Ethics & Medicine

An International Journal of Bioethics

Vol 28:2
SUMMER 2012
ISSN 0266-688X

Ethics & Medicine An International Journal of Bioethics
Vol 28:2 SUMMER 2012 ISSN 0266-688X

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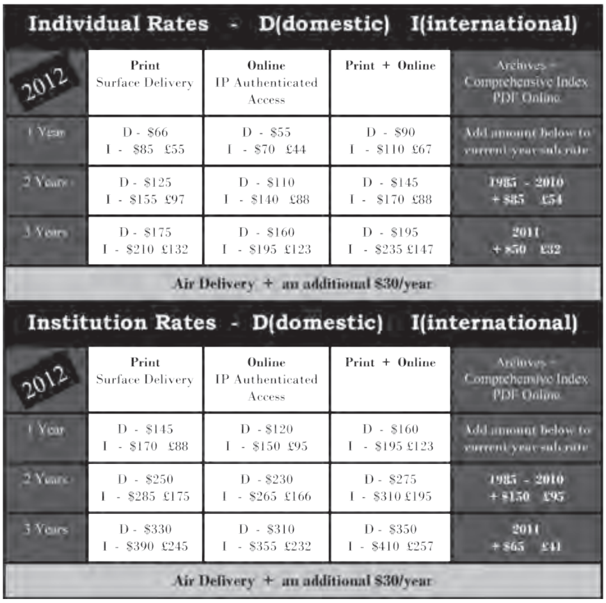
info@bioethicspress.com
www.ethicsandmedicine.com

SUBSCRIPTIONS

Ethics & Medicine is published three times a year by The Bioethics Press, Ltd. Subscriptions may be obtained and address changes can be made with the publisher at the address above.

The mission of *Ethics & Medicine* is to reassert the Hippocratic consensus in medicine as seen through the lens of the Judeo-Christian tradition on the conviction that only a robust medical professionalism is able to withstand the challenges of emerging biotechnologies and their clinical applications.



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Ethics & Medicine: An International Journal of Bioethics
ISSN: 0266-688X © 2008 by The Bioethics Press, Limited

Ethics & Medicine

An International Journal of Bioethics

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VOL 28:2, SUMMER 2012
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EDITORIAL

THE IDEA OF THE MODERN HOSPITAL

C. BEN MITCHELL

Having just spent an extended period of time with a family member in an excellent hospital, I am thankful for physicians, nurses, and the other individuals whose vocation is in health care. I was struck once again, however, by how secular many hospitals have become, despite the fact that most of their patients are people of deep faith.

Historically speaking, hospitals are not secular institutions. In fact, the modern hospital system owes its existence to people of faith. Rabbinic sources often cite the second century BC book of *Ecclesiasticus* as a reminder that medicine owes its origins to God: "Honor the physician . . . from God the physician gets wisdom . . . God brings forth medicines from the earth and let a prudent man not ignore them" (39:1). Christians have been leaders in medicine and in the building of hospitals because Jesus of Nazareth healed the sick and disabled. The early church not only endorsed medicine but also championed care for those who were compromised by illness.

Admittedly, the Greeks and Romans made great contributions to early medicine, but, as University of Washington historian of medicine Albert Jonsen maintains, "the second great sweep of medical history begins at the end of the fourth century, with the founding of the first Christian hospital at Caesarea in Cappadocia, and concludes at the end of the fourteenth century, with medicine well ensconced in the universities and in the public life of the emerging nations of Europe."[1] This extraordinary, formative period in medicine was characterized by the Church's intimate involvement. Jonsen argues,

> During these centuries the Christian faith . . . permeated all aspects of life in the West. The very conception of medicine, as well as its practice, was deeply touched by the doctrine and discipline of the Church. This theological and ecclesiastical influence manifestly shaped the ethics of medicine, but it even indirectly affected its science since, as its missionaries evangelized the peoples of Western and Northern Europe, the Church found itself in a constant battle against the use of magic and superstition in the work of healing. It championed rational medicine, along with prayer, to counter superstition.[2]

As a means of caring for those who were ill, St Basil of Caesarea founded the first hospital (c. 369). Christian hospitals grew apace, spreading throughout both the East and the West. By the mid-1500s there were 37,000 Benedictine monasteries alone that cared for the sick. It was not until four centuries after St Basil's hospital that Arab Muslims began to build hospitals.

Furthermore, as Charles Rosenberg shows in his volume, *The Care of Strangers, The Rise of America's Hospital System*,[3] the modern hospital owes its origins to Judeo-Christian compassion. Evidence of the vast expansion of faith-based hospitals is seen in the legacy of their names: St. Vincent's, St. Luke's, Mt. Sinai, Presbyterian, Mercy, and Beth Israel. These were all charitable hospitals, some of which began as foundling hospitals to care for abandoned children.

Similarly, in Europe, great hospitals were built under the auspices of the Judeo-Christian tradition. Indeed, an ancient French term for hospital is *hôtel-Dieu* ("hostel of God”). In 1863, the *Société Genevoise d’Utilité Publique* called on Swiss Christian businessman Jean Henri Dunant to form a relief organization for caring for wartime wounded. Thus, the emblem of the Red Cross was codified in the Geneva Convention one year later. In Britain, Dame Cicely Saunders founded the hospice movement by establishing St Christopher’s Hospice in the south of London in 1967.

This historical survey is meant to be a reminder of that famous axiom: “ideas have consequences.” E&M

Endnotes

1. Albert R. Jonsen, *A Short History of Medical Ethics* (Oxford: Oxford University, 2000), 13.
2. Ibid.
3. In 1800, with a population of only 5.3 million, most Americans would only have heard of a hospital. Philadelphia’s Pennsylvania Hospital was founded in 1751, New York Hospital in 1771, and Boston General did not open until 1821. But by just after the mid-century mark, hospitals were being established in large numbers, and most of them were religious. Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (New York: Basic Books, 1987), especially Chapter 4.

GREY MATTERS

WHEN MORAL ARGUMENTS DO NOT COMPUTE: PROSPECTS FOR AN ETHICS CHECKER

WILLIAM P. CHESHIRE, JR., MD

Advances in computer processing speed are yielding ever more powerful automated text proofing technologies. Extrapolating forward, an intriguing question is whether a future version of the word processor's spell checker might offer the option of an ethics checker.

The Spell Checker

The spell checker has become a familiar application within modern word processing programs. Indispensable to the great majority of writers who spell imperfectly,[1] such programs also improve the typing performance of those who write in a second language, have dyslexia, or whose fingers simply miss the intended key from time to time.

Application of spell checking technology in the physician's office, when linked to electronic medical records, is helping to reduce medication prescribing error.[2] Clinical use requires standardized nomenclature in order to reduce variability in the way data is captured and analyzed.[3] Accordingly, the healthcare system has created an international Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) to enable systematic information exchange and analysis.[4]

The spell checker program does not "know" how to spell in the way the brain understands language. The word to a computer program is nothing more than a sequence of alphanumeric characters delimited by a white space.[5] In much the same way that an American who knows nothing of the Chinese language might decipher a Chinese message by matching the characters one by one to those in a dictionary, computer software compares the digital representations of words to standard vocabulary databases, but at lightning speed.

Spell checkers have gained in mechanical sophistication, yet they retain certain flaws. Some common checkers when scanning the word "neuroethics" will suggest replacing it with "neurotic." Depending on the program's settings, the substitution may occur automatically. Primitive spell checkers that test single words in isolation will not recognize correctly spelled words occurring out of context, for example, "there" when the writer intends "their." Spell checkers have inspired at least one poem. The rhymester's line "It plane lee marks four my revue Miss Steaks I can knot sea"[6] perfectly passes the spell checker's scrutiny.

Beyond Spell Checking

Enhanced computer processing speed has afforded new functionalities. Beyond simple spell checking, current software also analyzes grammar, noting punctuation, vocabulary usage, and sentence structure. Such software can track consistencies of spelling, repetitious phrases, stale words, and excessive jargon. To a limited degree, some checking software also analyzes style, allowing the author to match the choice of words or sentence structure to the intended audience.

Text checking functionality is also integral to content-control software. A common example is Internet filtering software designed to restrict what content is available to a reader when delivered over the World Wide Web. Beneficial uses include parental control software that restricts children's access to objectionable material, blocking, for example, pornography on a home computer connected to the Internet. Some software packages block webpages using terms deemed to be hate speech but in so doing may also risk blocking unobjectionable sites that use the same words in educating the public about the history of human rights abuse. Some authoritarian governments have misused filtering software for the purpose of censoring political or religious content.[7]

The Ethics Checker

After scanning a selected excerpt of text, spell checkers typically ask the user whether to continue checking the remainder of the document. To *really* check the remainder of the document may in the future entail the option of an ethics checker. Computer processing speed and digital memory capacity continue to rise exponentially. Moore's law describes this rate, which continues to double approximately every two years.[8] Might the accelerating trajectory of spell checking software soon cross into the domain of ethics, marking the text of grey matters with red ink?

Ethics checking has, in a way, already arrived. One can now check a manuscript against published documents to ensure that the author has not plagiarized. Worse than misspelling a word is spelling an entire paragraph word for word exactly the way another writer has done in print. Lifting text and calling it one's own is unethical, for which reason published material is legally protected by copyright. Plagiarism detection software represents a further extension of spell checking technology that compares blocks of text to comprehensive databases of published material to verify originality.[9] Current plagiarism checkers are capable of comparing documents against tens of billions of digital resources.[10] Editors are finding such tools useful in detecting fraud and misconduct in manuscripts submitted to professional journals.[11]

Unrealized further options may be within reach of current computing technology. A hypothetical ethics checker application might, at the simplest level, flag or block specific words regarded as troublesome to ethics discussions. Some proponents of synthetic biology, for example, have recommended using the word "construct" in lieu of "create," which they believe may carry religious connotations, when describing to the public controversial research projects intended to synthesize cellular life in the laboratory.[12] Another example is the word "rationing," which conveys a different meaning than "allocation" when referring to scarce organs for transplantation.[13] An ethics language checker might be useful to spot such "obstacles at the heart of communication,"[12] assisting the writer in presenting a more favorable argument and minimizing potentially negative perceptions.

The problem with even a well-intentioned public relations software tool is that it might too easily become an apparatus for euphemism. Word choice can elucidate or conceal. Ethical conduct of scientific research should employ language that accurately describes the work undertaken rather than substituting terminology based primarily on what is perceived to meet with public approval. Ethical use of a word processing ethics checker should strive for accuracy in descriptive language and diligence in applying all relevant moral principles.

Ruth Macklin, who acknowledges the validity of culturally-defined universal principles while rejecting the notion of moral absolutes,[14] might want an ethics checker to expunge forever the word "dignity" from bioethics. "Dignity," writes Macklin, "is a useless concept in medical ethics and can be eliminated without any loss of content."[15] Moreover, she accuses bioethicists who appeal to the language of human dignity of covertly injecting religious ideas into medical ethics.[15] In response, Macklin's view represents neither a consensus nor the final word on dignity. Numerous authors have eloquently articulated the importance of human dignity as a foundational principle, neglect of which would impoverish medical ethics.[16-19] An equitably designed ethics checker should flag not just certain value-laden words but also proposals to exclude them from discussion.

A useful ethics checker could also mine the document for absolute terms such as "always" and "never" and prompt the writer to consider whether exceptions might apply. Conclusions in ethics are seldom black and white.

Another useful function for an ethics checker would be to screen for vulgar language. Profanity filters are routinely available for web applications such as those that host Internet forums. Effective screening for the underhanded *ad hominem* insults that occasionally substitute for reasoned arguments in bioethics discourse would likely require more nuanced textual analysis than current software could consistently achieve. A robust ethics checker would spot harsh criticism and suggest more diplomatic language. Ethics checking software could also flag pointedly rhetorical words such as "barbarity," "diabolical," "crass," and "utopian." It might suggest alternative wording such as "wrongdoing," "discourteous," "insensitive," and "overly optimistic." Such functionality could be considered a kindness enhancement.

Programmers might design ethics checking software to detect nuances in language that reveal unconscious bias in writing patterns. Studies have shown that healthcare professionals, among others, harbor unconscious racial and social biases that may contribute to disparities in health outcomes.[20, 21] Further, some currently available software packages are designed to assist the writer in avoiding expressions that some readers might construe as gender bias. More sophisticated textual analysis software might one day analyze a writer's patterns in word preference much as a human observer interprets body language to detect subtle prejudices, which might reflect underlying cultural conventions or individual attitudes.

On rare occasion, an ethics checker may detect signs of overt psychopathology in a user. Distinguishing pathological thought patterns from prose that merely describes or comments upon pathological ideas would be an essential feature of reliable ethics checking software. If a future computer infused with ethics software were intelligent enough to identify potentially malicious ravings of the psychologically unstable, it might be a matter of time before a lawsuit were brought alleging that the manufacturer of the ethics checking software should bear legal responsibility for not having detected or reported menacing thought patterns in the writing of a criminal who had used the software.

Cleansing text from all bias would, nonetheless, be an improper goal for ethics checking. One reason is that not all biases are harmful. The physician ought to have the bias of desiring that the patient gets well. Secondly, an important role of ethics is to weigh questions of value and purpose. Normative ethics expressions are not neutral but seek to reach conclusions for appropriate or inappropriate conduct. What moral weight to assign to biases is a human value judgment for which inert lines of computer code can be only messengers. The values that ethics checkers would implement originate in the minds of writers and programmers. It matters, of course, whose values ethics checking software would incorporate.

Additionally, because the task of representing the flow of ethics thought would require standardization of data, the digitization of ethics discourse could potentially decrease variabilty in the ways of thinking about ethics. Whether a monopoly on ethics checking algorithms could lead to a default methodology for applying ethical theory or to a digitally imposed orthodoxy are questions that merit forethought.

An ethics checker worth its price tag would look beyond word choice to probe for clues about the writer's method of moral reasoning. The useful ethics checker would be able to distinguish among arguments that appeal, for example, to consequentialism, specific moral rules, or virtue principles. First generation ethics checkers would search for words and phrases generally used in constructing various forms of argument as well as the types of citations the author chose in support. More advanced ethics checkers might eventually track a line of reasoning as precisely as computers now process mathematical calculations.

For the sake of argument, let us assume that artificial intelligence software will in due course afford a level of computed textual analysis that approximates some aspects of human intelligence. Gains in processing speed might enable ethics checkers to advance beyond analyzing whether the information in a document was ethically prepared to managing the writer's ethical thinking.

Such software would not only help with the correct spelling of "utilitarianism" but could also assist with its implementation by providing prompts and guidance during text editing and redrafting. The discerning user would, no doubt, prefer to use an ethics checker offering a range of prompts including deontologic, virtue-based, gender-sensitive, ethnosensitive and other approaches, since accommodating diverse considerations is more likely to lead to wise decisions. A robust ethics checker would not function like a spell checker, indicating only whether a selection of text is correct or incorrect. Rather, it would function more like a thesaurus, prompting the writer to consider a number of related ideas, additional perspectives, and references for further reading.

The software would approve the simple and reject the simplistic. Sorting out assertions based on ethical egoism from those based on ethical altruism would require a single click of the mouse. Uncertainty about an argument's cogency could be settled in a nanosecond. Calculated scores would rate a document as to its level of concreteness or abstraction as well as the proportion of factual to emotive language usage. The ethics checker would tirelessly spot logical fallacies and offer corrective suggestions.

Soliciting feedback from the ethics checker would carry the additional benefit of being a private experience. Silicon would sharpen iron, obviating the potential embarrassment of receiving criticism from human collaborators or editors.

Final Check

Access to ethics checker software alone would not ensure that thinking and writing would become more ethical. What matters is how such technology is used, by whom, and toward what ends. Turning on an ethics checker might seem like a virtual ethics consultation, but it must be remembered that it is just an invitation to an array of electrons on a circuit board to contribute information to the process of ethics deliberations. Electronic circuits can no more understand moral principles than can calculators, though they number the stars, perceive light or wonder about the heavens.

Words can be digitized and sorted. Words also correspond to ideas that transcend machine processing. No number of megabytes can take the place of the mind in wrestling with human ethical dilemmas. Well-crafted computer systems may supply information to assist and extend human thought, but the most accurate ethics checker would prove to be an inadequate moral prosthesis. If the future should furnish ethics checking software, great care will be needed to avoid excessive reliance on computational resources as a substitute for thorough ethical reflection.

Authentic human engagement in ethics will always be needed. Otherwise, computational ethics checks could play out to be humanity's checkmate. To paraphrase Lewis, apparent power over the computer may amount to power exercised by those who program the computer over those who use it, with the ethics checker as their instrument.[22]

Table 1. Proposed criteria for a useful ethics checker

- Complement, not substitute for, ethical thinking
- Detect and clarify, but not edit out, moral bias
- Distinguish genuine argument from verbal attack
- Catch unstated presuppositions
- Identify ambiguity and loose associations
- Detect logical fallacies
- Assess consistency in reasoning
- Identify overlooked arguments on both sides of a question
- Suggest a range of alternative perspectives
- Assist in rendering rhetoric more diplomatic

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CLINICAL ETHICS DILEMMAS

EXPERIENCING DIFFERENCES BETWEEN EUROPEAN AND AMERICAN END-OF-LIFE CARE: A DIFFICULT DISCONTINUATION OF LIFE SUPPORT

DIANA GILBERT, MD, FRANKLIN TRIMM, MD, GREGORY W. RUTECKI, MD

Editor's Note: This column presents a problematic case that poses a medical-ethical dilemma for patients, families, and healthcare professionals. As it is based on a real situation, some details have been changed in the effort to maintain confidentiality. In this case, the medical community is unaware of the treatment plan recommended by a foreign physician.

