Ethics & Medicine

An International Journal of Bioethics

Vol 32:3
FALL 2016
ISSN 0266-688X

EDITOR: C. Ben Mitchell
Union University, Jackson, Tennessee, USA
bmitchell@uu.edu

ASSISTANT EDITOR: Jacob Shatzer
Palm Beach Atlantic University, West Palm Beach, Florida, USA
jshatzer@sterling.edu

ASSOCIATE EDITOR: Henk Jochemsen
Prof Dr. G. A. Lindeboom Instituut, Ede, The Netherlands
lindinst@che.nl

MANAGING EDITOR: Carol Marlin
The Bioethics Press, Ltd
info@bioethicspress.com

EDITORIAL ASSISTANT: Abigail Wills
abigail.wills@my.uu.edu

BOOK REVIEW EDITOR: Sharon F. Billon
sbillon@sbcglobal.net

EDITORIAL ADVISORY BOARD:

Francis J. Beckwith
Baylor University, Waco, Texas, USA

Don Buckley
Spanish Trail Family Medical Center, Pensacola, Florida, USA

George L. Chalmers
Honorary Physician, Glasgow, Scotland

E. David Cook
Wheaton College, Wheaton, Illinois, USA

Scott E. Daniels
Virginia Commonwealth University, Richmond, Virginia, USA

Andrew Fergusson
Christian Medical Fellowship, London, UK

David Fletcher
Wheaton College, Wheaton, Illinois, USA

Nick Hallam
Consultant Virologist, Edinburgh, Scotland

C. Christopher Hook
Mayo Clinic, Rochester, Minnesota, USA

Tom Kennedy
Berry College, Mount Berry, Georgia, USA

John F. Kilner
Trinity International University, Deerfield, Illinois, USA

Jennifer Lahl
Center for Bioethics and Culture, San Ramon, California, USA

Calum MacKellar
European Bioethical Research, Edinburgh, Scotland

Donal P. O'Mathuna
Dublin City University, Dublin, Ireland

Robert D. Orr
Department of Clinical Ethics, FAHC, Burlington, Vermont, USA

Barbara Parfitt
Glasgow Caledonian University, Scotland

John Peppin
Center for Bioethics, Pain Management & Medicine,
Des Moines, Iowa, USA

Scott Rae
Talbot Theological Seminary, La Mirada, California, USA

Peter Saunders
Christian Medical Fellowship, London, England

Joyce Shelton
Trinity International University, Deerfield, Illinois, USA

Robert Song
University of Durham, England

Agneta Sutton
Centre for Bioethics and Public Policy, London, England

Gordon Wenham
Trinity Theological College, Bristol, England

Stephen Williams
Union Theological College, Belfast, Ireland

Donald K. Wood
University of Illinois College of Medicine at Chicago, Illinois, USA

PUBLISHER

The Bioethics Press, Limited
2421 W. Pratt Blvd. #420
Chicago, IL 60645-4666 USA
Phone/Fax: +1.530.482.3248
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.

***Ethics & Medicine* ~ 2016 ~ Subscription Rates**

Individual Rates - D(domestic) I(international) **1 year below - 2 & 3 year subscriptions available on website**				
Print	**D - $72**	**I - $93 £61**	**Surface Delivery included** **Air Delivery - Add an additional $30/year**	
Online IP Authenticated	**D - $61**	**I - $77 £49**		
Print + Online	**D - $99**	**I - $119 £72**		
Archives— PDF Online	**1985-2014**	**D - $95** **I - £60**	**2015**	**D - $55** **I - £35**
Institutional Rates - D(domestic) I(international) **1 year below - 2 & 3 year subscriptions available on website**				
Print	**D - $176**	**I - $205 £130**	**Surface Delivery included** **Air Delivery - Add an additional $30/year**	
Online IP Authenticated	**D - $149**	**I - $176 £113**		
Print + Online	**D - $195**	**I - $234 £150**		
Archives— PDF Online	**1985-2014**	**D - $180** **I - £115**	**2015**	**D - $80** **I - £50**

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

CONTENTS

INSTRUCTIONS TO CONTRIBUTORS

Articles for publication are welcomed by the editors. Ethics & Medicine is peer reviewed. Material submitted may be returned for revisions. Articles should be submitted in both electronic and hard-copy format. Authors should supply removable cover sheet with the title of the article and author's name. No other personal attribution should appear at the head of each article. Contributors will be notified as soon as possible of editorial decision, though the process can take some time. Contributors are asked to follow the pattern of published material for length, subheading, and so forth. Different referencing conventions are acceptable provided consistency is maintained throughout the paper. An outline C.V. should accompany each contribution.

MANUSCRIPTSFORPUBLICATIONSHOULD BE SENT TO

C. Ben Mitchell, Ph.D., Editor
Ethics & Medicine
1050 Union University Drive
Jackson, Tennessee 38305 USA
Phone: +1-731-661-5915
Fax: +1-731-661-5118
bmitchell@uu.edu

ADVERTISING AND SALES

Ethics & Medicine is pleased to accept advertising; contact The Bioethics Press, Ltd. where current rates are available. No editorial endorsement is implied in the advertising.

COPYRIGHT

Copyright for articles and book reviews will be retained by the author(s). If authors or reviewers wish to republish all or part of their contribution elsewhere within twelve months of publication in Ethics & Medicine, permission should be sought from the editor and mention made of its publication in the journal. Publication in Ethics & Medicine assumes permission to publish in electronic format. Permission to make multiple copies must be sought from the publisher.

Ethics & Medicine is published in association with:

THE CENTER FOR BIOETHICS AND HUMAN DIGNITY
2065 Half Day Road
Bannockburn, Illinois 60015 USA
Phone: +1-847-317-8180
Fax: +1-847-317-8101
info@cbhd.org
www.cbhd.org

PROF. DR. G. A. LINDEBOOM INSTITUUT
Postbus 224, NL6710 BE
Ede, The Netherlands
Phone: +31-318-69633
Fax: +31-318-696334
lindinst@che.nl
www.lindeboominstituut.nl

ABSTRACTS AND INDEXING

PROQUEST INFORMATION AND LEARNING
789 E. Eisenhower Parkway
PO Box 1346
Ann Arbor, MI 48106-1346 USA
Phone: 1.734.761.4700 X 3333
Fax: 1.734.997.4229
info@il.proquest.com
www.il.proquest.com

SCOPUS, ELSEVIER
North or Central America
South America
Europe, Middle East or Africa
Japan
Asian and the Pacific
info@scopus.com
www.scopus.com

RELIGIOUS AND THEOLOGICAL ABSTRACTS
121 South College Street
Myerstown, PA 17076 USA

THE PHILOSOPHER'S INDEX
c/o The Philosopher's Information Center
1616 East Wooster Street
Bowling Green, Ohio 43402 USA
Phone: +1-417-353-8830
Fax: +1-419-353-8920
info@philinfo.org
www.philinfo.org

TYPESETTING

Typesetting by Andrew DeSelm
andrewdeselm@gmail.com

PRINTING

Kelvin Printing (1993) Pte Ltd
Michelle FM Loke
michelle@excelprintmedia.com

Contributors

Mary B. Adam, MD, MA, PhD, is Director of the Maternal Newborn Community Health Program at AIC Kijabe Hospital. She is a Visiting Professor at Strathmore University in the Institute of Healthcare Management, Nairobi, Kenya and a Fellow of the Center of Bioethics and Human Dignity in Deerfield, Illinois. She currently resides in Nairobi, Kenya.

Justo Aznar, MD, PhD, is currently director of the Institute of Life Sciences at the Catholic University of Valencia, "San Vicente Mártir." He is a member of the Pontifical Academy for Life. He is former head of the Department of Clinical Pathology at the University Clinical Hospital La Fe, Valencia, Spain, and director of the Biochemistry Research Unit of this hospital. He currently resides in Valencia, Spain.

Gloria Casanova, PhD, is currently a member of the Bioethics Observatory and Professor of Bioethics at the Catholic University of Valencia, "San Vicente Mártir," and at Pontifical John Paul II Institute for Studies on Marriage and Family at its Spanish Section. Her dissertation focuses on the ethics of human relationships and its biotechnological context. She currently resides in Valencia, Spain.

William P. Cheshire, Jr., MD, MA, is Professor of Neurology and Chair of the Ethics Committee at the Mayo Clinic in Jacksonville, Florida; Chair of the Ethics Committee for the Christian Medical and Dental Associations; and Senior Fellow at The Center for Bioethics & Human Dignity. The views expressed herein are his own and do not necessarily reflect the positions of the professional organizations with which he is affiliated. He currently resides in Ponte Vedra Beach, Florida, USA.

Lucía Gómez-Tatay, MS, is currently a PhD student and member of the Molecular and Mitochondrial Unit and the Bioethics Observatory, Catholic University of Valencia, "San Vicente Mártir." Her dissertation focuses on the ethics of Synthetic Biology. Her other areas of interest include ethics of mitochondrial replacement, iPS cells and practical application of Personalism to ethical analysis. She currently resides in Valencia, Spain.

Grzegorz Holub, STM, PhD, is Associate Professor of Philosophy at the Department of Philosophy of the Pontifical University of John Paul II in Cracow, Poland. His areas of research include bioethics, environmental ethics, and philosophy of the human person. He currently resides in Cracow, Poland.

Terence Lovat, BTh, BLitt, BEd, MA, ThM, PhD, is Emeritus Professor in the area of Philosophy, Religion and Theology at the University of Newcastle, NSW, Australia, and Senior Research Fellow at Oxford University, UK. He currently resides in Newcastle, NSW, Australia.

Paul Walker, MBBS, PhD, FRACS, FACS, is a member of the Clinical Unit in Ethics and Health Law at the University of Newcastle, NSW, Australia, and a member of the Royal Australasian College of Surgeons Ethics Committee. He is a surgeon in Newcastle, NSW, Australia.

Nellie Wamaitha is an advocate in the High Court of Kenya. She is currently studying theology at Wycliffe Hall, University of Oxford and apologetics at the Oxford Centre for Christian Apologetics. She currently resides in Oxford, United Kingdom.

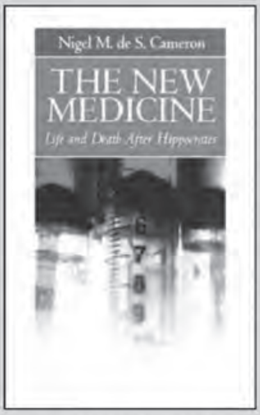
Ethics & Medicine

An International Journal of Bioethics

Bulletin Board

THE NEW MEDICINE : LIFE AND DEATH AFTER HIPPOCRATES

By Nigel M. de S. Cameron



ISBN 0-9711599-3-9
0-9711599-0-4

In the reprinting of a very important book for our current times, Dr. Cameron links the rise of the "new medicine" and the fall of the Hippocratic tradition to society's increased acceptance of the practices of euthanasia and assisted suicide. He states that "the medical profession is liable to follow any fundamental shift in society's values" and point to the relationship between Nazi Germany and the Nuremberg "medical crimes" as an example. In the absence of the Hippocratic prohibition against the killing of patients by their physicians, the fundamental value of protecting life is displaced. "the desire of society to avoid suffering, financial burden, and the inconvenience then lead to increasing support for physician-assisted suicide and euthanasia. The author contends that it is imperative for the medical profession to return to its Hippocratic roots.

