that, in him, suffering has purpose and death is defeated.

### **Twig of Terebinth**

The Church Father Jerome rejoiced at the founding in Rome in 394 A.D. of the first hospital in Europe, observing that Fabiola had thus transplanted a “twig from the terebinth of Abraham upon the Ausonian shore.”<sup>5</sup> St. Jerome, who had learned Hebrew from a Jewish convert who came to him like Nicodemus by night, would have been familiar with the phrase “terebinth of Abraham,” the ancient Jewish expression for a hostel.<sup>6</sup> The faith of Abraham and the images it evokes in Jewish tradition deserve close examination. For it is beneath the terebinths of Mamre, where Abraham set up his tent, that we discover the spiritual genesis of the hospital.

While the beginnings of hospitals are recorded in the history of the Christian church, the full story is older still. To apprehend its origins we must look back to the Hebrew patriarchs and prophets and to the words of the LORD God who instructed Israel how to treat the sick. By so doing, we may realize that the Christian values that shaped the development of hospitals ultimately trace their roots back to the Jewish faith out of which Jesus taught (Matt 5:17, Luke 24:44, Rom 11). The signposts of this faith of Abraham (Rom 4:16, Gal 3:14), which leads to everlasting life, are ever available in the revealed Word of God, the Bible.

### **The Lord Provides**

The LORD himself initiated the practice of visiting the sick when he appeared to Abraham by the terebinth trees of Mamre during the pain that would have followed his circumcision (Gen 18:1). For the rest of his years Abraham must have been reminded of that visitation and his soul comforted every time he lifted his eyes to gaze upon a terebinth. This magnificent symbol of refuge and



refreshment, its roots drawing water from an underground aquifer, its enormous branches stretching heavenward, the terebinth stood as a solitary source of welcome shade under the burning desert sun.

Terebinth, *אֵלֹן* (*elon*), sometimes translated “oak” from the pictorial Hebrew language, suggests strength and derives from the root *אֵיל* (*ayil*), meaning “ram.” So also when Abraham lifted his eyes atop Mt. Moriah, he saw the ram that God provided as a substitute for the sacrifice of his only son (Gen 22:13). Jesus said that “Your father Abraham rejoiced to see my day, and he saw it and was glad.” (John 8:56, NKJ). The children of Abraham (Gal 3:7) may likewise rejoice in the resources for healing that God has provided through hospitals and appreciate in these twigs of terebinth the ministry birthed by believers in God’s only Son, who was sacrificed for us.

### Abraham’s Hospitality

Jewish tradition credits Abraham as being the father of hospitality. Just as the Church Father Jerome had likened the founding of a hospital to the planting of a terebinth tree, extrabiblical Jewish literature construed the beginning of a tradition of hospitality from Abraham’s planting a tamarisk tree in Beersheba (Gen 21:33). According to Jewish lore, the Hebrew word *אֶשֶׁל* (*eshel*), meaning “tamarisk” or “grove,” stood for the *אֶשֶׁל* (food), *אֶשֶׁל* (drink), and *אֶשֶׁל* (escort) provided by Abraham.<sup>7</sup> Noticing that rearranging the first two letters made the word *שְׂאֵל* (*sha’al*), meaning “ask,” rabbinic midrash supposed that the word tamarisk referred metaphorically to an inn where Abraham received wayfarers and provided food and drink—whatever was asked for—including basic medical attention when required.<sup>8</sup>

According to legend, after his guests had enjoyed hospitality, they would thank Abraham. But Abraham would refuse their gratitude and teach them that their true host, who deserved thanks and praise, was the Ruler of heaven and earth, the one God who wounds and heals, who forms the embryo in the womb and brings life into the world, who causes the plants and trees to grow, who kills and makes alive.<sup>9</sup> Hospitality from Abraham’s viewpoint was inseparable from acknowledgement that the true source of all blessings, health included, was the living God.

### I Was Sick and You Visited Me (Matt 25:36)

To the practice of hospitality Scripture added the teaching of mercy. And from their covenantal relationship with the Author of all mercy, the Jewish sages derived the practical ethic of concern for the sick. This responsibility extended to the individual as well as the community. For example, Jewish tradition interpreted the instructions to “keep the way of the Lord” (Gen 18:19) and “walk after the Lord” (Deut 13:4) to include the visiting of the sick (Gen Rabbah 49:4), a duty known as *bikkur cholim*. Scripture clearly established a duty to the sick (Exod 21:18-19; Lev 25:35-37, Heb 13:2) and to the stranger (Lev 19:34). In addition, rabbinic tradition taught that, by visiting the sick, one removed a portion of the patient’s suffering, whereas abandoning the sick was like shedding blood.<sup>8</sup> Prominent persons were not exempt from this obligation (Nedarim 39b),

nor could a patient be excluded on the basis of religion (Lev 25:35), for withholding mercy would dishonor the divine Name.<sup>10</sup> The Jew was also obligated to pray for the sick (Shabbath 12a-b).

Out of God's covenant with the Jews, the world received the principle that, in their actions toward others, people of faith are responsible to a righteous God who dispenses mercy and judgment. Such a people possessed the ethical basis to become dedicated ministers of healing.

### Sanctuaries of Mercy

A possible prototype of the hospital was leperous King Azariah's isolated house recorded in 2 Kings 15:5 and 2 Chronicles 26:21. While this was an example of a house set apart for a leper (King Uzziah) during biblical times, Scripture does not indicate whether the afflicted king opened his doors to his less fortunate co-sufferers.

Jewish tradition later contributed an important forerunner of the hospital. During the Second Temple period, Jews organized town brotherhood societies, known as *chaber ir*, which concerned themselves with charitable deeds including visiting the sick.<sup>8</sup> These societies continued into the Middle Ages and by the eleventh century had established hostels for the poor and sick. This hostel, the *hekdesh*, by modern standards was usually a primitive arrangement and consisted of one or two rooms with as many as six beds, ill-equipped for nursing, and without any regular medical attention.<sup>11</sup>

The literal meaning of *הַקְּדֵשׁ* (*hekdesh*), which derives from the Hebrew word *קָדֹשׁ* (*kadosh*), meaning "holy," was a place consecrated for the poor. Such refuges for the wayfarer and the sick may have existed in ancient times.<sup>12</sup> Perhaps it was the *hekdesh* to which Jesus alluded in the parable of the good Samaritan (Luke 10:34).

Yet despite the rich Hebraic concept of mercy and the emphasis on hygiene found in many of the Mosaic laws, public hospitals did not develop within ancient Israel. One reason, according to the 19th century Jewish physician Julius Preuss, may have been that the establishment of an institution for the sick "would have signified a reversal of understanding, and an alienation of the deep-rooted concept of hospitality which was practiced without reservation and was actually considered to be a holy duty."<sup>8</sup> Still another reason may have been the following theological stumbling block.

### Be Ye Holy (1 Pet 1:16)

To the instruction of mercy Scripture added the command of holiness. God is at once "merciful and gracious" (Exod 34:6) and utterly holy, pure, and righteous. The Holy One, blessed be he, commanded his people, "You shall be holy; for I am holy" (Lev 11:44, NKJ).

But sin had breached the relationship between humanity and the holy God. Scripture solemnly disclosed the seriousness of that breach. Anyone whose illness or deformity showed that he or she might be tainted by sin was not permitted to approach and profane the sacred altar of God (Lev 21:18-23). To do

otherwise meant that person must be cut off from God's presence (Lev 22:3). The high priest was forbidden to become ceremonially unclean by entering a place where there was a dead body (Lev 21:11). By implication, by entering any place where the sick were dying, he would risk unintentional transgression of the commandment. Since the children of Israel were called to be "a kingdom of priests and a holy nation" (Exod 19:6), the prohibitions on priests were eventually applied more broadly.

In the Torah, Israel had received God's own pattern for righteousness. But in applying their interpretation of its teachings they would collide with a dilemma that no amount of analysis or diligence could resolve. How could they exercise the Lord's standard of mercy while maintaining the thorough separation from uncleanness that holiness required (Lev 15:31)? Could purified hands reach out to the sick or to sinners without becoming contaminated? To walk the path of holiness meant, so it seemed, occasionally if not systematically to withhold mercy from those who most desperately needed it—those afflicted by the consequences of sin.

And yet the prophet Ezekiel during his day reminded the wayward shepherds of Israel of the importance of mercy, hurling at them this rebuke: "You have not strengthened the weak or healed the sick or bound up the injured." (Ezek 34:4, NIV). Ancient Israel had fallen short of the mark of caring for its sick after the Lord's example of caring for Israel. (Christians today are not immune to the same error.)

The resolution of this problem would require, not a multiplication of commandments, but an encounter with the divine coalescence of all holiness and mercy in the person of the Messiah.

### **Love Your Neighbor as Yourself (Lev 19:18)**

The renowned rabbi from Nazareth bids us come in our imaginations to the place where the roads of holiness and mercy meet. Jesus' parable in Luke 10:30-37 concerns a man lying by the roadside robbed, beaten, nearly dead. Members of the most respected echelons of that society, a priest and a Levite, in their unwillingness to defile a limited form of holiness, neglect to honor God's incomparable holiness. Keeping their distance they pass him by. But a Samaritan, an outcast, shows him mercy. Salvation comes from the one who fulfills the Torah, yet is the least expected savior. So compelling is this parable that centuries later many a hospital would be named after the good Samaritan.

### **Unmeasurably Merciful**

In his words Jesus was in harmony with the teaching of the prophets (Hosea 6:6, Micah 6:6-8, Matt 12:7), that God prefers mercy to sacrifice. In his life and death Jesus demonstrated that God's mercy exceeded even the prophets' expectations. For God had sent into the world his only Son to open the way for sinners to be reconciled to him—sinners, because those who are well have no need of a physician (Matt 9:12-13). He humbled himself to become a man, suffered as we suffer, was crushed that we might be covered with mercy, was bruised that we might be healed. He submitted to an agonizing execution on the

cross, so that through his atoning sacrifice we might be spared the terrible penalty of sin. The risen Lord Jesus, having conquered sin and death, freely offers those who come to him life everlasting.

Who can comprehend the love of God, who did not keep holiness to himself but chose to sanctify his Name by mercifully extending it to such unworthy creatures as ourselves? He loves us so much that he allowed his Son to become defiled, allowed "him who knew no sin to be sin for us, that we might become the righteousness of God in him" (2 Cor 5:21, NKJ). There is no greater gift. The cross was the catalyst that would free the followers of Jesus to keep his commandments (John 14:15) in fulfillment of the ethical principles of the Torah concerning the care of the sick. A people made righteous by God could not be defiled by extending mercy to others.

### **Shadows of Things to Come**

The Judeo-Christian tradition of the hospital thus traces its heritage to Abraham's tent amidst the terebinths of Mamre. This historical parable from the first book of the Bible inspired the ancient Jewish traditions of hospitality, visiting the sick, and the *hekdesht*, all of which exemplified the ethical principles needed for hospitals to develop. But these were mere shadows of a more excellent ministry that was to come (Heb 8:6, 10:1). If keeping the Torah had produced such traditions and teachings, how much greater would be the response to the fullness of God's revelation of himself in the Messiah?

As Christianity expanded out from Jerusalem into the known world, as many hearts as received this faith were transformed through an encounter with the very face of mercy in the Messiah of Israel. Communities of Christians dedicated to the welfare of all sorts and conditions of sick and afflicted people initiated a profound revolution in caring in which hospitals could be conceived.

The moral foundation upon which hospitals first appeared originated in the faith of the people of the Bible. This faith and its implications for healing, which the world received through the Jews, came to fruition through Jesus the Jewish Messiah. No other religious, philosophical, or social system devised by civilization throughout the course of history can be credited with the origin of the hospital.

### **Greek Gods and Roman Ruins**

During the earliest years of Christianity, the most popular healing resources among first century Gentiles were the temples of Asclepios. While these Greek temples represented one of the most prominent achievements of ancient medicine, they were in no sense hospitals but rather a blend of pagan shrine and health spa which made ample provision for magical conjurings but not for lodging of the sick.

Considering the significant moral and empirical contributions from Hippocrates, it is interesting to ask why Greek medicine failed to bring forth hospitals. The flaw may have been the prevailing idea in Greek philosophy of an ontologic dualism which strictly distinguished soul from body. The Platonic

teaching that the human body was an unimportant prison for the vital mind-soul, and something from which to be liberated, severely limited any ethos for healing the body.

The pagan religions, in fact, tended to abandon the sick whom they thought had incurred the disfavor of the gods. The care of the sick was certainly not the main purpose of Roman military medical facilities, for example, which were designed solely to return the soldier to the battlefield. Extensive treatment, nursing care, and provision for the poor were never considered.<sup>13</sup>

### **Ministry of Healing**

The Hebraic understanding, by contrast, viewed the body, mind, and soul as a unity that framed a whole person, a gift from God, created in the divine image (Gen 1:26). The Bible emphasized that the human body came with the responsibility to take care of it. Properly understood, the human body was a vessel which, if used correctly, could carry out God's purposes.

Supreme affirmation of the value of the human body came upon Israel in the Incarnation. Since God had humbled himself to become a man, no longer could the dignity of any human being be disregarded. It is no coincidence that the birth of the hospital, a unique historical development, followed the singular historical birth of the Son of God. Once "God was manifested in the flesh" (1 Tim 3:16), there could be no doubt that it was good to care for the bodily needs of other human beings.

This biblical understanding proved exceedingly fruitful. Into first century Hellenistic culture arrived the early followers of the risen Jesus of Nazareth with their heartening ministry of healing bodies as well as souls. It is no wonder that a suffering world turned avidly toward Christianity in search of salvation of body and soul.

Remembering that Jesus had "suffered for us" (1 Pet 2:21), compassion for the suffering welled up in the hearts of believers. Grateful that their sins were forgiven, and liberated from the paralyzing hold of guilt and condemnation (Rom 8:1), they experienced the freedom to do good works joyfully. And the Comforter, the Holy Spirit (John 14:26), enabled these believers to minister to the sick with love as never before.

This ministry began in humble servitude, after Jesus' example of washing his disciples' feet (John 13:14). This ministry extended to Jew and Gentile, indeed to all people, for every human being is created in the image of God. And this ministry of mercy required touching even those considered to be unclean (Luke 8:46, 10:34), just as Messiah had died for us while we were yet sinners (Rom 5:8).

Remembering that Jesus had been mocked, beaten, abandoned, then executed on the cross, later generations who would claim his name could not bear to look upon suffering and remain idle. No longer could the sick be regarded as rejected by God, for Jesus demonstrated that God desires to be with the poor in spirit and shares in our sufferings. Pellegrino and Thomasma summarize:

Being sick was no longer a disgrace, a public sign of individual sin, as Job's friends had so belligerently insisted. Rather, illness came to be accepted as the result of Original Sin shared by the whole of humanity (John 9:2-3, 11:4) . . . . The sick person was not to be rejected but was owed a special level of solicitude. The Christian was to see Christ in every suffering man and woman (Rom 12:15; 2 Cor 1, 2, 7, 10).<sup>14</sup>

Jesus also spoke of a mystery that continues to quicken the hearts of believers who care for the sick: "I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me" (Matt 25:40, NIV). These words urge us to apply the example Jesus has shown us in caring for our neighbors (John 13:15). In the simple act of reaching out to others in mercy, divine grace somehow infuses the human gesture of charity. In the shared moment God dwells with caregiver and sufferer (Matt 18:20).

### **Communities of Faith**

Christian healing began through communities of faith that "continued steadfastly in doctrine and fellowship, in the breaking of bread, and in prayers" (Acts 2:42). Into the hearts of these obedient believers the Holy Spirit poured the love of God (Rom 5:5). Such love bore the fruit of occasional healing miracles as well as the sustained ministry of aid to those afflicted souls who awaited complete healing in the life to come. Both types of healing affirmed the gospel of salvation through faith in the risen Messiah (Acts 3:6).