Column Editor: Ferdinand D. Yates, Jr., MD, MA (Bioethics), Professor of Clinical Pediatrics, State University of New York at Buffalo, and Co-chair of the Healthcare Ethics Council, Center for Bioethics and Human Dignity at Trinity International University.

Question

An American mother no longer wishes to care for her handicapped child. Should the American system allow a European-trained physician to address euthanasia for the purpose of organ donation?

Case Presentation

A four-year-old girl with severe medical disabilities was admitted to the hospital under the care of a neurologist who had immigrated to the United States after receiving his training in Europe.

After an uncomplicated pregnancy and vaginal delivery, the child was born with lissencephaly and cerebral palsy in addition to being blind and deaf. Her neurological deficits were severe, and she required the placement of a ventricular-peritoneal shunt. She had both petit mal and grand mal seizures and required feedings through a gastrostomy tube. Over the subsequent years, she required numerous hospital admissions for aspiration pneumonias and various viral infections. In addition, she had developed chronic muscular spasms from the cerebral palsy that were reasonably well-controlled with medications. At two and half years, she required placement of a tracheostomy with oxygen supplementation prior to discharge, because of persistent respiratory distress. The child's mother, having expected that the tracheostomy and oxygen would have helped the child more, was now disappointed that the respiratory condition appeared unlikely to improve.

During the prior four years, the girl's single mother had received substantial home care services. The week prior to this admission, these services were withdrawn because of lack of continued external funding. The mother was distraught, as she had no other caregiver support. As home services were ending, the patient's mother petitioned a particular neurologist for assistance in the withdrawal of life-sustaining care from her daughter. The physician suggested admission to the hospital with the explicit intent of withdrawal of medical care and organ donation. Subsequently, he proceeded to provide the mother with handwritten orders for his recommendation of medical treatment, and admission was planned for the day that he was scheduled to return from a previously planned trip to Europe.

On admission to the hospital, a medical-pediatric resident examined the patient and obtained the pertinent medical history from the child's mother. The resident, who had cared for the child during prior hospital admissions, found nothing by history or physical examination that was substantially different from prior exams. In particular, the neurological exam revealed the same global deficits as previously noted, and the child did not appear to be in any pain. The resident's examination did not reveal any new acute medical process or any deterioration in the ongoing chronic medical condition. During the admission process, the child's mother presented the orders from the neurologist to the medical resident.

The resident had serious reservations about the content of the medical orders and attempted to call the neurologist. When the admitting attending physician could not be reached, the resident subsequently contacted the Pediatric Residency Program Director, and an Ethics Consultation was requested.

Denouement

As the physical condition of the child was essentially the same as during prior hospitalizations, the child was provided with comfort care, and there was no clinical deterioration in the child's condition. When the attending neurologist returned, he initially scolded the resident for not following his orders. However, after subsequent conversations with another pediatric attending physician, he acknowledged that he had not fully understood the "living donor" protocol, and he concurred that the patient did not meet such criteria. The child's mother informed the neurologist that she did not want to take her child home, and they met privately. Subsequently, the physician prescribed a single fentanyl patch – for pain – and then discharged the child to terminal home care. The dose exceeded the routinely recommended dose for pain but was in the upper limits of the acceptable dosing range when taking into account the prior use of narcotic medications in the patient. The child died at home – forty-eight hours later – with only her mother present. There was no autopsy or drug screening. The child was cremated immediately. The discharge summary, dictated by the neurologist, was inconsistent with the chronic stable medical condition that was documented on the admitting history and physical done at the time of the child's last hospital admission.

Comments by Dr. Rutecki

The medical community in which this case occurred is learning to amplify its ethical interface with hospital staff. Ethics Committee and consultation activities have been relatively recent and limited in scope. Over time, further efforts in cases like this one may include education aimed at the "Dead Donor Rule," the Law and Euthanasia, as well as differences between European and American contemporary practices in this important area. Also, although Ethics Committees and Consultants should not be viewed as “policemen,” the mother and neurologist’s home care for this child should have been supervised, particularly in regard to pain medications and their potential to adversely affect breathing. If concern persists in regard to the neurologist, future charts should be audited to ensure compliance with United States law and health care practice.

Editor’s Comment

It is not unusual for physicians to have distinctly different approaches to a specific medical issue. So long as there is no violation of the standard of medical practice within the medical community, this is often referred to as the ‘‘art of medicine.’’ If such a violation occurs, there may well be medical-legal consequences. Physicians are medical emissaries who need to be aware of the nuances of the country and medical community of which they are a part.

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07 12-14 2012 HUMAN
RECLAIMING
DIGNITY
in a Culture of Commodification

Are We Forming Ourselves for a Posthuman Future?

JACOB SHATZER, MDIV

Introduction

Technology promises seemingly limitless possibilities. Some sound far-fetched to contemporary ears, and many people hesitate at the prospect of adopting them. For example, posthumanists proclaim a coming day when human consciousness will be “uploadable” onto a hard drive, enabling “eternal life” for a self in a machine. However, few today would volunteer for this opportunity, recognizing something less than human about this type of “consciousness,” something that violates human dignity. This hesitance may not last, and some less threatening uses of technology may serve to ease this transition. Two in particular are virtual worlds and the use of robots in healthcare.[1]

First, virtual worlds are becoming increasingly popular. This immersive milieu provides the experience of “living” a “Second Life” that in many cases becomes more psychologically “real” than embodied life. Second, robots are emerging as options for human care and (some would assert) companionship, especially for the chronically ill and the elderly. As robotic caretakers with greater abilities are developed, people may become more comfortable with the idea of interacting with them rather than with humans. These experiences shape individuals in profound ways, and people may become more likely to embrace a future of forsaking the physical body for another medium of consciousness.

In order to provide a vision of biotechnology that affirms human dignity and human flourishing, these practices must be analyzed and assessed from a theological perspective. Such analysis and assessment should not only evaluate what is right or wrong about the practices in themselves but also should seek to understand how the practices form moral agents for future decisions.

Secular Liturgies

In his book *Desiring the Kingdom*, theologian James K. A. Smith argues that a proper anthropology views human beings primarily as lovers, a position traceable at least as far back as Augustine. Smith sees four important elements to this anthropology: 1) humans are intentional creatures whose fundamental way of intending is love or desire; 2) this love (which is often unconscious and non-cognitive) is always aimed at some particular version of the good life; 3) sets of habits and dispositions prime us to be oriented and to act in certain ways; and 4) affective, bodily means such as bodily practices, routines, and rituals, grab hold of the heart through the imagination and form the person.[2] What the person loves is what the person worships.

Smith’s model shifts identity formation from primarily an issue of cognition (what do I think or believe?) to also one of affection (what or whom do I love?). Loving rightly requires practice, and practice often happens in mundane ways. There are two types of habits: “thin” habits (activities like flossing that seemingly do not touch love or desire) and “thick” habits (meaning-full activities that significantly shape our identity and loves).[3] Yet, no practice – thick or thin – is neutral. Thin practices can serve thick ends. For example, exercising can serve the end of wanting to spend many years with one's family or the end of becoming more attractive in order to leave one's spouse and start a new life with someone else. Thick formative practices are "meaning-laden, identity-forming practices that subtly shape us precisely because they grab hold of our love—they are automating our desire and action without our conscious recognition."[4]

For Smith, "liturgy" serves as a lens for analyzing and evaluating practices. He defines liturgies as "ritual practices that function as pedagogies of ultimate desire."[5] While this obviously applies to religious practices, it can be extended to other activities as well. These "secular liturgies" help us to understand how humans are being shaped in fundamental ways by cultural institutions and practices that are often left unanalyzed. Smith highlights three examples. The mall (consumerism) reflects what matters and shapes what matters. The military-entertainment complex (nationalism, especially as promoted via national sporting events) seeks to orient allegiance solely to the state. The university, also, is not primarily about information but about shaping imagination and desire so that students will pursue a particular vision of the good life—one influenced by secularism and consumerism.[6] Secular institutions project a version of what is broken in the human condition, what true flourishing looks like (what should be loved or desired), and how to act in order to achieve success. Simple practices are not innocent, for they form the heart.

The philosophical anthropology of the human as lover and the understanding of "secular liturgies" raise the stakes for understanding virtual worlds and robotics from a Christian theological perspective. Certainly, straightforward questions can be asked of both: is it right or wrong to kill an avatar online? Do robotic caregivers harm patients physically or emotionally? However, the concept of "secular liturgies" opens up another horizon to be explored: How do virtual worlds and robots in healthcare form moral agents by shaping their loves? Such an exploration will be conducted in two ways. First, we will analyze each practice for how it shapes loving: what it says about the human condition, its vision of true human flourishing, and its views of actions that lead to success. Second, we will seek to evaluate how this practice does or does not prepare the agent to be more amenable to the "posthuman future."

Virtual Worlds

What once was the realm of science fiction (think *Star Trek*'s Holodeck) is becoming increasingly possible for people with home computers and decent Internet connections. There are three types of virtual reality, defined based upon the level of immersion: *fully immersive* (with a head-mounted device); *semi-immersive* (with large projection screens); and *nonimmersive* (with a personal computer). This classification depends on how much the user can perceive the real world while engaged in the virtual world.[7]

Here we are most concerned with nonimmersive virtual worlds (virtual worlds are characterized by their persistence; they exist all the time whether an individual user participates or not) because of their widespread availability. Virtual worlds influence a larger proportion of the population than more immersive forms of virtual reality. Within this classification are two categories. Ludic virtual worlds are "rule-based games involving direct competition between players." Paidic worlds, on the other hand, "emphasize free play and creativity with less emphasis on rule-constrained competition."[8] Paidic virtual worlds are also known as "non-game virtual worlds,"[9] and it is here that we will focus for our analysis.

Second Life is one of the most popular examples of the Paidic type of virtual world. It is "a virtual social network platform that allows its residents to create alternate identities, drawing from real and idealized life," and "possibilities are endless when in avatar form."[10] Account creation is free, so there is no cost to basic exploration of the world.[11] More people are spending increasing amounts of time in such worlds, and some scholars, such as economist Edward Castronova, predict that the real world will have to change if it wants to lure these people out of the virtual world and back into being fully participating members of society.[12] About five years ago, Second Life received a round of publicity lauding its promising future, but not everyone has been successful in capitalizing on it. Some even think that this particular virtual world's future is limited,[13] and, in general, the speculations have come a bit more down to earth. Linden Lab, the creator of Second Life, has downsized and has started to focus on users selling virtual goods to each other.[14]

However, the site still shows modest growth, and metrics indicate that many people still find life "in-world" worth their time. As of the end of June 2011, there were just over 2.4 million registrant signups. According to data from late 2010, almost 600,000 users would be online within a period of a week. Money is involved as well, even though startup is free. Any user can build objects, but to maintain creations a user must purchase "land" in Second Life. Approximately 34,000 have active "homes" in the world.[15] There is also a bustling in-world economy, complete with a currency (Linden dollars) that holds an exchange rate with the U.S. dollar. In fact, in the first quarter of 2010 user-to-user transactions totaled $160 million.[16] Whatever the future of Second Life in particular, virtual reality and virtual worlds merit careful thought.

Evaluation proceeds in two stages. First, virtual worlds in general and Second Life in particular can be analyzed as a "secular liturgy" using the questions brought forward by Smith. It serves as a practice that shapes love. Second Life communicates that the problem with the human condition is lack of meaningful relationships and possessions. People do not feel connected to others, mainly for two reasons. Either they do not feel their appearance represents them well, or they are not geographically close to people with common interests. Second Life enables one to alter one's appearance and to connect with people from all over the world. Second Life also revolves around possessions: you can build or buy a house, car, clothes, and gadgets that you could never afford in real life. The vision of human flourishing that is projected is one in which users can create selves without the limitations that physical bodies impose (e.g., not the right complexion, too much weight) so that relationships can be built based not on physical appearance but upon the projected self and common interests. Also, the limits to possessions are removed, so that users can have essentially whatever they want with a relatively small investment. Success in this world means authentic self-expression that leads to fulfilling interaction with like-minded people in a world filled with remarkable beauty and possessions, all on the screen.

Second, virtual worlds do indeed seem to shape people in a way that makes them more likely to accept a posthuman future. By providing and encouraging opportunities for disembodied self-expression, virtual worlds can influence people to be less committed to embodied existence. Also, users can learn to enjoy experiences on the screen, whether that is an experience of a digital sunset or a car. Success in a virtual world is much easier to control than in “real life,” since in real life we are subject to so much that exceeds our own reach: our particular bodies, our relationships and responsibilities, our (ongoing perception of a lack of) possessions, and the struggles (and victories) that go along with all of that.

Robotics in Healthcare

The warning bells are tolling: “Doctors, nurses and carers, watch out for your jobs. The future of medical care is here – and it is not human. Humans compare unfavourably with robots, tiring easily, taking longer to train, needing special fuel, being expensive to maintain, becoming easily bored by repetitive tasks – and – you just can not get the spare parts for them.”[17]

Robots are becoming more common in healthcare. Colin Jervis, director of UK-based Kinetic Consulting, divides these robots into three types: operational robots (which are used in surgery), humanoid robots (which walk and move like humans, performing care tasks), and miniature robots (which may one day be released into humans to maintain and repair them).[18] The focus here will be on the second group. Both operational robots and miniature robots raise questions, but they can also be seen as tools that aid or extend human work, such as a robot that a surgeon guides. Humanoid robots, on the other hand, replace human interaction in care situations, and they raise different questions. Humanoid robots are not designed to operate less invasively but to take the place of human-to-human interaction. Even just two years ago, critics claimed that “the technology being developed is too far from commercialization for venture-capital funding.”[19] Yet in June of 2011, it was announced that Intel has made its first ever investment in robotics. “Intel sees a rich mix of digital devices supporting future healthcare needs…[and] is banking on a future in which programmable humanoid robots with voice and face-recognition capabilities plus location awareness can aid in diagnostics and theraputics [*sic*].”[20]

Humanoid robots are promoted as the solution to the problem of an aging population. With an increasing number of elderly people needing care, the fear is that the economics will just not work out for humans to maintain the roles of caregivers. Jervis notes four main ways that robots can assist the elderly and the chronically ill: make up for cognitive decline (remind patients to take medicine); enable patients and caregivers to interact more efficiently (via video links); collect data and monitor patients (heart rate, blood-sugar levels); and assist with domestic tasks (cooking and cleaning).[21] All of these are positive and necessary things. However, those who trumpet the benefits of the robot set up the debate to their own advantage. The alternatives are “independent living with personal robots v. nursing homes” or “prohibitive cost of human care v. cheaper cost of personal robots.” Such debates are often won before they even begin.

In her book *Alone Together*, psychologist Sherry Turkle explores interactions between humans and robots at great length. At one point she reports research on Paro, a robot baby seal developed in Japan to serve as a companion to the ill, elderly, and emotionally troubled. Turkle recounts people becoming absorbed in a perceived relationship with this “pet.”[22] She refers to the “robotic moment,” by which she means “our state of emotional – and I would say philosophical – readiness. I find people willing to seriously consider robots not only as pets but as potential friends, confidants, and even romantic partners.”[23] So, whether humanoid or not, robots are being proposed as solutions to two sets of problems: medical and emotional attention.

Humanoid robots can be analyzed in the same two ways as virtual worlds. First, the use of humanoid robots serves as a secular liturgy, shaping humans as lovers. From this perspective, the human problem is one of deteriorating physical bodies, loneliness, and limited financial resources. Pushing further, the problem viewed from the perspective of society as a whole seems to be that there are just too many ill and old people. The view of human flourishing, then, is one in which the ill and elderly can be cared for (a noble goal) and continue to live independently. However, the robot solution also seems to propose that for the rest of society flourishing means not having to make the sacrifices necessary to provide care personally or to pay a higher price for the aged to be cared for with dignity by another human being. Finally, success in this model is a mix of noble goals and often ignoble motives: care for the elderly and the chronically ill but in a way that is as inexpensive (in the sense of both financial and emotional investment) as possible.

Second, the use of humanoid robots for healthcare does indeed seem to shape people to be more accepting of a posthuman future. This happens on three levels: that of the elderly who learn to interact with the robots, that of the healthcare professionals who partner with the robots, and that of those making decisions for elderly relatives. For the elderly, developing affectionate feelings toward robots based on perceptions of companionship (as seen by Turkle) will make them less opposed to an existence interacting with robots. Healthcare professionals using and interacting with the robots will become more accustomed to partnering with artificial intelligence to perform key tasks. And for those making decisions for others, choosing the option of robots can make them more open to using and interacting with robots in an increasing number of situations. While humanoid robots will not inevitably lead to a posthuman future, an unreflective use of them can lead to dispositions that are more favorable to such a future.

Conclusion

These two practices have not been chosen arbitrarily. Virtual worlds make us increasingly comfortable with the concept of disembodied reality, and robots in healthcare make us more at ease with interacting with machines. The first helps us think about existence without our bodies; the second helps us envision relating to other "bodies."

In sum, if we are concerned about the human – or posthuman – future, we must also be concerned about current practices that will equip us for the choices we make in that future. As James K. A. Smith's thought demonstrates, our lives are filled with a multitude of practices that shape us. Virtual worlds and robotics in healthcare are two such practices, practices that in-and-of-themselves seem harmless in many ways but that can potentially move us in directions that we do not want to go if we leave them unanalyzed and adopt them uncritically.