"In the post-WW II era physicians began to water down the basic tenets of the Hippocratic tradition, and then they abandoned them. That's what this important book is all about: the rise and fall of Hippocratic medicine."
C. Everett Koop, Former US Surgeon General

"In **The New Medicine,** *Dr. Cameron has done much to earn the title of a second Hippocrates."* **Harold O.J. Brown, Professor of the Theology and Philosophy Reformed Theological Seminary**

"The New Medicine *is a persuasive manifesto that should be welcomed by those who have the courage to join a movement to reform aimed at restoring medicine to its healing mission."* **Richard John Neuhaus, Director Religion and Public Life**

Place an ad here for your book, college/grad course, or perhaps a newsletter or website……..

Our **Media Rate Kit** is available at

www.ethicsandmedicine.com

The ***E&M*** **Bulletin Board** is now open for posting!
Please send your announcement or ad to
info@bioethicspress.com

EDITORIAL

Are Doctors Human?

C. BEN MITCHELL, PHD

In her own extraordinary style, the English polymath Dorothy L. Sayers (1893-1957) asked in a series of published essays, *Are Women Human?* Her answers, according to the subtitle, are "penetrating, sensible, and witty." Indeed they are. She was an amazingly gifted thinker and an equally gifted writer.

The same question is increasingly pertinent with respect to the medical profession. Are physicians human? But why would one ask such a question? First, the profession is increasingly being dehumanized as the nature of professionalism is eroding. To be a professional is to "profess" something—to declare loudly, clearly, and publicly. In medicine, the act of profession happens in at least two ways. One is when the physician takes an oath to use the virtues and skills obtained in medical training "for the patient's good." As readers of *Ethics & Medicine* will know, almost no medical schools require graduates to commit themselves to the Hippocratic Oath in its traditional form, and those oaths which are taken are typically eviscerated of their commitments to a shared, content-full morality. And, as Robert Orr, et al., found in their research, very few of the oaths retain an affirmation of the sanctity of human life or even proscribe sexual relationships between physicians and patients (see Robert Orr, Norman Pang, Edmund Pellegrino, and Mark Siegler, "The Use of the Hippocratic Oath," *The Journal of Clinical Ethics*, Vol 8, No 4 (1997): 377-388).

The other way the profession of medicine is declared is when the physician sees the patient and asks, "How may I help you? What seems to be the problem? Where does it hurt?" In doing so, a physician is implicitly proclaiming both a certain competence and a decided commitment to treat the patient well—and not to harm. Human medicine is guided by deep virtues expressed in a healing relationship between a professional and a patient. The loss of professionalism in its classical form is leading to the erosion of trust between doctors and their patients.

Contemporary medicine is also being dehumanized by the growing technologization of medicine. This is not to say that technology is not potentially beneficial in the diagnosis and treatment of illness. Clearly, technology, wielded appropriately, can be an important factor in healing. But as in other arenas, over-reliance on technology can alter the way we inhabit the world. We have all doubtless been witnesses of the newly evolving hunched shoulders of our family, friends, and colleagues who peer incessantly and pathologically into their smart phones. Labs, x-rays, scans, and other tests are invaluable in medicine, but so are palpation, auscultation, and the art of observation. Many physicians in the developed world spend as much or more time on their digital devices in the examination room than they do with the patient. Technologized medicine risks being dehumanized medicine.

Physicians must work increasingly hard to resist the dehumanization that results from the erosion of professionalism and the escalation of biotechnology, if not for the profession itself, at least for the good of the patient. It isn't easy and it's not going to get any easier in the near future. But physicians are, in fact, human, and they will eventually recover the humanity of human medicine. **E&M**

Vol. 32:3 Fall 2016

GREY MATTERS

The Robot Will See You Now: Can Medical Technology Be Professional?

WILLIAM P. CHESHIRE, JR., MD

> *Doctors are not healthcare vending machines, but professionals who understand the difference between negative rights, such as the right to refuse treatment or be left alone, and positive rights, including entitlement to treatment.*
>
> – David Stevens[1]

Abstract

As innovative technology replaces more and more of what physicians do, the question arises whether there is any limit to the potential medical capabilities of technology at the bedside. Drug-dispensing kiosks, robotic surgery, computerized sedation devices, and other novel medical technologies bring practical advantages while also raising philosophical questions about the nature of the relationship between the patient and technology that serves as a proxy for the healthcare professional. Moreover, the shift in language from "professional" to "provider" accommodates a detrimental attitude that regards technical performance and human care to be interchangeable. This paper unpacks the meaning of professionalism from the perspective articulated by the Christian Medical & Dental Associations and examines its technical, ethical, and spiritual aspects vis-à-vis surrogate technology. A close examination of the meaning of professionalism finds that there are aspects of medical practice that are irreducibly human.

Introduction

"The hard part is giving up control," said I to the anesthesiologist. Astonished, he looked up from the chart and saw that I was still awake. Moments before, he had injected carefully measured doses of midazolam and propofol into my intravenous line. That is the last thing I remember.

Trust

The moment I went unconscious, my life was in the hands of my anesthesiologist, who throughout the surgical procedure diligently watched my vital signs, monitored my oxygenation, and ensured that air reached my lungs and that my blood pressure and heart rate remained stable. Anesthetic agents are no candy; they can cause breathing to stop and blood pressure to drop. If anything were to go wrong, he possessed the knowledge and skill to respond, reassess a complex situation moment by moment, and implement any of numerous medications or procedures as the condition required. Ingrained in that response would be care and concern. Later, when I awoke from surgery, I knew that I had been kept safe by my physician colleague who has dedicated his career to preserving life. The year was 1998.

Enter Automation

If I had had the procedure done 15 years later, my anesthetic might have been delivered and monitored, not by a physician, but by a computerized sedation system. In 2013 Johnson & Johnson introduced an innovative device called Sedasys®, a computer-assisted, personalized sedation system that administers intravenous propofol during select procedures, such as colonoscopies and upper endoscopies. The device monitors the patient's physical signs that indicate the level of sedation and adjusts the rate of drug delivery automatically. Designed to shorten the time of recovery from anesthesia, reduce cost, and increase efficiency, its workings feature alarms and safety locks to prevent dosing errors.[2,3]

In 2016 Johnson & Johnson pulled Sedasys from the market.[4] One reason the device did not gain acceptance may have been the published findings that same year of a study that found a 13% increase in the risk of complications in patients who underwent colonoscopy with anesthesia services—typically with propofol—as compared to standard sedation with a benzodiazepine and narcotic.[5] As the determining factor in the study was the choice of drug, not the delivery system, in principle the prospect of replacing the anesthesiologist with a machine remains.

Additional surrogate technologies knock at the hospital door. Increasingly, healthcare consumers are accessing healthcare resources via self-service interactive kiosks that assist with health data entry and provide health screening, including tests of vision, weight, blood pressure, and symptom checkers.[6-8] The FDA has even considered authorizing the use of prescription drug vending machines where consumers could enter a few answers to an online questionnaire, self-diagnose, and receive pharmaceuticals that currently require a medical examination and a prescription from a physician.[9,10]

Future generations of these and other technologies that substitute for tasks previously performed by physicians are likely to offer even more sophisticated capabilities. Like many past technological innovations, if used wisely, they can enhance efficiency and make possible new and better ways of delivering healthcare. Unlike previous technologies, they may have the potential to substitute for physicians personally. Can physicians be replaced by technology, or is there an irreducibly human aspect of medicine that should be defined, guarded, and preserved?

Professionalism

Physicians and other healthcare workers are professionals. They avow that they are competent and willing to care for the sick, and they commit to healing as their way of life. Professionals are not the same as service providers.

Physician ethicist Robert D. Orr has pointed out the confusing recent usage of the word "professional" to denote anyone who does something for money.[11] Widespread misapplication of this word has reduced the perceived meaning of professionalism in medicine. At the same time, the term "provider" has slipped into the culture of healthcare. Although the shift to calling physicians "providers" is well-intentioned as language inclusive of midlevel caregivers such as physician assistants and nurse practitioners, linguistic demotion to "provider" is, in fact, dismissive of the professionalism of all these groups.

Word choice matters. A provider, Orr observes, develops a contractual relationship with a consumer, whereas a healthcare professional develops a covenantal relationship with a patient. A provider learns a trade, gets a job, and pursues a business to gain a market share. A healthcare professional, by contrast, undergoes many years of difficult training and sacrifice, develops a practice, and pursues a vocation for the purpose of serving others.[11]

With that distinction in mind, one can more easily imagine technology stepping in to fulfill the role of a provider than a professional. Many of the functions of a provider can be approximated, if not replicated, by technology that stores and retrieves information, executes well-defined tasks with minimal error, and performs utilitarian services for monetary profit.

Considering the trajectory of innovation, it may be tempting to imagine that future improvements in technology will eventually bridge the gap between provider and professional. If the difference between a machine as provider and a human as professional is merely one of a difference in the degree of functional capacity, then there would seem to be no reason why a sufficiently advanced computer wired to mechanical attachments could not, in principle, satisfy the definition of a medical professional.

Furthermore, the belief that that gap had been bridged would likely erode the integrity of medicine. Attitudes toward human professionalism would be influenced even by the erroneous perception that an artificially intelligent robot with a stethoscope had nullified the practical distinction between a provider and a professional.

To explore this question explicitly, this essay will examine the meaning of professionalism as articulated by the Christian Medical & Dental Associations (CMDA).[12] A corresponding document for understanding the meaning of a provider might be the owner's manual that comes with the purchase of any automobile, computer, internet service device, vending machine, or coffee brewer, and will not be considered in detail here.

The Technical Aspect

Professionalism has, first of all, a technical aspect.[12] This begins with the acquisition of a large volume of knowledge that draws from multiple complementary disciplines. The technical aspect comprises a system for organizing and integrating this information, a method for analyzing evidence and assessing its reliability, and a way of evaluating its relevance to specific clinical problems. The professional continues to add to this knowledge, learns from experience, is prepared to reevaluate and, when appropriate, reject previously held theories when confronted by conflicting yet convincing new evidence.

In addition to knowledge, professionalism consists of technical skill. Examples include the exquisite dexterity required to thread a fine catheter safely through a patient's arterial arborizations and the precision of the surgeon's scalpel when slicing through living tissue to excise a tumor. Technical skill also involves communication, for example, the delicate choice of wording required to probe into sensitive topics of personal health or convey bad news.

Years of rigorous study are required to gain and perfect this technical competence. Scholarly learning continues throughout the lifetime of the professional, who seeks new knowledge and improvement in the skills of application with ever-advancing proficiency. Aiming always toward excellence, professionals establish and enforce standards of practice.[13]

Each component of the technical aspect of professionalism could, in principle, be performed by sufficiently advanced technology. Already robotic surgery is gaining widespread acceptance based on a variety of outcome measures.[14,15] Advances in artificial intelligence might one day push the boundaries of some types of technical performance beyond human capability. As measured by technical competence, a robot might become at some future time an adequate medical provider, but technical competence alone does not make a medical professional.