Christian fellowship later gave rise to institutions of healing. There, dedicated individuals presented themselves as living sacrifices (Rom 12:1) unto their loving heavenly Father on behalf of others. These humble servants followed the example of the healing ministry of Jesus Christ, who had selflessly laid down his life for us (John 3:16).

The Bible contains no architectural plans by which to erect hospital buildings, but thankfully it does supply a blueprint for the soul. Were hospitals mere constructions of brick and mortar, if they had bulging budgets and the finest technology yet lacked compassionate caregivers, they could offer nothing of lasting value to the sick and hurting (1 Cor 13).

### **Earliest Hospitals**

The Roman Emperor Constantine prepared the ground by issuing in 313 A.D. an edict of religious toleration, which gave Christians the freedom to establish public hospitals. Among the most ancient hospitals was the Edessa plague hospital founded in 350 by St. Ephraim Syrus. Most famous was Basilius, founded in Cesarea in 369 by St. Basil.<sup>13,15</sup> This Bishop of Cesarea and author of doctrinal treatises was deeply moved by the life of Jesus, whom he named the "Great Physician," who "endured to suffer with us in our infirmities and was able to come down to our weakness."<sup>16</sup> Imitating divine humility, Basil ministered in person to the poor and was revered as a shepherd of souls. He owned but a single worn-out garment. Lepers, who were often entirely abandoned, he took in himself, treating them as family, and despite their unattractive appearance he was not afraid to kiss them.<sup>17</sup>

## The First Transplants

In the same year that Fabiola planted in Rome her “twig of terebinth,” 394 A.D., an ancient terebinth six furlongs from Hebron was passing away. That terebinth was known to the first century Jewish historian Josephus as the very terebinth of Abraham, which local tradition claimed had continued since the creation of the world.<sup>18</sup> According to later Jewish accounts, this patriarch of trees had withered and died during the reign of Theodosius, which was from 392 to 395.<sup>19</sup> But if what had passed away was glorious, what remained was much more glorious (2 Cor 3:11). For Fabiola’s renowned hospital would be a model for an institution of healing that would transform the world for ages to come.

The balm for which Jeremiah longed to soothe the unhealed wounds of Israel had come and would be shed abroad for many. This “balm in Gilead” to which the prophet referred (Jer 8:22) was another name for the resin drawn from none other than the terebinth tree,<sup>20</sup> and which in ancient times was applied medicinally.

By the time the Church began to cultivate this new grove of terebinths, it was already losing sight of the reality that its own broadening branches had been grafted into a Jewish tree (Rom 11:17-18). The rich foliage of these early hospitals nevertheless magnified the Hebraic traditions of hospitality and mercy in which they were rooted. From twigs of terebinth the Church constructed tabernacles of healing in which God’s Spirit could dwell with those who suffered. In this way the offshoots of Abraham’s ancient tree would ever point to the true Healer, Jesus, who said, “Before Abraham was, I AM.” (John 8:58).

## Monastic Hospitals

In the early Middle Ages, buildings known as *xenodochia* attached to churches became places of refuge for the poor and sick. Many of them later became the property of monasteries, which assumed the responsibility for organized medical care in Europe for more than five hundred years. Skilled physicians, many of them monks trained by apprenticeship, could be found at some monasteries. Monks of the Benedictine order, however, were forbidden to study medicine but instructed to cure disease solely through prayer for divine intervention.

The Christian hospitals of the Middle Ages were the first ever to be devoted to long-term support of the diseased, the poor, and the downtrodden. The helping of the sick had begun dominating Christian life, especially once the Crusades brought to Europe epidemics of typhus, smallpox, leprosy, plague, and many other contagious diseases. With the arrival of the Black Death or bubonic plague in the 14th century, hospitals increasingly became terebinths of weeping (Gen 35:8). But where disease abounded, grace abounded much more (Rom 5:20). The number of hospitals proliferated, and many hospital orders were founded, such as the Order of the Knights of the Hospital of St. John of Jerusalem, the Order of Lazarus which was devoted to the care of lepers, and the Order of the Holy Ghost.

### **The Twig Makes Aliya**

Jerusalem's first hospital opened its doors in 1844 under the direction of the London Society for Promoting Christianity Amongst the Jews.<sup>21</sup> Born out of the 18th century evangelical revival in Anglican churches in England and America, this ministry, which continues today by the name Shores (Hebrew for *root*), also built the first Protestant church in the Middle East—Christ Church, within the walls of Jerusalem's Old City. These Christians saw in the prophetic writings of the Old Testament that God was not finished with the Jewish people. Anticipating the return of the Jewish people to their Land, the Society undertook to bless Jerusalem's poor and sick by providing for their medical needs, often gratis, and for their spiritual needs, with copies of the Tanakh (Old Testament) and Brit Hadashah (New Testament) at the patients' bedsides. The result was a complete renewal of the public health system of Jerusalem as well as desperately needed relief during and following two world wars. This hospital provoked not only controversy but also jealousy (Rom 11:11).

### **From Mamre to Minnesota**

Just as "Luke the beloved physician" (Col 4:14) journeyed alongside the Apostle Paul, in the best medical traditions scientific curing prospers when accompanied by spiritual caring.

In the early days of the Mayo Clinic in Rochester, Minnesota, Dr. William J. Mayo was treating a seemingly hopeless case. He said to Sister Joseph, "I know she can't live, but you burn the candles and I'll pay for them." Miraculously, the patient lived.<sup>22</sup>

The success of the Mayo brothers' surgical practice was due in part to the Franciscan Sisters with whom they affiliated. These frugal Roman Catholic nuns raised the funds to build St. Mary's Hospital and took on all of the nursing and housekeeping tasks. Their unceasing toil and continued willingness to offer whatever sacrifice was needed in the care of their patients exemplified a level of dedication surpassing mere earthly motivations. One notable result was a very low inpatient mortality rate, which helped overcome the public distrust of hospitals in a time when improved antisepsis and advances in medical, surgical, and nursing training were just beginning to transform the hospital from its reputation in those days of asylum for the unwanted sick and poor to a place of healing. To this the sisters added the ineffable benefits of prayer.

The Christian healing ethic recognizes no case of human suffering to be hopeless.

### **Return to the Terebinth**

The modern biomedical enterprise, particularly in the United States, has far surpassed the quality of health care available during any previous time in history. That is, except for the people Jesus healed completely in the few years before he went to the cross. We have much for which to be thankful. We should also be watchful that, in our enthusiasm for scientific advances, we do not sever hospital medicine from its sustaining biblical roots.



In the face of so many ethical dilemmas created by the ability of medical technology to determine matters of life and death, may we keep returning for wisdom, for moral guidance, and for renewal of our compassion to the terebinth of Abraham. Let us sit beneath the shade of its branches and seek the reliable council of the Great Physician, Jesus Christ, Messiah of Israel, until such time as he returns and wipes away every tear. **E&M**

## References

- 1 William J. Mayo, "Address delivered at the dedication of the teaching hospital of the University of Michigan," *Journal of the Michigan State Medical Society*, 1926, pp. 9-12.
- 2 Edmund D. Pellegrino and David C. Thomasma, *The Christian Virtues in Medical Practice*, Washington, D.C.: Georgetown University Press, 1996, p. 48.
- 3 Ronald L. Numbers and Darrel W. Amundsen, *Caring and Curing: Health and Medicine in the Western Religious Traditions*, New York: Macmillan, 1986.
- 4 Albert S. Lyons and R. Joseph Petrucelli, *Medicine: An Illustrated History*, New York: Abradale Press, 1987.
- 5 "Letter to Pammachius," 397 A.D., *The Principal Works of St. Jerome*, trans. by W. H. Fremantle, G. Lewis, W. G. Martley, 1892. In: P. Schaff and H. Wace, *The Nicene and Post-Nicene Fathers*, in: *The Master Christian Library*, Albany, OR: Sage Digital Library, 1997. St. Jerome (ca. 342-420 A.D.), translator of the *Vulgate Bible*, is also known for having built a hospital in Bethlehem.
- 6 Philip Schaff, *History of the Christian Church*, Grand Rapids: Eerdmans, 1910, Vol. III, p. 970.
- 7 Louis Ginzberg, *The Legends of the Jews*, Philadelphia: The Jewish Publication Society of America, 1925, Vol. V, p. 248.
- 8 Julius Preuss, *Biblical and Talmudic Medicine*, trans. by F. Rosner, Northvale, NJ: Jason Aronson, 1993, pp. 441-5.
- 9 *Genesis Rabbah* 54:6. Also Ginzberg, Vol. I, pp. 270-1.
- 10 Elliot N. Dorff, "The Jewish Tradition," in: Numbers and Amundsen, pp. 5-39.
- 11 "Hekdesh," *Encyclopedia Judaica*, Vol. VIII, p. 1033.
- 12 Harry Friedenwald, *The Jews and Medicine*, Baltimore: The Johns Hopkins Press, 1944, pp. 516-7.
- 13 Lyons and Petrucelli, p. 272.
- 14 Pellegrino and Thomasma, p. 47.
- 15 Arturo Castiglioni, *A History of Medicine*, trans. by E. B. Krumbhaar, New York: Alfred A. Knopf, 1941, p. 256.
- 16 St. Basil, "Letter to a fallen virgin," *Treatise de Spiritu Sancto: The Nine Homilies of the Hexaemeron and the Letters of Saint Basil the Great, Archbishop of Caesarea*, trans. by the Rev. Blomfield Jackson, London, 1894, p. 391. In: *The Master Christian Library*, Albany, OR: Sage Digital Library, 1997.
- 17 Schaff, Vol. III, p. 902.
- 18 Flavius Josephus, *The Wars of the Jews*, Book 4, Ch. 9, Section 7, in: *The Works of Josephus*, trans. by W. Whiston, Peabody, MA: Hendrickson, 1987, p. 689.
- 19 Ginzberg, Vol. V, p. 235.
- 20 Flavius Josephus, *The Antiquities of the Jews*, Book 8, Chapter 7, translator's footnote, in: *The Works of Josephus*, trans. by W. Whiston, Peabody, MA: Hendrickson, 1987, p. 225.
- 21 Kelvin Crombie, *For the Love of Zion*, London: Hodder & Stoughton, 1991.
- 22 Helen Clapesattle, *The Doctors Mayo*, Minneapolis: University of Minnesota Press, 1941, p. 261.

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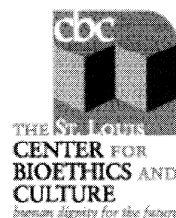
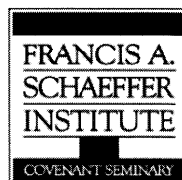
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## THE NEW EUGENICS AND THE NEWBORN: THE HISTORICAL “COUSINAGE” OF EUGENICS AND INFANTICIDE

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Nearly five months after the U.S. Supreme Court handed down its *Roe v. Wade* decision, striking down all state abortion prohibition statutes, a renowned pediatric surgeon gave the commencement address at Wheaton College. It was an address that was so understandably shocking, the evangelical college administration departed from their time-honored practice of printing the speech in their alumni magazine.

The speaker was Dr. C. Everett Koop, then Surgeon-in-Chief of Philadelphia’s Children’s Hospital and Professor of Pediatric Surgery at the University of Pennsylvania. In his speech, Dr. Koop bristled at Justice Blackmun’s recent statement in *Roe* that the Court “need not resolve the question of when life begins.” Koop thundered to his young audience:

Indeed we not! Where does this lead? It leads to infanticide and euthanasia. If the law will not protect the life of a *normal* unborn baby, what chance does a newborn infant have after birth, if in the eyes of a Justice Blackmun the baby might be *less than normal*[?]<sup>1</sup>

Then Dr. Koop may have stepped on the “third rail” of commencement etiquette by posing the following hypothetical to the graduating class and their parents:

I wonder how many people would be here today if their parents could have had a legal abortion or if a liberal permissive society could have eliminated all of the babies *thought not to be perfect* shortly after birth.<sup>2</sup>

Although shocking and outrageous at the time, the subject of infanticide was just beginning to be discussed in the arcane publications and symposiums of academia.

Yet it was not so much a question of infanticide that Dr. Koop presented—*normal* newborns were not at risk. It was the possibility of eugenics or “eugenical choice” that was beginning to taint medical ethics—a contagion of discrimination that would travel from the medical journals and philosophy departments into hospital maternity wards, neonatal intensive care units, and courtrooms.

Eugenics, from the Greek for “good birth” (or “good heredity”), advances a hierarchy of human lives. It was a powerful social movement in the early twentieth century before being momentarily discredited by the Nazis, then returning. On the top are those lives well worth living—lives worth expending

resources upon—and on the bottom are those deemed worthless or burdensome or costly. For the disabled newborn (until recently, referred to by pejoratives such as “defective” or “deformed”), this hierarchy is a utilitarian justification for medical discrimination, a new brand of eugenics. Eugenics, however, seldom surfaces in a culture without being accompanied by socially sanctioned infanticide.

When *Roe v. Wade* was first handed down, many realized with horror that much of the Court’s reasoning could just as easily be used to defend infanticide. In 1973 there were few doctors more qualified than Dr. Koop to articulate the eugenic impact of *Roe* upon disabled newborns.<sup>3</sup> In his 1973 commencement speech, Dr. Koop shared several predictions that would result from *Roe*. With shocking clairvoyance, he foresaw that imperfect newborns would be at risk next because the Court “left the decision between feticide and infanticide very hazy by refusing to come to grips with the time life begins.”<sup>4</sup> Although this was not the legal holding of the case, Koop had identified a philosophical shift: from an ethic of equal human moral worth where *all* patients are cared for, to a hierarchical ethic where some are *no longer patients*.<sup>5</sup> “Neglect,” under euphemism, would be an acceptable treatment option for the disabled newborn. “Too costly” or “burdensome,” under proper euphemism, would be acceptable diagnoses.

Koop had hardly penned the words of the commencement speech he was about to give when he read in *Time* magazine that infanticide “choice” was being advocated. Dr. James Watson, co-discoverer of DNA’s double helix, was quoted as saying:

If a child were not declared alive until three days after birth, then all parents could be allowed the *choice* that only a few are given under the present system.... The Doctor could allow the child to die if the parents so chose and save a lot of misery and suffering.<sup>6</sup>

Watson, of course, was advocating the extension of the option of eugenic infanticide from a very “few” to all parents, just as abortion had recently been decriminalized and extended to all women.

## **Revival of Eugenics and Infanticide**

It is the purpose of this paper to argue that there is a historical “cousinage” between eugenics and infanticide, and that the New Eugenics contributes to a culture in which the disabled newborn is both unwelcome in life and unprotected in law.<sup>7</sup>

Infanticide is one of those perplexing taboos practiced in secrecy and sometimes prosecuted in criminal court, but rarely discussed. Just over a century ago, the topic of infanticide was hardly mentioned except in the context of the great social evils, such as slavery or child labor.<sup>8</sup> It was tragic, an inexplicable crime committed out of apparent desperation or insanity. Fifty years ago a researcher could hardly build a bibliography of articles by American academics or scholars that advocated infanticide.<sup>9</sup>

Today one will find hundreds of books, journal studies, and magazine articles on the topic. American newspaper reports of criminal infanticide or abandonment committed by desperate teenage mothers in denial is sadly commonplace. But the *abundance* of scholarly discussion of medical neglect as a treatment option for a disabled infant is new, and it began with a study published in 1973 in the *New England Journal of Medicine* by Raymond S. Duff and A. G. M. Campbell. These doctors documented 43 cases of withholding care from handicapped infants at Yale–New Haven Hospital, indeed breaking what they termed the “public and professional silence on a major social taboo.”<sup>10</sup> (Joseph Fletcher broke the silence in pastoral theology in 1968, by suggesting that Down’s syndrome infants be “put away” either in a sanitarium or “in a more responsible lethal sense”; he offered comfort to bereaved parents by saying there is “no reason to feel guilty” because such an infant is “not a person.”<sup>11</sup>)

In the wake of the Duff and Campbell article came several moral philosophers, psychologists, and other academics advocating eugenic infanticide. Some, such as Michael Tooley, even argue that newborns are not “self aware” true persons, and thus it is not a crime of murder to kill them. In arguments reminiscent of pre-Roe abortion advocates, Tooley points out that neonaticide is found in all cultures, and is a fairly common practice. Anthropologically, he argues, it has served an important role in human evolution since mothers need not waste time caring for infants with poor life outcomes.<sup>12</sup>

Princeton’s Peter Singer is the most outspoken advocate of infanticide in the bioethics arena, arguing that there are cases where it is not only permissible to kill a disabled child, it is probably ethically required. To Singer, outmoded religious inhibitions and ancient medical oaths need to be abandoned because they stop people from thinking for themselves.