Both of these practices invite future work and thought. First, advances in Internet research provide the opportunity for more in-depth analysis of virtual reality and virtual worlds. While earlier studies focused more on utopian or dystopian predictions,[24] more recent research has become increasingly measured and realistic, seeking to understand how everyday Internet practices contribute to the formation of a whole life. Refusing to fall into binaries such as "virtual" and "real," future studies can help us to understand more about how online life forms one piece with a person's entire life, and what implications this has for moral development.

Second, as robotic healthcare (once again, distinguishing humanoid robots from other types) becomes more common, longer-term studies will need to be done regarding the effect of these robots on the emotional well-being of the elderly and chronically ill. Studies such as Turkle's are helpful in illustrating how individual people reacted when she interviewed them, but more studies need to be done on, for example, whether people maintain emotional bonds with their robot seals over years and years. Such studies will aid in understanding how robot "relationships" really change the way people feel about human relationships. Early evidence does seem to indicate that the use of such robots makes people more comfortable with non-human "relationships," but additional data is necessary.

Christian communities must demonstrate counter-practices in both scenarios. While the Bible and Christian tradition do not clearly rule out life partially lived in virtual worlds or utilizing robots to take care of the elderly, Christianity does provide a positive view of humanity created in the image of God, a strong sense of the importance of life in community, and the necessity of service and sacrifice. When virtual worlds and robotics in healthcare tempt us to forsake these values, we must correct our practices to cultivate the love of God and the love of neighbor that is the Greatest Commandment.

Virtual worlds and robotics in healthcare are not secret agents of the posthuman future. But just as many different things in our lives, they shape our hearts, teaching us to love certain things and pursue certain goals. And when these goals lead us away from Christian values such as the dignity of each human life and the importance of being embodied beings, we must be thoughtful about where we are being led. The answer is not to buy into a slippery-slope argument and reject such technologies outright, but instead we must interact with them carefully, with an eye to the values and visions of flourishing that they can entail. Living eternally in a machine may sound far-fetched and repulsive now, but the choices we make about the technology we do have will impact the way our children and grandchildren conceive of the relationship between man and machine.

Endnotes

1. An earlier version of this article was presented as "Forming Ourselves for a Posthuman Future?: Virtual Reality and Robotics," at "The Scandal of Bioethics: Reclaiming Christian Influence in Technology, Science, and Medicine," the Center for Bioethics and Human Dignity's 18th annual international conference on bioethics in July 2011. Special thanks are due to Hans Madueme, who graciously read the paper for me due to an unforeseen absence.
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3. Ibid., 82.
4. Ibid., 83.
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7. Mario A. Gutiérrez, Frédéric Vexo, and Daniel Thalmann, *Stepping into Virtual Reality* (London: Springer, 2008), 2.
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9. For a helpful description of two such worlds, see Kathryn Stam and Michael Scialdone, "Where Dreams and Dragons Meet: An Ethnographical Analysis of Two Examples of Massive Multiplayer Online Role-Playing Games," *Online—Heidelberg Journal of Religions on the Internet* 3, no. 1 (2008): 61-95.
10. Phylis Johnson, *Second Life, Media, and the Other Society* (New York: Peter Lang, 2010), xvi-xvii.

11. For a helpful description of how to sign up for a typical virtual world, see Edward Castronova, *Synthetic Worlds: The Business and Culture of Online Games* (Chicago: University of Chicago Press, 2005), 29-50. Castronova's description includes a typical payment method, which does not apply in this case. This chapter still gives a good taste for those who have no previous exposure to these worlds.
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22. Sherry Turkle, *Alone Together: Why We Expect More from Technology and Less from Each Other* (New York: Basic Books, 2011), 8-9.
23. Ibid., 9.
24. See Heidi Campbell, "Internet and Religion," in *The Handbook of Internet Studies*, ed. Mia Consalvo and Charles Ess (Malden, MA: Blackwell, 2011).

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Vol. 28:2 Summer 2012

Making Martyrs of our Children: Religiously Based Requests in Pediatrics

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Abstract

Julian Savulescu's approach to handling religiously based requests for inappropriate medical treatment in pediatrics focuses primarily on physical safety, a secular conception of well-being and future autonomy. In this paper, I argue that such an approach is culturally and religiously insensitive and overlooks other important values. An acceptable approach will give more consideration to cultural and religious beliefs while still holding them to a high ethical standard.

Introduction

In *Prince v. Massachusetts* (1944), the U.S. Supreme Court ruled that Sarah Prince, a Jehovah's Witness (JW), violated child labor laws. The nine-year-old child entrusted to her care was caught distributing religious literature. The opinion of the court famously stated: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." The child in this case was not in physical danger; nevertheless, this case is often cited when parents make religiously based requests for inappropriate treatment, or violations of the standard of care (I will call these *M-requests*, miracle or martyr requests).

In this paper, I consider Julian Savulescu's approach to handling M-requests for children and suggest that it is too insensitive and uncritical for our modern pluralistic society. His conditions hold parents to a high ethical standard, but they undervalue cultural and religious beliefs.

Savulescu's Approach

Savulescu suggests the following standards for limiting the kinds of choices parents can make for their children:

1. It must be *safe* enough, compared to other interventions children are exposed to.
2. The parent's choices must be based on a *plausible conception of well-being* and a better life for the child and not on some idiosyncratic, unjustifiable conception of the good life. In addition, the choice must be based on a good enough expectation of realizing a good life. For this reason, while competent adults can refuse life-saving blood transfusions for themselves, parents cannot refuse life-saving blood transfusions for their children on any grounds.
3. It must be *consistent with development of autonomy and a reasonable range of future life plans for the child*. For example, while adults may be allowed and even have a good reason to have one of their healthy limbs amputated,

> parents could never have the healthy limb of their child amputated for many reasons, including the fact that it removes a range of possible good futures from the child's grasp. Female circumcision and the removal of an organ of female sexual pleasure severely constrain the range of possible good lives for that child, stunting the possibility of full sexual satisfaction. It should not be permitted. Male circumcision is different precisely because the possible consequences are more mixed and more uncertain. The reasons for accepting male circumcision include social and cultural considerations as well as medical considerations such as reduced risk of disease (e.g., penile cancer) and infection (e.g., HIV and HPV) (Savulescu, 2007, 32).

These conditions are helpful for a number of reasons. First, they establish a strong presumption in favor of protecting the lives of children. Second, they prevent religious liberty from becoming an unqualified absolute. If it were absolute, it could be used to justify the most atrocious acts such as the Jonestown massacre of 1978 in which Jim Jones instructed his followers to consume a cyanide-laced drink. Parents were to give it first to their children and then lie down and die next to them in a mass murder-suicide. Religious liberty cannot vindicate such actions. Ruth Macklin argues, "It is one thing to require that cultural, religious, and ethnic groups be treated as equals; that conforms to the principle of justice as equality. It is quite another thing to say that any cultural practice whatsoever of any group is to be tolerated and respected equally. This latter view is a statement of extreme ethical relativism" (Macklin, 1999, 133). Savulescu's set of conditions holds beliefs to a high ethical standard in order to protect the lives of children, but the conditions suffer from a number of problems.

Safe Enough

First, it is not clear *how* safe is "safe enough." It would make a big difference if the basis of comparison included all of the legitimate risks children are exposed to outside the hospital, like riding in cars or on bikes.[1] This would, I think, make this condition very permissive; on the other hand, if the basis of comparison included only the risks entailed by other medical interventions, then the condition is very strict. Savulescu probably means the latter.

If the basis of comparison only includes medical interventions, then this standard seems indistinguishable from the standard of care, which would mean that *any* conflict between parents and physicians ought to be resolved by ignoring the parents and their beliefs. I find this too paternalistic because it violates *The Principle of Parental Discretion*, defined as the right parents have to make decisions for their children. Allen E. Buchanan and Dan W. Brock describe the reasoning given for such a principle: (1) parents do a better job in principle than anyone else; (2) parents bear the consequences of such choices, so they should have some control over the choices; (3) parents have a right to transmit values to their children because they need socialization and development; and (4) the family is an important social institution that requires freedom from oversight and control to work effectively (Buchanan and Brock, 1989, 232-234). Mark Sheldon says, "More than any other institution in society, the family…values human beings simply because they *are*, not because of any use to which they can be put. And, for this reason, it is probably in a child's best interest…that the family be maintained to the extent that it is…consistent with this objective of such nurturance" (Sheldon, 2001, 178). *Parens patriae* – the doctrine that the state has the authority to intervene to protect children's interests – is invoked when parents fail in their responsibilities, and this is as it should be. However, the difficulty with M-requests is in determining when parents have failed their children, and it is not clear that an M-request that entails more risk than other medical interventions necessarily constitutes child neglect or abuse. Hence, to accommodate parental discretion, "safe enough" ought to be given a more permissive interpretation.

Also, "safety" seems to mean mere physical safety to Savulescu, but this ignores other kinds of harms that can occur, for example, psychosocial and spiritual harms. Making children wards of the state may protect them physically but harm them in other ways that have been overlooked. A recent example occurred when more than 460 children were taken into state custody when Texas authorities raided the Yearning For Zion compound on a tip that underage girls were being married off to older men. Surprisingly, an appeals court later ruled that Texas authorities had overstepped their bounds: "Evidence that children raised in this particular environment may some day have their physical health and safety threatened is not evidence that the danger is imminent enough to warrant invoking the extreme measure of immediate removal prior to full litigation of the issue" (CNN.com, 2008). The raid in Texas led top prosecutors in other states to assure the polygamist groups in their states that they would not be raided (NPR.org, 2008). The ruling of the appeals court demonstrates the following point: the physical safety of children is important, but it is not the only concern.

Psychosocial safety should be a consideration in deciding M-requests because children can suffer psychological trauma as a result of an M-request or from being taken into state custody. Also, they can be harmed socially if the treatment results in their being marginalized in their societies. For example, in some African societies women who do not undergo circumcision find it very difficult to get married. Such a consideration may not ultimately justify the practice of female circumcision (also known as female genital mutilation), but it is important information.

Children can also be harmed spiritually, which, for example, may occur if the treatment that the M-request was intended to avoid is viewed as sinful by the community. The patient and the patient's family might be ostracized or excommunicated, resulting in a fracturing of the patient's spiritual development. In addition, there might be eternal consequences that cannot be undone. For example, many JWs think that receiving a blood transfusion will result in divine judgment. To ignore or reject such beliefs without first engaging them seriously is an act of disrespect for matters of conscience that is incompatible with a liberal pluralistic society (in fact, the whole focus of the JW blood issue to date has been on the physical risks involved).

An American Academy of Pediatrics (AAP) statement on M-requests seems to support Savulescu's position:

> The AAP opposes religious doctrines that advocate opposition to medical attention for sick children. Adherence to such views precludes appropriate assessment and intervention to protect children. The AAP believes that laws should not encourage or tolerate parental action that prevents implementing appropriate medical treatment, nor should laws exempt parents from criminal or civil liability in the name of religion…The AAP considers failure to seek medical care in such cases to be child

> neglect, regardless of the motivation" (American Academy of Pediatrics, 2001, 169-170).

In this statement, the AAP does not distinguish between different types of harm, focusing entirely on physical safety. In fact, the statement makes it clear that no other conceptions of safety can compete. This is troubling, but I do not think that the AAP is being intentionally insensitive. In fact, a recent policy by the AAP concerning female circumcision demonstrates its cultural sensitivity. The AAP suggests that a compromise might be reached between physicians and immigrant communities who request female circumcision by offering a "ritual knick" instead (American Academy of Pediatrics, 2010, 1088-1093). The "knick," which has been accepted by some African communities already, is a symbolic practice relating to circumcision and is less harmful (but is currently illegal in the U.S.).

In short, safety should not be analyzed solely in physical terms. Doing so oversimplifies a complex issue, and Savulescu's *safe enough* condition needs to give consideration to all types of harm and be more sensitive to cultural and religious beliefs.

A Plausible Conception

Second, the notion of a "plausible conception of well-being" is suspect. Savulescu explains that he wants to rule out idiosyncratic beliefs, but if a particular belief is plausible to seven million people in the world (a conservative estimate of the number of active JWs), then it is not idiosyncratic. He rejects the JW conception of well-being, however, when he gives the example that a parent can never refuse a child a life-saving blood transfusion. Plausibility, to Savulescu, appears to be grounded on an objectivist view of reasons, which he defines as the following: "Whether a person should be offered a treatment turns on the objective values of the *physical* circumstances of that person's situation, such as the chance of prolonging a life in which a person can carry on worthwhile relationships with others, achieve worthwhile goals, and so on" (Savulescu, 1998, 383). If this is not what Savulescu means by "plausible conception of well-being," then he should make this clear. In the meantime, this interpretation will serve as a useful representation of a widespread assumption. Requiring a conception of well-being that includes only the patient's physical circumstances is problematic because few people would satisfy it.

Spiritual well-being is at least as important as physical well-being (if not more) to religious communities across the world. Consider, for example, the Buddha's teaching on the Middle Way. He taught that the path to nirvana was not to be found in the extremes of asceticism or earthly living; rather, it was to be found in the middle. In this way, he affirmed both physical and spiritual well-being. In addition, traditional Christianity rejects the doctrine of medical vitalism – that physical life is the highest good. It teaches that the physical body has value based on the creation and resurrection of the body, but it also stresses the importance of spiritual well-being and eternal life in heaven (I Timothy 4:8).

Even non-religious individuals want more than mere physical well-being. John Hardwig points out that physical health and longevity are not the primary goals of most patients. He says, "Patients usually want much, even most, of what doctors have to offer. But they do not want all of it; they do not always even want very much of it…Indeed, in hindsight it is easy to see that only a very odd person has better health and a longer life as her #1 priority" (Hardwig, 2010, 330). Individuals, as Hardwig points out, engage in all kinds of risky behaviors on the basis of personal goals and values. For example, many individuals choose academic careers which entail sedentary lifestyles – not the best option if physical health and longevity are the goals. Hence, Savulescu's condition of plausibility should be expanded to be more representative.

Another serious problem with Savulescu's condition is that he appears to define the notion of plausibility by content; in other words, he thinks that there is a set of beliefs that ought to be universally recognized as implausible or irrational, for example, the belief that God prohibits blood transfusions. If content were used to assess plausibility, the temptation would be much greater to dismiss the beliefs of other cultures too quickly (epistemic imperialism) before investigating how people in those cultures actually arrive at their beliefs. Plausibility as content is not sensitive enough to the diversity of rational beliefs across cultures. A better model would assess plausibility by norms of reason because it would acknowledge that (1) there are rational people in every culture, (2) that rationality is not defined by one's own culture, and (3) it is not the case that one's own culture is *prima facie* more reasonable than others (see Zagzebski, 1999 for further discussion of this). Austin Dacey suggests some norms of reason that might be helpful here: "honesty, consistency, rationality, evidential support, feasibility, legality, morality, and revisability" (Dacey, 2008, 17). He unpacks his norms in the following way:

> Honesty means we typically say what we really think; rationality, that we take efficient means to our ends (at least); consistency, that we are prepared to accept the implications of our views as they apply in other instances; evidence, that it matters how our reasons link up with the real world (or don't); feasibility, that the proposal is realistic; legality and morality, that it is in accord with our laws and ethics; and revisability, that we are prepared to entertain objections, criticisms, and changes (Dacey, 2008, 52).

Rather than deciding that certain beliefs are irrational *a priori*, Dacey's approach would entail an investigation into how particular beliefs were arrived at and how the beliefs are held. For example, what sort of evidence are they based on? What goals do the people hold? How open-minded are they? I do not have the space here to offer a complete model of rationality, but I point the reader to Linda Zagzebski's compelling article "Phronesis and Christian Belief" (1999) in which she presents a model of rationality based on a theory of virtue. In sum, it is dangerously imperialistic to base the plausibility of any conception of well-being on content; instead, it should be based on norms of reason.

Future Autonomy

Savulescu's third condition represents the most common concern raised against M-requests, namely that parental choices must be consistent with the development of autonomy and a reasonable range of future life plans for the child. The problem with M-requests for children is that their effects are irreversible and that it is very possible that if the child were old enough to make her own decisions, she would reject the M-request and the belief system it is based on. Many think that autonomy with regards to matters of conscience is preeminent because such beliefs are deeply personal, and we just cannot decide such matters for others, even children. Such beliefs are too mysterious, complex, or subjective. Sheldon sums up this view:

> While the state does not know truly what is in the child's best interest, neither does anyone else. What the parents believe is in the child's best interest may be mistaken.

> Given that no one knows what is in the child's best interest, the role of the state is to ensure that children ultimately become adults, able to decide, independently, what is in their own best interest. It is not even that the state assumes that it knows it to be in the child's best interest to become an adult. It may not be. It is simply that no one knows what is in the child's best interest, and the responsibility of the state is to make certain that persons who make decisions which are irrevocable do so when they are competent. (Sheldon, 2001, 178).

Future autonomy is an important principle, but it is complicated because there are competing values. Adrienne M. Martin points out that religious practices are worthy of some respect apart from considerations of autonomy: "Surely we value such practices and institutions, and individuals' participation in them, for multiple reasons unrelated to autonomy. Religion can be a deep source of meaning in individual and community lives; it can build and maintain communities" (Martin, 2007, 39). Religious liberty is an important value worth protecting, and doing so means protecting not only the rights of the autonomous individual to practice religion but also the freedom of families and communities to act on faith even when they impact the lives of their children in ways that would be disagreeable to others.