The Ethical Aspect

Secondly, professionalism has an ethical aspect.[12] Professionalism involves the judicious application of technical knowledge and skill in order to heal and not to harm, in keeping with the principles of beneficence, non-maleficence, respect for persons and their autonomy, and justice. In other words, professionalism requires wisdom. Aristotle called this type of wisdom "phronesis," meaning practical virtue, which involves an ability to discern how and why to act morally as well as excellence of character. Neither sheer information, no matter how voluminous, nor mechanically-guided instrument movements, no matter how precise, are sufficient for phronesis, because clinical judgment and moral probity are also required. Phronesis entails vigilance in avoiding harm, whether that be preventable adverse outcomes or the use of immoral means to a desired end. Phronesis entails acting "with caution and forethought, protecting the patient's health, safety, and confidentiality."[12] Phronesis extends to "a stewardship responsibility to foster affordability and availability of care by applying medical or dental resources prudently."[12]

Phronesis is also concerned with the professional's personal character. Technology may be morally neutral, but the professional must not be. In relation to the patient, the healthcare professional possesses special expertise, and this asymmetrical power over the patient "must always be exercised for the patient's good."[12] The relationship of the healthcare professional to the patient is also one of moral equality. As a fellow human being, the healthcare professional is sensitive to the patient's vulnerability and responds with empathy. Professionalism also entails the discipline of communicating "respectfully with colleagues and team members, acknowledging the contributions of all."[12]

The CMDA position on professionalism states: "The doctor has the moral responsibility to respect the worth and dignity of all patients, who at all times are his or her equals as persons. Moral equality mandates mutual respect; there must be trust and integrity of communication combined with cooperation in giving and receiving care."[12] Accordingly, the healthcare professional "should treat patients without favoritism or discrimination"[12] and choose treatments that "accommodate the patient's perspective, as health is integrally related to the patient's life goals, needs, and personal values."[12]

This ethical aspect of professionalism departs from and surpasses what is possible through technology alone. Technology by its nature lacks the competence to weigh questions of value and purpose; this competence is held and exercised by technology's human designers and users.[16] Ethics, unlike a computer program, assigns to each possible action varying levels of priority according to moral judgments. The physician will drop whatever he or she is doing to respond immediately and assist someone who has suddenly stopped breathing. The computerized sedation system responds only in the way it has been programmed. To the computer, all electron pathways along its circuits are accorded equal weight. All available actions are morally equivalent. All programmed actions, whether injecting an ampoule of epinephrine or dispensing a cup of espresso, are accomplished with equal readiness.

The new field of affective computing challenges some of the distinctions between human communication and automatic computer programming. By decoding patterns of facial muscle activation and voice inflection, computer programmers can write code that adds to computer-generated speech a layer of intonation imitating human emotion.[17] Such software impersonates but does not reflect genuine compassion. Computers can be programmed to provoke emotional responses in humans but ultimately cannot comfort. Algorithms cannot care. This is why the CMDA statement exhorts the healthcare professional in attitude not to be "limited to the reductionistic tendencies of science or economics" but to "strive for ever-increasing moral discernment and knowledge of life's higher meanings and obligations."[12]

The Christian Aspect

In addition to the two previous aspects, which apply to all healthcare professionals—but not necessarily to robots—the Christian healthcare professional recognizes a third and transcendent aspect to medicine.[12] The CMDA statement on professionalism states that the Christian healthcare professional "appreciates and encourages a deeper meaning of health and illness in the context of the special value and eternal destiny of human life."[12] From this worldview perspective, "The Christian doctor appreciates that the patient's dignity derives from having been created in the image of God."[12] The significance of this truth for medicine, both historically and personally, is profound, for it means that every patient is a person of inestimable worth.

Through the Judeo-Christian tradition comes the principle that, in their actions toward all others, people of faith are responsible to a righteous, merciful, and loving God who is deeply concerned for the sick and suffering.[18] The Christian healthcare professional, therefore, is motivated by the expectation of divine judgment to do what is right and to do it well. But unlike the dictates of healthcare policy or law that enforce compliance through rules and out of fear, and unlike the cold, calculating code of computer programs, God's commands are backed by love, which infuses the Christian healthcare professional with an ethic of care that reaches farther than would be possible through one's own strength.

Furthermore, CMDA acknowledges that the Christian healthcare professional is imperfect. Knowing that he or she is accountable to God for the care provided fellow human beings, and despite diligent effort and the best of intentions, "medical care is sometimes imperfect or inadequate. Faith in Christ provides the doctor with humility, encouragement, and the inspiration to improve and persevere."[12]

Finally, the CMDA statement affirms that the Christian healthcare professional "knows that true wholeness consists not only of physical health and emotional well-being but ultimately in being in a right relationship with God through faith in Jesus Christ."[12] The Christian who is called to a healthcare profession "is given a ministry: humble service of others in a spirit of self-sacrificial love for all, including the neediest and the lowliest."[12]

Alongside the inspired and compassionate healthcare professional, technology made to function as a medical provider falls flat on its face. The swiftest and sleekest robots are spiritually inert. Machines cannot aspire. Erroneous automatons feel no remorse. Whereas technology might be crafted to imitate, and perhaps eventually substitute, for a *provider*, technology that mimics the *professional* can never be more than a caricature. As one physician news commentator put it simply, "Medicine needs human contact."[19]

Conclusion

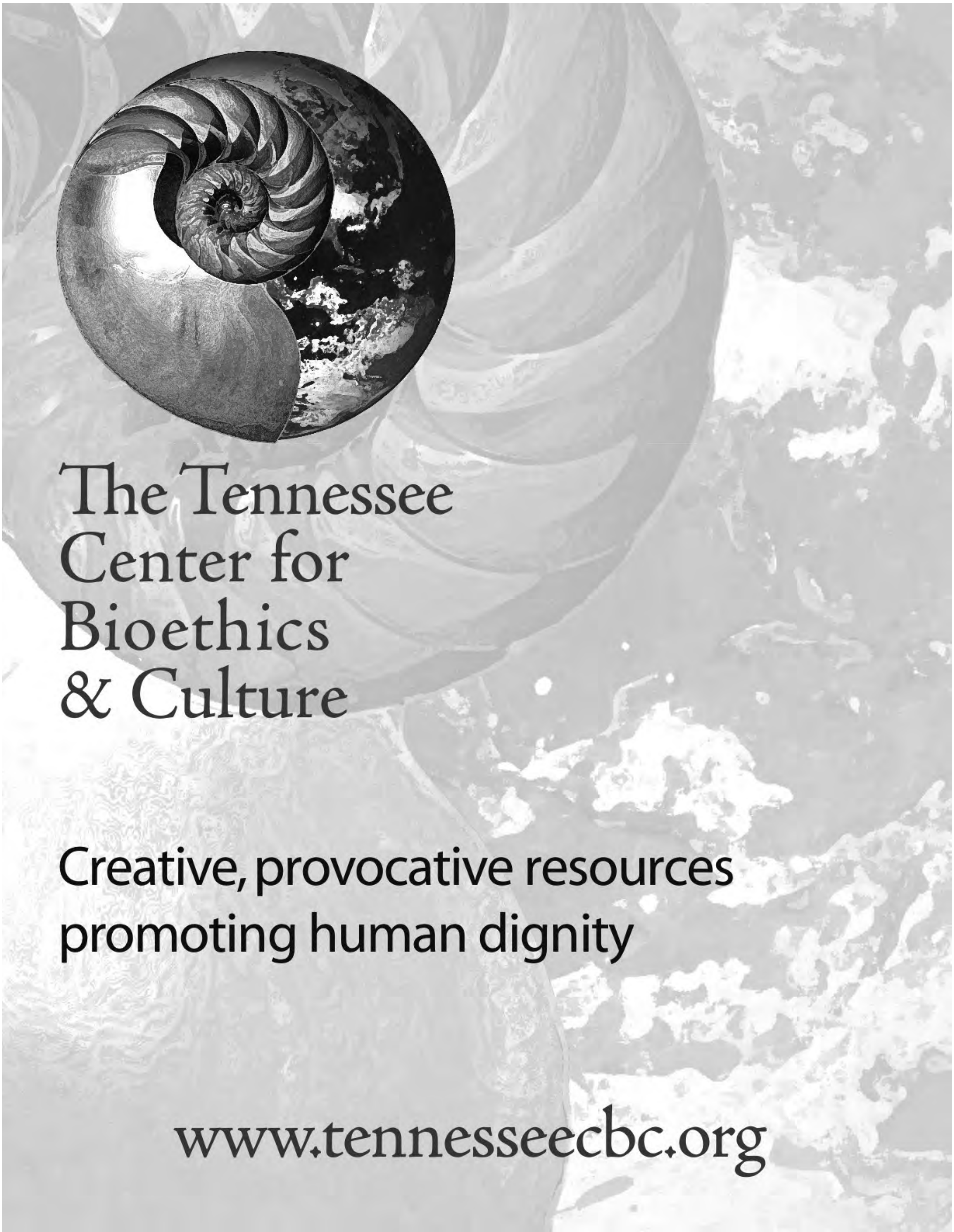
Several months later I happened to pass my anesthesiologist colleague in the hallway. Embarrassed at my impoliteness for having fallen asleep during our conversation, I apologized. Graciously, he smiled. In that moment of shared humor, we acknowledged a uniquely human experience. We knew that undergoing anesthesia was something more than a temporary cessation of cerebral information input and output. We understood that delivering anesthesia to a human patient meant something more than flipping a switch and counting numbers.

References

1. Stevens D. Medical martyrdom? How to defend your right of conscience. *Today's Christian Doctor* 2007; 38(3): 18-21.
2. Frankel TC. New machine could one day replace anesthesiologists. *The Washington Post*, May 11, 2015.
3. Rockoff JD. Robots vs. anesthesiologists. *The Wall Street Journal*, October 9, 2013.
4. Reader T. Anesthesia use for colonoscopy attracts new scrutiny. *HealthLeaders Media*, April 13, 2016.
5. Wernli KJ, Brenner AT, Rutter CM, Inadomi JM. Risks associated with anesthesia services during colonoscopy. *Gastroenterology* 2016; 150(4): 888-894.
6. Wrenn G, Kasiah F, Syed I. Using a self-service kiosk to identify behavioural health needs in a primary care clinic serving an urban, underserved population. *J Innov Health Inform* 2015; 22: 323-328.
7. Lowe C, Cummin D. The use of kiosk technology in general practice. *J Telemed Telecare* 2010; 16: 201-203.
8. Couret J. FDA approves SoloHealth station. BizJournals.com, June 5, 2012. Accessed at: http://www.bizjournals.com/atlanta/news/2012/06/05/fda-approves-solohealth-station.html
9. Mercola J. FDA wants prescription drug vending machines. Mercola.com, May 21, 2012. Accessed at: http://articles.mercola.com/sites/articles/archive/2012/05/21/fda-patient-kiosks.aspx#!
10. Zieger A. Consumer health IT tools could allow self-prescribing. HealthcareScene.com, March 23, 2012. Accessed at: http://www.hospitalemrandehr.com/tag/self-service-prescriptions/
11. Orr RD. Will you be a provider or a professional? *Ethics & Medicine* 2013; 29(3):147-150.
12. Christian Medical & Dental Associations, Professionalism Ethics Statement, April 24, 2014. Used with permission. The primary author was the author of this paper. Archived at: https://cmda.org/resources/publication/professionalism-ethics-statement

13. Cheshire WP, Hutchins JC. Professionalism in court: The neurologist as expert witness. *Neurol Clin Pract* 2014; 4: 335-341.
14. Jeong W, Kumar R, Menon M. Past, present and future of urological robotic surgery. *Investig Clin Urol* 2016; 57: 75-83.
15. Foote JR, Valea FA. Robotic surgical training: Where are we? *Gynecol Oncol* 2016 Jun 2, epub ahead of print.
16. Cheshire WP. When moral arguments do not compute: prospects for an ethics checker. *Ethics & Medicine* 2012; 28(2): 71-76.
17. Luneski A, Konstantinidis E, Bamidis PD. Affective medicine. A review of affective computing efforts in medical informatics. *Methods Inf Med* 2010; 49: 207-218.
18. Cheshire WP. Twigs of terebinth: The ethical origins of the hospital in the Judeo-Christian tradition. *Ethics & Medicine* 2003; 19(3): 143-153.
19. Alvarez M. Will doctors be replaced by robots under ObamaCare? FoxNews.com, September 30, 2013.