Medical schools have also accommodated on this issue. It is common nowadays at medical school graduations to recite the Prayer of Maimonides or the Declaration of Geneva or a modern version of the Hippocratic Oath, as rewritten by faculty or students. The contemporary modifications revise or leave out the “I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion.”<sup>13</sup> (Philosopher Peter Singer’s utilitarianism would perhaps revise the Hippocratic oath into an imperative to “do no harm...to society.”)

## **Troubling Questions**

Why has the traditional Hippocratic Oath been “contemporized” or removed from medical graduation ceremonies? Why has there been so much discussion in the past thirty years of medicalized infanticide?

Many advocates claim that new technology and rising costs of care have created, by necessity, a kind of rationing or triage. Yet there has always been new technology. Costs have always risen. Triage and rationing are only appropriate in wartime, catastrophe, or famine (and it should be argued that peace and emergency food relief are better solutions than euthanasia of weaker members of society).

Another question: How can we explain the rise in the discussion of the permissibility of infanticide in the last quarter of the twentieth century, when there are fewer and fewer infants born disabled? It is amazing, following the eugenic logic of abortion, that a magnitude of over one million abortions annually for thirty years has not made the infanticide of imperfect newborns a moot point.<sup>14</sup> After all, with so many tests available to detect imperfections before birth, and the elimination of so many imperfect, unwanted, or financially burdensome human beings *en utero*, who would need to discuss *ex utero* abortion?

The sorry fact is that legalized abortion has not made every child a “wanted” child. It has heightened the bar at the entrance gates of life at the expense of less-than-perfect newborns. The tolerance for imperfection is now lower. Expectations for healthy children are higher. Although childhood diseases have been eradicated, infant mortality has dropped, and children today are born healthier than in years past, there is greater discussion and advocacy of infanticide in academia than ever before. The reason: the New Eugenics brings with it many rationales to permit euthanasia of handicapped newborns. After all, “infanticide is euthanasia in an age group.”<sup>15</sup>

### **Burdens to the Body Politic**

Eugenics is not new to science and medicine. A term coined by Francis Galton in 1883, eugenics began as a movement to create a superior form of humanity by creating the conditions that would encourage the reproduction of the “fit” while discouraging the “unfit.”<sup>16</sup> Galton, in his book *Hereditary Genius*, argued that human beings should take control of their own evolution using breeding techniques known to science. The eugenics movement “spread rapidly in the early years of the twentieth century among the cultural elite and the intelligentsia....”<sup>17</sup> It was a blend of popular nineteenth century biological science and philosophy, and it appropriated the power of the state to achieve its end of improving the genetic shape of the populace.

In the first decades of the twentieth century in the United States, eugenic science was applied in two ways, through both “positive eugenics”—a program of encouraging marriages between “fit” couples to produce “fitter families” with many children—and “negative eugenics.” While “positive eugenics” used persuasion, “negative eugenics” used coercion and was based upon the assumption that the genetically inferior were a threat to the state and therefore the state had to act in order to protect society as a whole.

The eugenics movement influenced federal legislation to restrict the influx of racially “deficient” immigrants. State laws were enacted to prevent, segregate, or sterilize the “unfit.” These laws were designed to “protect the class of socially inadequate citizens...from themselves” in an effort to “promote the welfare of society by mitigating race degeneracy and raising the average standard of intelligence.”<sup>18</sup> Alcoholism, crime, insanity, idiocy, imbecility, and epilepsy were thought to be hereditary. Such institutionalized people were, in the words of the Virginia Sterilization Act of 1924, “by the propagation of their kind a menace to society.”<sup>19</sup> By the mid 1930s, over half the states had eugenic sterilization laws on their books, and over 20,000 legal sterilizations had been performed.<sup>20</sup>

Eugenics is utilitarian and rejects equal human moral worth, therefore always creating a class of outsiders, burdens—even enemies—of the body politic.

Discredited momentarily by totalitarianism and the Nazis, the eugenics movement lost popular support. With the rise of new medical technologies, however, its hierarchical and selective ideology has been allowed to return with new force. The New Eugenics uses the power of the state but is uncoercive. It has adapted itself to embrace *some* of the ideals of a free society, but has enveloped itself in a legal theory of rights, choice, freedom, and privacy.<sup>21</sup> Rather than being *legislated*, its agenda is *permitted* by the rule of law (i.e., the expansion of rights). In the New Eugenics, the primary branch of government to expand its agenda is not the legislature, but the judiciary.

### **Ancient “Cousinage”**

There is an ancient cousinage between infanticide and eugenics. Historically, the one is seldom found without the other. They are related because both place blame upon the disabled infant for being unwanted, inconvenient, or a burden to parents or society. They promise relief from overcrowding or crime or burdensome medical expense. They promise to reduce poverty by reducing the poor. And they advocate viewing humanity through a bifocal “quality of life” lens where humanity is either standard or sub-standard. Here, the fit are allowed to survive, and nature, “red in tooth and claw,” is allowed to take its course, making its own life and death decisions.<sup>22</sup>

The lexicon of eugenics is one of prevention, selection, and enhancement. Infanticide is “the killing of a born infant by direct means or by withholding something necessary for its survival.”<sup>23</sup> Presenting itself as merciful and compassionate, infanticide is prominent in the eugenics agenda. Since ancient times great philosophers have advocated society’s disposal of unwanted children as a kind of eugenic triage at the entrance gates of life. In Plato’s ideal state, physically defective infants are eliminated in an obscure location.<sup>24</sup> Infanticide, however, is only one method of Plato’s eugenic control and planning. The philosopher recommends state regulations for marriages and births as a way to apply the knowledge of breeding to improve human beings:

...the best of either sex should be united with the best as often, and the inferior with the inferior, as seldom as possible; and that they should rear the offspring of the one sort of union, but not of the other, if the flock is to be maintained in first-rate condition.<sup>25</sup>

Aristotle’s eugenic plan for the state included a near-perfect citizenry where “nothing imperfect or maimed” is brought up. The state regulated the number of children a couple produced and if anyone exceeded the state permit, pregnancies would be ended by abortion.<sup>26</sup>

Eugenic infanticide was not just a philosophical topic for the ancients, it was commonly practiced and even mandated. The ancient Twelve Tables, the early Roman written legal code, required deformed children to be quickly killed.<sup>27</sup> Plutarch wrote that the Spartan system required newborns to be examined by the elders for a determination of whether the baby would be reared or sent to a

ravine to die. One scholar estimates ancient Athenian female infanticide rates may have been as high as ten percent (in a society with frequent wars, there was a preference for male children).<sup>28</sup> Soranus' ancient gynecological text contains a eugenic chapter listing criteria for determining whether a newborn child was worth rearing.<sup>29</sup>

### **Infanticide: From Barbaric Crime to Compassionate Medicine**

In the modern world, infanticide and eugenics continue their cousinage, eliminating the imperfect newly born that were not identified and eliminated *en utero*. In days past, infanticide was committed by midwives and parents (usually the birth mother).<sup>30</sup> Modern eugenic infanticide, however, involves an additional party: *an attending physician*. Here, the historical antecedents break down because the healing arts and the medical disciplines usually kept their distance from such practices.<sup>31</sup> The Hippocratic tradition forbade the healing arts from being used to bring harm to any patient. Medicine, protected by the oath to do no harm, reflected charity and compassion in its very essence of healing. When nothing could be done to heal, and health could not be restored, the historic medical mission would never rationalize destroying the patient or facilitating suicide. Care and comfort would be provided to the dying. Yet by the end of the twentieth century, infanticide was being rehabilitated from the barbaric practice it was to a compassionate medical choice. The doctor's first medical question today with disabled newborns may more often be "Should we treat?" when years ago the question was "How do we treat?"

In the modern world, some of the forces leading to infanticide have diminished: social stigma, superstition, and ritual sacrifice. Even the widespread use of infanticide to limit families or to eliminate a female child in populous countries is beginning to come under global scrutiny. Anti-poverty programs and support for unwed mothers have reduced criminal infanticide. New social forces, however, have begun to take their place. Infants born premature or with disabilities in today's world face a new landscape of advancing medical technology, ethical issues, expensive treatments, costly or limited health insurance, a highly competitive economy for families and health care providers, and a legal-social devaluation of the infant before birth. Ironically, today's world may be as dangerous to the disabled newborn as the world of past centuries.

### **Infanticide and Eugenics in Film**

A striking example of the "cousinage" of infanticide and eugenics is seen in comparing three films: an American silent movie, a Nazi propaganda film, and a modern medical school educational film.

The first eugenics film in the United States advocating infanticide was *The Black Stork* (1916), made by muckraking journalist Jack Lait and Dr. Harry J. Haiselden, a surgeon in Chicago's German-American Hospital. Based loosely upon a fictionalized account of the high-profile Baby Bollinger infanticide case attended by Dr. Haiselden, the film begins with a eugenic mismatch, Claude, who has an unidentified inheritable disease:



Despite repeated graphic warnings from Dr. Dickey (played by Haiselden himself), Claude marries his sweetheart, Anne. Their baby is born so severely disabled that it needs immediate surgery to save its life, but Dr. Dickey refuses to perform the operation. Anne is torn by uncertainty until God reveals a lengthy vision of the child's future, filled with pain, madness and crime [he murders Dr. Dickey]. Her doubts are resolved, she accepts Dr. Dickey's judgement, and the baby's soul leaps into the arms of a waiting Jesus.<sup>32</sup>

The film is filled with horrifying pictures of other child and adult "defectives" and contrasts a farmer's quarantine of diseased cattle with a neglected derelict (who represents a danger to society because he is not quarantined).

Dr. Haiselden felt that impaired infants like Baby Bollinger were better off dead than living in state institutions for the incurable or feebleminded. He "secretly permitted many other infants he diagnosed as 'defectives' to die during the decade before 1915...[and] over the next three years he withheld treatment from, or actively speeded the deaths of, at least five more abnormal babies."<sup>33</sup> The *Chicago Daily Tribune* quoted Haiselden advocating doctors not to tie umbilical cords of 'defectives' newborns and allow them to bleed to death: "Instead of struggling to save deformed children and those marked plainly for insanity and uselessness," the surgeon continued, "physicians should [s]ave only the fit."<sup>34</sup>

The popular German euthanasia film *I Accuse (Ich klag an)* by Wolfgang Liebeneiner under the Ministry of Propaganda premiered in 1941 and featured a story about a talented woman who grows progressively disabled due to multiple sclerosis. Unable to bear the thought of being a burden, she begs for euthanasia. Her husband assists her suicide, to the accompaniment of mournful piano music. A small segment of eugenic infanticide propaganda is found in a subplot which involves parents of a disabled baby who beg a doctor to kill it as an act of mercy. Two years earlier Dr. Karl Brandt headed up Hitler's infanticide program, a program instituted by secret order, which permitted German disabled infants to be euthanized (Jewish infants were excluded). Midwives and health workers willingly reported births of "defective" newborns. This medicalized killing was a precursor to the infamous T-4 eugenics program (Tiergarten 4, the address of the Chancellery) which euthanized thousands of disabled adults. Although the T-4 program was later rescinded by Hitler after public pressure, the eugenic infanticide directive continued.<sup>35</sup>

The first American educational film for the medical profession on the use of infanticide was *Who Shall Survive?* produced in 1972 by Johns Hopkins Hospital and Medical School. In the 25-minute documentary a newborn infant with Down's syndrome was permitted to die by "inattention."<sup>36</sup> The infant had an intestinal blockage (a nearly identical medical case as the Bollinger baby dramatized in *The Black Stork*), but instead of undergoing corrective surgery (the parents refused consent), the infant was moved to a corner of the nursery. Without nutrition, the child died 15 days later.<sup>37</sup> The film, shown at the Kennedy Center Symposium in 1972, was probably the first large public conference on infanticide in the United States. The documentary presents nobody that objects to the so-called "treatment." Instead, medical inattention is offered as an acceptable example of managing a difficult neonatal problem.

## **Hierarchies of Human Worth**

A common theme in eugenics is the disparaging attitude toward the disabled. The disabled child is considered to be of marginal value (or no societal value at all). The eugenic rationale behind the New Infanticide is that the disabled are inferior—or even a threat to society (financially or otherwise)—and must be weeded out. The analogy of the garden was a common illustration used by proponents of eugenics in the 1920s to illustrate the danger of allowing weeds to reproduce unchecked. Good plants must be cultivated and nurtured, while weeds must be eliminated and held in check for the greater benefit and beauty and productivity of the garden. These disparaging attitudes toward the disabled have resulted in the development of social patterns that tolerate—and even encourage—the practice of infanticide today.

Down's syndrome infants have long been disparaged by some doctors and government bean counters. Dr. Benjamin Spock in his 1946 *Baby and Child Care* suggests immediate institutionalization of the “mongoloid” infant because it is “hardly human.”<sup>38</sup> In 1970, the *Encyclopedia Britannica* listed for the last time Down's syndrome under the heading of “Monster.”

In 1974, a former analyst in the U.S. Surgeon General's office was quoted in *Fortune* as predicting that with an investment of five billion dollars in producing a program to reduce the incidence of Down's syndrome by diagnosis and abortion, society could save eighteen billion dollars. Similar programs to reduce other genetic disease could save up to a hundred billion dollars. The analyst warned, “If we allow our genetic problems to get out of hand, we as a society run the risk of overcommitting ourselves to the care of and maintenance of a large population of mentally deficient patients at the expense of other urgent social problems.”<sup>39</sup> There are many similar stories in 1930s Germany of propaganda used to exaggerate the cost to the Reich for caring for nonproductive defectives and “useless eaters.”