Moreover, maximizing a child's future autonomy is not always in the child's interests. For example, if a child has a gift for athletics, the parent's decision to enroll her in after-school academic programs instead of athletics may preclude the child from ever becoming a world class athlete. The child's future autonomy is protected – she can always pick up athletics later – but the option of being a great athlete may have been removed (Baines, 2008, 143). Parental decision-making limits options one way or another, and it would be unfortunate if parents never nurtured their children's natural gifts because of concerns about maximizing future autonomy.

Female circumcision in Africa poses another problem for Savulescu's notion of autonomy. In some African cultures, refusal to have a girl circumcised may result in social marginalization and the limitation of social options:

> Female circumcision is viewed by most circumcising communities as an initiation into womanhood. It ensures female fertility, provides a source of identity, and prescribes a social status; the lack of circumcision can lead to social exclusion and shunning. Circumcision is perceived as a test of courage in preparation for the pain of childbirth, a sign of maturity, a source of respect among peers, and an honor for the girl's family. In some communities it becomes a passport to marriage…The elaborate ceremonies such as songs, dances, chants, and teachings about wifely duties create immense social pressure to conform…Sooner or later [an uncircumcised girl] becomes an object of ridicule by her relatives and neighbors…Ridicule can become ostracism, preventing any communal support at a time when it is most needed (Wangila, 2007, 100-112).

Savulescu is against female circumcision because it limits sexual autonomy and is irreversible (in some of its forms); nevertheless, his view would limit autonomy in another sense: an uncircumcised girl's social opportunities are greatly restricted. Hence, sexual autonomy and future social opportunities are in conflict. Which one is more important for young women?

Consider the following case study from a recent issue of the *Hastings Center Report*:

> Joy is a thirteen year old Jehovah's Witness who developed anemia due to a massive Staphylococcus infection, which affected her blood, bones, and lungs. With antibiotics, her condition improved, but her physicians now believe they must intervene surgically to remove the excess pus and scar tissue in her chest cavity. However, they are unwilling to do so without recourse to a blood transfusion because Joy's anemia makes the procedure very risky. Joy and her parents have stated that they are against the transfusion, and Joy has clearly and intelligently articulated her religious beliefs and the JW position on blood in the absence of her parents. To many, Joy seems to be a mature and competent young woman (Orr and Craig, 2007, 15-16).

Savulescu would stress Joy's future autonomy and reasonable (physical) life plans, so he would probably recommend invoking *parens patriae*, securing a court order (as is the case in almost every pediatric blood transfusion case), and forcing the transfusion. Some think that at thirteen Joy might be considered a mature minor; if so, autonomy might require that we respect Joy's wishes. Debating the mature minor issue is not within the scope of this paper, so I will simply stipulate that she is not a mature minor to make her case relevant to the issues being debated in this article (or we might just change the case so that her age is lowered to ten to ignore the mature minor issue).

If her caregivers invoke *parens patriae* and force the transfusion and she survives, she might face possible expulsion from her community and rejection by her family, which would drastically limit her future autonomy.[2] If she does not survive, then this situation becomes a tragedy upon tragedy because, from the perspective of the family, Joy is physically and eternally separated now.

Some might say that since the Watchtower organization forgives involuntary blood transfusions these worries would evaporate. In fact, for this reason, some JW parents are reportedly relieved when they are informed that a court order will be secured. Although many Witnesses may feel this way, it is unlikely that all will, so we need to consider those who do not. The fact that many JWs (and physicians) think that God would not hold children responsible for a forced blood transfusion doesn't alone justify our ignoring the protests of parents who disagree. Consider a similar case. I mentioned earlier that traditional Christianity would not support the doctrine of medical vitalism, but that does not keep some Christians from invoking their Christian beliefs in support of keeping patients connected to life support beyond what is thought medically reasonable. The fact that some Christians hold unorthodox beliefs does not mean their beliefs can be ignored. They may hold these beliefs very deeply. Also, a JW recently discussed the transfusion issue with me, and she compared the command to avoid blood products with the command to refrain from premarital sex. She said that JWs would be forgiven if sex were forced upon them (rape), but that does not make the experience desirable. In the same way, forced blood transfusions may be forgiven, but that does not solve the problem entirely.

Joy's case presents a problem for views like Savulescu's, because without a good reason to prefer an objectivist (non-religious) view of reasons it is not immediately apparent whether this M-request is unreasonable.[3] Sheldon says that the state's only concern should be to protect a child's future autonomy, so all other worries and considerations are irrelevant. It is certainly easier on caregivers to simply have one pair of directives: the future autonomy and physical care of children. Nevertheless, such an approach oversimplifies the issue and is incompatible with the virtue of cultural sensitivity that we expect from modern medical professionals. If and when medical professionals find it necessary to reject M-requests, it ought to be done only after taking a family's values seriously.

Conclusion

I have shown that Savulescu's conditions suffer from a number of problems, but these problems can be overcome by making the conditions more culturally sensitive, reformulating them in the following way:

1. *Rational*- Is the request based on a rational conception of well-being? Is it in accord with norms of reason?
2. *Safe*- Is the request safe enough? Is the risk comparable to other legitimate risks the child is exposed to outside the clinic? Here, *safety* is interpreted holistically: physical, psychosocial, and spiritual.
3. *Future-oriented*- Does the request have the child's future autonomy and development in mind? Here, autonomy must be weighed against other values such as social opportunity.

I do not have the space here to completely develop this reformulation, but I would like to say a few words to point in a general direction. Savulescu defines plausibility in terms of content. As I have shown above, it is more culturally sensitive to evaluate beliefs in terms of norms of reason; moreover, I think that *plausibility* is a loaded term. *Plausibility* connotes a much stricter standard than *rationality*, so I suggest exchanging the former term for the latter.

Dacey's norms of reason are a helpful starting point. These rules govern public discourse, and, to the extent that the hospital is part of the public square, it makes sense that a family's beliefs could be held to such standards. Some might think that evaluating religious beliefs in the clinic violates religious liberty, but it is important to keep in mind that the scope of this paper is limited to families who make M-requests for their children, parents who are requesting special treatment. I am not arguing that these norms should be applied with political power more widely in society, nor should they be applied to other cases in the clinic (requests made by adult patients based on unreasonable beliefs may be granted on the basis of patient autonomy – if they do not harm others). However, M-requests for children require a higher ethical standard.

It is possible that an M-request could fail the rationality condition but satisfy the safe and future-oriented conditions. For example, female circumcision in Africa may be unreasonable; for example, it is unlikely that a rational person would ever believe that removal of a clitoris would ensure a girl's purity or fidelity (you don't need a functioning clitoris to be unfaithful). Nevertheless, virtuous parents might still choose to circumcise their daughters due to the social opportunities or protection it would secure for the child. As mentioned earlier, sexual autonomy is an important value, but it is not the only value. On the other hand, it is hard to imagine how an M-request for female circumcision would ever be granted outside a limited number of African communities. For example, all such M-requests made in the U.S. should be denied (even if the patient is African) because there are plenty of social opportunities for uncircumcised women in the larger society. In addition, there are other options like the new AAP policy mentioned above.

Finally, I want to be clear that I am not arguing for the increased permissibility of M-requests. Actually my argument may cut both ways in practice: some M-requests that until now have been rejected might gain standing (e.g., some less harmful types of female circumcision) while others may no longer be acceptable (e.g., refusal of childhood vaccinations). Whether they are accepted or rejected, M-requests should be carefully considered in a way that is sensitive to matters of conscience while holding them to a high ethical standard.[4]

Notes

1. Thanks to John Hardwig PhD for this insight.
2. Thanks to Annette Mendola PhD for this insight.
3. Pascal's Wager is an instructive analogy here. Pascal presents a pragmatic justification for believing the traditional Christian God exists because we are not in a good position to evaluate the evidence. The way to decide whether to believe in God is to consider the payoffs: if we choose to believe in God (wager that he exists) and it turns out that he exists, then we are rewarded with endless life in heaven – an infinite value. If he does not exist, we have merely lost some earthly advantages – a finite loss. The prudential person will conclude that she has more to gain by believing in God and more to lose by not, so she will choose to believe in God. In the same way, Joy's choice seems reasonable given her background beliefs. Her choice is between an infinite gain and an infinite loss. Savulescu briefly mentions Pascal's Wager in an endnote (Savulescu, 1997, 288).
4. The author would like to thank Heather Bock, John Hardwig PhD, Glenn Graber PhD, Annette Mendola PhD, Frank Mashburn PhD, and the Faith and Philosophy group at the University of Tennessee for comments on earlier drafts.

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Medicine and Human Identity in Alexander Solzhenitsyn's *Cancer Ward*

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Abstract

Among its various themes, Alexander Solzhenitsyn's novel Cancer Ward *addresses the shortcoming of the paternalistic tendencies in medicine. Through the development of three characters in particular (the clinician, Dontsova; the patient, Oleg; and the family doctor, Oreshchenkov), Solzhenitsyn shows the de-personalizing effects of a bureaucratic paternalism, which primarily treats patients as though they were biological machines. Patients are subjects who cannot and should not be reduced only to causal, physiological laws and whose need for personal and spiritual connections with other subjects is vital to their purpose and wellbeing.*

About a third of the way through the novel *Cancer Ward* we read a conversation between the cancer ward patient Pavel Nikolayevich, who is dying of throat cancer, and his visiting wife Kapa. She says,

> Apparently until recently your illness could only be treated in Moscow, everybody was sent there, but then they started treating it here, you see, to improve the standard of the local specialists. Doctors are a detestable race, anyway. How dare they talk about production achievement when it's living people they're processing? I don't care what you say, I hate doctors.*

Although it is a harsh statement, it expresses a criticism Solzhenitsyn makes throughout the book—the practice of medicine has become too impersonal and too paternalistic.

Is Solzhenitsyn right with these charges about medicine? Of course, we can argue either side of this issue. That is, for medicine to treat and cure patients, especially those who may have fatal and complicated problems like cancer, medical science must develop more and more powerful technologies, and this development depends on vast and interworking systems of economics and engineering to manufacture and use complicated and specialized technologies. Yet, the more medicine becomes technologically advanced and the more we design technology to treat the largest possible percentage of the population, the less the individual becomes the focus of the treatment. It seems we are faced with a horrible dilemma: for medicine to advance in treatments, it must become more impersonal in dealing with patients.

However, this dilemma is not our only choice. One way to read Solzhenitsyn's novel is to realize that it is possible to advance medicine and still maintain the patient's humanity as the primary focus, and, hopefully, in the conclusion, I will have made this case.

Cancer Ward can be read in several ways. It is certainly a political critique with its allusions to the oppressiveness, callousness, and cruelty of the Soviet Union. It is hard to imagine a harsher criticism of Stalinism than what Solzhenitsyn has his mouthpiece, Oleg Kostoglotov, think to himself near its end. "A man dies from a tumor, so how can a country survive with growths like labor camps and exiles" (p. 520). Of course, Solzhenitsyn had to camouflage his political critiques, which he often did through the allegorical use of animals. In the next-to-last chapter, Oleg visits a zoo and is struck by the parallels between several animals and Soviet society. A squirrel runs senselessly in a wheel when it does not have to, driven by the illusion that something new would happen, but in the end it would only die exhausted, an allusion to the proletariat. An expressionless, whiskered, rapacious tiger (called "Mr. Tiger") stares at Oleg, evoking from him hatred and horror, an allusion to Stalin. Also, Solzhenitsyn probably has Stalin in mind when he calls an amoral zoo visitor who blinded a Macaque Rhesus monkey by spitting tobacco into its eyes "evil" rather than using a political cliché, such as "an agent of American imperialism," even ends the book rehashing why anyone be so cruel for no obvious reason—"An evil man threw tobacco in the Macaque Rhesus's eyes. Just like that . . ." (p. 532).

In real life, Solzhenitsyn was unjustly sentenced to a gulag for eight years for writing near the end of WWII (in which he served with honor) statements that were interpreted as critical of Stalin's conduct ("the man with the mustache") during the war and then afterwards without trial exiled under Article 58 for three years to Kok-Terek in southern Kazakstan.[1] He developed testicular cancer (seminoma) there and stayed in a cancer ward. He has the character Oleg parallel his life.

Solzhenitsyn had good cause to criticize how the Soviet system treated him, but in the novel he ponders larger and more universal issues than his particular circumstance such as, "What is the nature of human identity?" "How does disease assault it?" and "Does the practice of medicine help people affirm their humanity while struggling with and dying of cancer?"

In addition to reading the novel politically, I think it is consistent with Solzhenitsyn's literary imagination to use it as an assessment of the ethical realities of medical practice in general and of the kinds of paternalism forced upon patients who depend upon medicine to prevent death or to slow its encroachment in particular. My contention is that in the novel Solzhenitsyn correctly shows the ethical shortcomings of a particular justification of medicine—the "paternalization of health care"— and offers a way of viewing how the humanity of patients (not just the "fix" of their illnesses) can remain the primary focus of medicine.

The novel is complex with many characters representing numerous political, religious, and existential viewpoints and with many personal subplots running throughout it, but we can find Solzhenitsyn's critique of medicine in the way he depicts and develops three characters—a clinical doctor, a patient, and a family doctor.

The Clinical Doctor—Ludmila Afanasyevna Dontsova

Dontsova is the head of the radiotherapy and fluoroscopy of the ward, and Gangart, who agonizes over the impersonal treatment of the patients in the ward, is her understudy. Donstova has dealt with X-rays, injections, and surgeries for so long that she hardly ever sees the patients as people who live with pain and the fear of death. Rather, they are something broken that needs fixing, and her job is to fix their illnesses.

Dontsova is a highly trained specialist placed by the central agency in the remote area of Tashkent, away from the inner circles of the medical bureaucracy, and she works in cancer ward Number 13. We first read of her as she argues with Pavel, a party loyalist who has throat cancer. Pavel believes he is not ill and wants to be discharged, but she derides him for his ignorance. When he adamantly insists on knowing the truth of his illness she says, “Generally speaking, we don’t have to tell our patients what’s wrong with them, but if it will make you feel any better, very well—it’s lymphoma.”

Pavel then asks, “You mean it’s not cancer?” To which she replies, “Of course it’s not” (p. 47).

Dontsova not only thinks she does not owe the patient the truth about his condition, but also she thinks she has the right to lie to him, for lymphoma can be cancer, and Pavel can possibly die of it. Later she justifies her reasons for withholding the truth and lying to Pavel: “Doctors have one sacred principle: the patient must never be frightened, he must be *encouraged*” (pp. 77-78; emphasis added). At this point we see the first indication of Dontsova’s paternalism, and its ethical drawbacks become one of the book’s dominant themes.

What is paternalism? According to Tom L. Beauchamp and James F. Childress, it is “the intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.”[2] It refers to the practice of an authoritative agent limiting the freedom or autonomy of a person to improve the welfare or promote the interests and desires of the other person. Beauchamp and Childress see this as a conflict between the doctor’s beneficent approach to caring for the individual and the patient’s right for self-determination (autonomy). The person in authority justifies the action because the action intends to benefit the other, and because the doctor’s beneficence actually does contribute to the patient’s wellbeing, the patient should surrender part of self-determination to the doctor’s judgment and medical practice.

There are different types of paternalism (for example, hard versus soft paternalism, moral versus welfare paternalism), and the best way to explain Dontsova’s action is in terms of weak versus strong paternalism. Simply put, weak paternalism limits a patient’s freedom to choose certain means toward an end or goal, whereas strong paternalism determines the kind of ends and goals a person can choose regardless of whether the person is aware of the determination or not.

In a sense, medicine always tends toward paternalism. That is, patients come to a physician because the doctor knows more than the patient about how to treat a problem and has the means to give the treatment. Every time a patient engages a physician she enters an informal contractual arrangement in which she surrenders an amount of her autonomy so that the physician can treat her to the best of the physician’s ability. If a patient agrees totally in an informed and reasonable way with the doctor’s advice and actions and is not subtly coerced by incentives, then the moral issues involved with paternalism are not as poignant. They arise when the doctor has to subsume, through either direct or indirect ways, the patient’s autonomy to her authority as the treating physician. This is a moral issue because we typically think that a person has the right of self-determination, and though we may rely on and need the help of others, the help cannot come at the expense of our own autonomy. That is, we should not be belittled as persons just so we can be helped. However, we also recognize that autonomy needs moral guidelines, that we are not always right about how to determine our own lives. For instance, we think we should intervene when a person unnecessarily lacerates or destroys herself. Though she chooses to act this way, it actually weakens and possibly destroys her true self and purpose.

Weak paternalism, then, would be a physician recommending or applying certain treatments which the patient may not condone so that both the doctor and patient can reach the same end and goal, for example, health and the resumption of normal activities. In this instance, the physician would argue that she knows more about treating illness and disease than does the patient.

Strong paternalism goes a step further and the physician or others attempts to define the patient's ends and goals and prescribes ways to reach them. This form of paternalism is harder to define. What are the ends and goals of life that a patient alone should articulate and seek for herself? What would such ends and goals look like and what would be the necessary conditions for a successful definition of life's ends and goals?