William P. Cheshire, Jr., MD, MA, is Professor of Neurology and Chair of the Medical Ethics Committee at the Mayo Clinic in Jacksonville, Florida; Chair of the Ethics Committee for the Christian Medical & Dental Associations; and Senior Fellow in Neuroethics at the Center for Bioethics & Human Dignity. The views expressed herein are his own and do not necessarily reflect the positions of the professional organizations with which he is affiliated. He currently resides in Ponte Vedra Beach, Florida, USA.



What Is the Role of the Church When a National Government Has Internal Healthcare Policies That Fail Its Own Citizens?

NELLIE WAMAITHA; MARY B. ADAM, MD, MA, PHD

Introduction

Healthcare is prominent on the global agenda, and among the many questions worth considering is whose responsibility it is to provide healthcare to citizens. This question is important because it helps us know whom to address in each situation as we discuss what ought to happen to make healthcare provision less unjust than it is. This question would, of course, be answered differently in different nations depending on the healthcare system adopted either legislatively or through practice or a mix of both in that particular country. But the moral question remains. Who bears the moral responsibility of ensuring that every person has access to healthcare services in a just manner? Is it the role of the government to provide healthcare, or does governmental responsibility only extend to ensuring that healthcare is provided? Is it the responsibility of the individual citizens, or is it that of those with the resources and opportunities to act? In this article, we will be concerned with what happens when a government assumes the role of provision of healthcare services and fails its citizens, using Kenya as a case study. We argue that because of the high value the church places on human beings as the bearers of God's image, and because the church is the means through which God's justice is actualized on earth, the church has a responsibility to be involved in the provision of just healthcare, particularly when a government fails.

Historical Background

In Kenya, like in many African countries, life prior to the colonial era was organized communally, and healthcare was often left to the family or to medicine-men or medicine-women who had some knowledge of the body, herbal medicine, and minor surgery. Often, illness was attributed to evil spirits or interpreted as an expression of displeasure from the ancestors or God. Mediums, priests, elders, or witch doctors would in such instances be called upon to perform rituals or offer sacrifices for healing. During the colonial era, colonial governments in Africa established and managed hospitals and health centers. At the same time, churches such as the Catholic Church and Christian missionaries were also heavily involved in the provision of healthcare. Therefore, the government systems that African states inherited at independence were already involved in the provision of healthcare. For many African countries, healthcare has remained the primary responsibility of the government. The high poverty levels in many African countries have slowed the growth of private healthcare initiatives that could significantly bear the healthcare burden.[1] African governments continue to struggle to fulfill this responsibility. In April 2001, the heads of states of African Union countries pledged in the Abuja Declaration to allocate at least 15% of their annual budget to healthcare. However, ten years later in 2011, only 3 countries were on track according to a World Health Organization (WHO) Report.[2] While governments have the primary responsibility, a substantial amount of the care that is actually provided has been offered by medical ministries of the church, with faith-based organizations providing up to 50% of the acute care in many low-income African countries. In countries like Kenya through the 1990s, these organizations handled up to 40% of the pharmaceuticals supply.[3]

Kenya

Kenya uses the rights approach in healthcare in line with WHO thinking on health. WHO has enshrined "the highest attainable standard of health as a fundamental right of every human being."[4] The Constitution of Kenya provides that "every person has the right to the highest possible attainable standard of health, which includes the right to health care services, including reproductive healthcare."[5] It states that "every child has the right to basic health care."[6] The Constitution also stipulates that no person shall be denied emergency medical treatment.[7] It further provides that the State shall put in place affirmative action programmes designed to ensure that minorities and marginalized groups have reasonable access to healthcare.[8]

In its attempts to fulfill these obligations, the Kenyan government has had some measure of success in certain aspects of healthcare. The government offers free HIV testing to all citizens and free baby deliveries in government health facilities. Immunizations are also free, and there has been significant success in campaigns to vaccinate increasing numbers of children. However, supply chain problems and lack of health systems to track immunization defaulters and the lack of community health infrastructure mean only 68% of children are fully vaccinated and 37% of women still deliver without the benefit of a skilled birth attendant according to the Kenya Demographic and Health Survey (KDHS) 2014,[9] although this is an improvement over 56% according to KDHS 2008-2009.[10]

At a general level, however, the public healthcare system in Kenya is riddled with problems. Many are a result of economic and development related difficulties such as inadequate funds and resources, shortage of medical personnel, insufficient health centers and medical equipment, lack of medical supplies, and poor infrastructure.[11] Other problems include:

- Corruption in management of funding and distribution of medical supplies—there is widespread mismanagement and embezzlement of funds intended to be used in the provision of public healthcare. Kenya continues to have one of the highest levels of corruption in the world, having been ranked in the bottom quarter of Transparency International's 177 country survey in 2014.[12] This greatly affects the provision of healthcare in the country as funds supposed to be invested in healthcare provision are misappropriated.
- Healthcare workers' strikes—strikes by healthcare workers over unpaid salaries and poor working conditions are common in Kenya and they often have devastating effects on the public healthcare system with deaths of patients resulting from lack of care during the strikes being reported.[13] These

strikes are often a result of mismanagement of funds and inefficiencies within governmental agencies.[14]

- Healthcare financing and National Hospital Insurance Fund (NHIF)—the government of Kenya in 2015 increased the monthly contributions towards NHIF, the national health insurance fund. This was followed by a public outcry over the fee increase indicating a lack of trust in the public system. There was, consequently, very poor uptake by the informal sector. This outcome is a demonstration that justice matters have to be approached in a holistic manner. Health is closely tied to other social justice matters and economic disparities undoubtedly complicate a national health insurance scheme in a country such as Kenya where 42% live below the poverty line (UNICEF Figure).
- Distance to a facility—in some parts of Kenya, the nearest health facility is more than 5 km away from most households. Studies show that being 5 km away from a health facility significantly reduces the use of skilled birth attendants, thus affecting child mortality.[15]

Whose Problem Is It?

Although the Constitution of Kenya grants every Kenyan the right to the highest standard of health, the reality is that many do not have access to even basic healthcare. The government has simply not been able to meet the health needs of the country or the high ideals set out in the Constitution. This current failure by the government raises the question of what responsibility the church bears in relation to healthcare provision. This is a poignant question for the church to consider, especially in light of the history of medical care.

Churches have been involved in healthcare for much longer than governments have. After the resurrection of Christ, his little band of followers shook the world. A new world order was instituted as Christians embraced the teaching of Christ and message of the Kingdom of God. Wherever Christ's followers were scattered by their persecutors they taught and demonstrated love for every person including the sick, the poor, and the rejected. Christ had taught them to love each other and to esteem every person regardless of social position and wealth and had exemplified this in his life. After the power of the Holy Spirit came upon them, followers of Christ were able to do just that. This Christian spirit of love was not just the preserve of first century Christians but has been the mark of devout believers in Christ over the ages. It was Christians who first volunteered to take care of lepers and people affected by the plague of Cyprian in 250, setting up the earliest healthcare systems.[16] The church's commitment to love and justice is what led to the development of healthcare institutions in the first place. Atkinson notes that "The Church has been involved in the founding of hospitals: there was one founded by St. Basil in the fourth century; the Augustinian canons founded St. Thomas' Hospital in London in the twelfth century. St. Christopher's pioneer hospice was established in Sydenham in 1967. The church has also contributed to the training of doctors and the setting up of medical missions."[17] The church has historically been in this regard "a people with a hope sufficiently fervid to sustain the world as well as itself."[18] There is no reason why this should not continue.

Not Just the Responsibility of Governments

This early and robust involvement of the church in the provision of healthcare challenges the modern expectation that healthcare is mainly the responsibility of governments. It was not so at the beginning, nor for many years after that. The church, being the institution through which God communicates his grace and love to humanity, has a duty to demonstrate the workings of the Kingdom of God here on earth. It continues to have a role even when the government picks up responsibility in matters such as healthcare provision. As Atkinson states, "The church's ministry of healing is part of this great story of salvation."[19] Assuming that the healthcare burden should be borne by governments is too linear and simplistic an approach to a complex problem. Government resources have in many countries, especially developing countries, proven to be inadequate on their own to provide healthcare to citizens. And there are often disparate political and economic considerations that negatively affect the provision of healthcare by governments. As the followers of the great Physician, the church has an enduring obligation to be involved in the provision of just healthcare in a world that continues to be desperately in need of healing. If the church were to leave healthcare provision in the hands of governments in countries like Kenya where the government has not delivered basic healthcare to its citizens, that would constitute an abdication of the church's duty to act justly and love mercy (Micah 6:8). The church should seek to be an influence on whatever state actor is involved where possible, and it should continue to be involved in helping the sick and the poor because this is a commandment from the Lord (Matthew 25:34-40). F. A. Hayek writes these sobering words:

> It is one of the greatest weaknesses of our time that we lack the patience and faith to build up voluntary organizations for purposes which we value highly and immediately ask the government to bring about by coercion (or with means raised by coercion) anything that appears as desirable to large numbers. Yet nothing can have a more deadening effect on real participation by citizens than if government, instead of merely providing the essential framework of spontaneous growth, becomes monolithic and takes charge of the provision for all needs, which can be provided for only by a common effort of many.[20]

The church should be one such voluntary organization in healthcare delivery. Bringing much-needed healthcare to those who require it is costly, and the church should bear what it can of that cost. Hauerwas rails against attempts at "Having justice without risking the self, as when we ask the state or the 'revolution' to see that justice is done, but in a manner that does not significantly affect our own material position."[21] Other than revealing a superficial commitment to justice, such attempts are rarely successful.

The Church, Image of God, and Justice

Moltmann defines health as "the strength to be human."[22] He continues to say that "if we understand health as the strength to be human, then we make being human more important than the state of being healthy." By his definition, health becomes important because it allows us to be human. To put it in other words, our desire for and pursuit of health is an affirmation of the value there is in simply being human. This understanding shows us how closely linked health is with the question of what it means to be human. The church takes the view that human beings are the bearers of the image of God. “God created man in His own image, in the image of God He created him; male and female He created them” (Genesis 1:27, NASB). Creation in God’s image communicates the idea that human life is sacred and human beings are intrinsically valuable and therefore deserving of being treated justly and with dignity.[23] Every human being has intrinsic value that is not affected by their gender, race, convictions, wealth, or status in society.

Creation in the image of God also means that all men are equal, providing a strong philosophical foundation for the just treatment of all people since all are equal and valuable. The vision of human beings as the valuable bearers of God’s image compels the church to try harder and for longer than governments in healthcare matters and to include everyone, particularly the poor and needy because of the example of Christ. This is often wonderfully demonstrated by Christian medical practitioners such as the missionary doctors who work in rural Africa or those Christians who responded to calls to provide treatment to patients in Ebola-affected areas in Africa in 2014. The realities of healthcare provision in a world where resources can never be enough can be handled with compassion by the church because the church grasps the importance of expending all efforts to ensure that all human life is treated as sacred and God is honored.

The Church and Justice in Healthcare

Any discussion about the provision of healthcare touches on justice, itself a complex subject. A single definition of justice has been elusive over history, partly due to the complexity of the topic and the vastness of its areas of application. Macintyre underscores this varied complexity when he says,

> Some conceptions of justice make the concept of deserts central, while others deny it any relevance at all. Some conceptions appeal to inalienable human rights, others to some notion of human contract and others again to a standard of utility. Moreover, the rival theories of justice which embody these rival conceptions also give expression to disagreements about the relationship of justice to other human goods, about the kind of equality which justice requires, about the range of transactions and persons to which considerations of justice are relevant and about whether or not a knowledge of justice is possible without a knowledge of God.[24]

These competing understandings of justice complicate not only discussions on just healthcare but the practical delivery of health services. As would be expected, where the framework for the just provision of healthcare is unclear, it is quite difficult to establish what level of duty is required or to come up with a functional measure of how to determine that these obligations have been met and justice has been done.