In the 1980s we find a flurry of eugenic cases involving the disabled in the United States. In 1980, the Supreme Court refused to hear an appeal made on behalf of Phillip Becker, an institutionalized San Jose California teenager with Down's syndrome. His parents refused consent for heart surgery arguing that he was a burden. After a three-year custody battle won by another family, Phillip finally received heart surgery.<sup>40</sup>

The “Baby Doe” case began when a Down's syndrome infant was born on April 9, 1982, with esophageal atresia, then allowed to die by attending physicians in accordance with parental wishes. The Indiana Supreme Court upheld the parents' right to refuse surgery. The infant was placed in an isolation room where he died without treatment or nourishment on April 16, 1982, despite an appeal to the U.S. Supreme Court and several willing adoptive parents. This case led to President Reagan's threat to withdraw funds from hospitals that discriminate against disabled patients, and an application of Section 504 of the Rehabilitation Act of 1983, establishing the right of all newborn children to receive customary medical care, an effort that was ultimately defeated by a medical community resistant to the idea of having the government dictate courses of treatment in hard cases.<sup>41</sup>

## Drawing a Line Between Abortion and Infanticide

The legal status of the unborn, diminished in 1973 by *Roe v. Wade*, was further diminished in 2000 by the U.S. Supreme Court in *Stenberg v. Carhart*.<sup>42</sup> This decision, handed down three summers ago, further eroded the legal status of the newborn as the Court struck down the partial-birth abortion bans in thirty states. These were statutes that prohibited a particular type of abortion known as “intact dilation and extraction” (D & X) because they involved a partial delivery of the fetus, often still alive.<sup>43</sup> Nebraska and other states sought, in their legislation, to draw a bright line between abortion and infanticide.<sup>44</sup> Nebraska Attorney General Don Stenberg in his brief to the Court argued that the procedure “borders on infanticide.”<sup>45</sup> Attorneys Nikolas Nikas and Dorinda Bordlee of Americans United for Life argued in an amicus brief that “Nebraska’s ban on killing a child in the process of birth is reasonably related to its interest in preventing the erosion of the line between abortion and infanticide....[The state law] creates a firewall against infanticide.”<sup>46</sup> It was noted in the *Journal of the American Medical Association* that even many abortion advocates “found intact D & X too close to infanticide to ethically justify its continual use.”<sup>47</sup> Before a Senate Hearing, attorney Helen Alvaré termed the procedure “one-fifth abortion and four-fifths infanticide.”<sup>48</sup>

The Court majority struck down the state laws, but in a stinging dissent, Justice Thomas termed the abortion procedure “infanticide” and also wrote that *Roe v. Wade* was “grievously wrong.”<sup>49</sup> Justice Kennedy, who was part of the majority in *Planned Parenthood v. Casey*, wrote a surprising dissent in *Stenberg v. Carhart* because he believed state interests could include erecting a barrier to infanticide and that these were permitted by the Casey decision.<sup>50</sup> Kennedy felt that Nebraska’s state interests could include a concern for the life of the unborn and for the partially born, as part of preserving the integrity of the medical profession (so that doctors are regarded as healers) and in “erecting a barrier to infanticide.”<sup>51</sup> Justice Thomas, in his dissent, advocated the state’s profound interest in deeming life as precious and protecting against the dehumanizing process of abortion.<sup>52</sup> This comment has led many to conclude that if the *state* has this profound interest, certainly *the medical community does too*.<sup>53</sup>

On a positive note, the U.S. Senate passed the Born Alive Infants Protection Act last year, ensuring that an unborn child born alive during an abortion is considered a full legal person under federal law.<sup>54</sup> This is a good step toward building a firewall between abortion and infanticide.<sup>55</sup>

## Building a Culture of Life

A culture of life begins with a language of life. Non-pejorative language should always be used when referring to any human being. The terms “birth defect” or “defective fetus” are unacceptable, as their usage implicitly refers to inanimate objects, such as the “defective product” from a mail order catalogue. Parents who are shocked and disappointed at finding that their new child suffers from a significant disability need compassionate support and accurate information on state assistance for cost of care, special needs adoption, institutional alternatives, and support groups.<sup>56</sup>

Although three decades of failed public services and government funded programs have promoted abortion, neglected adoption, and fostered adolescent pregnancy, a culture of life may also be advanced in state and federal legislatures to provide real choices to women with crisis pregnancies and parents with disabled newborns who need extra help.

As Chaim Potok wrote, “Don’t despise small beginnings.” There was an especially positive development in 2002’s legislative session that could be replicated in several other states. On July 1, 2002, in Louisiana, the final state budget included an appropriation of \$1.5 million in federal TANF dollars (Temporary Assistance for Needy Families) to fund abortion alternative services. These services include crisis pregnancy centers, maternity homes, and adoption centers.<sup>57</sup>

This program, known as Project WIN (Women in Need), is a strategy which provides true choice—and real hands-on help—for women with difficult pregnancies or circumstances. Project WIN first began in Pennsylvania by the initiative of the late Democratic Governor Bob Casey, who was fiercely committed to his party’s tradition of protecting the most vulnerable members of society.<sup>58</sup> Since the program’s beginnings in 1995, Project WIN has helped more than 50,000 Pennsylvania women—and probably prevented tens of thousands of abortions. Groups like Real Alternatives, Americans United for Life, and state and local church pro-life and pro-family groups are planning and working collaboratively in other states on similar initiatives for this year.

Another legislative solution to criminal abandonment and neonaticide is the “Safe Haven” bill, designed to protect the lives of infants that would otherwise be abandoned. As in centuries past in Europe, this law allows unwanted newborns to be anonymously relinquished by their mothers at a fire station or hospital, then turned over to the local child and family services for foster care or possible adoption. The provision also covers “boarder babies,” newborns abandoned in hospital maternity wards by drug-addicted or HIV-infected mothers.<sup>59</sup> In 2001 nineteen state legislatures enacted Safe Haven bills. A total of thirty-five states now have these protections.<sup>60</sup> As President Bush stated in his inauguration address, “whatever our views of its cause, we can agree that children at risk are not at fault. Abandonment and abuse are not acts of God, they are failures of love.”<sup>61</sup>

Creating a culture of life in our state legislatures requires a stronger safety net for women who have difficult pregnancies or who live in poverty and unemployment. Family-strengthening and life-affirming programs such as: improved access to prenatal health care through State Children’s Health Insurance Program (SCHIP); parental leave; affordable and expanded child care alternatives; part-time and flextime work opportunities; and initiatives to improve child support help address the root causes of abortion and infanticide.

Parenting a child with a disability will become a more viable option for more people if society provides more support for parents in general through both public and private funds. An adequate safety net must be both broad in its services and *highly visible*.

Programs such as these do much to reduce the coarseness of our society. But even with a patchwork of all fifty states, together with federal laws, the New Eugenics will still be a threat to the disabled newborn unless the “do no harm” Hippocratic tradition is restored in medicine. As long as “neglect” is an accepted treatment option, and medical discrimination may be applied to some patients whose lives are deemed less than worthy for living, all state and federal laws mentioned above will not produce a country where the disabled newborn is welcomed in life and protected in law. Patients that are dying should remain patients, and (if possible and comforting) receive food and water. Comfort is not a euphemism for neglect. The Hippocratic Oath represents an ethic that practices healing whenever healing is within its power, and comfort when it is not.

This medical ethic is nowhere better observed today than in the midst of a Middle East nation torn by violence, bloodshed, and hate. One would expect that of anywhere, an ethic of discrimination and neglect in the interest of national security might be found here. Dr. Avraham Rivkind, head of the trauma unit at Hadassah University Hospital in Jerusalem, wears two beepers and a cell phone, even to bed. When a human bomb goes off in Jerusalem, Dr. Rivkind knows within minutes, and often reaches the emergency room before the lines of ambulances with blast victims arrive. In his work, he takes no notice of whether patients are perpetrators or victims. When asked how he could perform emergency surgery on a terrorist (on the Sabbath, no less), he replied:

Because I'm a doctor, a believing Jew, a human being, I would never allow a patient to die whom I could save. But this saving of life is more than my medical requirements: It's a mission. By fixing the holes in their chests and bellies, I'm making a statement that I'm not like those forces of darkness that want to engulf this country in blood.... The Hadassah motto is taken from the prophet Jeremiah who cried for the “healing of my people.” The healing of all peoples is the only way to rescue the future of this region.<sup>62</sup>

The prophet Jeremiah uses these words as a metaphor for the healing of the land, a healing that we could use today so that the parents of a disabled child are properly seen as “saints” for the extra love and care they provide, not looked down upon as “sinners” to bring such a child into the world. **E&M**

## References

- 1 C. Everett Koop, M.D., Sc.D., “Of Law, Of Life, and the Days Ahead,” unpublished address delivered at the commencement exercises of Wheaton College, June 4, 1973, p. 8 (speech manuscript in the Americans United for Life archives) (emphasis added).
- 2 *Ibid.*, p. 8 (emphasis added).
- 3 Dr. Koop was predicting the philosophical, medical, and social effects of *Roe v. Wade*; the legal holding expanded and created a woman's right and dealt only with the constitutional status of the unborn human being (a status divided up by the Court into a hierarchy of trimesters).
- 4 *Ibid.*, p. 12.
- 5 Thanks to Wesley J. Smith, in his book *Culture of Death: The Assault on Medical Ethics in America* (San Francisco: Encounter Books, 2000), for using the expressions “equal human moral worth” (instead of the time-worn “sanctity of human life”) and “hierarchies of human worth” (instead of the quality-of-life ethic). In pluralist debate of these issues in the public square, these non-sectarian expressions serve to

## Ethics & Medicine

- better communicate the recent departure from the centuries-old political ideals of equality in the American psyche.
- 6 *Ibid.*, p. 12-13. Koop also referred to an article in the May 1973 issue of *Johns Hopkins* magazine that advocated the active assistance “to help a dying child die as quickly and painlessly as possible.” Dr. Watson was quoted from *Time*, May 28, 1973 (emphasis added).
  - 7 I am indebted to Fr. Richard J. Neuhaus for his keynote address, “The Return of Eugenics,” at the Americans United for Life conference, “*Reversing Roe v. Wade Through the Courts*,” Chicago, Illinois, October 1987. He later published an essay on the topic, “The Return of Eugenics,” *Commentary*, April 1988: 15-26. Fr. Neuhaus describes the intellectual cousinage between Darwin’s evolutionary theories and Galton’s eugenic theories (in real life the authors were also cousins). Fr. Burchaell in *Rachel Weeping* (1990) also discussed the “cousinage” between abortion and infanticide.
  - 8 One example of the mention of infanticide as a grave moral evil with two (not one) victims is the famous suffragist speech in 1854 by feminist Elizabeth Cady Stanton to the New York legislature. She poignantly describes the plight of women charged with infanticide being tried before juries of men only. See Elizabeth Cady Stanton, Susan B. Anthony, and Matilda Joslyn Gage, eds., *History of Woman Suffrage*, Vol. 1 (New York: Fowler & Wells, 1881, reprinted 1969), 597-8.
  - 9 With only a few exceptions, *The Reader’s Guide to Periodic Literature* had no entry for “infanticide” until the 1980s. Interestingly, under “Infanticide” it says, “See murder.” The pejorative habit of listing “Infants, Deformities” and “Birth Defects” has been happily replaced by “Infants, Disease” in the 2000 *Guide*.
  - 10 Raymond S. Duff and A. G. M. Campbell, “Moral and Ethical Dilemmas in the Special Care Nursery,” *New England Journal of Medicine* 289 (1973): 890.
  - 11 Bard, B., and J. Fletcher, “A Right to Die,” *Atlantic Monthly*, 3 (April 1968), 59-64. There is “no reason to feel guilty about putting a Down’s syndrome baby away, whether it’s ‘put away’ in the sense of hidden in a sanitarium or in a more responsible lethal sense. It is sad, yes. Dreadful. But it carries no guilt. True guilt arises only from an offense against a person, and a Down’s is not a person.”
  - 12 Tooley advances an argument for infanticide based upon self-awareness. He argues that only “continuing selves” have a right to life, selves that have more than merely momentary desires or interests. To have a right to life, a self must be self-aware of existing over time, and have a sense of the future. See Michael Tooley, *Abortion and Infanticide* (Clarendon Press, Oxford, 1983).
  - 13 See the “Medical Oath Registry” of the American Medical Association’s Ethics Resource Center at <http://www.ama-assn.org/ama/pub/category/5573.html> (last accessed 08/19/2003). For a translation of the 400 B.C.E. classic oath by Francis Adams, see <http://classics.mit.edu/Hippocrates/hippooath.html>.
  - 14 By 1980, seven years after *Roe v. Wade*, there were over 1.6 million abortions performed annually, almost one abortion for every two live births (source: The Alan Guttmacher Institute, 1992). Since 1990 there has been a steady decrease. U.S. Centers for Disease Control and Prevention *Morbidity and Mortality Weekly Report (MMWR)*, Vol. 51, No. SS-3, “Abortion Surveillance United States - 1998” (June 7, 2002), provides statistics for reported abortions which are less than AGI’s figures.
  - 15 C. Everett Koop, M.D., “Ethical and Surgical Considerations in the Health Care of the Newborn with Congenital Anomalies,” paper presented at the International Conference on Infanticide and the Handicapped Newborn, Americans United for Life, Chicago, Illinois, December 6, 1980, p. 2.
  - 16 For online primary documents and introductory essays, see the Dolan DNA Learning Center’s “Eugenics Archive” funded by the National Human Genome Research Institute at <http://www.eugenicsarchive.org>.
  - 17 Wesley Smith, *Culture of Death: The Assault on Medical Ethics in America* (San Francisco: Encounter Books, 2000), 35.
  - 18 The *Virginia Sterilization Act* was passed by the legislature in March 1924. Upheld by the U.S. Supreme Court in *Buck v. Bell*, 274 U.S. 201 (1927).
  - 19 *Virginia Sterilization Act* (1924).
  - 20 Donald K. Pickens, *Eugenics and the Progressives* (Vanderbilt University Press, 1968), 91.
  - 21 *Griswold v. Connecticut* 381 U.S. 479 (1965) invalidated a state statute criminalizing the use of

- contraceptives with a constitutional “right of privacy” found in the penumbra of the Constitution’s *Bill of Rights*. This right of privacy was later expanded in *Roe v. Wade* when the Court invalidated state statutes criminalizing abortion.
- 22 The Quality of Life ethic is best exemplified by Dr. Anthony Shaw’s crass “formula” for measuring an infant’s expected “quality of life.”  $QL = (NE) (H + S)$ , where QL stands for “quality of life” and NE for the child’s “natural endowment.” H and S are the resources (not limited to financial support but including affection and training) that the family and society, respectively, would be expected to devote to the infant’s well-being. Anthony Shaw, “Defining the Quality of Life,” *Hastings Center Report*, October 1977, 11.
  - 23 C. Everett Koop, M.D., “Ethical and Surgical Considerations in the Health Care of the Newborn with Congenital Anomalies,” paper presented at the International Conference on Infanticide and the Handicapped Newborn, Americans United for Life, Chicago, Illinois, December 6, 1980, p. 2.
  - 24 Plato, *The Republic*, v. 460 ff.
  - 25 Plato, *The Republic* (translated by B. Jowett) (New York: Modern Library, 2000), v. 459, p. 182.
  - 26 Aristotle, *Politics*, vii. 16.
  - 27 *Twelve Tables of the Decemviri Consulari Imperio Legibus Scribundis*, Table iv. 1: “Rights of Fathers.”
  - 28 Mark Golden, “Demography and the Exposure of Girls at Athens,” *Phoenix* 35 (1981) 330.
  - 29 Plutarch, *Morals*; Soranus, *Gynecology*. See also: D. Engels, “The Problem of Female Infanticide in the Graeco-Roman World,” *Classical Philology* 75 (1980), 112-20. W. V. Harris, “The Theoretical Possibility of Extensive Infanticide in the Graeco-Roman World,” *Classical Quarterly* 32 (1982), 114-6.
  - 30 Sparta is one notable ancient exception to this.
  - 31 The German medical community, which abandoned the taking of the Hippocratic Oath in the 1930s and began instituting government-sanctioned eugenic infanticide, is one exception.
  - 32 Martin S. Pernick, *The Black Stork: Eugenics and the Death of “Defective” Babies in American Medicine and Motion Pictures Since 1915* (New York: Oxford University Press, 1996), 5-6.
  - 33 Pernick, 4.
  - 34 “Doctor to Let Defective Baby Expire Unaided: Mother Approves Surgeon’s Refusal to Prolong Life of Malformed Infant,” *Chicago Daily Tribune*, November 17, 1915, p. 7. There is an apparent typo in the article which reads: “physicians should have only the fit.” A reproduction is available in Pernick, 144b.
  - 35 Wesley Smith, *Culture of Death*, 40-3.
  - 36 Francis A. Schaeffer and C. Everett Koop, M.D., *Whatever Happened to the Human Race?* (Fleming H. Revell Co.: Old Tappan, New Jersey, 1978), 55-6.
  - 37 The documentary was shown in 1971, at the Eisenhower Theater in the John F. Kennedy Center for the Performing Arts, Washington, D.C. The doctor in charge of the case stated that in the previous five years at Johns Hopkins, at least four babies with Down’s syndrome had died after parents refused consent for surgery. <http://www.altonweb.com/cs/downsyndrome/index.htm?page=timeline.html> (last viewed, 8/19/2003).
  - 38 Benjamin Spock, *Baby and Child Care* (1946): “If [the infant] merely exists at a level that is hardly human, it is much better for the other children and the parents to have him cared for elsewhere” (p. 478).
  - 39 Gene Bylinsky, “What Science Can Do About Hereditary Disease,” *Fortune* (September 1974), 152.
  - 40 The U.S. Supreme Court refused the appeal on March 31, 1980.
  - 41 Shortly after Baby Doe’s death, President Reagan issued a memo to the Secretary for Health and Human Services with the instruction that federal laws prohibiting discrimination against the handicapped be “vigorously enforced” (a reference to the *Rehabilitation Act of 1973*, Section 504: “No otherwise qualified