A minimum version of strong paternalism would be a physician preventing a person from committing suicide because the physician believes either that all human life has inherent value or that the patient still has many values to realize and experience in her future. A maximum version of strong paternalism would be a physician trying to determine for the patient what kind of human being she should be, the physician presuming to know more about the human nature to which the patient should live up than the patient knows for herself.

With these distinctions in mind, we ask if Dontsova is being paternalistic toward Pavel, and, if so, in what way? She says that she does not have to tell the whole story to her patients. Her justification for this withholding is that it would encourage the patient, that it would be to Pavel's wellbeing not to know. However, then she lies to him, saying his lymphoma is not cancerous when in fact it is, and eventually Pavel's lymphoma becomes malignant. Perhaps withholding information from a patient to keep the patient's spirits and hopes for recovery high, believing that such an attitude would make her a better patient for the doctor and may actually contribute to her wellbeing is a weak form of paternalism.

However, it is hard to justify lying to a patient as a legitimate form of weak paternalism. The issue is not which means of treatment would work best but whether the person has enough moral value to be treated with enough respect not to falsify the experience which the patient has to assess and to which she must adjust. Of course, we can lie to another because we have no respect at all for the other, but this would not be based upon the moral worth of the other person. What would justify lying to another person in terms of the moral worth of the person? If the justification is that the lie is for the good of the person, then we would not be saying that the person *as she is* requires us to lie to her. Rather, we would be saying that the person *as she ought to be* requires us to lie to her, and thus the lie is justified to reach that particular understanding of what kind of person the patient *should be*. Hence, any attempt to justify lying based on the value of a person has to be based upon what we think the person should be, in contrast to who she actually is.

Is it possible for Dontsova to justify the lie, thinking that the lie would be necessary to encourage Pavel? It is doubtful that Dontsova could make such a convincing argument without slipping into strong paternalism. She lies because she thinks Pavel is not the kind of being who should know that he has cancer and may die from it. She looks at Pavel as only a patient whom she treats, not as a being with his own unique right of self-definition and determination. This is strong paternalism, and it becomes more obvious as the novel progresses.

In the chapter titled "The Doctor's Worries," Solzhenitsyn describes the younger doctor, Vera Gangart, walking through the ward feeling a constricting melancholy. Too many patients are untreatable, and many die. She feels she is not adequately trained or emotionally oriented to deal with such tragic results and has not gained the type of confidence Dontsova has in her own authority as a treating physician.

However, Dontsova's confidence comes across as a callous attitude and undermines her relationship with the patients. During a long and vitriolic dispute with Oleg Kostoglotov, he snaps at her for condescending to him when he asks when it will be time for him to be released from the ward. She talks to him like a child: "You see, you start from a completely false position. No sooner does a patient come to you than you begin to do all his thinking for him. . . . And once again I become a grain of sand, just as I was in the camp. Once again nothing *depends* on me" (p. 74). Oleg had spent time in a political prisoner camp, and, because of Dontsova's paternalism and impersonal treatment of him, he feels he is back in the prison camp being told what kind of human being he should be.

Instead of responding to Oleg's insistence to be treated as a unique individual, Dontsova spouts the medical principles she had learned in school and practice. For her, Oleg is not a person; he is a patient to be cured. Oleg fights this depersonalizing attitude by blurting out to her, "But I don't want to be saved at any price! There isn't anything in the world for which I'd agree to pay *any* price! . . . I came to you *to relieve my suffering*!" (p. 75).

Oleg realizes that to Dontsova he is just a "recovery percentage" defined by how the Academy of Medical Science prescribes him to be treated. But Dontsova does not hear his plea to be treated as an emotional being who needs individualized palliative relief. In fact, she demands him to accept his transfusions and X-ray treatments with gratitude as though she knows what is best for him. Oleg then sees clearly what the real existential issue is—"Why do you assume you have the right to decide for someone else? Don't you agree it's a terrifying right, one that rarely leads to good? You should be careful. No one's entitled to it, not even doctors" (p. 77). However, Dontsova's feels entitled to make these decisions for people. The issue is not merely which treatment works best but what kind of living being Oleg: he feels the tension between seeing himself as a being with a personal center which defines and expresses his uniqueness and value and being treated as a biological machine that operates by causal laws of physiology.

Dontsova is so hardened in her confidence that she arrogantly tells Oleg that he must accept her authority to treat him the way she has been taught "not just with faith but with *joy*! That's the only way you'll ever recover!" (p. 79). To this, Oleg is left speechless. Then Solzhenitsyn gives us a glimpse into her thinking: "She was there to save life, no more and no less. In their clinic it was nearly always life that was at stake, nothing less than that. Ludmila Afanasyevna was unshakably convinced that any damage to the body was justified it if saved life" (p. 85). Oleg is a biological organism, operating by causal rules, thatcan be fixed by Dontsova's treatments, and Oleg's lack of trust and faith in her role as his healer offends and even personally hurts her.

Dontsova cannot allow any room for doubt in her approach to curing her patients. If a treatment does not work, then she cannot question her right and authority to continue to treat and experiment on her patients. She reasons to herself,

> Could the question arise of a doctor's *right* to treat? Once you began to think like that, to doubt every method scientifically accepted today simply because it might be

> discredited or abandoned in the future, then goodness knows where you'd end up. . . It was a universal law: everyone who *acts* breeds both good and evil. With some it's more good, with others more evil (p. 88).

For Dontsova, the doctor is always right, even if the treatment fails, because what she learns can be used to save lives in the future. This belief plants an attitude of infallibility in her and convinces her that though everyone's decisions may breed both good and evil, her decision as the treating physician will always breed more good.

In Dontsova's mind, she is not acting and reasoning with Oleg as a solitary doctor. The whole profession backs her approach to curing Oleg and her authority to demand him to submit to her treatment. A huge, powerful bureaucracy acts with her.

At this point we see another form of paternalism at work in Dontsova's approach to medicine—the contrast between individual paternalism and bureaucratic paternalism. Individual paternalism occurs when a doctor appeals to the coherence and evidence of her own reasons to limit the patient's freedom and autonomy. In such an instance, the patient deals directly with the physician's paternalism (usually an informed consent tries to settle this concern with the patient).

However, with bureaucratic paternalism multiple layers of authorities as well as previous and removed decisions are brought to bear upon the patient's freedom to decide what is best for her welfare. The doctor does not merely appeal to the correctness of the treatment. She appeals to the authority of the profession and industry. Of course, the more shared and corroborated a knowledge claim is, the more trustworthy it is, because the claim would have passed through multiple tests and examinations. However, the issue is not the certainty that can come from collaborative scientific research and the peer-review process of gaining knowledge but whether a doctor is justified to limit the freedom and autonomy of a patient by primarily appealing to the bureaucracy of her profession.

It is as though Dontsova is telling Oleg, "you should accept my authority to determine what you should do because a large and impressive institutional system backs me up." Consider the levels of authority that Dontsova represents to Oleg. First, her personal authority confronts him. Second, there is the institution in which the physician works, with its buildings, personnel, complicated professional groups, and dollar-value. Third, there are the companies who design the technologies and drugs. Fourth, there are the doctors who conduct the early phases of the research protocol to determine if the treatments work. Fifth, there are the professional journals, representatives from industries, medical schools, and colleagues who persuade the treating doctor to use the projected treatments. When the treating physician claims that the profession backs a treatment, she is doing more than speaking to the patient about what she thinks is best for the patient. There are four removed layers of bureaucracy bearing upon the patient. They are nameless and abstract from the actual decision, and, because they are abstract, they cannot be argued with, leaving the impression on the patient that it would be irrational and self-detrimental not to submit to this appeal to the legitimacy and power of the medical bureaucracy.

When a doctor assumes she has the right to limit a person's freedom to determine what is best for her own self-understanding as the person she is by primarily appealing to the bureaucracy supporting her, she dismisses having to reason directly with the patient. The patient thus feels condescended to and disrespected as a rational being. This is what Oleg feels. He is a human being with his own right of self-determination and should not be disrespected by the profession, which claims to act for his wellbeing.

Though it would be easy to condemn the role of Dontsova in the story because of her paternalism, later Solzhenitsyn has us sympathize with her to illustrate an important aspect of what it means to lose one's identity through illness. About two thirds into the story, Dontsova gets cancer. She develops cancer of the esophagus, which she discovers about four months after the debate with Oleg. She is now on "The Other Side of the Coin," the chapter's title.

"Dontsova never imagined that something which she knew inside and out and so thoroughly could change to the point where it would become entirely new and unfamiliar. For thirty years she had been dealing with other people's illnesses, and for a good twenty she had sat in front of the X-ray screen" (p.445). She is now a victim of the treatments she had given for twenty years, in each instance believing that she knew what was best. Instead of "physician heal thyself," the phrase is now reversed: "physician kill thyself." On that day, "she ceased to be a rational guiding force in the treatment, she had become an unreasoning, resistant lump of matter. The moment she admitted the disease existed, she was crushed by it like a frog underfoot" (p. 446). Instead of becoming just a patient who falls into "recovery percentages," she is now a unique individual, with her own plea to live and not to suffer. In realizing her mortality, she recognizes her own unique humanity and also the unique humanity of her patients.

About the last mention we have of Dontsova is in these thoughts from her—

> At any other time Ludmila Afanasyevna wouldn't have let [Oleg Kostoglotov] get away with such a rude reply, she would have given him a good dressing down. But right now her will had sagged, she was scarcely able to complete her rounds. Outside her line of duty, to which she was now bidding farewell, she couldn't really object even to Kostoglotov. It was true, it was a barbarous treatment (p. 456).

Finally, she sees that whenever medicine paternalistically disregards the humanity of its patients its treatments seem barbarous, no matter how successful they had been in the past, no matter the positive results for future research, and no matter how well-intended they were.

For Dontsova, cancer is no longer something objective and abstract from human pain. It is personal. Prior to her illness, she called cancer a "seminova," a "lymphoma," or a "melanoblastoma." Now it is something different, something new and unfamiliar. Throughout the book, Solzhenitsyn uses metaphors to describe cancer: a "crab," which, once it has its claws on you, will not let you go (p. 10); a "swine" that breeds uncontrollably (p. 198); "snakelike" (p. 247); and a "panther of death" that hides and then pounces on unsuspecting people (p. 249). It is easier to control and fix what we can name with abstract and Latin words, but it is far harder to handle an invasive, pernicious, volitional force. That is what cancer feels like to those suffering it, and at last Dontsova fears what she cannot control with her medical treatments.

Dontsova's fate indicates an aspect of the tragic nature of medical care. She had intended to cure, but she created the conditions that led to the opposite—her death. No matter how technologically advance and competent medicine becomes, it cannot stop mortality and the unforeseen and unintended negative consequences of medicine's well-intended treatments. Because she was conditioned not to accept failure, Dontsova's paternalism had blinded her to this tragic dimension of medical care.

Perhaps, this illustrates one of the most critical aspects of medical paternalism—it does not want to recognize the natural limitations of medical care. With the influence of technology, physicians seek to control as many situations as possible. More and more powerful technologies are needed and used to exercise more control so that the physician can keep the misunderstanding that she can eliminate the tragic dimension of medical care. The more central and important technology becomes in treating patients, the more medicine tends toward bureaucratic paternalism. Because the physician approaches the patient primarily in terms of how technology is used to treat the patient, the decisions implied in the kind of treatment get farther away from the actual discussion with the patient. That is, as was laid out above in the description of bureaucratic paternalism, someone has to decide how to treat the disease generally, then someone manufactures a technology to give the treatment, then a research protocol is performed with degrees of success, then the physician is taught how to use the technology and who is likely best treated by the particular modes of technological treatment, then the physician determines whether the technology should be used, and finally the patient is informed of the decision. But the determinations of the effectiveness of the specific technology are far removed from the actual patients, and those who make these determinations do not and cannot know the actual personal costs to the individual patients.

In bureaucratic paternalism, the patient is not only treated impersonally, she is depersonalized. Her emotional center, her fears and hopes have to be put to the side. To justify the continual advance of medical treatments, she must be defined in a way that can be treated by the controlling technologies. The patient must be approached as a biological machine, who medical science can describe by causal laws and who, when broken, medical technology can repair.

Of course, most physicians would deny such a negative description and assessment of their profession, and no one would want to see herself as the callous and arrogant Dontsova. However, physicians need to be aware of the force that the medical bureaucracy bears upon the patient and how powerless the patient can feel before it.

Moreover, Solzhenitsyn's critique is deeper than only exposing the bureaucratization of medicine. He criticizes its underlying justifying idea. When Dontsova tells Oleg "that any damage to the body was justified if it saved life [and advanced medical research, which would save future lives]" (p. 85), the justification seems innocent and straightforward. However, when she gives the justification, coupled with the authority of bureaucratized medicine behind her, we hear something else. She not only implies that the "end justifies the means," but also she insinuates that because she knows how to treat Oleg she also knows what end Oleg should seek. It may seem that Dontsova is arguing a simple utilitarianism; that is, for Oleg to reach his end he should choose medicine's treatment as the best way to realize or maximize that end. But in fact, her argument implies that she knows to what end Oleg should be committed and that his end would be reached only through her treatment. He would better understand his end, if he submitted to Dontsova's treatment, because, in her eyes, Oleg is the kind of being that is best defined as one treatable by medical technology.

There is a circular argument here. Dontsova's medical paternalism starts off by claiming that it has the correct and necessary treatment, which is the right means to employ in the situation. The goal of the treatment is to save life and, if possible, gain health. Health is a goal because it leads to happiness, and everyone seeks happiness.

However, happiness means functioning in a healthy way according to the kind of organic being that can be treated by medical technology. The end of medical science becomes defined by the means it uses to treat beings that it has defined according to ways that conform to being treated with its technology. The goal of medical treatments becomes a restatement of the means it uses to treat patients.

When Oleg protests and says, “Why do you assume you have the right to decide for someone else? Don’t you agree it’s a terrifying right, one that rarely leads to good? You should be careful. No one’s entitled to it, not even doctors” (p. 77), he is doing more than saying he does not want the treatment. He is saying that he does not want to be the kind of person that bureaucratic medicine is defining him to be, because it rejects his own sense of self and, hence, de-personalizes him. This is the novel’s most serious critique of the kind of medicine exemplified in Dontsova.

The Patient—Oleg Filimonovich Kostoglotov

As was said above, Oleg’s life parallels Solzhenitsyn’s. He fights in the war, is unjustly imprisoned, is exiled, and suffers cancer in a cancer ward. The authorities send Oleg to the ward in Tashkent, where he stays four months. When he arrives, no beds are available, so he lies down on the floor. The young doctor Vera Gangart almost trips over him and chides him for lying by the main staircase.

> “Who are you?” she asked him.
>
> “A human being,” he answered quietly, unperturbed.

Vera eventually gets Oleg’s admission papers, which had been issued to him, and Oleg yells at her.

> “Wait a minute, wait a minute.” He suddenly came to life. “Give me back that paper. I know these tricks.”
>
> “What are you afraid of?” She turned round, offended. “Don’t you trust me?”
>
> He looked at her doubtfully and grunted, “Why should I trust you? You and I haven’t drunk from the same bowl of soup. . . .” (p. 62).

This starts Oleg’s continual battle with the ward to be treated as a human rather than as an object. He rejects Dontsova’s paternalism from the beginning. Earlier he told Dontsova that he had read Descartes (presumably, *Discourse on Method*) and believes he should doubt all knowledge claims, especially what doctors claim to know.

He does two things that particularly irritate the doctors. First, before he entered the ward, he had read the medical textbook *Pathological Anatomy* by Abrikosov and Stryukov, which postulated that tumors are connected to the central nervous system. From this idea, it is reasoned that a patient might cure herself by changing her thinking, a form of self-induced healing (p. 133). Dontsova sees this conclusion as nonsense and becomes annoyed with Oleg that he would even consider that there could be another way to be treated besides the one she prescribes.

Second, while in the ward he had read that *chaga* (a fungal growth on a birch tree) and a root from Issyk Kul have healing powers. So he sends for them, trying to circumvent Gangart and Dontsova’s treatments (pp. 141 and 226). The doctors try to dissuade him of their effectiveness and take them away. In reply Oleg asserts that they do not know for certain that *chaga* and the root will not work. Then, he bitterly claims, “Oh, I know about your sacred science," he sighed. "If it were all so categorical, it wouldn't be disproved every ten years! What is there for me to believe in?" (p. 228).

With this charge, he is not necessarily challenging the role of scientific research and the need for continual revisions and restarts. Rather, he challenges the paternalism and condescending superiority of a profession that cannot even be categorically certain about its conclusions and which must revise or overturn most of its conclusions every ten years.

However, more is implied by Oleg's critique than only the above point about medicine's success and failure rates. For Oleg, Dontsova's medical paternalism misconstrues human identity. Oleg expresses his understanding of human identity in three places. First, in the long running argument he has with Dontsova, mentioned above, Dontsova challenges his logic in rejecting his X-ray treatments and hormonal transfusions which eventually make him sexually impotent. He should be more reasonable and understand that she is working for his best, because the human body is designed to respond favorably to the treatments. In an outburst of protest, Oleg blurts,

> "Obviously there's no logic." Kostoglotov shook his shaggy black mane. "But maybe there needn't be any, Ludmila Afanasyevna. After all, man is a complicated being, why should he be explainable by logic? Or for that matter by economics? Or physiology? (p. 75).

For Dontsova, a person is a biological machine that can be fixed when broken. The full range of human identity seems to be reduced to physiology and the causal laws that can explain it. If Oleg would agree to this reductionism, he would understand her logic and assent to the treatments and thus be healed.