There is therefore need for the church’s voice in what justice is and how that impacts healthcare. In the midst of these varying approaches the church can contribute its special understanding of justice as stemming from the righteousness of God. Justice in the delivery of healthcare has tended to focus on the just allocation of resources. However, although the allocation of resources is hugely important, the problems of healthcare provision are not merely problems of lack of resources. Often there are other factors such as political or civil conflict, natural disasters, ongoing ramifications of ill-advised political policies, and the personal decisions of individuals, which also negatively influence global health. In a world that is clearly perplexed by healthcare problems, the church has an opportunity to participate in the discussion on justice with a clear voice spoken not from the sidelines but from the bedsides of the sick. This opportunity ought not to be missed.

In *What Is Economic Justice* Andrew Hartropp argues that the righteousness of God is the basis for human justice. He says, "Human justice means practical righteousness in relationships, conforming to the norms of appropriate treatment that God has set and commanded."[25] This understanding is reflective of biblical teaching that justice is an expression of the righteous character of God in his relations with his creation. Hartropp goes beyond distributive justice notions by stating that justice is more than fairness (in response to Rawls) and that it is not just allocational. Biblical justice, he asserts, is more involved at a personal level and is more relational. God himself personally responds to the injustices against his people in Egypt and comes down to deliver them (Exodus 3:7–9). Enrique Nardoni states something similar in *Rise Up, O Judge* when he states, "justice is a person's actions in obedience to God's will concerning his or her relationship to others. One who does justice towards others imitates God's compassion."[26]

By defining justice as an expression of the righteous character of God in how we relate with other people, Hartropp here presents a compelling definition not because it is simpler than other understandings of justice but because it recognizes that it is in the context of relationships that people make decisions about how they shall act. By drawing attention to the character of God in relationships, a relational conception of justice captures more of the transcendent beauty of justice than definitions constrained to fairness only or allocation of resources only. Unlike other approaches such as Rawl's, specific guidelines are not given. Rather than propositions, this view presents the righteous God as the standard to be appealed to in each relationship context. Hartropp is aware that this involves diligence to know the will of God but says that "The practical difficulties of doing this should not keep us from diligently seeking the will of God…"[27] When we do so, he says, we will find that "there is a match between that which God wills and that which leads to human flourishing."[28]

If the righteousness of God is the standard in our relational treatment of those in need of healthcare, then our conception of justice will go beyond the allocation of resources from an existing public pool and will involve sacrificial love and sacrificial giving. God himself has modeled this in his relationship with us through Christ. Such an understanding of justice goes beyond what one would demand in political and social theories of justice. And yet when a country such as Kenya needs to reverse the results of systemic injustice, sacrificial dedication to justice instructed by the righteous character of God and motivated by love for God and neighbour (Matthew 22:36–40) is what is needed. As Atkinson notes, "God's justice transforms our human concepts of justice and extends them into compassion and redemption."[29] Moreover, an understanding of justice that recognizes the relational nature of justice guards against the "artificialization of people and demands that each person be treated as a person in relationship not only with the church, society, and other men but with God as well. This is evidently an understanding of justice that only the church could espouse fully, whether it be the church universal, the local church, or individual members. As a governing principle of relations, referring to the character of God as the standard would be natural for the church but foreign to others. Since this conception of justice is needed in healthcare, it is further reason for the church to get involved.

What the Church Is Doing and Can Do

In countries such as Kenya where there are great gaps in the provision of healthcare because national policies and the public system undermine the just provision of healthcare to citizens, the role of the church in healthcare becomes of special importance. And the fact is that the church in Kenya is making great contributions to healthcare. Various church denominations such as the Catholic church, the Presbyterian church, and the African Inland Church have developed health infrastructure in the country and continue to be actively involved in the provision of healthcare in various parts of the country. The Catholic church, for instance, "runs close to 30% of all healthcare facilities in Kenya. The Church has an expansive network which consists of 448 health units (54 hospitals, 83 health centres and 311 dispensaries) and more than 46 Community Based Health and Orphaned and Vulnerable Children (OVC) Programs. In the Arid and Semi-Arid Areas, the church has and manages mobile clinics for nomadic communities; these are difficult areas that other organizations, including the government, are not able to reach."[30] The African Inland church runs the Kijabe Hospital, which is one of the best training hospitals in the region.

At the local church level, individual churches often organize *harambees* (fund raising events) to pay medical bills of members and their families. During the 2008 post-election violence many churches offered assistance to victims of violence when the government would not. Local churches are enlisted by the government to assist with vaccination campaigns, and they have been useful in persuading people to have their children immunized. Individual church members have been involved in fundraising efforts for their friends and family, and many have served their sick family and friends by attending to their physical and spiritual needs whilst sick.

However, more can be done given the great need in the country. There is need for creativity in the initiatives that the church comes up with. One of the greatest health needs in Kenya is health education. Here the church can play a greater role at significantly little cost to itself by making use of existing church facilities for training and enlisting the services of health practitioners who are members of the church as trainers. Christian medical practitioners could spearhead immunizations or other health initiatives in communities. Churches with access to funds could invest more in setting up health centers and training institutions. There is also an attendant responsibility on individual members of the church to do what they can to ensure that those who it is within their power to help receive the care they need and that there is justice in its delivery.

In addition to being actively involved in the provision of just healthcare, the church also has a responsibility to speak the truth. The church universal has failed in not confronting false health and wealth teaching and in not routinely stating that fake faith healing is a false and dangerous teaching. The health and wealth gospel is a problem in Kenya as well. On New Year's 2015, 5 people died while waiting to be healed by Prophet David Owuor, a well-known preacher and "healer," at a crusade in Nakuru, one of the larger towns in Kenya.[31] In 2011, East African countries witnessed an unprecedented event where thousands of sick people travelled to a remote village in Loliondo, Tanzania over a period of several weeks for a miraculous drink that "cured" almost all diseases.[32] The drink was being supplied by Babu Ambilikile Masapila, a retired Lutheran pastor with no medical training, and at some point the traffic jam to his compound stretched for more than 10 kilometers at a time,[33] delivering 20,000 patients from Kenya, Tanzania, Uganda, and other countries weekly to his compound.[34] It is estimated that at least 52 people died waiting in line for the drink.[35] In addition, other patients died after discontinuing the medications they were taking for their chronic illnesses, such as HIV treatment or treatment for hypertension. With no evidence that the magical cure worked, and given the danger of HIV-positive patients spreading the disease believing themselves to be well, to take just one example, it is deeply tragic that some churches encouraged their members to go and that many of those that did not encourage their members failed to speak up against it in time.

Spirituality and Health

Atkinson criticizes the WHO definition of health, "a state of complete physical, mental and social well-being," for being too limited because it makes no reference to a person's spiritual condition.[36] This statement is significant because of the strong connection between spiritual health and physical health. The following statement by Olivier et al. highlights this connection:

> Religion may operate as an asset in a variety of ways. For example, religious convictions and worldviews have directly and tangibly impacted on health through the work of missionaries who came to Africa, setting up mission hospitals, many of which are still relied upon today, and in more rural parts of Africa are often the only healthcare facilities available…. However religion has more intangible and indirect effects on health that, better understood and leveraged, might offer great potential for impacting health in Africa, whether through volunteerism and education, behaviour change and the building of social capital, through seemingly mundane experiences such as singing in a choir regularly, or through the ways in which religious involvement engenders hope or resilience.[37]

Health is a complex matter, entwining the physical, social, moral, and spiritual aspects of a person. We cannot, for instance, successfully deal with health problems without addressing the problem of sin. Dante Alighieri (1265–1321) in *The Divine Comedy* outlines the 7 deadly sins as follows: wrath, greed, sloth, lust, pride, gluttony, and envy. These vices demonstrably have a strong correlation with health problems or with the deterrents of progress in the provision of just healthcare, underscoring the teaching of Jesus on the Sermon on the Mount that people need spiritual healing more than anything else. Our problems are primarily spiritual and we are in need of redemption and rebirth more than we are in need of physical healing. Ultimately, only the power of God can truly heal us in all the ways we need healing and help us make a substantial contribution to the alleviation of the suffering of others.

Conclusion

Because of its belief in the existence of a relational God who loves people, the redemption of humanity and creation though Jesus Christ, and the promise of eternal life, the church is in the unique position of providing helpful answers to a world that is ailing both physically and spiritually. The church should teach and indeed teaches that man's true healing comes through a living relationship with God and by consistently reminding us that we have an eternal hope, works to eliminate the fear of death. The church then must in pursuit of the righteousness of God and as an expression of love for our neighbors work tirelessly to formulate a robust response to the healthcare needs of the world. It is able to do this with a clear-minded soberness because it has an eternal perspective and with urgency because it loves and values the bearers of God's image.

References

1. The State of Healthcare in Africa, KPMG Full Sector Report, 2012.
2. The Abuja Declaration: 10 Years On, WHO, August 2011.
3. Kawasaki, E., Patten, J. (2002). Drug Supply Systems of Missionary Organizations Identifying Factors Affecting Expansion and Efficiency: Case Studies from Uganda and Kenya. Geneva: WHO/EDM. Accessed Sept 25, 2015.
4. World Health Organization Fact Sheets: The Right to Health http://www.who.int/mediacentre/factsheets/fs323/en/. Accessed Sept 25, 2015.
5. The Constitution of Kenya , 2010. Article 43 (1) (a)
6. Constitution of Kenya, 2010, Article 53 (1) (c)
7. Constitution of Kenya, 2010, Article 43 (2)
8. Constitution of Kenya, 2010, Article 56 (e)
9. Kenya Demographic and Health Survey, 2014, p. 129
10. Kenya Demographic and Health Survey, 2008-2009, p. 120
11. V. Obare, C.E. Brolan and P.S Hill, International Journal for Equity In Health 13(123), 20 December 2014. Indicators for Universal Health Coverage: Can Kenya comply with the proposed post-2015 monitoring recommendations?
12. Transparency International, Corruption Perceptions Index 2014, Retrieved from www.transparency.org/cpi2014
13. 2012, September 13. Kenya Doctors Start Nationwide Strike. The Daily Nation, retrieved from http://mobile.nation.co.ke/; 2015, August 19. Nyeri Nurses Adamant as Strikes enters Fourth Day. The Daily Nation, retrieved from http://mobile.nation.co.ke/counties
14. 2015, August 13. 11 Patients Die as Strikes Paralyse Health Services. The Daily Nation, retrieved from http://mobile.nation.co.ke/
15. Ettarh RR, KimaniJ. Determinants of Under-five Mortality in Rural and Urban Kenya: Rural and Remote Health 12: 1812. (Online) 2012. Available: http://www.rrh.org.au
16. Ferngren G.B, A New Era in Roman Healthcare: How the early church transformed the roman empire's treatment of its sick – Retrieved from www.christianhistoryinstitute.org/magazine/article
17. David Atkinson, The Church's Healing Ministry: Practical and Pastoral Reflections, London: Canterbury Press (2011), p. 3
18. Stanley Hauerwas, The Peacable Kingdom: A Primer in Christian Ethics Indiana: University of Notre Dame Press (1983), p. 101
19. Atkinson, p. 81
20. Hayek F.A. Law Legislation and Liberty, Vol. 2. The Mirage of Social Justice Chicago: The University of Chicago Press (1978), p. 151
21. Hauerwas, p. 105
22. J. Moltmann, God in creation London: SCM (1985), p. 273
23. Kilner J.F, Dignity and Destiny: Humanity in the Image of God. Grand Rapids, Michigan: Wm. B. Eedermans Publishing Co, (2015), p. 313
24. A Macintyre, Whose Justice? Which Rationality? London: Duckworth, (1988), p. 1
25. A Hartropp, What is Economic Justice? Biblical and Secular Perspectives Contrasted, Eugene,