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- handicapped individual shall, solely by reason of handicap, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance"). The "Interim Final Rule" (also known as the "Baby Doe Guidelines") issued by the Department of Health and Human Services to all hospitals was stronger in its language ("Baby Doe Guidelines," Office of the Secretary, Department of Health and Human Services, *Nondiscrimination on the Basis of Handicap*, 48 Federal Register 9630 [1983]). Interim Final Rule modifying 45 *Code of Federal Regulations*, para. 84.61. This was followed by "Proposed Rule," *Nondiscrimination on the Basis of Handicap Relating to Health Care for Handicapped Infants; Proposed Rules*, 48 Federal Register 30846 (1983), 45 *Code of Federal Regulations*, Part 84.
- 42 *Stenberg v. Carhart*, 530 U.S. 914 (2000).
- 43 The Court declared the Nebraska statute unconstitutional for two reasons. "First, the [Nebraska] law lacks any exception 'for the preservation of the...health of the mother' [quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 879 (1992)]....Second, [the Nebraska law] 'imposes an undue burden on a woman's ability' to choose a [D & X] abortion, thereby unduly burdening the right to choose abortion itself" [quoting *Casey*, 505 U.S. at 874]. *Stenberg v. Carhart*, 530 U.S. 929-30.
- 44 *Nebraska Revised Statutes Annotated*, 28-328(1) (Supp. 1999).
- 45 Brief for Petitioners, 49, *Stenberg v. Carhart* (No. 99-830).
- 46 Brief of *Amici Curiae* Louisiana and Mississippi in Support of Petitioners, 15, *Stenberg v. Carhart* (No. 99-830).
- 47 M. LeRoy Sprang, M.D. & Mark G. Neerhof, D.O., "Rationale for Banning Abortions Late in Pregnancy," 280 *Journal of the American Medical Association* 744 (August 26, 1998), available at <http://www.ama-assn.org>.
- 48 Senate Hearing before the Senate Comm. on the Judiciary, 104th Cong. 248 (1995), 116 (statement of Helen M. Alvaré, Esq.): "It kills a child when 80 percent of his or her body is already outside the womb."
- 49 *Stenberg v. Carhart*, 530 U.S. 982-3, 980 (Thomas, J., dissenting).
- 50 *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Stenberg v. Carhart*, 530 U.S. at 960 (Kennedy, J., dissenting).
- 51 *Stenberg v. Carhart*, 530 U.S. 961-2 (Kennedy, J., dissenting).
- 52 *Stenberg v. Carhart*, 1006-6 (Thomas, J., dissenting).
- 53 Stephanie D. Schmutz, "Infanticide or Civil Rights for Women: Did the Supreme Court Go Too Far in *Stenberg v. Carhart*?" 39 *Houston Law Review* 529 (Summer, 2002).
- 54 H.R. 2175, July 18, 2002. Similar bills were vetoed twice by President Clinton.
- 55 Until the federal law was passed, states needed the "Born Alive" laws to protect infants born alive despite abortion procedures intended to end their life *en utero*. The failure of Senate Bills 1661 and 1662 in Illinois, drafted in response to Oak Lawn's Christ Hospital abortion policy, was a remarkable failure in the 2002 legislative session.
- 56 For more information, see The Professional Advisory Committee, National Down Syndrome Congress Position Statement on Prenatal Testing and Eugenics (August 1994) at <http://www.ndscenter.org/old/position.htm>.
- 57 LA H.B.1 (signed into law as part of Louisiana's general budget on July 1, 2002). AUL staff counsel Dorinda Bordlee testified before the Louisiana House and Senate appropriations committees in support of securing these funds.
- 58 For how his pro-life views led to his ostracism by his party, see Nat Hentoff, "Robert Casey, Democrat: Life of the Party," *The New Republic*, June 19, 2000.
- 59 "A Flurry of Baby Abandonment Leaves Houston Wondering Why," *New York Times*, December 26,



1999, 14.

- 60 National Conference of State Legislatures, Abandoned Infant Legislation 2000-2001, at <http://www.ncsl.org/programs/cyf/ABSL2001.htm> (Arizona, Arkansas, Delaware, Idaho, Illinois, Iowa, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Wisconsin) (last updated Nov. 7, 2001).
- 61 President George W. Bush, *Inaugural Address*, January 20, 2001, <http://www.whitehouse.gov/news/inaugural-address.html>.
- 62 Avraham Rivkind, M.D., "A Doctor's Story: Awaiting the Wounded," *Chicago Tribune*, July 14, 2002, Section 2, p. 7.

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## THE ETHICS OF ADVERTISING STRATEGIES IN THE PHARMACEUTICAL INDUSTRY<sup>1</sup>

LARS REUTER, PHD

Generating business is, obviously, the *raison d'être* of advertising. Its core concept is to present a new or renewed product in order to gain a market position or to maintain that of a product already launched. Advertising rests on the assumption, then, that in a market of competing products, a consumer is able to make a choice, which may be influenced through mainly conscious or subconscious channels or both, depending on the degree to which human nature is understood as mostly free or determined. Consequently, and more fundamentally, advertising, and especially its strategic use, may signal an attitude of superiority, since its recipients are regarded as individual instances of standard or at least predictable behaviour, whose desires and needs can be analysed and systematised. Hence, advertising presents archetypes of human life and its style, promising that a particular product will elevate or empower one to become or to remain what one ought to be. Key notions in forming these archetypes are, for example, 'independence,' 'youth,' 'health,' 'beauty,' 'status,' 'control,' 'affluence,' and 'pleasure.'

These general remarks are valid for pharmaceutical products, too, at least to the extent that they are produced *for sale*. There is a certain reluctance, however, to regard health as a mere commodity, since it is often, at least in Western culture, valued in conjunction with human rights, if not indeed identified as such, as exemplified by European-type public health systems and their political and academic support.<sup>2</sup> International conferences on health and human rights have stressed the universalist aspect of this claim.<sup>3</sup> Interestingly, this reluctance is typically limited to medication or specific medical procedures *per se*, whereas other factors influencing one's health, e.g., the quality of food, clothing, and accommodation, are accepted as commodities relegated to the responsibility of the individual.

Similar to other simple qualifications, the notion of 'health' is interwoven with its contrary term, here that of 'disease,' one used in support of the other. It is not unusual, then, to define the term 'health' as it is done in the OED, namely as "the state of being well and free from illness in body and mind,"<sup>4</sup> mirroring the traditional Christian definition of evil as the privation of goodness. From the experience of human contingency, the ideal and, hence, truly desirable human state is thus extrapolated. It is this antelapsian state that the advertising strategies of the pharmaceutical industry promise to recuperate for the patient, now finding herself in the entrapment of postlapsian contingency. It is, therefore, not completely surprising that pharmaceutical advertisements would carry religious overtones, for just as salvation religiously speaking is somewhat dependent upon means, advertising promises to provide such in order to overcome the contingencies humans may experience, be it in health, hygiene, nourishment, mobility, or social interaction.

Pharmaceutical products differ from others in three distinct ways. First, the potential user may only gain access to a specific product through his or her physician, since a (albeit shifting) number of these products are being administered through the channel of prescriptive procedures, intended to minimise the risk of disproportionate or other forms of inadequate use. Hence, the physician is the primary target for advertising on prescription drugs. Moreover, the actual customer is typically the health care provider on whose behalf the physician may act in selecting a drug deemed sufficiently appropriate. Fees paid by the patient are in this regard less an expression of a business transaction than of tax revenue. In public health systems, decisions on available drugs may also be taken on political grounds, which widens the scope of advertising strategies in this field, replacing advertising with its less eye-catching twin, lobbyism.

Second, pharmaceutical products serve the interests of financial, personal, and scientific gain alike: The producer expects a return of development costs and the generation of profit, the researcher wishes to explore or advance, the patient desires a greater state of health or well-being, and the physician may wish to comply with his own motives of altruity or power. This diversity of interests is somewhat revealed when new products are presented in medical journals or at academic conferences (co-)sponsored by the industry.

Third, the development of pharmaceutical products is particularly delicate, since they are designed to treat standard malfunctions in human beings showing individual traits, which at some stage requires testing on humans rather than, for instance, on animals. The desire to create “new safe medicines faster”<sup>5</sup> (NSMF) and to custom-design medication increase the need for trials involving humans at much earlier stages of the research and development process, in part also to respond to concerns about animal testing.

Any ethical evaluation built on arguments rather than assertions depends on knowledge rather than mere assumptions. When analysing the advertising strategies in the pharmaceutical industry, gaining such knowledge requires transparency, since one can only understand what is clear to the mind. It is necessary, then, that even in advertising, transparent communication is used. This is somewhat analytically evident, for the industry has to comply with rules of ethical conduct and their legal interpretation governing all individual and juridical persons forming a society if it indeed intends to act ethically correct and in accordance with law, both attitudes stemming from free<sup>6</sup> decisions subject to powers of internal or, in particular in the case of the latter, external enforcement. In other words, I contend that information on products be clear, true, and respectful.

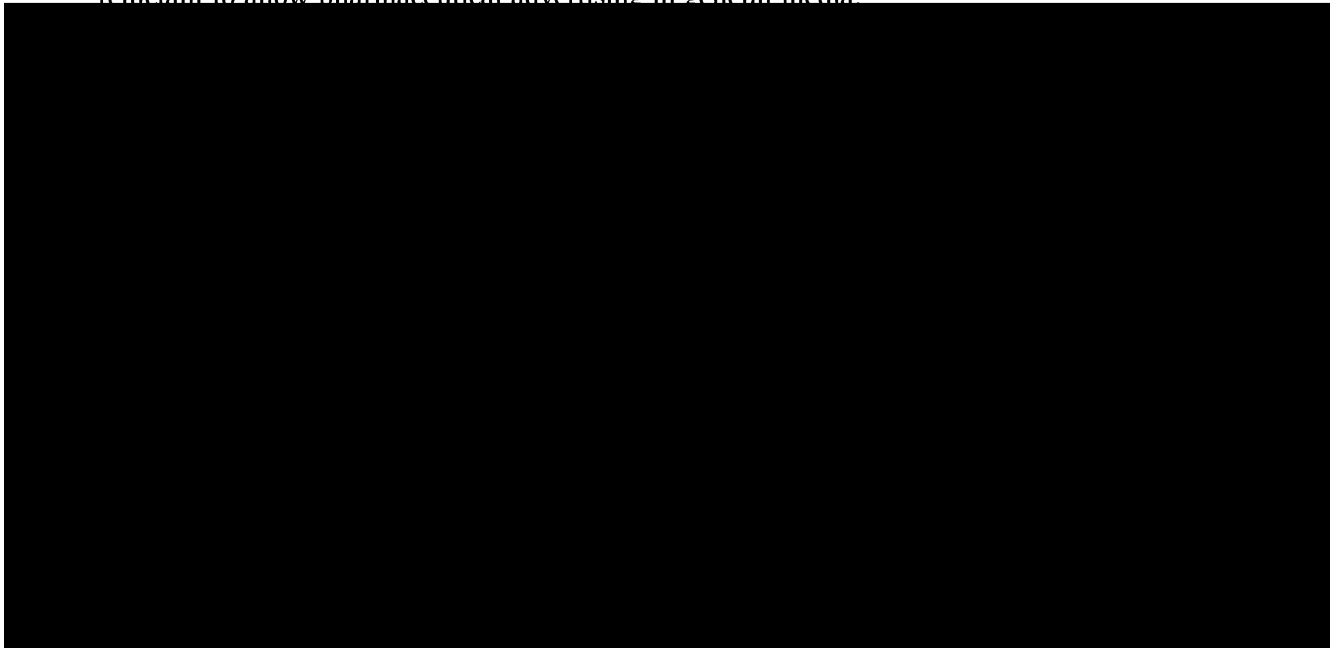
It so happens that the very idea of democracy likewise presupposes transparency, since it is formed, at least ideally, by the sum of informed individual decisions. If information and education in a democratic society were intended to influence the other without or even against his or her consent, i.e., manipulation, the very foundation of the democratic society would be at stake. In this regard, it is important to stress that all humans are equal simply because they are humans and not because some humans have agreed on such an idea. Consequently, willingly exercising specific power over another human being in

order to maintain or gain an assumed state of superiority or advantage is showing disrespect towards human equality and is, simply for that reason, evil.

Transparency is, thus, a secondary principle derived from the primary notion of benevolence, since it seeks to eliminate inequalities stemming from knowing what others either do not know or, worse, which one does not want them to know. Consequently, advertising strategies of the pharmaceutical industry have to tell what they seek. If one wants to convince physicians of the advantages of a particular product in a splendid Caribbean setting, it should not be called a conference, but a promotional tour. If a physician is offered a fee for administering new medication to his or her patient as part of its testing, the patient should be informed about the test and the personal gain. If a new product is featured in print media, it should be presented as an advertisement and not as a journalistic item. Note in this regard Ronald Jeurissen's remark that

[I]n a society that is dominated by organizations, a true participatory democracy will only be possible if organizations are themselves open to public accountability from without and individual responsibility from within. It is only through responsible people inside the organization, that a company can become a responsible citizen. Thus, we see a threefold task of business ethics arising: the task to develop a just, participatory and sustainable society, supported by communicative organizations that are manned by actively responsible people.<sup>7</sup>

Closely intertwined with the notion of transparency is that of honesty, reflecting the degree to which fair human interaction depends upon openness. For promoting pharmaceutical products, this entails an obligation not to promise more than what can be fulfilled. Even though exaggeration is a standard means of rhetoric, one should remember that a suffering person does not necessarily understand the presentation of a new colitis drug on equal terms with the ways in which washing powder is presented as constantly improving its bleaching and cleansing qualities. It is for this admittedly paternalistic reason (among others) stemming from concerns about inadequate use that the Nordic countries are reluctant to allow pharmaceutical advertising in general media



welcomed by the other. A question, a touch, a glance, demonstrative neglect, or even mere inattention are instances of intrusions that might become invasive. Advertising is in much more danger to do so, since it addresses itself to the other by using various conscious and subconscious channels of communication. Engaging in this business thus requires an attitude of responsibility, particularly of the one intruding. William Schweiker fittingly describes such responsibility, albeit in a different context, as

a response to the worth of contingent life that solicits our respect and even care; it is a sense of the intrinsic worth of the integrity of life. This experience is a second moral naiveté that transpires within an activity of interpretation. The moral self is not the starting point of value because the self is constituted and transformed through an activity defined by an insight into the claims of others on us. Radical interpretation as the activity basic to moral responsibility is the means by which the self-understanding of agents who exercise power is transformed in order to respect and enhance the integrity of life.<sup>8</sup>

It is this very objective that advertising is called to respect, too.