But this reductionism misses a very essential aspect about human identity. Though it may be possible to understand muscles, bones, tumors, blood, etc. according to laws of cause and effect, the self, which has those muscles, bones, tumors, blood, etc., cannot be explained by the same laws of cause and effect. There is no science of the individual, of that which is the self-aware center that experiences the world. We can contradict ourselves and even decide not be saved just so we can affirm our right not to be reduced to physiological laws. A muscle, bone, organ, tumor, blood cell, etc. cannot contradict its own physiological laws, but a self can, and the self is what suffers the pain of dying and the terror of death. Dontsova's paternalism has to ignore and even deny this self in order to treat the person. She has to simplify human identity to fit the person into the scheme of treatment. In truth, her transfusions and X-rays do not touch the self and hence cannot heal it.

Second, about two months into his stay at ward Number 13, Oleg has a long conversation with another former exile, Elena Alexandrovna. The two recall the happy moments they experienced with the common people in the remote areas of Ush-Terek in the year 1954. Solzhenitsyn then has us listen to Oleg's thoughts.

> And obviously she was right. It is not our level of prosperity that makes for happiness but the kinship of heart to heart and the way we look at the world. Both attitudes lie within our power, so that a man is happy so long as he chooses to be happy, and no one can stop him (p. 266).

The reality of "kinship of heart to heart and the way we look at the world" is beyond what Dontsova's medicine can treat. Our most profound happiness comes from the intimacy of being recognized, appreciated, and bonded to other selves. This kinship entails people sharing the same way of looking at the world through interpreting experiences in emotionally similar ways and wanting to share, for example, the same joys, grief, wonders, compassions, sorrows, and hopes.

It may be that Dontsova would not in principle deny such kinship, but her reductionism dismisses it as irrelevant to her medical approach to the patient. Thereby, she never personally identifies truthfully with those whom she treats. She may correctly understand a muscle, bone, organ, tumor, or blood cell, but she abstracts these from the heart of the person, from that aspect of the self that seeks and needs intimacy with other persons. Furthermore, her paternalism requires ignoring this need for kinship so as to approach the person as a biological machine that can be treated with her technology and hence repaired. Because this need for kinship is disregarded in Dontsova's approach, Oleg feels that he is being de-personalized so that she can find a way to treat him.

Third, in the chapter titled "Transfusion of Blood," Vega Gangart tells Oleg that the transfusions of female hormones he has been taking will not eliminate his libidinous desires but will make him incapable to act on them. He begins to wonder what good he would be to anyone and repines that he had always wanted to marry. He tries to shake away all his beliefs and desires about what he had wanted in life. Then, curiously, he asks Vega if she had read two immensely popular books by the famous venerologist Dr. Friedland, *Behind the Closed Doors* and *The Suffering of Love* which had come out in the 1920's. In these books, Friedland claims that marriage is exclusively based on the physical dimension of sexual attraction and that most women live frustrating lives because they have not experienced sexual fulfillment in marriage. According to Friedland, the psychological (the "kinship of heart to heart") is secondary, and incompatibility between partners is explained according to physiological factors.[3] Vega quietly and timidly says she did. Then Oleg says,

> Reading them made a shattering impression on me, but it was somehow emptying as well. I had the feeling I didn't really want to live any more . . . Such consistent, logical, irrefutable materialism, and the result was . . . the point of living? . . . You see, that sort of attitude destroys everything human on earth. If you give in to it, if you accept it and everything it entails. . . (pp. 334-335).

Though Oleg knows the importance of sexual intimacy and desires it, he rejects Friedland's reductionism just as he does Dontsova's reductionism. Friedland and Dontsova both represent a stifling and de-personalizing view of human nature. Of course, we are sexual beings made for sexual union and are physical bodies which can be treated by transfusions and X-rays, but we are more than these. Being human is something more. The possibility of kinship with others indicates that humanity has an identity that cannot be sufficiently explained by a venerologist or an oncologist. This is not an extraordinary claim. But what is extraordinary, and one of the novel's main points, is that paternalistic medicine, in order to treat persons, ignores and in cases has to dismiss the essential and inescapable importance of this reality, capacity, and desire of persons to form the kinship of heart to heart.

The Family Doctor—Dormidont Tikhonovich Oreshchenkov

From Dr. Dontsova's paternalism and Oleg's rejection of it, we could conclude Solzhenitsyn has only a negative view of medicine. However, he does not, and in the character of Dr. Oreshchenkov, the 75-years-old, independent family doctor, we read of Solzhenitsyn's vision of how medicine can attempt both to cure and to respect the humanity of the patient without becoming paternalistic.

Oreshchenkov had been Dontsova's teacher and mentor, and after she discovers the cancer she goes to him for counsel. He is a widower, living in the same place in which he has conducted private family practice for the last ten years.

He taught for thirty years at the local medical college and while there learned general practice, pediatrics, surgery, epidemiology, urology, ophthalmology, radiology, and oncology. In his later years, much to the protest of state and medical authorities, he practiced outside the clinics so that he could bring all his study and learning to deal with patients in the most welcoming and accepting place he could—his home. Because he did not think it was necessary for his work as a physician, he did not submit his Master and Doctor's theses, maintaining that if a doctor sought to become an "Honored Scientist," she would be ignoring her primary responsibility to treat people.

When Dontsova sits in front of him describing her symptoms, she notices that he does not take his eyes off of her. "Oreshchenkov watched her steadily, his glance never wavering and his angular eyebrows expressing not one millimeter of surprise" (p. 417). His inviting look encourages her to talk not only of her cancerous symptoms but also of what also deeply worries her—her children. Her divorced daughter's life grieves her, and her aimless and rebellious son worries her as much as her cancer. It is as though Oreshchenkov hears one story with two sides to it—her illness and her mother's worry.

Solzhenitsyn then says of Oreshchenkov, "The expression on Oreshchenkov's face indicated that he heard stories like this before. He said, 'You know, one of the problems is that our young people have lost one of their most important preceptors—the family doctor!'" (p. 421). With this statement we see how Oreshchenkov begins to connect people's illness with their personal identity. He then makes the seemingly incomprehensible claim that

> The family doctor is the figure without whom the family cannot exist in a developed society. He knows the needs of each member of the family, just as the mother knows their tastes. There's no shame in taking to him some trivial complaint you'd never take to the outpatients' clinic, which entails getting an appointment card and waiting your turn, and where there's a quota of nine patients an hour. And yet all neglected illnesses arise out of these trifling complaints (p. 422-423).

It is his belief and experience that because the family doctor combines both scientific knowledge of physiology and diseases with the personal knowledge of the life of the patients over a period of time that the family doctor can detect illnesses earlier than can a specialist in a clinic. This information is possible only because the person's physical wellbeing and emotional wellbeing are inseparable.

A person is not first a physical being and then a separate social being and another separate spiritual being. Rather a person is one self who experiences the world physically, socially, and spiritually—an individualized power of experience. If a doctor thinks she can heal a person by only treating the physical, by reducing the patient's life to what can be causally explain by laws of physiology, then the doctor de-personalizes the patient. It is because the family doctor knows the patient in the multiple ways in which the patient experiences the world that the family doctor is indispensable for the success of medicine to heal patients.

Because of this understanding of human identity, Oreshchenkov says that doctors must first approach the patient as a "subject."

> The primary doctor should have no more patients than his memory and personal knowledge can cover. Then he could treat each patient as a subject on his own. Treating diseases separately is the work on the *feldsher* [an assistant doctor, not fully qualified] level. . . . But the patient's organism isn't aware that our knowledge is divided into separate branches. You see, the organism isn't divided. . . How can we understand the patient as a single subject? . . . If you wanted to understand the patient as a single subject there'd be no room left in you for any other passion. That's the way it is. The doctor should be a single subject as well. The doctor ought to be an all-rounder (p. 425).

At the core of each person is that which experiences the world in separable ways and which itself is not divided. The subject is the power of experience and cannot be known directly. It is known indirectly through the multiple dimensions of experience, that is, the physiological, social, and spiritual. Any influence whether constructive or destructive upon these multiple ways of experience affects the self. Because these multiple ways of experiencing the world come from one unique subject, it is de-personalizing to reduce the patient only to the physiological, social, or spiritual. The intent to heal the sick must approach the patient as a sick subject, not just a sick body. And for Oreshchenkov, the family doctor is the best primary care giver for the sick patient because she knows the person as a subject.

Curiously, after sharing this view with Dontsova, Oreshchenkov realizes that the conversation has not done Dontsova any good at all. Then, from the veranda door a St. Bernard dog walks into the room and stares at Dontsova "in transcendental detachment" (p. 426). Inexplicably, the presence of the dog refreshes and cheers her up. "She rose from the table thinking that maybe she wasn't in such a bad state after all, even if she did have to undergo an operation" (p. 427).

At first sight, it seems too sentimental and contrived for Solzhenitsyn to bring into the scene the large rescue dog. Perhaps. Earlier in the novel, when Oleg is describing the ultimate value of the "kinship of heart to heart" as is mentioned above, he also says, "Nowadays, we don't think much of a man's love for an animal; we laugh at people who are attached to cats. But if we stop loving animals, aren't we bound to stop loving humans too?" (p. 269). Oleg then recalls a particular pet dog he had known while in exile, Beetle, who was a mutt about the size of a German shepherd. Beetle was a great companion for his owners, the Kadmins, and reflected back to them their kindness and compassion and seemed to adopt their humane principles. However, Beetle was eventually cruelly shot and killed senselessly by some ruffians who were roaming the streets drunk, looking for dogs to shoot.

Maybe the point is that pet animals reflect back to us how we want to relate to the world. If we want "kinship of heart to heart," then we find the desire met and also confirmed. If we define ourselves as cruel and insensitive, then animals show the awful consequences of that orientation. When Dontsova sees the St. Bernard, she sees something reflected back to her. She really desires the "kinship of heart to heart" even more than she does to live as and be known as an "Honorable Scientist." The experience with the St. Bernard awakens in her the real reason why she visits her mentor. She wants to know if there is something more important to her life than her cancerous, dying body.

The brief experience with the dog helps her understand herself as a "subject," and for that she feels refreshed and cheered in her humanity.[4]

At the end of the chapter Solzhenitsyn has us read of Oreshchenkov's ultimate beliefs. After his wife died, he sought more than anything "pure transparency" and a "silent immobility" in which he realizes for himself "an image of the whole meaning of existence" that is beyond his particular time and work and found in the "unspoiled, undisturbed and undistorted . . . image of eternity with which each person is born. Like a silver moon in a calm, still pond" (p. 428). For some, this description of life's ultimate basis and orientation may seem a superstitious belief, a fanciful wish projection, or a deadening of consciousness. But for Solzhenitsyn it follows from his notion of the person as a subject.

As a subject the person is the self-aware, individualized power of experience, who has empirical, mental, and self-conscious experiences and is thus unique and distinctly individual. The most satisfying and compatible experiences a subject can have in which there would be the "kinship of heart to heart" would thus be with other subjects. If an experience of eternity is possible, it would not be of changeable and divisible objects but of what is utterly unique and distinctly individual in an unlimited way. Whereas a person is a self-aware, individualized power of experience in a limited way, eternity would be that which has the possibility of experience in an unlimited way. If this is possible, then it would follow that the experience of eternity would be the greatest possible experience a person as a subject can have.

It may be that Solzhenitsyn offers this bit of metaphysics to reinforce his overriding point that for medicine to treat the person as a whole being who experiences the world from the unity of being a subject, medicine must respect this type of experience, which a patient can have. If a doctor were to ignore or dismiss this type of religious experience in the patient, then she would de-personalize the patient and fall into the worse aspects of paternalistic medicine.

Certainly, if persons are not subjects and are reducible to causal explanations of physiological laws, then this spiritual dimension can be ignored and dismissed. If medicine is primarily based on materialistic assumptions in which the person is seen as a biological machine, then perhaps there is no way to persuade medicine to consider the person as a subject. However, one could say Solzhenitsyn writes this novel to combat this attitude as an overly simplistic and arbitrary explanation of the human experience, and, worse still, as the major premise from which the insensitivities and de-personalizing tendencies of paternalistic medicine would naturally follow.

Conclusion

It is true that Solzhenitsyn is often described as a Romantic who wants society to return to economically, industrially, and technologically simpler times, but it does not follow that we should think he wants medicine to reverse its technological advances. However, he does want medicine to avoid being as paternalistic as he describes Dontsova being toward her patients in the novel's first half.

If the above presentation of the novel's implied criticism of medical paternalism is correct, then what consequences can we derive from it?

First, the dominance of technology in medical care has to be questioned. This questioning does not mean medicine should use less technology, but it does mean that the medical profession needs a clear understanding of the purpose and power of technology. Technological progress tends to dominate over other ways to approach problems. Of course, medical technologies have proven to be powerful and often successful in treating diseases, but it must be admitted that not all new technologies are successful. Yet, the tendency is to think that because we have been successful with technology, we should define problems in ways that technology can fix them, and when this occurs, we come close to experiencing what Neil Postman calls "Technopoly"—"a state of culture. It is also a state of mind. It consists in the deification of technology, which means that the culture seeks its authorization in technology, finds its satisfactions in technology, and takes it orders from technology."[5] I do not think we need to reject the value of technology as much as Postman does, but we need to admit that it exerts a powerful influence on the practices and goals of medicine. We need to be most concerned about its implied notion of human identity—we are primarily a biological machine which follows causal physiological rules, and when the patient is ill medicine finds the way to fix the problem through new technologies. This approach gives technological medicine tremendous power to dominate the patient and consequently engenders the de-personalizing effects of paternalistic medicine.

Second, the traditional superiority given to the medical specialists over the family doctor should be reversed. Because the family doctor understands the patient from the long-term engagement with the patient, the family doctor, if possible, needs to be the primary care physician of the patient in all cases. The specialist should thus serve the family doctor and always work through and with the family doctor in treating the patient. Of course, this would require a large increase of the number of family doctors who are familiar with many medical specialties and also have the ability to listen to patients and remember their stories of life and illness. Medical schools and professional societies should promote the family doctor as the highest level of practicing medicine, because the family doctor would be able to best understand how to coordinate the appropriate treatments with the particulars of her patients. It is possible that a specialist can serve in this role, but as one who knows how the specialty coordinates with other important aspects of the patient's overall health, familial and social state, and self-understanding. Of course, this reversal of importance would challenge much of the medical establishment that has created a system in which the highest financial rewards and accolades go to specialists. The point is not to remove the importance of the specialist but to see her as working on behalf of the family doctor for the patient.

Third, medical training should include a large exposure to the study of the humanities.[6] Because physicians need to keep in mind that the patient is a subject, not merely a biological machine, the study of literature, philosophy, psychology, sociology, and theology should be part of their curriculum. It is not enough to know only physiology, anatomy, diseases, etc. The physician must also know what is involved in "the kinship of heart to heart" and to be able discern it in people lives. Of course, not all texts in the humanities would equip the physician with this kind of knowledge, but the medical schools should design a humanities curriculum that would expose students to the various ideas of human nature, the importance of love and family, the affects of the experience of mortality on a person's self understanding, and the importance of the ethical, aesthetical, and religious virtues in developing a sense of being a subject. Helle Mathiasen and Joseph

Alpert are surely right when they say, "both medicine and literature are humanistic arts. They resemble each other in the objects, effects, and aims. The object of medicine is the study of human life. . . . Literature, too, has the human being for its object."[7] This enlarging of the medical school education would be an added burden to the profession, but if the profession wants to fulfill its vocation as the treatment of people who are subjects and not just biological machines, then it is something the profession must bear.

Endnotes

1. G. Goldberg gives an interesting interpretation of the novel as illustrating the many ways exile can be experienced. He shows that the cancer ward is a form of exile and having a disease is a form of exile and that, just as those in geographical exile need someone to help them return home, those who are sick need a healer to restore them "Exilic Effects of Illness and Pain in Solzhenitsyn's *Cancer Ward*: How Sharpening the Moral Imagination Can Facilitate Repatriation, *Journal of Medical Humanities* (2009), 30, 29-42.
2. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, fifth edition (Oxford: Oxford University Press, 2001), p. 178.
3. For a good discussion on the role of sexual identity and attraction in the novel, see Richard Hallett, "Masculine and Feminine in Solzhenitsyn's *The Cancer Ward*," in *Forum for Modern Language Studies*, (1981), 17:4, especially pages 297-300, which is particularly helpful in clarifying how medicine should not ignore the way that medicine influences sexual identity.
4. The role of animals in *Cancer Ward* is a study in itself. Their allegorical use has already been mentioned in this article, but Solzhenitsyn's estimation of them is more than just as a literary device. They communicate something "spiritual," something about the connection of subjects with each other. The role of the St. Bernard definitely says this, but elsewhere in the novel Solzhenitsyn mentions the "miracle of spirituality" (p. 507) when Oleg senses in a Nilgai antelope the presence of Vega calling him to her at the zoo. Perhaps this expansive understanding of spirituality reflects the nature-mysticism that is so much a part of the Russian Orthodox teaching of the divine presence within nature.
5. Neil Postman, *Technopoly: The Surrender of Culture to Technology* (New York: Vintage Books, 1993), 71. Postman is leery of how the dominance of technology changes the practice of medicine. He gives three warnings: "First, technology is not a neutral element in the practice of medicine: doctors do not merely use technologies but are used by them. Second, technology creates its own imperatives and, at the same time, creates a wide-ranging social system to reinforce its imperatives. And third, technology changes the practice of medicine by redefining what doctors are, redirecting where they focus their attention, and reconceptualizing how they view their patients and illness," p. 105.
6. For a good example of what I am recommending see what is done at Yale Medical School—"Teaching Literature and Medicine," *Journal of Medical Ethics* (1999), 25, 278-279— but I would add to the study of literature the study of philosophy, theology, and psychology, especially as they concentrate on human identity, the bases of human experiences, and the way human identity is formed by social relationships.
7. Helle Mathiasen and Joseph S. Alpert, "Only Connect: Musings on the Relationship Between Literature and Medicine," *Literature and the Arts in Medical Education* (2001), 33:5, 349-351. Steven M. Radwany and Bernard H. Adelson make the same case in "The Use of Literary Classics in Teaching Medical Ethics to Physicians," *Journal of the American Medical Association* (1987); 257:12, 1629-1631.