Oregon: Wipf and Stock Publishers (2007), p. 10

26. Nardoni E. (2004). Rise Up, O Judge: A Study of Justice in the Biblical World (S.C Martin, Trans): Baker Publishing Group (2004), p. 234
27. A Hartropp, What is Economic Justice? Biblical and Secular Perspectives Contrasted, Eugene, Oregon: Wipf and Stock Publishers (2007), p. 27
28. A Hartropp, What is Economic Justice? Biblical and Secular Perspectives Contrasted, Eugene, Oregon: Wipf and Stock Publishers (2007), p. 27
29. Atkinson, p. 62
30. Catholic Health Commission of Kenya, Retrieved from www.kccb.or.ke/home/commission/12-catholic-health-commission-of-kenya/ 16 August, 2015
31. 2015, 1 January. Five people die at Owuor `healing` crusade in Nakuru. The Daily Nation, p. 1
32. 2011, 26 March. Loliondo pilgrimage marred by deaths and accidents. The Daily Nation, retrieved from http://mobile.nation.co.ke/
33. 2011, 28 March. I'm off to Loliondo to buy a miracle cure for corruption. The East African, retrieved from http://www.theeastafrican.co.ke/
34. 2012, 24 November. How fortunes have changed for Loliondo's Babu. The Daily Nation, retrieved from http://www.nation.co.ke/
35. 2011, April 16-22. Masapila's 'magical' mugariga. The Arusha Times, retrieved from http://www.arushatimes.co.tz/2011/14/Society_2.htm
36. Atkinson, p. 4
37. Olivier J, Cochrane JR and Schmid B. ARHAP Literature Review: Working in a Bounded Field of Unknowing, (CapeTown, African Religious Health Assets Programme, 2006)

Nellie Wamaitha is an advocate in the High Court of Kenya. She is currently studying theology at Wycliffe Hall, University of Oxford and apologetics at the Oxford Centre for Christian Apologetics. She currently resides in Oxford, United Kingdom.

Mary B. Adam, MD, MA, PhD, is Director of the Maternal Newborn Community Health Program at AIC Kijabe Hospital. She is a Visiting Professor at Strathmore University in the Institute of Healthcare Management, Nairobi, Kenya and a Fellow of the Center of Bioethics and Human Dignity in Deerfield, Illinois. She currently resides in Nairobi, Kenya.

Towards a Proportionist Approach to Moral Decision Making in Medicine

PAUL WALKER, MBBS, PHD, FRACS, FACS; TERENCE LOVAT, BTH, BLITT, BED, MA, THM, PHD

Abstract

In the secular Western tradition, three frameworks are recognizable as offering guidance for ethical decision making. These are deontology, teleology, and virtue ethics. Four principles distilled from these frameworks (autonomy, non-maleficence, beneficence, and justice) have historically guided ethical decision making in clinical situations. Our current era is characterized by both widespread technological change and widespread immigration. This has contributed to a pronounced value pluralism amongst both patients and clinicians. The understanding that each clinical doctor-patient contact has a basis in moral philosophy, which seeks to maximize the good of the patient, impels clinicians to seek a balance between a priori *rules and empirical consequences. This approach is framed here as Proportionism. It can be put into practice via communicative discourse amongst those involved in the decision to be made, and has both applicability and merit for moral decision making in clinical contexts.*

Key words: Medical ethics; Moral decision making; Principlism; Proportionism

Introduction

In the secular Western tradition, three frameworks are traditionally recognized as offering guidance for ethical decision making. These are the deontological, teleological, and virtue ethics frameworks. These frameworks are substantive (stand-alone) and normative (associated with a sense of oughtness or shouldness). Deontological ethics predicates moral responsibility on the intrinsic nature of the Act, and thus its framework is largely independent of situation or context. Conversely, teleological ethics predicates moral responsibility on the consequences of the Act, and thus its framework is at least partly conditional upon the situation or context. Virtue ethics focuses on the character of the agent, and thus its focus is more on the actor than the act. Maximizing the Good of the patient is the final purpose of medicine.

Action-guiding principles distilled from the normative frameworks have further helped to guide ethical decision making in clinical situations—for example, the four principles of autonomy, beneficence, non-maleficence, and justice, proposed by Thomas Beauchamp and James Childress.[1]

Although sometimes under-appreciated, since clinical medicine inherently involves interacting with other human persons, each clinical doctor-patient contact has a basis in moral philosophy. Especially in our current epoch of widely disparate value systems, both patients and clinicians may bring widely disparate perspectives to the consultation. A balancing of ethical imperatives, as viewed from different perspectives, is thus required.

The Normative Ethical Frameworks

Deontological ethics (from the Greek *deon* or duty, obligation) is derived principally from the philosophical perspective of Plato, who built on the earlier thoughts of Pythagoras. In Plato's understanding, Goodness, Justice, and Right are givens, emanating from the gods, and, as such, there can be no negotiation around situations or circumstances. Platonists therefore rely on rules which determine ethical behaviour via their relationship with the absolute.[2]

The progenitor Medieval Christian philosopher in this framework was Augustine. In the Modern era, Immanuel Kant is associated with the original formulation of the Deontological framework. Whether an Act is morally good or not is intrinsic to the Action itself, dependent upon its concordance with a set of rules or principles, independent of its consequences. Contemporary-era exponents in bioethics include Paul Ramsey[3] and William May,[4] amongst others.

In clinical practice, an example could be that of a clinician who watches her patient suffer a painful, fearful, and distressing death. As she leaves the ward, the family ask whether their loved one suffered as he died. Under the deontological framework as originally conceived, it is the clinician's duty always to speak the truth, regardless of situation or of consequences. It may be that the clinician has a strong sense, or even independent knowledge, that knowing the facts has potential to cause further trauma to some family members but, regardless, will feel an obligation to relay the facts as they occurred because that is the only moral pathway available. This signals a shortcoming with strict adherence to deontological ethics. Another difficulty includes the challenge of knowing wherein our duty lies in any given situation. What actions are, in practice, impermissible? Traditionally, those nominated are derived from Judaeo-Christian teachings, or can sometimes be referenced in Kant's own writings.

Teleological ethics[5] (from the Greek *telos*, or end, final purpose) is derived in part from the philosophical perspective of the ancient Greek Sophist, Protagoras, who, as portrayed by Plato in his dialogues, believed that there were no absolutes with respect to knowledge, but only relatives. Truth is therefore relative to context. Hence, in contrast with Plato's Socratic conceptions of *the* Good/Just/Right, Protagoras conceived *pragmatic* good/just/right in the circumstances given.[6] In the Modern era, Jeremy Bentham and John Stuart Mill are associated with the utilitarian formulation of the teleological framework, which is concerned with making moral decisions based upon the outcome or potential outcome which follows the Act. Whether an Act is morally good or not depends on whether it brings about the best consequences, independent of the reasons for acting. Contemporary-era exponents in bioethics include Peter Singer[7] and Marcus Singer,[8] among others.

As a clinical example, consider the allocation of limited health care resources. In a given hospital there is only one renal dialysis machine available. Six patients require dialysis to stay alive. Five patients need it daily but briefly, but the sixth requires it for a whole day, precluding the use of the machine by the other five. Under a teleological framework, the five are chosen for dialysis over the one—who is refused dialysis.

Following upon earlier writings of the Stoics and Platonists (amongst others), *Virtue* or *aretaic ethics* (from the Greek arête or virtue, excellence) developed as a synthesis of the absolutists with the situationists, through the ethical speculation of Aristotle. In his *Nicomachean Ethics*, Aristotle proposed that the knowledge and practice of the Good constituted the basis for *eudaimonia*, a flourishing life that accorded with the final purpose of a well-lived life. Aquinas represents seminal medieval era Christian interpretation of the Aristotelian synthesis, influenced by Islamic writings brought to the West partly as a result of the Crusades. The virtue ethical framework focuses on the character of the agent performing the action. Contemporary-era exponents include Julia Annas,[9] Christine Swanton,[10] and Edmund Pellegrino.[11,12]

In the setting of the physician *qua* physician, Pellegrino restates the Aristotelian definition of virtue—"the state of character which makes a man good and which makes him do his own work well,"[13] as "a character trait which disposes the physician habitually to act well and wisely with respect to medicine, to its ends and purposes."[14] The final purpose or end-goal of medicine is the Good of the patient. Pellegrino articulates four goods of the patient—the techno-medical Good, the perceptual Good, the Good of the patient as a human person, and the *summum bonum*.[15] In clinical practice, maximizing the Good of the patient has more recently been articulated, under the virtue ethics framework, as empathic, compassionate caring.[16] One of the disadvantages attributed to the virtue ethics framework is that an explicit theory of right action is not articulated. For a deontologist or a teleologist, right action is prior to the concept of the virtuous person whereas, for a neo-Aristotelian, the virtuous person is constituted prior to right action.[17]

Appeal to the substantive normative moral frameworks in order to guide moral decision making in medicine has been complicated by uncertainty about which normative framework to apply and, if more than one, with what weighting each should be applied. Thus, attempts followed which aimed at simplifying the decision-making process in clinical situations by determining a smaller number of principles and rules derived from them. This constituted an appellate approach wherein justification for specific ethical decisions in clinical practice was made via appeals to these rules or to their parent principles.[18] Beauchamp and Childress proposed a set of four discrete *prima facie* principles—respect for autonomy, non-maleficence, beneficence, and justice. Persisting as highly influential in medical ethics, they derive from the substantive normative frameworks, so allowing for a common moral language amongst clinicians. Although the four principles are conceived of as having equal weighting, the principle of respect for autonomy has been the most paradigm-influencing principle and, contemporarily, is generally regarded as taking priority over the other three.[19] The moral philosophical sense of autonomy leans towards the sense inherent within Kant's practical imperative: namely, since all persons have intrinsic moral worth, it is impermissible to treat another human as a mere means to an end. As applied to patients, it thus encompasses the concept that the individual makes decisions, free from the controlling influence of others, in the vision of their own values and with adequate understanding of the decision, its necessity and consequences. Mill's sense of this imperative provides the grounds for individual primacy; that is, individuals have the liberty to express their freedom, even to harm themselves, provided they do not harm others.[20] Recent biomedical advances render more problematic questions around respect for autonomy in several areas, including, for example, the innovation of fully implanted permanent pacemakers.[21]

Two further thoughts follow. First, autonomy and beneficence are principles in tension with each other. It is not permissible to coerce or deceive patients, even in their own interests. The principle of beneficence is likely to make appeal to consequences and so be justified teleologically, while the rules of permission are binding independent of consequences, and so are justified deontologically.[22] Second, a richer account of autonomy implies that the patient should not simply act upon desire. This is because the patient recognizes the other (those in relationship with the patient), and that the patient connects with their actual situation-in-the-world, a world which is not only shared with others but which means that moral decision making must be predicated upon the actual reality of their illness situation. Hence, there is an argument that if the *telos* of Medicine is helping patients via seeking to maximize the Good of the patient, then beneficence must replace autonomy as the *prima facie* first principle.

Non-maleficence imposes a negative duty or obligation not to inflict harm. This duty is usually regarded as taking precedence over the duty of beneficence. For example, it is not morally acceptable to sacrifice one person in order to harvest sufficient organs to save five others, despite the obvious utilitarian attraction. “Harm” for a deontologist entails that which contravenes the imperatives; for a teleologist, it comprises a negative in the calculation of utility; for a virtue ethicist, however, it is what may be an impediment to achieving *eudaimonia*.