Finally, pharmaceutical advertising is a crucial tool in the quest for correcting human inadequacies so tightly connected with the modern project. The martial language of 'killing pains,' 'fighting disease,' and 'the battle for public health' reveals the assumption of an ideal human state to which those not finding themselves in it at present need to be elevated or transformed. Endearing as such an ideal might be, it fails to understand the entrapment of our condition, which hardly is free from at least instances of deprivation of body and mind, most prominently displayed in our aging. It might be more liberating to accept this condition rather than continue to desire its fundamental transformation in vain, which our species nevertheless seems to enjoy so very much. **E&M**

## References

- 1 Substantially revised version of a paper given at the European Ethics Network and Politeia joint conference Leuven, 25–27 May 2000.
- 2 Cf. Sylvie Stachenko, Director for Health Policy and Services, WHO Regional Office Europe: "A key foundation in the 'Health for All' policy [a European WHO policy, in the latest version endorsed in 1998 as 'Health 21,' LR] is the concept of health as a human right. Clearly, an implication of the human right to health must be that society provides for a system of financing that guarantees every individual access to necessary care." Sylvie Stachenko: Solidarity for Health, in: Günther Leiner et al. (ed.): *Congress Report European Health Forum Gastein 1999 (EHFG). Bad Hofgastein/Austria 6th to 9th October 1999. Health and Social Security. Creating a better Future for Health in Europe*. EHFG: Bad Hofgastein 2000, 33-38, 36.
- 3 Among these, "[t]he first international Conference on Health and Human Rights was held at Harvard University in Cambridge, Massachusetts (USA) from 22–24 September 1994. This Conference brought together more than 350 individuals from the health and human rights fields from 42 countries for three days of intense discussion." Conference Report: First International Conference on Health and Human Rights, in: *Health and Human Rights*, 1 (2), 129-35, 129. Ibid, 125-27, 125 the editorial by Marvellous Mhloyi is vehemently defending this universalist claim on grounds of human civilisation: "The concepts of human rights and health are not alien to any nation that has endeavored to free itself of political oppression, sometimes at extremely high costs, while striving to provide medical services to its populace. (...) The intricate relationship between health and human rights embraces not only civil and political rights but—perhaps first and foremost—the right to health. This right is relentlessly threatenend

by economic, geopolitical and social inequities." The second international conference was held in 1996 and the third in September 2000.

- 4 Here taken from the Oxford Advanced Learner's Dictionary of Current English, 5th ed. 1995.
- 5 This initiative originates in a EUFEPS project (European Federation for Pharmaceutical Sciences) that received strong support from the European Commission and was in focus at the EUFEPS conference 20–23 October 2002 in Stockholm, Sweden).
- 6 I shall not discuss here whether 'freedom' in this context be understood as merely a non-determined choice, as self-determined or as fully free, each resting on particular anthropological assumptions and claims.
- 7 Ronald Jeurissen: *Integrating Micro, Meso and Macro Levels in Business Ethics*, in: *Ethical Perspectives 4* (1997), 252.
- 8 William Schweiker: *Power, Value and Conviction. Theological Ethics in the Postmodern Age*. The Pilgrim Press: Cleveland, Ohio, 1998, 109.

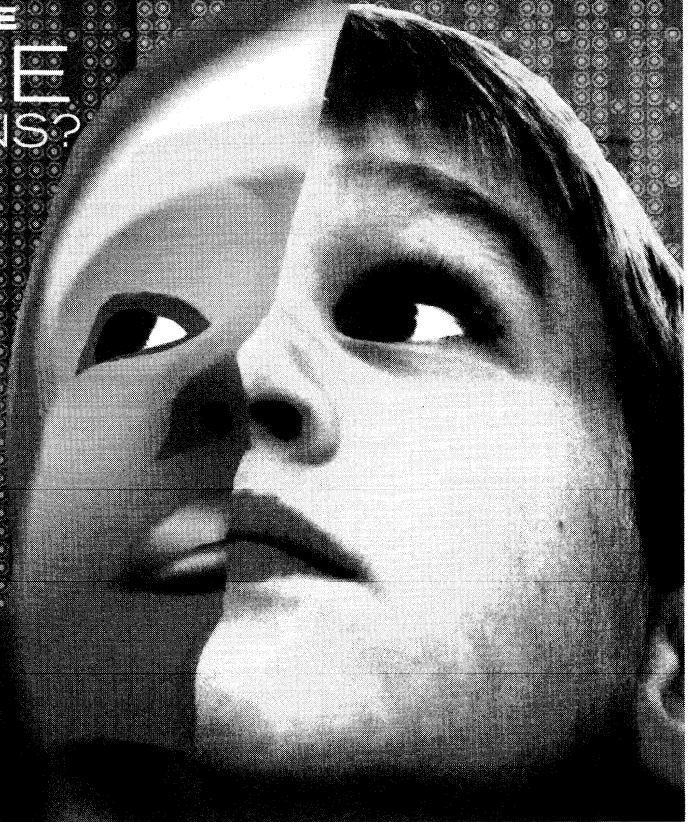
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## BIOTECHNOLOGY UPDATE: NEWS AND VIEWS

### **Democracy's Greatest Trial: Four Key Challenges for the Biotech Century**

NIGEL M. DE S. CAMERON, PHD

Cloning was bad enough, but the stem-cell debate has made it even harder. How are ordinary folk to grasp what's at stake in the biotech debates? What are they to make of the "experts" who rule the airwaves and the op-ed pages? And, having grasped what's going on, how are they to influence events? The more insistently we ask these questions, the bigger loom the challenges to democracy.

Here is a summary of the problem.

In brief, the biotech "stuff" is just not what we are used to. That does not mean you have to be on the Nobel shortlist to take part in the discussion. Indeed, one of the key lessons for this debate is that we all need to join in. But we do need to know a little about the subject. I raised this in a column some weeks ago, and pointed out that everyone did high school biology, and most of those who read this followed it up with more biology in college. Even those who did not are generally capable of following the explanations given in the news magazines.

Yet the essential problem remains, that we confront huge questions that the democratic process was not designed to handle—fast-paced changes in our understanding of science that challenge all of us who want to stay on top of developments and challenges that focus on controlling and changing the nature of the human being itself.

There are really four questions here.

1. Terminology and ignorance. There is no alternative to expecting responsible citizens to develop a basic familiarity with what's happening in biology. Our local newspaper carried a report the other day on a high school senior who had just graduated despite the challenges of life in a wheelchair. "Stem-cell research" might cure her problem, she told the reporter, but "the government won't allow it." Well, those who follow the debate will note at least three basic mistakes in that statement: work on adult stem-cells is hugely promising and is being funded energetically by the federal government; basic work on embryonic stem-cell lines is also being funded; and there is no federal prohibition on privately-funded work that involves destroying embryos to obtain embryonic stem-cells. Moreover, the federal legislation that many of us have been championing and the president wants to sign would not affect destructive embryo research, merely cloning to mass-produce the embryos.

Unless citizens (and journalists) can learn to make and appreciate such distinctions, as the biotech agenda gets more sophisticated, democracy will find itself increasingly dislocated and biotech will run out of control.

2. Experts rule. Feeding on public ignorance and fear, the biotech industry has taken on a defensive and disingenuous posture: its “experts”—whether scientists or bioethicists or plain PR people (BIO, the industry group, recently re-named its chief lobbyist “VP of Bioethics”)—have adopted a mantra, well articulated in the slogan “cures now.” They claim to be in favor of cures for disease; they imply that their opponents are not. So hearings are peppered with wheelchairs, and the endorsement of disease advocacy organizations is cultivated as a trump card. The people in general are ignorant of the science and scared of disease. The biotech industry and its key scientists tell us not to worry and to trust them to seek cures for our woes. Meanwhile, their political sponsors deny that there should be any limitation on their freedom. We should leave it all to the experts; they know best and we can trust them.

3. A new politics. As the cloning debate has already shown, the questions raised by biotechnology are not the same kind of issues as have traditionally divided our politics. The very fact that opposition to cloning has come from some on the “extremes” of the pro-life and pro-choice positions on abortion illustrates this dramatically, but the novelty of these questions goes deeper than a marriage of convenience. Conservatives and “progressives” share a respect for human nature and a distrust of manipulative interventions that will enable certain men and women to re-shape others. This pits the more radical progressives against those they thought were their friends, who want the freedom to do what they choose—and thereby, ironically, to let big biotech business do what it chooses. And on the conservative side, it pits those who treasure the sanctity of life against libertarians and others who uncritically favor business interests.

It’s hard to predict how this newfound alliance between those divided by their general political philosophy, and their view on issues like abortion, will develop. What is clear is that the bio questions do not fit into our traditional politics, and they therefore present us with special political challenge. This combination of pro-life and pro-choice forces could prove a novel and potent force. It could also be easy to sideline.

4. Bio and multilateral discussion. The bio issues are being considered in many multilateral fora, from the Council of Europe to various agencies of the United Nations. It has been recognized that they are fundamental questions that affect all of humankind; and that it is hard to see how individual nations can control them. All well and good: but we know how hard it is to exercise democratic accountability in these international bodies. Indeed, it can be hard to discover what it is they are doing. This has become a pressing issue with the U.S. decision to rejoin UNESCO, the United Nations Educational, Social, and Cultural Organization, which is set for October of this year. UNESCO has long hosted the International Bioethics Committee, which is working on a long-term goal of a “universal instrument” in bioethics—that is, a convention that covers the bio waterfront.

It makes sense for us to work for global agreement on these issues, but ensuring that such bodies are responsive to public opinion presents a huge challenge.

That’s four of the special challenges we face. There will be others.

*The following is a letter that was sent to the members of the U.S. Senate from a group of over 100 feminists and others concerned about human cloning. Those opposed to human cloning come from many sides of the political spectrum; this is an opportunity for coalition-building across traditional political lines, and such coalitions are much needed to counteract the clout and financial resources of the pro-cloning bloc.*

## **OPEN LETTER TO U.S. SENATORS ON HUMAN CLONING AND EUGENIC ENGINEERING**

**Senate Majority Leader Tom Daschle**  
**Senate Minority Leader Trent Lott**  
**Members of the Senate**

cc: President George W. Bush

Members of the House of Representatives

**March 19, 2002**

Dear Senators,

The United States Senate will soon be considering legislation on human cloning. Your decisions will have profound implications for the future of humanity.

The new technologies of human genetic engineering are among the most consequential technologies ever developed. If used wisely they hold great promise for preventing and treating disease, but if misused they could lead to a future more horrific than any we might imagine.

These technologies are being developed at a frenzied pace. The general public has had little real opportunity to understand and consider their full implications. There are few significant controls over their use.

These conditions leave us vulnerable to being pushed into a new era of eugenic engineering, one in which people quite literally become manufactured artifacts. The implications for individual integrity and autonomy, for family and community life, for social and economic justice and indeed for world peace are chilling. Once humans begin cloning and genetically engineering their children for desired traits we will have crossed a threshold of no return.

Given the rapid pace of development, the enormous stakes, the lack of societal controls and the fact that informed public debate has barely begun, what is the responsible course of legislative action at this time?

With regard to human cloning, we believe the answer is straightforward.

First and obviously, the United States should ban the creation of full-term human clones ("reproductive cloning"). There is no unmet need that requires the creation of genetic duplicates of existing people. Surveys show that 90% of Americans support bans on reproductive cloning. Nearly thirty countries world-wide have already agreed to such bans. The United States should do likewise without delay.

Second, the United States should enact a moratorium on the creation of clonal human embryos for research purposes (often prematurely called "therapeutic cloning"). The widespread creation of clonal embryos would increase the risk that a human clone would be born, and would further open the door to eugenic procedures. Fortunately, important research on embryonic stem cells does not yet require the use of clonal embryos. A moratorium would allow time for alternatives to research cloning to be investigated, for policy makers and the public to make informed judgments, and for regulatory structures to be established to oversee applications that society might decide are acceptable. A moratorium on research cloning is a middle ground between the two positions of an immediate permanent ban and an unconstrained green light.

We strongly urge as well that the United States join with other countries, under the auspices of the United Nations, to work towards an international convention that would ban dangerous

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applications of the new genetic technologies, while encouraging the many applications judged to contribute to the improvement of human well-being.

We are long-time advocates for human rights, the environment, and social justice. We are strong supporters of women's health and reproductive rights, disability rights, and biomedical research. We believe in the inherent equality and human dignity of all people. We want to help ensure that our descendants live in a world in which these values are sustained and nurtured.

We believe that a ban on reproductive cloning and a moratorium on the creation of clonal embryos are the policies most consistent with the values and commitments we share. We strongly urge you to support legislation that would enact such policies into law.

Sincerely,

(Signed by over 100 people)

From the website of the Center for Genetics and Society: [www.genetics-and-society.org](http://www.genetics-and-society.org)

## **BIOTECHNOLOGY NEWS UPDATE**

### **Adult Stem Cell Advances**

Recently, numerous advances in treatment research involving adult stem cells have been reported. Among them are the use of frog extracts to encourage normal human adult cells to revert to a stem cell state, and advances with bone marrow cells to regenerate pancreatic cells in mice with diabetes and regrow myelin in people with multiple sclerosis. Other stem cells from human blood show promise in restoring mobility to rats after stroke.

Helen R. Pilcher, "Frog eggs rejuvenate human cells: Amphibian extract may take adult DNA back to stem-cell state," *Nature Science Update*, July 15, 2003 (<http://www.nature.com/nsu/030714/030714-3.html>).

Dwayne Hunter, "Stem-like Cells from Blood Show Promise for Stroke," *Betterhumans Daily*, July 15, 2003 (<http://www.betterhumans.com/Print/article.aspx?articleID=2003-07-15-2>).

Press Release, "Stem-like cells from peripheral blood restore function in rats with severe stroke," *EurekAlert*, July 7, 2003 ([http://www.eurekalert.org/pub\\_releases/2003-07/uosf-scf063003.php](http://www.eurekalert.org/pub_releases/2003-07/uosf-scf063003.php)).

Hilary Waldman, "Bone marrow holds promise in treatment of MS: Stem cells capable of regrowing nerve tissue," July 7, 2003 ([http://www.knoxnews.com/kns/health\\_and\\_fitness/article/0,1406,KNS\\_310\\_2090820,00.html](http://www.knoxnews.com/kns/health_and_fitness/article/0,1406,KNS_310_2090820,00.html)).

Press Release, "'Immortalized' cells enable researchers to grow human arteries," *EurekAlert*, June 6, 2003 ([http://www.eurekalert.org/pub\\_releases/2003-06/dumc-ce060303.php](http://www.eurekalert.org/pub_releases/2003-06/dumc-ce060303.php)).

Helen R. Pilcher, "Human arteries grown from scratch," *Nature*, June 6, 2003 (<http://www.nature.com/nsu/030602.060302-15.html>).

### *Human Embryos of Mixed Gender Developed in Chicago Lab*

Provoking outcry from both the scientific and the ethical communities, a group of scientists recently reported at the European Society of Human Reproduction and Embryology meeting that they had produced human embryos at the blastocyst stage that contained both male and female cells. Those involved in the research claimed that they were simply using the differences between cells with and without Y chromosomes as markers for potential gene therapy applications, but the research was immediately condemned by those running the conference,

with one official saying, "There are very good reasons why this type of research is generally rejected by the international research community."

Rick Weiss, "Scientists produce human embryos of mixed gender," Washington Post, July 3, 2003 (<http://www.washingtonpost.com/wp-dyn/articles/A1608-2003Jul2.html>).