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Vol. 28:2 Summer 2012

Human Germline Genetic Enhancement and C. S. Lewis's *The Abolition of Man*

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Abstract

The Abolition of Man, written over 60 years ago by C. S. Lewis, focuses on the importance of objective values. In it, Lewis asserts that a person cannot be fully human without the existence of objective values. He explores the basis for objective values and imagines a scenario in which the pursuit of the control of human nature through scientific technology would by the nature of the project separate itself from objective values and lead to the abolition of man. However, what he imagines might happen by the hundredth century A.D. is beginning to be possible in the twenty first. Research on germline gene transmission in animals suggests that germline genetic modification capable of changing the future of the human genome may be possible in the near future. Germline genetic modification is the focus of an extensive ongoing ethical discussion. This includes issues of safety, justice, and the limitations of human subject research. A major focus in the discussion is the issue of whether germline genetic modification for enhancement is ethically distinct from that done for therapy or prevention and whether genetic enhancement of future generations should be allowed. An analysis of Lewis's thoughts in *The Abolition of Man* adds an insightful perspective to the contemporary discussion of whether human germline genetic enhancement should be permitted.

Keywords: objective values, common morality, human enhancement, germline genetic modification

Men without Chests – The Importance of Objective Values

Lewis began *The Abolition of Man* with his concern that in the context of teaching students about English composition the writers of a text that he referred to as *The Green Book* were actually teaching philosophy. Lewis stated that the authors of the text, while ostensibly instructing about the use of language, were teaching "firstly, that all statements containing a predicate of value are statements about the emotional state of the speaker, and, secondly, that all such statements are unimportant" (15). The students who used the text would understand that statements about values were not objective statements that could be true or false because objective values did not exist.

Lewis made it clear that to deny the existence of objective values was to deny an essential part of what makes us human. We are not just animals that respond instinctively to our appetites. As human beings we are capable of perceiving how things ought to be and conforming ourselves to that reality. We are able to make moral choices in which we use our rational capacity to moderate how we respond to our desires. Lewis, following the thoughts of Plato and the medieval theologian Alanus, stated that human beings are made in such a way that reason, symbolized by the head, governs the appetites, symbolized by the belly, by means of the chest which is the seat of not just emotions but also sentiments and values (34). For our values to be capable of controlling our appetites they need to be more substantial than emotions and based on something more solid than the appetites that they control. There need to be objective values which have a truth that is outside of ourselves on which our personal values are based for our values to be able to play that controlling role. To deny the existence of objective values is to remove the foundation of that governing part of a person. One is left with unmediated intellect and appetites. In Lewis's terms it creates men without chests (34).

Lewis was concerned with those who denied the existence of objective values by defining statements about values to be statements about the speaker's emotions. Today the existence of objective values is more commonly denied due to a broad concept of tolerance and an evolutionary concept of human values. We live in a pluralistic society in which people hold many beliefs that are incompatible with each other. A common response to that fact is a very broad understanding of tolerance that says no one set of values has more claim to truth than another. However, as J. Budziszewski has noted, that understanding of tolerance is logically self-contradictory since it is necessary to commit to some objective good that is furthered by tolerance to have a reason to assert that tolerance is good (40).

Those who hold such a broad understanding of tolerance in spite of its contradictory nature commonly understand values to be based on an evolutionary form of cultural relativism similar to that proposed by E. O. Wilson. It states that values exist due to the survival benefit that they confer on human beings in a society that functions better due to those values. This allows for different cultures to have different values and makes the survival of the social group the ultimate evolutionary value. Even though those who deny objective values today do it differently, that denial suffers from the same problems it did in Lewis's day.

The Way –The Basis for Objective Values

Although the writers of *The Green Book* taught there were no objective values, Lewis noted in his second chapter, titled "The Way," that they had written a book with the practical purpose of influencing its readers to agree with the ideas they were teaching. They had an end in sight that they held to be good for more than just themselves and therefore must have believed that there was something that was good for its own sake (40). Lewis wrote that "a great many of those who debunk … traditional values have in the background values of their own which they believe to be immune from the debunking process" (41). Those who believe in cultural relativism still have values such as tolerance, equal rights for minorities and women, and fairness that they would apply to all cultures. To hold evolutionary cultural relativism as the basis for morality and still live as if values that you hold are universally true is inconsistent. There are some who assert that there are universal moral values that are based on human evolution that are not different for different cultures but are still not objective because they are simply genetically derived adaptations that appear to us to be objective (Ruse). However, this leaves the problem that once we know that those values that appear to be objective are just evolutionary adaptations, we have no reason to follow them. Lewis helps us to see there are only two valid options. One is to accept that there are objective moral values. The other is to deny all values and live by your appetites.

Since the majority of people, including the writers of *The Green Book* and those who propose evolutionary cultural relativism, live as if there are objective values, what is the basis for those values? Lewis held that the values of common morality, which he called the Tao, were self-evident. They were "things so obviously reasonable that they neither demand nor admit proof" (53). The basic precepts of the common morality have been understood universally across cultures and across time. It is "not one among a series of possible systems of value. It is the sole source of all value judgements. If it is rejected, all value is rejected. If any value is retained, it is retained" (Lewis 56). This does not imply that any one person or society has perfectly understood this ultimate source of moral value but that progress in understanding it can only come from within the common morality and not by the denial of it. Those who reject objective common morality are left with the concept that human moral values are a natural psychological phenomenon that served a purpose in human development but have no objective validity and are just one more part of nature that we can seek to control (Lewis 62-63).

The Abolition of Man – Human Control of Nature Leads to Nature's Control of Humans

The desire to enhance human functioning and capabilities lies within the human project of controlling nature through the use of science and technology. We have benefited from this project in many ways, not the least of which is the ability of modern medicine to cure or control many diseases that have afflicted mankind for ages. There is, however, a cost that we pay when we use science and technology to control nature. By analyzing nature into predictable parts we lose the sense of awe we have for its complexity and lose our sense of wonder at its design. We also lose the ability to see it in its wholeness. As Leon Kass has put it, "knowledge permitting prediction and (some) control over biological *events* has been purchased at the cost of deep ignorance, not to say misunderstanding, of *living beings*, ourselves included" (282).

Lewis saw the danger that existed in the application of the scientific project of controlling nature to human life. He understood that "what we call Man's power over Nature turns out to be a power exercised over other men with Nature as its instrument" (69). Lewis's insight that "all long-term exercises of power, especially in breeding, must mean the power of earlier generations over later ones" (69) relates to the potential effects of germ line genetic enhancement. He also understood that the nature of the project of taking control of the characteristics of the lives of future human beings would separate those taking that control from the objective values of common morality. The power to determine the genetic characteristics of future generations is a power that will entice those with that power to believe that there is nothing about human beings that they cannot control (74). Just as an evolutionary understanding of human beings and human morality leads to a rejection of objective values, the power to determine the characteristics of future human beings will do the same. It is not that limited genetic enhancements could not theoretically be compatible with objective values but that the overall project of controlling the genetic makeup of future generations will lead to an irresistible temptation to include every human characteristic, including our moral values, in the things to be controlled. That is what leads to the rejection of objective values. It leaves those who would decide what future generations of human beings will be like without any objective basis on which to decide how to make them. They are left only with their own desires which are a part of nature, and, thus, "Man's conquest of Nature turns out, in the moment of its consummation, to be Nature's conquest of Man" (80).

The Ethics of Human Germline Genetic Enhancement

Although Lewis imagined his scenario taking place in the hundredth century AD (71), developments in genetic science suggest the issue of human germline genetic enhancement will need to be dealt with in the twenty-first century. Germline modification has been done in numerous animals, including mice, rats, sheep, and a primate, the rhesus monkey (Cole-Turner, “Religion and the Question” 3). Kiuru and Crystal list thirty seven references to experiments in animals using genetic modification to attempt to enhance physical performance, mental performance, or appearance (Kiuru and Crystal 331-2). Genetic modification can involve somatic cell modifications that impact only the individual being treated or germline modifications that change the genome of an individual and the individual’s descendents. They can be used to correct specific genetic diseases or possibly to enhance human characteristics. This paper is focused on human germline genetic enhancement which has elicited a wide array of ethical opinions and most closely fits the scenario imagined by Lewis.

The discussion of the permissibility of human germline genetic enhancement has focused on several issues. Although there are some like the National Science Foundation and James Watson who have advocated moving forward toward human genetic enhancement without much reservation (President’s Council 6-7), many ethical issues have been raised. Concerns about issues of safety, methods, and justice impact human germline modification in any form. The distinction between therapy and enhancement, the role of our concept of human nature, the power exercised by those involved, and the goals to be pursued come into play specifically with genetic enhancement.

Safety and the avoidance of potential harms out of proportion to the possible benefits are ethical concerns for any new biotechnology. Nearly everyone agrees that human germline modification should not be done until there is an acceptable level of safety (Cole-Turner, “Religion, Genetics” 205). This is particularly of concern with germline modifications in which there are not only risks to the individual treated, which have been significant in attempts at somatic genetic therapy, but risks to future generations as well (Cameron and DeBaets 102). The risks to the children produced using genetic technology and their progeny are most concerning when they are being balanced against enhancements rather than the prevention of life-threatening genetic diseases (President’s Council 49). In response to those concerns, many consider safety a technical issue that scientific progress would be expected to overcome. J. Robert Loftis expresses the thought that the key to safety concerns is proper regulation and has faith that the regulatory mechanisms in place governing medical research are adequate to address the issue (65).

Related to concerns about risk are concerns about the methods needed to do germline genetic modification and how human subject research ethics applies to the development of germline modification technology. Current techniques for germline modification in animals involve producing genetically modified embryos. Many of those embryos are defective and only a few survive to produce the viable genetically modified animals. To prevent the birth of children with serious defects as a result of the procedure, embryos would need to be tested prior to implantation and those appearing to be defective would need to be destroyed. Those who place a high moral value on human embryos find this method of germline modification to be impermissible in humans just as they would any other form of embryo-destructive research (Shannon 60, Cole-Turner, “Religion, Genetics” 206-8).

Rebecca Dresser has raised the issue of how difficult it would be to meet ethical standards of human subject research in developing the techniques for human germline modification. Studies to determine the safety and efficacy of human germline modification would subject not just embryos but the children born as subjects of the studies to “serious risks with a low probability of direct health benefit” (Dresser 2). The studies would also need to follow the subjects for their entire lifetime and their descendents as well to assess for adverse effects (Dresser 2). The practical difficulties of recruiting subjects for this type of study and obtaining their continuing consent to be monitored for generations would make ethical research on human germline modification extremely difficult (Dresser 5-6). Unfortunately, the development of human reproductive technologies such as in vitro fertilization has a history of ignoring the ethics of human subject research and the issue of the destruction of embryos by proceeding directly to clinical use without the safety studies or other review required of other medical technology.

There are several ethical issues related to justice with human genetic modification. For both genetic treatments and enhancements there is concern that the procedures will be expensive and unequally distributed, giving additional advantages to the rich and further disadvantaging the poor (Cahill 158, Cameron and DeBaets 102). Germline genetic enhancements raise concerns about transforming the current gap in wealth into new forms of genetic inequity that might cause insurmountable divisions in the human race (Cole-Turner, “Religion, Genetics” 210). Loftis and Fritz Allhoff argue that these are societal issues that are best addressed by providing just means of distribution, not by prohibiting the development of human germline enhancements (Allhoff 44, Loftis 68).

Some of the most serious ethical concerns about human genetic modification relate to modifications for the purpose of human enhancement. However, considering the ethics of human enhancement raises the question of whether enhancement can be distinguished from treatment and whether that distinction is ethically relevant. Many see the distinction between therapy and enhancement as something that is intuitive to most people, important in principle, and a good starting place for discussion, but difficult to define (Cameron and DeBaets 95, Cole-Turner, “Religion, Genetics” 211, President’s Council 13-15). Those who attempt to define it more precisely make it clear that enhancement involves modifications that are not for the purpose of treating or preventing diseases (Green 104) and use a robust concept of disease in their definition (Juengst 135-6). While some would consider the distinction between therapy and enhancement morally irrelevant and focus on individual autonomy and an individual assessment of risks and benefits for any intervention (Harris and Chan 338-9), most bioethicists accept the distinction, consider it morally relevant, and are able to draw the line between therapy and enhancement clearly in most situations (Allhoff 41).

A fundamental concern among those who accept enhancement as a distinct category is the negative impact genetic enhancements could have by altering human nature. In discussing the issue of human enhancements in general, the President’s Council on Bioethics stated, “ If there are essential reasons to be concerned about these activities and where they may lead us, we sense that it may have something to do with challenges to what is naturally human, what is humanly dignified, or to attitudes that show proper respect for what is naturally and dignifiedly human” (286-7). In contrast, others do not consider the alteration of human nature something to be concerned about. Loftis states that concern about altering human nature would only be legitimate if there were something special about human nature but that there is nothing special about human nature since it is just the outcome of evolutionary processes (72). David Heyd discusses the relevance of human nature to genetic enhancement in detail. Following a line of modern rational naturalistic philosophy, he concludes that human nature "is the power humans have to define their identity, both individual and collective, to decide what they are and would like to be" (Heyd 163). He asserts that human nature cannot serve as the basis for the rejection of genetic enhancement because there is no fixed set of properties which forms what humans essentially are since we are the result of an open-ended process of evolution that lacks direction (Heyd 165). Since the concept of human nature is so open-ended in secular thought based on scientific naturalism, the ethical concerns about the alteration of human nature can best be understood in theological terms in relation to the Creator (Cole-Turner, "Religion, Genetics" 212-3). Cameron and DeBaets note that human nature is distinct both by our being created in the image of God and by human nature being assumed by God in the incarnation (104). This human nature that persists in spite of our being fallen is the basis for the inherent dignity and value of human life on which human rights and the moral status of human beings are based. Since human nature is central to theological ethics there is reason to be concerned about the alteration of human nature by genetic enhancement, but this is not accepted by those who reject theological arguments.

Another concern deals with whether those who would attempt to enhance human abilities by genetic modification can be trusted with that power. Gilbert Meilaender notes the arrogance of the project by asking, "What estimate of ourselves – our virtue and wisdom – would we need even to want to become so fundamentally the shapers of humanity?" (43) Cameron and DeBaets echo Lewis in noting that the techniques for germline modification would concentrate power in the hands of a few people and observe that "such power would either likely or necessarily be corrupting" (103). Juengst et al. are concerned about how these techniques would lend themselves to exploitation by entrepreneurs (23). There is also concern that parents could misuse these techniques in exerting undue power over their children (President's Council 283). Loftis suggests that much of the concern over the misuse of power in human genetic enhancement comes from the problems associated with the eugenics movement of the early twentieth century and that the answer to those concerns is adequate regulation by society to avoid coercion and assure justice (69-70).

Those who favor pursuing human genetic enhancement argue that anything that enhances an individual's abilities is good for that person and is worthy to be pursued (Harris and Chan 338). Understanding that germline enhancements impact people who are not able to consent to procedures done prior to their birth, Allhoff uses John Rawls's notion of primary goods and proposes that "germ-line genetic enhancements are morally permissible *if and only if* they augment primary goods or create abilities that would lead to their augmentation" (50). However the usefulness of the concept of pursuing primary goods in this context is limited by the complexity of human goods and how they would be impacted by germline genetic enhancement. As noted by the President's Council on Bioethics,

> As these questions make clear, human goods and good humans come in many forms, and the various goods and virtues are often in tension with one another. Should we therefore aim at balanced and "well-rounded" children, or should we aim also or instead at genuine excellence in some one or a few dimensions? It is not easy to answer. Yet absent knowledge regarding these matters, acting on the laudable

> intention of producing better children can be a tricky, not to say dangerous, business. (28)

The genetic conquest of aging would appear to be good, but "there may in fact be many human goods that are inseparable from our aging bodies, from our living in time, and especially from the natural human life cycle by which each generation gives way to the one that follows it" (President's Council 296).

Insights from *The Abolition of Man*

As noted by Cameron and DeBaets, Lewis had a "Christian understanding of what it means to be human," (100) but he expressed it in a way that was accessible to those who do not accept Christianity. Lewis understood that a significant part of what makes us human is our ability to use objective values to make the ethical judgments we use to direct our actions and control our natural appetites. Those objective values which are self-evident and have been understood across cultures and across time help us understand what it means to be human. Since the insights of common morality are available to anyone regardless of their theological position, they can help to communicate an understanding of what it means to be human to those who do not accept a scriptural or theological understanding of human nature. This understanding forms an effective counter to those who see human nature as the open-ended result of undirected evolutionary processes which we should be free to change.