Towards a Proportionist Approach

Aware of these difficulties, we argue here that moral decision making in clinical situations should look beyond established normative ethical frameworks or principles derived from them, towards an approach framed here as Proportionism. The Proportionist approach seeks the highest good based upon a balance between *a priori* rules and empirical “greatest good for the greatest number” utilitarian calculations, with, as its starting point, the actual reality of the patient and their situation.

In terms of historical development, William Godwin proposed a synthesis of rules and consequences. He allowed that following one’s duty constitutes the best decision-making premise for the individual and for the general population; however, the consequences of our actions need to be considered, and the happiness of a number of people is deemed to be of more value than that of one.[23] Joseph Fletcher describes a method of situational or contextual-based moral decision making, wherein “the situational variables are to be weighed as heavily as the normative . . . constants.”[24] Adherence merely to rules about permissibility and impermissibility effectively removes conscience and indeed the moral agents themselves from the decision-making process. The moral agent judges what is best in the particular circumstances, allowing for the foreseeable consequences. Richard McCormick accepts a somewhat Proportionist approach in making decisions in clinical situations—more than “a simple utilitarian calculus” but “more fruitful and Christian than deontology would allow us.”[25] Charles Curran argues for what he describes as a Theory of Compromise. He distinguishes absolute natural law from relative natural law. Absolute natural law is based on the “ontological, abstract human nature.”[26] Relative natural law is based on the actual reality of the human situation. In morally dilemmatic situations, the abstraction of absolute natural law is applied differently in different situations.[27] Not only must the validity of a norm for the individual be assessed, but its applicability in the knowledge of the features of the actual situation must be brought into consideration.[28] In a similar vein, Carol Gilligan emphasizes "responding to the particularities of the other person and of the concrete circumstances of their situation."[29]

In our contemporary era, widespread increase in technology available in the world, especially in terms of internet and television communication, imparts a substantially more disseminated knowledge of different cultures and ways of living. Widespread immigration exacerbates a pronounced pluralism and fragmentation, with increased tension amongst society's members following upon different life-views and value-constructs. Hence, in our current era, there is an awareness of a multiplicity of "truths," each of which is viewed from the individual's perspective.

We argue, therefore, that clinicians need to move away from an over-dependence on substantive frameworks or principles derived from them, towards a procedural framework, framed here as *Proportionism*. In a Proportionist approach, the clinical decision making is set in the context of this particular patient, in her actual situation. The empirical, greatest Good, utilitarian option is balanced by a proportional awareness of fundamental *a priori* rules. A rules-based decision is balanced by an appropriate proportion of empirical utility situation awareness. A Proportionist approach allows for tolerance of anomalous positions in an ethical dilemma where interpretations offered by both the deontological and the teleological frameworks are valid, but both need to be moderated and made complete by an empathic, compassionate, caring, self-insightful, and virtuous clinician in communicative discourse with the participants in the dilemma. Thus, together, in the language of the virtue ethical framework, they achieve practical wisdom in order to impel practical action which results in the flourishing of all in the discourse.

Two clarifications must follow. First, the substantive frameworks and principles are clearly of value in moral decision making. It is a question of balancing them, seeking to maximize the virtue in the decision to be made. Sometimes the balance will lean towards deontological rules, and sometimes towards teleological utility. Sometimes the balance will lean towards autonomy, and sometimes towards beneficence. For example, consider the situation where the exact location of a bomb outside a civic building could be revealed by torturing a suspected terrorist. The deontological maxim "do not torture human beings" makes torture impermissible in any situation. The teleological "greatest good for the greatest number" calculation will make torture of one permissible in order to save many. There needs to be dialogue about where the balance lies in this particular situation. The location of the balance-point, and hence the actual decision made, will clearly vary depending upon whether the situation is that the bomb is an explosive device liable to destroy the building and kill many people, versus the situation where the bomb is filled with indelible paint and likely simply to splatter the building and people outside.[30] As well, if clinicians and patients are to compare different values, the substantive ethical frameworks are useful to provide a conceptual understanding, and perhaps weighting of the values as ethical imperatives.

Second, the Proportionist approach, aware of the context of the clinical decision and sensitive to the need for dialogue amongst those affected by the decision, is not saying that morality is simply relativism or subjectivism. The substantive frameworks of deontology and teleology set the foundations from which the discussion begins. For example, in the case of a baby born with anencephaly, the deontological rule states that it is impermissible to actively kill the baby at birth. Dialogue about morally good options begins from this point.

Terence Lovat allows that deontologists may be unhappy with the Proportionist approach for "purporting to posit universal determinants that are in fact malleable to the situation at hand," and teleologists may be dismayed that "however rigorous the process and clear the result, [it] is liable to modification by insertion of the apparently mystical."[31] That is, clinicians should aim for "a balancing of universals . . . with the culturally contingent exigencies of the particular situations" of which we, as clinicians caring for patients, are an intrinsic part.[32]

Hence it follows that moral decision making in clinical situations requires a dialogue in order to fully understand the clinical setting of the particular patient and her illness. Elucidation of the social, moral, and religious principles important to the patient and the relatives involved is required. As well, it is necessary to come to understand the concrete realities of the illness at hand for this patient—including the nature of the disease itself and its prognosis, as well as contingent circumstances and values.

The Proportionist Approach in Practice

The wisdom in the Proportionist approach as a framework for making moral decisions in clinical situations is that it allows for a balanced weighing-up of absolute rules and relative consequences, aware of context. The process-centered understanding of Jürgen Habermas' discourse theory of morality and communicative action is one method of empowering the Proportionist approach so that it might be implemented in practice in clinical situations. Implicit and explicit recognition of inter-subjectivity is important.

Habermas' discourse theory of morality requires that the consequences for all persons affected must be considered. His principles of communicative action imply that discourse is based upon consensus, subsequent to inclusive and non-coercive reflective dialogue, conceived by him as "an intermeshing of the perspective of each with the perspectives of all."[33] Rather than appeal predominantly to a substantive ethical framework, or to principles derived from them, Habermas argues in favor of appeal to a process of dialogue and argumentation in order to answer the practical questions of moral decision making. Historically, George Herbert Mead's theory of social consciousness was also based upon inter-subjective relationships, as an extension of Kant's universalizability premise as the basis for moral decision making, via considering all interested parties impartially.[34] Habermas captured Kant's principle of the universalizability of his categorical imperative and widened its social applicability by reformulating it in his discourse theory of morality as requiring that *all* affected people must be able to agree that it is universalizable.[35] Kant's generalizability criterion gestures towards incorporating others, but Habermas' discourse theory of morality embodies it.

The dialogue which follows is predicated upon principles of communicative action. An individual clinician cannot, monologically, determine an ethical norm which is applicable to her patient. Nor, in a more nuanced understanding of autonomy,[36] is it ideal for an individual patient to make exclusively monological decisions, even about themselves, which will deleteriously impact upon those significant others who care for them.

In communicative action, speech and non-verbal actions are orientated to understanding, ultimately aiming to achieve consensus in a context in which all involved have an equal opportunity to contribute.[37] Habermas identifies the four most important presuppositions of the discourse as: inclusiveness, so that anyone who can make a relevant contribution is included; equal rights of all participants to engage in communication and contribute; absence of deception; and absence of coercion.[38] Assumptions underlying the discourse dictate that each participant mutually considers each other to be accountable; additionally, they mutually consider each other ready and willing to reach mutual understanding—by which he means that each acts so as to aim to reach consensus.[39]

In other words, since actual people are in a clinical situation, actual people need to dialogue in order to determine what matters to them, and so clinician and patient, together, should make the morally best decision in the situation in which they actually find themselves. The basis for hermeneutic understanding is reciprocal dialogue, wherein "all parties are open to one another and prepared to listen and change."[40] Undoubted practical difficulties in achieving the ideal dialogue notwithstanding, this process has both applicability and merit for moral decision making in clinical contexts.

Conclusion

In the complex world of moral decision making, within a society reflective of increasingly sociological, cultural, and religious diversity, a Proportionist approach balances *a priori* rules with empirical consequences. It allows for tolerance of anomalous positions in a moral dilemma. The *telos* of medicine is the Good of the patient, so the process begins from understanding the actual reality of the individual patient and the setting of her illness.

Habermas' discourse theory of morality generalizes and expands the Kantian categorical imperative, as determined by ethical monologue, to a wider consensus-seeking dialogue. Thus, consensual agreement is reached about what constitutes morally good action. Relocating ethical decision making from a monological space into one characterized by dialogue is especially appropriate to the clinical encounter. Inter-subjective contextual interpretation is incorporated via a process of reflective discourse. Thus, unforced consensual agreement is reached about what constitutes morally correct action in a given situation. The Proportionist framework is favoured here as the most apposite means for moral decision making in clinical settings.

Acknowledgements

We are grateful for the suggestions of two anonymous reviewers.

References

1. Beauchamp TL and Childress JF. (2009) *Principles of biomedical ethics*, New York: Oxford University Press.

2. Maritain J. (1964) *Moral philosophy: An historical and critical survey of the great systems,* London: Geoffrey Bles.
3. Ramsey P. (1970) *The patient as person,* New Haven: Yale.
4. May W. (1987) The profession and its integrity. In: Lammers S and Verhay A (eds) *On moral medicine.* Grand Rapids IN: Eerdmans.
5. Donaldson TM. (2012) *Ethical resources for the clinician: Principles, values and other theories.* Available at: http://www.intechopen.com/books/contemporary-issues-in-bioethics/ethical-resources-for-the-clinician-principles-values-and-other-theories, 23.
6. Lovat T. (2006) Practical mysticism as authentic religiousness: A Bonhoeffer case study. *Australian eJournal of Theology* 6: 1-11.
7. Singer P. (1979) *Practical ethics,* Cambridge UK: Cambridge University Press.
8. Singer MG. (1961) *Generalizations in ethics,* New York: Knopf.
9. Annas J. (1993) *The morality of happiness,* Oxford: Oxford University Press.
10. Swanton C. (2005) *Virtue ethics: A pluralistic view,* Oxford: Oxford University Press.
11. Pellegrino E. (2007) Professing medicine, virtue based ethics, and the retrieval of professionalism. In: Walker RL and Ivanhoe PJ (eds) *Working virtue : Virtue ethics and contemporary moral problems.* Oxford: Oxford University Press, 328.
12. Pellegrino ED. (2013) Moral choice, the good of the patient, and the patient's good. In: Moskop JC and Kopelman LM (eds) *Ethics and critical care medicine.* Dordrecht: D Reidel Publishing, xx, 236.
13. Aristotle. (1952) Nicomachean ethics. *The works of Aristotle Volume II.* first ed. Chicago: William Benton, Encyclopaedia Britannica Inc.
14. Pellegrino E. (2007) Professing medicine, virtue based ethics, and the retrieval of professionalism. In: Walker RL and Ivanhoe PJ (eds) *Working virtue : Virtue ethics and contemporary moral problems.* Oxford: Oxford University Press, 328.
15. Pellegrino ED. (2013) Moral choice, the good of the patient, and the patient's good. In: Moskop JC and Kopelman LM (eds) *Ethics and critical care medicine.* Dordrecht: D Reidel Publishing, xx, 236.
16. Gelhaus P. (2012) The desired moral attitude of the physician: (III) care. *Medicine, Health Care and Philosophy* 16: 125-139.
17. McDougall R. (2007) Parental virtue: A new way of thinking about the morality of reproductive actions. *Bioethics* 21: 181-190.
18. Childress JF. (1989) The normative principles of medical ethics. In: Veatch RM (ed) *Medical ethics.* Boston: Jones and Bartlett Publishers, 27-48.
19. Gillon R. (2003) Ethics needs principles - four can encompass the rest - and respect for autonomy should be "first among equals". *Journal of Medical Ethics* 29: 307-312.
20. Mill JS. (1952) On Liberty. *American State Papers, The Federalist, On Liberty, Representative Government, Utilitarianism* first ed. Chicago: William Benton, Encyclopaedia Britannica Inc, 267-326.
21. Walker P, Lovat T, Leitch J, et al. (2014) The moral philosophical challenges posed by fully implantable permanent pacemakers. *Ethics and Medicine* 30: 157-165.
22. Engelhardt HT. (1996) *The foundations of bioethics,* New York: Oxford University Press.
23. Godwin W. (1976) *Enquiry concerning political justice and its influence on modern morals and happiness,* Harmondsworth: Penguin.
24. Fletcher J. (1966) *Situation ethics: The new morality,* London: SCM Press.
25. McCormick RA. (1973) *Ambiguity in moral choice,* Milwaukee, Wis: Marquette University Press.
26. Curran CE. (1979) Transition and tradition in moral theology. London: University of Notre Dame Press, xiv, 255.
27. Ibid.
28. Habermas J. (1993) *Justification and application: Remarks on discourse ethics,* Cambridge: Polity Press.
29. Thomassen L. (2010) *Habermas: A guide for the perplexed,* London: Continuum International.