"Mixed-sex embryo controversy," The Scientist, July 8, 2003 (<http://www.biomedcentral.com/news/20030708/01>).

### *First Birth of Cloned Mule*

The University of Idaho researchers who recently cloned the mule named Idaho Gem were the first to clone any equine or hybrid animal. As hybrids between donkeys and horses, mules are always infertile. The mule's birth may have greater implications if the experiment is found to be repeatable with horses. The mule cloning varied from other recent animal clonings, as Idaho Gem was cloned from a fetus that was not brought to term instead of from an adult cell.

Sylvia Pagan Westphal, "Mule birth marks equine cloning breakthrough," New Scientist, May 29, 2003 (<http://www.newscientist.com/news/news.jsp?id=ns99993780>).

Associated Press Report, "Horse Family Gets Its First Clone," Washington Post, May 30, 2003 (<http://www.washingtonpost.com/wp-dyn/articles/A55619-2003May29.html>).

Maggie Fox, "Scientists Clone a Mule," Reuters, May 29, 2003 (<http://www.reuters.com/newsArticle.jhtml?type=topNews&storyID=2847124>).

### *New Drugs May Benefit Cancer Patients*

At the recent meeting of the American Society of Clinical Oncology, two new drugs were reported to offer a significant increase in survival to patients with colorectal cancer. Avastin blocks the growth of blood vessels to tumors, slowing the tumors' growth. Erbitux has been shown in studies to stabilize or shrink tumors for patients with advanced colorectal cancer. The makers of both drugs are seeking FDA approval. These announcements have stock surges for both companies, Genetech Inc. and ImClone Systems.

Justin Gillis, "New Drugs Help Cancer Patients," Washington Post, June 2, 2003 (<http://www.washingtonpost.com/wp-dyn/articles/A1128-2003Jun1.html>).

Toni Clarke, "Biotechnology Stocks Soar on Drug Data Optimism," Reuters, June 2, 2003 (<http://www.reuters.com/newsArticle.jhtml?type=topNews&storyID=2864862>).

### *Biotech Industry Forum Ends Without Resolution*

In a forum sponsored by the Pew Initiative on Food and Biotechnology, biotech industry representatives met with consumer and environmental groups to discuss issues of food safety and other concerns within agricultural biotechnology. The talks ended without resolution on a number of important issues, largely relating to government oversight of the industry. The members of the panel will consider meeting again in a year if funding is available for the event.

Randy Fabi, "US consumer groups slam biotech firms for ending talks," Reuters, May 30, 2003 (<http://www.reuters.com/newsArticle.jhtml?type=topNews&storyID=2853626>).

## *Ethics & Medicine*

"The Stakeholder Forum on Agricultural Biotechnology: An Overview of the Process," Pew Initiative on Food and Biotechnology, May 2003 (<http://pewagbiotech.org/consensus/FinalReport.pdf>)—requires Adobe Acrobat Reader to view.

### *American Medical Association Endorses Cloning for Research*

The American Medical Association has taken the step of officially endorsing human cloning for research purposes. While admitting that proper oversight is needed and physicians should not be coerced into performing such research, the AMA's declaration that cloning is ethical and consistent with a physician's duties deeply undermines the traditional understanding of physicians' duties to protect and care for patients. The push to clone human beings to gather embryonic stem cells also undermines the use of adult stem cells as a viable and valuable avenue of research.

Press Release, "AMA says use of stem cells for biomedical research is consistent with medical ethics," American Medical Association, June 17, 2003 (<http://www.ama-assn.org/ama/pub/article/1616-7773.html>).

Lindsey Tanner, "AMA Backs Cloning for Research Purposes," *Newsday*, June 18, 2003 (<http://www.newsday.com/news/nationworld/nation/sns-ap-ama-cloning.0,1350283.story?coll=ny-nationalnews-headlines>).

### *European Parliament Supports Comprehensive Cloning Ban*

Dr. Peter Liese of the European Parliament, which has recently voted for a comprehensive ban on human cloning, met with members of the U.S. Senate to discuss European hopes for a cloning ban in the U.S. Dr. Liese is a pediatrician and geneticist and came to the U.S. to encourage members of the Senate to pass a cloning ban. His remarks were insightful and helpful in understanding the international policy scene.

Press Release, "Brownback, Weldon, & Member of European Parliament Discuss Ban on Human Cloning," June 24, 2003 (<http://brownback.senate.gov/record.cfm?id=205465>).

### *Aborted Fetuses Could Be Used as a Source of Eggs for IVF*

Using egg maturation technologies currently being developed, aborted fetuses could soon become a new source of eggs for the IVF industry. A recent study of women who had donated eggs found that a full third of them would not be willing to donate again, so the industry is beginning to search for creative ways to meet the demand for eggs. The idea of using eggs harvested from aborted fetuses is unethical on many levels, not the least of which being problems for the children born whose mothers were themselves never born.

Martin Hutchinson, "Aborted fetus could provide eggs," *BBC News*, June 30, 2003 (<http://news.bbc.co.uk/go/pr/fr/-/2/hi/health/3031800.stm>).

"Aborted Fetuses Could Ease Egg Shortage—Scientist," *Reuters*, July 1, 2003 (<http://www.reuters.com/newsArticle.jhtml?type=topNews&storyID=3020045>).

Alan Mozes, "Third of U.S. Egg Donors Unwilling to Donate Again," *Reuters*, July 2, 2003 (<http://www.reuters.com/newsArticle.jhtml?type=topNews&storyID=3029071>).

### *Human Womb Transplants May Be Available Soon*

Scientists working to develop ways to transplant a uterus from one woman to another suspect that such transplants may be available in as little as 2–3 years. Researchers recently had success in mice with transplanted uteri. The mice were able to bear healthy babies. Such transplantations may soon be possible for women who were born without uteri, thereby enabling them to bear children, and has the potential to reduce the demand for surrogate mothers.

Helen R. Pilcher, "Mice born from transplanted womb," Nature Science Update, July 2, 2003 (<http://www.nature.com/nsu/030630/030630-3.html>).

"World First For Swedish Researchers - Mice Born From Transplanted Wombs," ScienceDaily, July 7, 2003 (<http://www.sciencedaily.com/releases/2003/07/030701222608.htm>).

Patricia Reaney, "Womb Transplants Possible in Three Years - Scientists," Reuters, July 1, 2003 (<http://www.reuters.com/newsArticle.jhtml?type=scienceNews&storyID=3019972>).

### *Implantable Human Tracking Chip Now Available*

A chip the size of a grain of rice has recently been introduced that can be implanted under the skin of a person to confirm identity and medical information for a patient. The United States FDA has agreed not to regulate the chips, provided the medical and other personal data of people who have the chip implanted is stored on a separate database and not on the chip itself. In order to access the data, the chip must be scanned and the serial number connected back to the stored information. The chip is being launched and is expected to be popular in Mexico, where it can also be used to track and identify victims of kidnapping.

"Implantable human tracking chip launched," CNN, July 21, 2003 (<http://www.cnn.com/2003/TECH/ptech/07/18/human.chip.ap/index.html>).

## **NANOTECHNOLOGY UPDATE**

### **Nanotechnology: Small Wonder or Grey Goo Nightmare?**

**By Amy Michelle DeBaets**

Nanotechnology, the science of manipulating materials at the molecular level, has come into the spotlight recently as the next wave in biotechnology. The term itself comes from a nanometer, 1 billionth of a meter, and potential nanotech applications range from medicine to textiles to weapons. Once considered the stuff of science fiction, nanotech is the latest rage among venture capitalists, and the field is being touted as the next big thing, the successor to the dot-com boom of the 1990s. Nanotech has even made it to the big screen, as it was recently featured in the blockbuster movie "Hulk."

What should we make of this tiny new science? Is nanotechnology simply chemistry and engineering as we have known them, only smaller? Or does this new scale present new problems, both ethical and practical? There are no simple answers to these questions, and we must be vigilant in understanding these new

technologies and how they affect our lives, both good and bad. On one level, nanotechnology is simply a fancy new term to describe the natural progression of existing technologies, like computer chips, getting faster and smaller. On another level, though, nanotechnological applications have the potential to restructure our selves and our world at the most basic level.

“Nanotechnology” is being used to describe a broad range of actual technologies. Their small scale is the only thing many of them have in common. Some of the first emerging applications are extra-small computer chips and batteries; others are stain-resistant fabrics. These are simple extensions of current technologies and are certainly harmless enough. The more distant prospect of nanobots cleaning harmful pollution by altering its molecular structure is one we would likely relish. But the technology that cleans our pollution could also create it. Nanobots that remove the cholesterol from our arteries and repair damaged cells could easily fail to stop with their desired functions. “Grey goo” has recently entered the public lexicon to describe a scenario in which nanobots replicate uncontrollably, altering the face of the planet.

Regulation and careful monitoring both inside and outside the scientific community will be critical as nanoscale science develops. The following articles give a taste of the advancements and discussion occurring in this burgeoning field.

“House and Senate Think Small: Nanotech Bills Advance,” American Association for the Advancement of Science, June 30, 2003 ([http://www.aaas.org/spp/cstc2/news/articles2003/030630\\_nano.shtml](http://www.aaas.org/spp/cstc2/news/articles2003/030630_nano.shtml)).

Gaia Vince, “Nanotechnology may create new organs,” *New Scientist*, July 3, 2003 (<http://www.newscientist.com/news/news.jsp?id=ns99993916>).

Tom Shelley, “Nanotechnology: Mass-Produced Nano?,” *Small Times*, June 23, 2003 ([http://www.smalltimes.com/document\\_display.cfm?document\\_id=6256](http://www.smalltimes.com/document_display.cfm?document_id=6256)).

Richard Fletcher and Lauren Mills, “Nanotechnology: The Next Small Thing,” *The Telegraph (UK)*, June 15, 2003 (<http://www.telegraph.co.uk/money/main.jhtml?xml=/money/2003/06/15/ccnano15.xml&sSheet=/money/2003/06/15/ixcoms.html>).

Press Release, “New UK study of nanotechnology: the small-scale science,” *EurekaAlert*, June 12, 2003 ([http://www.eurekaalert.org/pub\\_releases/2003-06/bis-nus061203.php](http://www.eurekaalert.org/pub_releases/2003-06/bis-nus061203.php)).

Miranda Fettes, “Small Science Has Some Thinking Big, Some Thinking Bad,” *Small Times*, June 26, 2003 ([http://www.smalltimes.com/document\\_display.cfm?document\\_id=6276](http://www.smalltimes.com/document_display.cfm?document_id=6276)).

David Hearst, “Sci-fi war put under the microscope,” *The Guardian*, May 20, 2003 ([http://www.guardian.co.uk/uk\\_news/story/0,3604,959469,00.html](http://www.guardian.co.uk/uk_news/story/0,3604,959469,00.html)).

Press Release, “New Nanoscale Device Reveals Behavior of Individual Electrons,” University of Wisconsin, June 3, 2003 (<http://www.news.wisc.edu/releases/view.html?id=8710>).

Matt Kelly, “U.S. Army has ‘big plans’ for nanotechnology,” *Small Times*, May 28, 2003 ([http://www.smalltimes.com/document\\_display.cfm?document\\_id=6068](http://www.smalltimes.com/document_display.cfm?document_id=6068)).

Stacy Cowley, “Nanotechnology key to scientific leaps, execs say,” *InfoWorld*, May 13, 2003 ([http://www.infoworld.com/article/03/05/13/HNnanotechnology\\_1.html](http://www.infoworld.com/article/03/05/13/HNnanotechnology_1.html)).

Barnaby Feder, “Nanotechnology creates a royal stir in Britain,” *International Herald Tribune*, May 20, 2003 (<http://www.iht.com/articles/96822.html>).

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## BOOK REVIEWS

### **Enough: Staying Human in an Engineered Age**

Bill McKibben

New York: Henry Holt and Company, 2003

ISBN 0-8050-7096-6, 299 pp., hardcover, \$25

Is human society in the 21st century marching inevitably toward using every new technology that comes along, including germline genetic engineering, cybernetics, and nanotechnology? Or is it possible for us to make choices between technologies and to say to some, "No thanks, we have enough"? In his new book, *Enough: Staying Human in an Engineered Age*, Bill McKibben (the author of *The End of Nature*) argues that while turning down new technologies is difficult, it is possible to selectively implement those technologies which better the human condition and reject those who degrade and destroy our humanity.

McKibben is not a Luddite, seeking to stop all progress of science and reject new technology on a wholesale basis. He is an environmentalist and a humanist who argues convincingly that certain types of scientific "progress," especially germline genetic engineering, do not benefit us as people, but instead threaten the very core of what makes us human.

He looks at the choices that may be available to the first generation of parents who have the option to genetically engineer their children. He sees their free will, the advantages they would like to confer upon their children, to make them exactly as they want them. All parents make choices to push their children in certain directions, but children always have the option to rebel, to break out of the mold their parents set for them, to become whoever they ultimately want to be. Genetically engineered kids would have that option to rebel taken irretrievably away from them. A genetically engineered child would never know, for instance, if she became a concert pianist because she wanted to or because it was programmed into her before she was born.

He also argues that such engineering creates a fundamental break with all of the generations of humanity that have come before:

If the engineering works as intended, the offspring will be superior to their parents. With a higher IQ, or a more manageable temper, or a better ear, or quicker reflexes. Not "better" as when a son grows in strength while his father declines, till one day their positions are reversed, but categorically better, of a higher order. *Different*. One reason we love and nurture our kids, or so the biologists tell us, is from an inarticulate desire to pass along our genes. But these won't be our genes precisely; they'll belong to whichever multinational created them. And these kids won't be our kids, not exactly. The gulf between their generation and ours will be enormous, their "evolution" accelerated.... That will cause confusion aplenty: talk about undermining parental authority. ("Dad, you just don't understand" will have a different, more literal meaning.) But it will also, with each progressive generation, sever those children more fully from their human past.

McKibben is practical in his understanding that such advanced, "designer" engineering would never be widely available, but would be an option only for the rich. The gap between rich and poor would grow dramatically and would go beyond socioeconomic status to become an ingrained, physical distinction.

He argues similarly that cybernetics, nanotechnology, and the scientific quest for immortality have effects that would also degrade our humanity, or possibly remove us from it entirely. McKibben's tone is serious and cautious without becoming excessively alarmist. About two-thirds of the way through the book, about the time the reader may begin to ask, "This stuff

is bad, but what can we really do about it? Isn't it inevitable?" he attempts to answer the questions using practical examples from history.

McKibben provides solid arguments and a framework for discussion of the need for practical limits on biotechnology. His book may be particularly effective in convincing those who believe that the "progress" of science is inevitable and those not drawn to religious arguments. *Enough* is written at a level suitable for a generally educated audience and never becomes excessively technical in nature. As he closes the book he writes, "To call the world enough is not to call it perfect or fair or complete or easy. But enough, just enough. And us in it."

**Amy Michelle DeBaets** is a Master of Divinity student at Princeton Theological Seminary in Princeton, New Jersey, USA, and Editor of the Biotech Update for the Council on Biotechnology Policy for The Wilberforce Forum.

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### **Everyday Bioethics: Reflections on Bioethical Choices in Daily Life**

Giovanni Berlinguer

Amityville, NY: Baywood Publishing Company, Inc., 2003

ISBN 0-89503-225-2, 164 pp., hardcover, \$38.00

Giovanni Berlinguer has crafted an informative and unique treatise on bioethics by placing the moral issues of medical technology of more recent times within the broader context of what he calls everyday bioethics. As he discusses the moral implications of issues related to recent biotechnology, Berlinguer pushes the reader to consider bioethics within a larger context of ethical issues that have plagued humanity for centuries. According to Berlinguer, bioethics as a subject is about the relationship between "frontier bioethics and everyday bioethics" (p. 148). By frontier he means ethical issues that confront mankind because of the life and death possibilities presented by recent technology. Everyday bioethics categorizes those ethical issues involving more general and historically recognized "moral reflections on birth, on the relations between men and women and among different human populations, on the treatment of the sick, on death, on the interdependence of human beings and other living creatures" (p. iii). He advances the idea that it is the interrelation of frontier and everyday bioethics that results in "the most fruitful thinking about moral principles" that govern both (p. iv).