Lewis also showed us that the scientific project of reducing nature to things we can understand, predict, and control assumes that all things including human nature and values can be understood, predicted, and controlled by science. That leads to a rejection of objective values and a rejection of what it means to be human. Those who pursue science and technology need to be aware that objective values stand outside the domain of science and should be relied on as a guide to science and technology. Only scientists with chests can truly benefit humanity.

The part of the scientific project that emphasizes control of nature also has inherent dangers. Lewis understood that the power exerted over nature by science and technology also involves power of those in control of the technology over other people. That power needs limits that science and technology do not provide. Power has been known throughout history to corrupt those who hold it. When that power is combined with a rejection of objective values resulting from a lack of understanding of the limits of science, it has the potential for great destruction. Objective values are needed to provide the boundaries for the power of science and technology to maintain its positive contributions to mankind while limiting its potential for domination and destruction.

The existence of the unchanging, universal objective values of common morality provides a foundation for understanding who we are as human beings. Those values can be understood as a part of the general revelation of God the creator which have been imbedded in every human conscience or simply understood as a self-evident part of how we and the world happen to be, but they are there. They make it possible for us to discuss ethics and whether we ought to pursue human germline genetic enhancement. They warn us against trying to make ourselves into what our appetites would lead us to desire and commend to us the virtue of humility and a willingness to accept that we are finite beings with limitations to what we can and should do. Those values remind us that the good life toward which we strive is "a life not of better genes and enhancing chemicals but of love and friendship, song and dance, speech and deed, working and learning, revering and worshipping" (President's Council 299). The essence of human germline genetic enhancement is making future human beings into what we want them to be. It inherently entices us to leave what we can know objectively to be good and seek to fulfill our desires and appetites. It entices us to risk harm to those whose genes are modified, destruction of embryos, lack of proper human subject research ethics, threats to justice, tampering with human nature, and abuse of power to fulfill our desires. Lewis helps us understand that what it means to be human is to be men and women with chests who base our decisions on objective values and resist the temptation to make future human beings into what we want them to be.

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BOOK REVIEWS

Nature's End: The Theological Meaning of the New Genetics

Richard Sherlock. Wilmington, Delaware: ISI Books, 2010 (Religion and Contemporary Culture Series).

ISBN 1-933859-39-2; 230 PAGES, PAPER, $25.00.

In this book, Sherlock is attempting a kind of meta-analysis of morality as a vehicle for thinking ethically about the implications of emerging genetic technologies from a Christian perspective. He focuses most of his attention on the possibilities for significantly increased longevity. Sherlock begins by challenging Aristotle's essentialist understanding of human nature, making the argument that we need to go beyond a simply naturalist approach to ethics to one which includes a transcendental perspective. He maintains that we must first determine what the purpose – the *telos* – of life is and then make judgments about genetic technologies from this perspective. He believes that the combination of stem-cell research and cloning represents the greatest threat, especially as they are applied to attempts at significantly increased longevity in humans. The renewed interest in natural law, which would include an analysis of human nature within community, would be a fruitful way to proceed. He identifies four theological features in the Western tradition that can help us construct a theological response: humility (recognizing our limitations), hope (grounded in God), love (which should be unconditional towards God and others, including embryos), and divine order (God's ordering of creation, as well as the creation of humans in God's image). Finally, he argues that Christians must aim at moral consensus, and then attempt a change of heart in the public square.

This book is very well researched and written. It provides a very solid analysis of a number of important thinkers and writings such as Aristotle, Hume, Aquinas, Calvin, papal documents, and the President's Commission on Bioethics, which would be of interest to anyone working at the intersection of ethics and genetic technologies. A real strength of this book is that it does provide a serious attempt at creating a framework for assessing genetic technologies. It challenges some of our assumptions in contemporary healthcare such as personal autonomy as the litmus test for much decision-making. It raises legitimate concerns about where these new bio-technologies may lead.

The book does have some weaknesses, however. Unless you are reading very carefully, it is sometimes difficult to determine when the author's analysis of a thinker ends and his own views begin. He sometimes makes sweeping generalizations about science and comes across as somewhat anti-science. His views will more naturally dovetail with those from a more conservative Christian perspective. His concerns about increasing the "natural" lifespan are spelled out, but he does not address the fact that we are all benefitting from scientific advances to enjoy the increased lifespan that we now have.

Overall, this book would be of particular interest to ethicists who are working in the area of ELSI (ethical, legal, and social implications of the Human Genome Project) research, and his focus on longevity is an important area that has not received much attention yet.

Reviewed by Donna Yarri, PhD (Religious Studies), who is an Associate Professor of Theology at Alvernia University in Reading, Pennsylvania, USA.

Incapacity and Care: Controversies in Healthcare and Research

Helen Watt, editor. Oxford: The Linacre Centre, 2010.

ISBN 978-0906561119; 146 PAGES, PAPER, $19.95.

The Linacre Centre, now renamed The Anscombe Bioethics Centre, is the Roman Catholic bioethics centre which produced *Incapacity and Care*, a selection of papers exploring the duties and proper attitudes of carers and health care professionals to those with mental incapacity.

The first paper, by David Albert Jones, the new Director of The Anscombe Bioethics Centre, deserves special attention. This is a well-written paper honing in on the conceptual shortcomings of the definition of personhood in terms of mental capacities, primarily self-consciousness and rationality. These concepts exclude many people we normally count as persons and are not a firm basis for solidarity with the incapacitated or with nascent human life. David Jones, therefore, puts forward an alternative definition of persons as beings with “a common rational nature” who are “constituted by their relationships to others and by their interdependence.” It is suggested that rationality, understood to be more or less well expressed, is no reason for seeing some people as lesser people. Fine! But, as Christians, should we not also take into account our relationship with and dependence on God and that, as human, we are created in His image, the image of our triune relational God? On this understanding, all humans are equal in human dignity.

Mounting a strong attack on English Law and practices such as selective abortion on the grounds of fetal abnormality, Aaron Kheriaty makes a comparison with the Nazi regime. In particular, he points a long finger at the Mental Incapacity Act 2005, which allows non-voluntary sterilisation of intellectually disabled people. A more sustained and even stronger attack on the Act is mounted by John Finnis. Carefully analyzing the terms of the Act, he faults it mainly on the basis of its legal shortcomings. “There is nothing in the Mental Capacity Act, so far as I can see, that challenges our ethical teaching or invites or requires a Catholic to do wrong,” he writes. But, he argues, the legislation does not protect individuals or the community from people whose conscience is unsound.

Seeing reproductive functioning as an integral part of bodily health, Anthony McCarthy takes up the theme of involuntary sterilisations of intellectually disabled people, arguing that it is never defensible to attack a person’s health for the sake of a good not related to health.

Other papers are about research on human subjects, euthanasia, and tube feeding. In a subtle and well-argued paper Helen Watt cautions against abuse when undertaking research on mentally disabled. While arguing that such people should not be deprived of the opportunity to contribute to the welfare of others, especially those with conditions like their own, she warns that these people are vulnerable and that it is for the competent to protect the non-competent. Wendy Hiscox examines the Dutch and Belgian euthanasia laws as well as actual practices. She notes that while these laws only legalize voluntary euthanasia, the practice of non-voluntary euthanasia is widespread in both countries. This suggests that the practice of voluntary euthanasia tends to lead to a practice of non-voluntary euthanasia. She argues against the legalisation of physician-assisted suicide and voluntary euthanasia in the UK—or anywhere else, for that matter.

A paper by Johanna Valiquette examines arguments for and against percutaneous endoscopic tube feeding in end-stage dementia. This is quite a technical paper, suited more for the expert than for the ordinary person interested in medical ethics. A. A. Howsepian also discusses tube feeding with a focus on the problem of identifying the persistent vegetative state and the question of whether patients in this state benefit from medically assisted nutrition and hydration. He argues that food and fluid clearly benefit them inasmuch as they would die if it were denied.

While the quality and novelty value of the papers vary, the book provides a wide overview of contentious bio-medical issues and, as such, would be of interest to students and others working in this field.

Reviewed by Agneta Sutton, **PhD,** Lecturer at Heythrop College in the University of London, UK.

Beyond Bumper Sticker Ethics: An Introduction to Theories of Right and Wrong, 2nd edition

Steve Wilkens. Downers Grove, IL: IVP Academic, 2011.

ISBN 978-0830839360; 230 PAGES, PAPER, $20.00.

As a university professor teaching bioethics, I have been using Steve Wilkens' insightful treatment of ethical theory for many years, but it was getting out of date (the first edition was published in 1995). So, it was with great enthusiasm that I greeted the arrival of the second edition last year.

The rationale for *Beyond Bumper Sticker Ethics* is a simple fact of life: the study of ethics can be dauntingly complex and sometimes a bit boring. Arcane terms such as meta-ethics, deontology, supererogation, normative ethics, and consequentialism dot the landscape and seem to make moral philosophy the realm of scholars in academic ivory towers.

Wilkens helps to dispel this reputation with an approach suited to just about everyone. He writes from a Christian perspective, summarizing the various approaches to ethics with simple "bumper sticker" slogans such as "When in Rome, Do as the Romans Do," representing cultural relativism, or "God Said It, I Believe It, That Settles It" as a description of divine command theory.

The author organizes his subject by differentiating among theories that are incompatible with Christian faith, theories that are neutral towards faith, and theories that presuppose it. He introduces the main historical advocates of each approach and then gives strengths and weaknesses of each view. Wilkens' conversational style is replete with real-life examples, allowing the reader to see the relevance of each theory for his or her own life.

If I have any criticism of the book, it is only that an introductory treatment may oversimplify to the point of distortion; I sometimes wish the author would include a few additional scholars or advocates of the various theories. In addition, Wilkens' division of theories into three categories may imply that certain theories are always inherently better than others, when, in fact, most of us use a "toolbox" of ethical approaches every day, and that is not a bad thing. Finally, interested and motivated students will be inspired to explore further. Therefore, a brief section of resources for further study at the end of each chapter would make this book even better.

Nonetheless, to help beginning students grapple with the everyday application of ethical theory for our lives, I highly recommend *Beyond Bumper Sticker Ethics.* Steve Wilkens has made some difficult and abstract ideas more accessible, an admirable feat in this complex society.

Reviewed by Dennis M. Sullivan, MD, MA (Ethics), Professor of Biology and Director of the Center for Bioethics at Cedarville University in Cedarville, Ohio, USA.

The Theory of Morality

Alan Donagan. Chicago: University of Chicago Press, 1979.

ISBN-13 978-0226155678; 294 PAGES, PAPER, $27.50.

The moral tradition undergirding Western culture historically is the Christian faith. Currently, Western culture desires to be governed by ideologies that repudiate the very religious tradition on which it is founded, leaving Western culture adrift in a sea of unanchored morality.

Without a stable moral foundation, society has no way to ground the veracity and virtue essential to its survival.[1] *The Theory of Morality* is a valiant attempt on the part of Alan Donagan to accomplish two feats: develop a purely philosophical moral theory that is consistent with the Hebrew-Christian tradition and simultaneously provide a valid secular philosophical argument for the Hebrew-Christian moral tradition that renders it applicable and acceptable for use in the public square.

Donagan begins his development of a moral theory by examining issues from an historical perspective – from the Stoics through intuitionism. Choosing the Hebrew-Christian tradition because of its shared conclusions about the common moral life accessible to all men by virtue of reason and, no less importantly, because of precedence (that this consensus has been maintained for millennia through vast social change cannot be accidental), Donagan then attempts to isolate the philosophical core of this tradition. From this point on, Donagan decants all theistic components of the tradition and develops a fundamental principle based on respect for rational nature from a modification of Kant's categorical imperative: "it is impermissible not to respect every human being, oneself or any other, as a rational creature." Since he understands common morality to involve human action both objectively (permissibility) and subjectively (culpability), he then deductively derives first-order principles (permissibility) with its specificatory premises and second-order principles (culpability) from this fundamental principle. Finally, he examines his system from the perspectives of consistency and consequentialism. But, like Kant, Donagan's attempt to demonstrate *a priori* that reason can by its very nature prescribe the fundamental principle of morality fails. Even so, he does not find that failed attempt dissuasive since he claims that traditional morality is effective even without an *a priori* demonstration of the fundamental principle. Respect for rational nature as the ground of morality rests on acknowledgment of its intrinsic worth.

It is apparent that this was a costly enterprise for Donagan; he has a vested interest in the outcome. At the writing of this book, he was a philosopher at the California Institute of Technology. Whether or not he is an Evangelical, he obviously holds Judeo-Christian sympathies as demonstrated on the title page with a Hebraic quote from the Wisdom of Solomon ("But the souls of the righteous are in the hand of God"), an English quote from St Paul's epistle to the Romans (Ro 3: 7-8), and one from Solszchenitzen's *Cancer Ward*. It also becomes abundantly clear, considering his proposed theory, that he is not as interested in developing a new moral theory as in finding a philosophical basis for a traditional morality that has governed for millennia but which has now been invalidated by our "enlightened" ideologies. His attempt to form a secularly acceptable grounding for traditional morality is commendable but ultimately deficient; its deficiency lies in his initial assumption that the Hebrew-Christian (or Stoic, for that matter) moral tradition can be separated from its religious roots. Just as separating the "branches" from the "Vine" results in futility, so ultimately is any attempt to legitimize moral theory apart from the God of its origin. Ultimately, the strength of a moral theory is only as great as its foundation, since a foundation of respect for rational nature is grounded ultimately on respect for a finite fallen human nature. While such a foundation is perhaps preferable to utility, it is still nothing but sinking sand.

Endnotes

1. This, in essence, is the argument of Anscombe. See G.E.M. Anscombe, "Modern Moral Philosophy," in *20th Century Ethical Theory,* Steven M. Cahn and Joram G. Haber, eds. (New Jersey: Prentice-Hall, 1995), 351-364.

Reviewed by Susan M. Haack, MD, MA (Bioethics), FACOG, who is a consultative gynecologist at Hess Memorial Hospital and Mile Bluff Medical Center in Mauston, Wisconsin, USA.

Genetic Dilemmas: Reproductive Technology, Parental Choices and Children's Futures, 2nd edition

Dena S. Davis. Oxford: Oxford University Press, 2010.

ISBN 978-0-19-537438-4; 211 PAGES, PAPER, $24.95.

Choice is one of our most basic liberties; we live in a choice-filled, pro-choice world. The objects of our choices are no longer limited to clothing or cars, but, with the explosion of reproductive technologies, include the "kinds of children" we procreate. It is to these choices that the book *Genetic Dilemmas: Reproductive Technology, Parental Choices, and Children's Futures* by Dena S. Davis is addressed. Davis focuses on specific technologies through a novel secular lens that examines the ethics of reproductive technologies from the unique perspective of the prospective child's right to an open future. In so doing, she provides genetic counselors with an ethical basis for limiting parental autonomy in their utilization of genetic technology.

Davis' approach is practical and principled. She is not interested in the metaphysical questions that swirl about these issues (for instance, the concept of the child as gift) or in the morality of the given technologies themselves. In so doing, she completely bypasses the issue of abortion. Her concern is that these technologies are used to further parental agendas, thereby compromising the child's future choices. Davis is firmly committed to autonomy, but she is most concerned with the autonomy of the child. She concludes that parental autonomy is bounded by the future autonomy of the prospective child, whom counselors have a responsibility to protect.

Davis limits her discussion to technologies by which parents make choices for their child or for the "kind" of child they will have: PGD that selects *for* a disability, childhood testing for late-onset genetic traits, sex selection, cloning, and enhancement. Early on she discusses the "harm conundrum" (Is it better to have a less than optimal life than no life at all?) and concludes that parents are obligated to protect their child's "rights-in-trust," providing the best possible life for their child. Thereby, she concludes that the deliberate choice of a defective embryo is morally wrong. She further argues that directed procreation turns hope into entitlement and a child into a means to the parents' ends; testing a child for adult-onset traits eliminates hope which is grounded in uncertainty and violates a child's later right to decide what personal information to disclose to their parents; and sex selection forces a child to conform to parental gender stereotyping beginning even before birth. Concerning cloning, Davis distinguishes between logistical and duplicative cloning, finding the latter immoral. While she acknowledges that expectations are found in all normal parent-child relationships, the investment involved in utilization of enhancement technology elevates these expectations to unprecedented levels and limits the right of each individual to be a surprise to herself (164).

Conceptually, we have shifted from procreation to reproduction and back to procreation—but with a new twist. We have replaced chance with choice by means of technology, exploiting it to fine tune our families and our preconceived notions of what kind of children we wish to have. Rather than using reproductive technologies to offer our children more open futures, we constrain them by means of it. The weakness in Davis' argument is that she applies it only to chosen children, beginning with the parents' choice to procreate a child, which nevertheless makes the child's rights contingent on parental choice. Conversely, responsibilities lack contingency: an emphasis on parental responsibility would obviate the conflict inherent in any rights talk but would carry the issue back to conception, opening the abortion issue so adroitly avoided. Ultimately, however, Davis' argument is an intriguing and a thought-provoking addition to the conversation, opening our eyes to the many ways in which we constrain our children by the choices made on their behalf.

Reviewed by Susan M. Haack, MD, MA (Bioethics), FACOG, who a consultative gynecologist at Hess Memorial Hospital and Mile Bluff Medical Center in Mauston, Wisconsin, USA.

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VOL 28:2, SUMMER 2012
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