In chapter one Berlinguer looks at the plethora of moral issues surrounding procreation and birth, noting that one must give primary concern to the destiny of the child when considering the ethics of such matters. Human dignity must be protected and the child should never be treated either directly or indirectly in a way that would violate the Kantian precept that man should never be treated as a means. His fourth chapter on the human body pointedly confronts the reader with the moral schizophrenia of many Western cultures with respect to the human body. On the one hand there is a glorification of the human body, while on the other hand it has been reduced to a commodity where parts are traded on the internet and cloning is considered for the creation of spare parts. His concern is that "the role now played by the market has been forgotten or underestimated in the bioethical debate" (p. 91).

Berlinguer devotes chapter two to a discussion of the ethics of population policies (which has a long history) that involves everything from immigration laws to the definition of the family. He warns against imprecise terms in ethical debates as well as the misuse of statistics. He argues that there are three controlling concepts that must be applied to the ethics of populations—human rights, pluralism, and equity (in contradistinction to equality). In the end, societies must not only have the right information, they must act rightly with that information. Furthermore, financial power must not supplant moral concerns in determining policies regarding demographic concerns.

Arguably the most provocative chapter is chapter three, titled “Work and Health: Foundations and Ethical Concerns.” In this chapter he forwards the notion that “the relationship between work and health lies at the interface between human biology and economics” (p. 55). Here, Berlinguer draws attention to the proper balance between market viability and individual health, or put another way, the balance between corporate profits and individual risks. He presses the application of the dignity of human life to its logical implications for the treatment and health of the worker. He recognizes the complexity of everyday bioethics and points to “values and interests that are in some cases incompatible” (p. 85). Nonetheless, he strenuously argues for appropriate ethical solutions that balance the dignity of man with the strength of the economy. Although he admits that there are no simple solutions to the dynamic moral complexities of the human experience, his thesis is that interfacing frontier bioethics with everyday bioethics will greatly enhance the possibility of meaningful solutions for both. For Berlinguer, everyday bioethics is frontier bioethics writ large.

One might debate how well he has connected frontier and everyday bioethics in all points, but it seems undeniable that he has made a measurable contribution to the bioethical debate by demonstrating there is a connection. His realistic perspective concerning the complexity of the human experience and the difficulty of balancing human dignity and economic interests gives a tone of sanity to his appeal for moral principles in a global context. However, it should also be noted that at times this realistic perspective is weakened by a naiveté regarding the global workability of possible solutions, which gives rise to an optimism unwarranted by the facts. Furthermore, while he speaks about morality (mostly from a Kantian perspective), he offers little in the way of a metaphysical foundation for morality. While not all will agree completely with Berlinguer’s thesis, none can read this book without gaining insight into and wisdom for the bioethical debate.

**Bruce A. Little, DMin, PHD**, Associate Professor of Philosophy of Religion, Southeastern Baptist Theological Seminary, Wake Forest, North Carolina, USA.

### **Setting Limits Fairly: Can We Learn to Share Medical Resources?**

Norman Daniels and James E. Sabin

New York, NY: Oxford University Press-USA, 2002

ISBN 0-19-514936-X, 208 pp., hardcover, \$34.50, £22.95

This book addresses the vexed, much-debated, and increasingly important question of sharing medical resources in a way the public will accept as fair and legitimate. The authors—one a professor of medical ethics and the other a professor of psychiatry—are based in the USA, but they recognise that problems of trust and legitimacy are international and not limited to the US system of competitive managed care. They consider that in order to ensure a fair and acceptable system, four conditions must be met. The first is that limit-setting decisions must be public; and not only the decisions but also the grounds for making them. Second, the grounds for decisions must be ones that fair-minded people can agree are relevant. Third, limit-setting decisions must be subject to revision and appeal. Finally, there must be some form of regulation.

The central problem revolves around the allocation of priorities. For a start, How much priority should a society give to its most seriously ill patients? At first glance, it might seem obvious that the sickest patients should have absolute priority. But that assumes that treatment would be effective; if not it would be a waste of money and would involve sacrificing substantially greater benefits that many others might have obtained. Another arguable view is that society should maximise the total benefit its health care expenditures provide, regardless of who gets the benefits. This was what was initially considered in the State of Oregon—until it was discovered that capping teeth would have a greater priority than surgery for appendicitis!

Many countries have debated at length the matter of priorities, and have found that there is no easy answer. The consensus is that most people will neither sacrifice everything to the

sickest, nor abandon them. The whole subject bristles with problems. If 'society' is to decide, who represents society? There is no plausible sense in which consumers selected to participate actually represent other consumers. What attitude should be adopted towards unproven treatments which patients or their families believe may make the difference between life and death—so-called 'last chance therapies'? What about new and costly technologies? Should the public be able to demand an expensive drug when a cheaper 'therapeutically interchangeable' one is available? The questions are endless.

The authors believe that only a public that has gone through a sustained educational process will be equipped to accept the fairness and legitimacy of any limits. And if clinicians are to support priorities and rationing, they must be able to see the policy rationale with the same emotional clarity and immediacy with which they see their individual patient's needs.

In the reviewer's opinion, this book is an excellent introduction to the subject.

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### **Why Bother Being Good?: The Place of God in the Moral Life**

John Hare

Downers Grove, Illinois: InterVarsity Press, 2002

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John Hare believes that one must have certain Christian beliefs for morality to make sense as either a private or public practice. He assumes that without this, background morality "as we are familiar with it," will break down and this "breakdown is harmful to people whether they believe in the background or not" (p. 28). In order to preserve social order he maintains that those who reject the Christian theological background will be required to find a substitute to "do the work that the theology used to do" which he says will not be easy and may be impossible (p. 9). Hare argues convincingly that the issue is not merely moral behavior, but determining a sufficient authority for the morality practiced.

In the first four chapters, Hare discusses how it is that one can be morally good, even though there is a "moral gap." This is the distance between the objective moral demand and man's native abilities to fulfill the demand. According to Hare, it is God who calls us to live a certain way and then offers us various kinds of assistance to live that way. God must help, he argues, because it is impossible for man to bridge this gap without God's help, which He provides through the work of atonement, justification, and sanctification. There seems to be a slight contradiction at this point because Hare also claims that non-believers can live moral lives, but he does not examine if and how God helps them.

In the last six chapters Hare reviews four often suggested secular sources for the authority of morality: native goodness, human nature, reason, and community. He examines each and concludes they are insufficient in and of themselves to give morality its authority. His assumption is that the proper (and maybe only) authority of morality is God's will as seen in that to which God calls us. It is his emphasis on God's will in relationship to morality, however, that raises the vexing philosophical/theological question of whether morality flows from the nature of God or whether it is solely a matter of the will of God. He says that we should think "of God as choosing the moral law as a route toward our final destination, which is to be united with God," and that "the commandments are better seen not as a necessity binding God but as a route God chose for us" (p. 143).

Hare's strongest argument undoubtedly is found in his critique of alternate secular sources of moral authority. The reader should also approvingly acknowledge his controlling assumption

that morality includes not only appropriate behavior, but also legitimate motivation that is properly grounded. This not only adds to the strength of the argument of his book, but is an important clarification for the ongoing public debate regarding the merits of legislating morality.

While there is much to commend this book in terms of content, the style unfortunately does not compliment the content. Hare often interrupts his argument with unnecessary comments (and even brief discourse) that distract the reader and detract from the flow of his argument. Furthermore, many will find themselves annoyed by his strenuous argumentation for a point only to unsatisfactorily conclude with something like, "But that is not enough." In one example of his inconsistency, Hare argues that those who believe in the moral life must believe "in self-rewarding morality, that everyone's virtue would make almost everyone happy" (p. 82); that is, if we are to be virtuous, we must believe in the benefits of everybody's virtue. However, he later says that "the important thing is that our commitment to morality does not depend upon our belief in the virtue of others" (p. 83). This seems to question, if not the former idea, at least the time spent developing it.

Unhappily for the force of argument, Hare's use of terms such as "moral faith" and "call of God" is inconsistent and gives the appearance of equivocation. At one point he speaks of moral faith as that which is necessary for believing in the providence of God—the idea that there is an ordering to the universe—therefore, it makes sense to live morally. Later, he applies moral faith as necessary when one thinks God is calling him to do something that appears unwise to others (pp. 200-201). Here moral faith is applied as a subjective notice. Furthermore, in the example just cited, the "call of God" has nothing to do with making a moral decision as is used elsewhere, so one wonders why this should call for moral faith.

Those who read Hare's book (and I hope many will in spite of its suggested weaknesses) will find much of the material informative. Many will find themselves agreeing with much of what Hare says, but his power to convince by compelling argument seems, to this reviewer, questionable.

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### Rethinking Peter Singer

Gordon Preece, Editor

Downers Grove, Illinois: InterVarsity Press, 2002

ISBN 0-8308-2682-3; 180 pages, paperback, \$18.00

Peter Singer is the *bête noire* of contemporary ethics, particularly so for those of us who hold to traditional understandings of moral values. It is safe to say that Singer takes what readers of this journal would consider the wrong view on every substantive issue in bioethics today, and he does so to an increasingly wide audience in society. The Australian thinker has been well known to philosophers for decades for his work in ethical theory and applied ethics but became known to the public only after his American appointment as the Ira W. DeCamp Professor of Bioethics at the University Center for Human Values, Princeton University. Singer powerfully contends for controversial positions, including his support for abortion, euthanasia, embryonic stem cell research, and infanticide, and his opposition to the position he has dubbed "speciesism," which is the preference for the interests of humans above those of animals. Singer is an outspoken critic of virtually every position that Christians and other traditionalists defend in the area of bioethics, and vigorously assaults what he considers the hypocrisy of those traditional values. Singer simply must be addressed forcefully, clearly, fairly, and effectively by those who wish to defend human dignity.

In this book, Singer is engaged by a capable group of Australian theologians associated with Ridley College, Australia, an evangelical Anglican theological college in Melbourne. Singer, whom Preece calls "probably the world's most famous or infamous contemporary philosopher," has as yet provoked little sustained response from either philosophers or specifically Christian

scholars. This book will be a valuable resource to those who want to understand Singer from a Christian perspective, joining the secular philosophical anthology, the much more affirming *Singer and His Critics*, edited by Dale Jamieson (Blackwell, 1999).

Preece, along with Ridley colleagues Graham Cole (now at Trinity International University in the United States), Lindsay Wilson, and Andrew R. C. Sloane, offer a set of well-researched, carefully argued critiques of many central points in Singer's troublesome views. Although they are not academic philosophers, they show excellent facility with the language and methodology of the field, and offer cogent critiques of Singer's philosophy.

Utilitarianism, the theory that Singer applies with pitiless consistency, had dominated English-speaking philosophy from the mid 19th-century until a few decades ago. Philosophers today overwhelmingly if not unanimously have rejected the theory because, with its insistence that the only morally relevant consideration is the production of benefits and minimization of harms, utilitarianism does violence to a number of important dimensions of morality. For example, it would forbid that one give any special preference to those within our circle of care, but rather see everyone as equally potential recipients of the impersonal benefits we can produce. Likewise, it requires such zealous activity in pursuit of utility maximization that it would consume all of our energy and would require us to abandon our non-utilitarian projects and pursuits. Most significantly, it would advocate actions that are morally monstrous, such as, in a famous example, requiring that under pressure from a threatening mob, a sheriff deliberately and knowingly frame and execute an innocent person.

Singer's views seem to be a *reductio ad absurdum* of utilitarianism. The views he advocates are in many cases so outrageous and counterintuitive that they are just the sorts of examples that opponents of utilitarianism typically offer as examples meant to show the implausibility of the theory. Similarly, while he calls welcome attention to the abuse of animals in our society, he is so extreme that he would repel many who otherwise might be sympathetic to that cause.

In his introduction, Preece, Director of the Centre for Applied Christian Ethics at Ridley, asks whether Singer is "Hero or Herod?" and provides a brief assessment of Singer's influence and a short biography. In the first chapter, "The Unthinkable & Unlivable Singer," he argues that some of Singer's "key ideas are (1) unthinkable, (2) 'yucky' or morally outrageous, (3) inconsistent, (4) impractical/unlivable and (5) based on a reductionistic model of humanity, ecology, rationality and morality." Singer's support of infanticide and bestiality are "unthinkable" and violate taboos that Singer wrongly regards as mere irrational holdovers of traditional religion. While Singer believes he takes the higher ground by attempting to omit emotion from ethical analysis, Preece insists on joining both rational and feeling-based responses in assessing moral issues so that we can identify and reject what is morally "monstrous." In a manner that happily avoids making a simple *ad hominem* attack on Singer, Preece points out Singer's inconsistency in his refusal to euthanize his mother, Cora, a physician and refugee from Nazi-controlled Austria who suffered from Alzheimer's disease. Preece offers a strong critique of Singer's utilitarianism on a number of grounds, including its insistence that one place one's own interests and projects on no higher level than utilitarianism allows. Many of his critiques are familiar to philosophers and all are well aimed.

Andrew Sloane, a physician who teaches Old Testament, theology, and ethics, takes aim at Singer's approach in "Singer, Preference Utilitarianism, and Infanticide." Preference utilitarianism aims at the furtherance of individual's preferences, rather than their benefit calculated in impersonal, abstract terms. Singer argues that killing infants does not thwart their preferences, since they don't as yet have any preferences, while doing so may satisfy the preferences of their parents. Sloane attacks both the theory and Singer's use of it in infanticide and defends a theistic account of ethics.

Graham Cole, who teaches theology and ethics, evaluates Singer's assessment of Christianity and its moral teachings in "Singer on Christianity: Characterized or Caricatured?" Singer objects to theism because he believes religious language is meaningless and that the problem of evil provides compelling argument against God's existence. Christianity, in particular,

reinforces a “dominion” view of humanity over nature that has led to many evils, and further it implies a sanctity of life view that Singer finds objectionable. Cole argues that Singer one-sidedly cites Scripture and Christian history to caricature the faith, and ably corrects Singer’s erroneous stereotypes.

Lindsay Wilson, lawyer and Old Testament scholar, critiques Singer’s treatment of humanity in “Human Beings—Species or Special?” Wilson believes that “the image of God” is a better basis for ascribing value than sentience, the ability to experience pleasure and pain. The *imago Dei* in particular holds that human beings are moral agents, morally responsible and morally accountable individuals which no animal could ever be. Wilson also objects that Singer doesn’t give enough weight to individual species and the importance of species diversity. He does agree with Singer, however, that the treatment of animals is an important ethical issue, and he appreciates some of Singer’s contributions in this area.

In the final chapter, “Rethinking Singer on Life & Death,” Preece attacks Singer’s support of voluntary euthanasia. Voluntary euthanasia is for Singer an area in which a quality of life ethic must supplant a sanctity of life ethic. Preece carefully explains the nature and limits of sanctity of life in a Christian perspective, and forcefully defends it against Singer’s assault.

Overall, this is a well researched book that goes far towards explaining Singer’s views and their significance for the contemporary bioethical debate. It goes far towards offering a Christian perspective on the issues Singer raises. *Rethinking Peter Singer* will be a valuable resource to all Christians and to others who wish to gain a better understanding of the issues that Peter Singer has forced into the public debate, and it deserves a wide readership. I have been recommending it to students and friends as a reliable, admirable analysis and critique of Singer and his positions.

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