30. Conway P and Gawronksi B. (2013) Deontological and utilitarian inclinations in moral decision making: A process dissociation approach. *Journal of Personality and Social Psychology* 104.
31. Lovat T. (2004) Aristotelian ethics and Habermasian critical theory: A conjoined force for proportionism in ethical discourse and Roman Catholic moral theology. *Australian eJournal of Theology* 3: 1-14.
32. Lovat T and Gray M. (2008) Towards a proportionist social work ethics: A Habermasian perspective. *British Journal of Social Work* 38: 1100-1114.
33. Habermas J. (1993) *Justification and application: Remarks on discourse ethics,* Cambridge: Polity Press.
34. Rasmussen DM. (1990) *Reading Habermas,* Cambridge Massachusetts: Basil Blackwell.
35. Habermas J. (1990) *Moral consciousness and communicative action,* Cambridge: Polity Press.
36. Walker P and Lovat T. (2014) Concepts of personhood and autonomy as they apply to end-of-life decisions in intensive care. *Medicine, Health Care and Philosophy* 18: 309-315.
37. Scambler G. (2001) Introduction: Unfolding themes of an incomplete project. In: Scambler G (ed) *Habermas, critical theory, and health*. London: Routledge, 1-24.
38. Habermas J. (2008) *Between naturalism and religion: Philosophical essays,* Cambridge UK: Polity Press.
39. Habermas J. (2001) *On the pragmatics of social interaction: Preliminary studies in the theory of communicative action*, Cambridge, Mass: MIT.
40. Habermas J. (1990) *Moral consciousness and communicative action,* Cambridge: Polity Press.

Paul Walker, MBBS, PhD, FRACS, FACS, is a member of the Clinical Unit in Ethics and Health Law at the University of Newcastle, NSW, Australia, and a member of the Royal Australasian College of Surgeons Ethics Committee. He is a surgeon in Newcastle, NSW, Australia.

Terence Lovat, BTh, BLitt, BEd, MA, ThM, PhD, is Emeritus Professor in the area of Philosophy, Religion and Theology at the University of Newcastle, NSW, Australia, and Senior Research Fellow at Oxford University, UK. He currently resides in Newcastle, NSW, Australia.

VOL. 32:3 FALL 2016

THE DIFFERENCE BETWEEN MORAL STATUS AND MORAL VALUE APPLIED TO THE ETHICAL EVALUATION OF THE USE OF HIPS CELLS

GLORIA CASANOVA, PHD; LUCÍA GÓMEZ-TATAY, MS; JUSTO AZNAR, MD, PHD

Abstract

In 2009 two studies were published in which living mice were obtained from induced pluripotent stem (iPS) cells derived from mouse fibroblasts. The technique employed was tetraploid complementation. It consists in the production of a tetraploid cell by fusing the two cells of a two-cell embryo and its injection with iPS cells at the morula/blastocyst stage. Then, the tetraploid embryo activates the reprogramming process and the iPS pluripotent cells become totipotent cells, able to develop in the same way as embryonic cells do. This fact has raised ethical concerns about the use of hiPS cells for biomedical purposes. Some authors have considered hiPS cells as a kind of primordial individual human life. If so, they would have a moral status equal to that of human zygote and would deserve the same respect. In this paper we argue against this idea on the basis of the distinction between moral status and moral value. Moral status is inherent to the nature of the organism and will accompany it until it is denatured and stops being what it is. Moral value is relative; it suits to adjective realities, not to substantive ones. For this reason the human zygote has a certain moral status, while hiPS cells have a moral value. However, cells resulting from the injection of hiPS cells into tetraploid embryos are worthy of the same respect due to the embryo resulting from fertilization, since they can develop as a human individual. Thus, these cells have a biotechnologically induced moral status.

Keywords: HiPS cells; Moral status; Moral value

Introduction

There is no doubt that embryonic stem cells are an excellent biological material for biomedical research. However, their use poses ethical problems, since the human embryos from which they come must be destroyed in order to obtain these cells. For this reason their use is ethically controversial.

This ethical problem has been largely solved due to the development of adult somatic cells reprogramming and the achievement of induced pluripotent stem (iPS) cells.[1,2] These cells are pluripotent stem cells capable of giving rise to many different cell types.[3,4,5] IPS cells are obtained from adult somatic cells through what is known as cellular reprogramming, which involves the dedifferentiation of the somatic cell by expressing four exogenous genes (Oct4, Sox2, c-Myc and Klf4) (although they can also be obtained by other means), which are usually introduced using a retrovirus, leading the cell to a pluripotent state.

However, an ethical reflection that raises questions on the use of human iPS (hiPS) cells has now been published in the *Journal of Medical Ethics*.[8] According to this paper, hiPS cells would have a moral status almost equal to that of a human zygote. If so, an ethical difficulty would be added for the use of these cells in biomedical experiences, since their destruction would involve destroying a human life.

This approach seems to require further reflection. When reprogramming of adult somatic cells was proposed by Yamanaka,[1] the process of cellular dedifferentiation finished when pluripotent cells, not totipotent cells, were obtained, i.e., the reprogramming of adult somatic cells should stop before reaching a type of cell that might give rise to a whole being of that species. In this case, no one would attribute a moral status similar to that of the blastocyst to the obtained pluripotent hiPS cells, and they could be used without any ethical objections.

However, Sawai[6] raises the possibility of attributing to hiPS cells a moral status similar to that of the early human embryonic cells, when the former are used in the so-called tetraploid complementation.[6] We will dedicate our reflection to evaluate this proposal.

Tetraploid Complementation Technique

This technique is now proposed to derive living beings from iPS cells. A very early stage normal embryo is manipulated to obtain a tetraploid embryo, whose cells have four copies of each chromosome, instead of the two copies in normal cells. However, this tetraploid embryo can only develop to the blastocyst stage. Then it can only lead to extra-embryonic tissue (placenta, etc.). For this reason, the tetraploid embryo is injected with iPS cells (which are diploid). The resulting organism will be a clone of the individual from which the somatic cells were obtained.

Two studies have been published that have used this technique to obtain living animals. In the first,[7] 37 iPS cell lines were produced from mouse fibroblasts and 10 to 15 cells from each cell line were injected to a different tetraploid blastocyst. A total of 848 blastocysts were injected. Viable offspring was obtained only from 3 of the lines, finally achieving 27 live mice, some of which matured and were reproductively competent, while others died shortly. In the second experiment,[8] 5 iPS cell lines were obtained, from mouse fibroblasts too. Also around 10 to 15 cells from each line were injected into a different tetraploid blastocyst, injecting a total of 387 blastocysts. Four mouse pups, of which only one survived to adulthood, were obtained. Interestingly, all came from the same cell line. For this reason the authors believe that it would be premature to make assumptions based on these results about whether iPS cells in general are functionally equivalent to embryonic stem cells.

However, we find it necessary to carry out an ethical reflection on the use of hiPS cells for these purposes.

Biological Nature of HiPS Cells and Their Ethical Implications

The reprogramming of adult cells was proposed by Yamanaka,[1] mainly in order to solve the ethical problems posed by the use of embryonic stem cells. The Japanese author stated it in an interview in *The New York Times* (M. Fackler *The New York*

Times 11-XI-2007),[13] in which he explained the reasons that led him to start his research into reprogramming of adult somatic cells.

Takahashi and Yamanaka achieved this by stopping cell dedifferentiation at a pluripotent stage, that is, avoiding the production of totipotent cells. Consequently, the feature that essentially defines hiPS cells is their pluripotency.

But what about hiPS pluripotent cells when used in the technique of tetraploid complementation? When hiPS pluripotent cells are injected into the tetraploid embryo, this activates the reprogramming process so that the pluripotent hiPS cells become totipotent cells, i.e., quasi-embryonic cells. If these cells are allowed to develop, they can produce a living embryo, as the experiments demonstrate.[7,8]

The term “totipotent” is used in the scientific literature in two radically different ways. The strict sense of totipotency refers to a one-cell embryo or zygote that is “capable of developing into a complete organism.” The second, weaker sense of totipotency refers to the ability of a cell to differentiate into any of the cells or tissues of the body, including cells of the placenta. A zygote is “totipotent” in both senses, yet iPS cells are “totipotent” only in the second sense.[9]

Therefore, we think that we can attribute a certain moral value to those totipotent cells that can lead to a living being in certain circumstances. But we believe that no moral value can be attributed to hiPS cells themselves, since they cannot generate a living being. In fact, they were created for this not to happen. This is what determines the ethics of their use in all circumstances. In short, we are of the opinion that attributing some moral value to hiPS cells is unjustified, and it is consequently meaningless to question the use of these cells for ethical reasons, as Sawai proposes.[6]

Relevance of Totipotentiality in Determining the Value of the HiPS Cells Cultured in Vivo

Sawai raises the possibility of extending the respect due to the human zygote to hiPS cells, seeing in these a kind of primordial human life, precursors of human embryonic and fetal life. This draws attention to the way of looking at hiPS cells as biological material for experimentation, with a merely instrumental value.[6]

This consideration is justified by the existence of the tetraploid complementation technique already mentioned, which could produce full human individuals from hiPS cells. These hiPS cells, once grown in vivo, reach the characteristics of embryonic totipotent cells, being more similar to them than to hiPS cells cultured in vitro.[10] In this regard, some investigators have demonstrated the paradoxical ambivalence of hiPS cells, since, depending on the environment in which they grow (i.e., in vitro or in vivo), they remain pluripotent cells or become totipotent cells, capable of giving rise to full human beings.

This has led some authors to wonder if what we call hiPS cells are not, rather, induced totipotent stem cells:

> If it is ultimately the technique that defines the status of the cell (as in Brüstle vs. Greenpeace case), it seems clear that in vivo iPS cells should be considered to be pluripotent cells. But, in doing so, are we committing a nominalist mistake that in the long term might have unanticipated consequences? If these cells include features

> of totipotency, should they be identified and defined as such? Or will there arise a need for an intermediate term characterizing those cells whose characteristics land between pluri- and totipotency?[10]

Sawai points out that "if the tetraploid embryos, injected with hiPSCs, were in a uterus—human or, in the future, artificial—, they would develop into human embryos, fetuses and mature human beings."[6] Thus, if it is the case that technology is intended to be used in this way, the hiPS cells employed can be considered as potential humans, "the buds of human life."[6] If hiPS cells can be considered as *germinal human life*, then they cannot be treated in a merely instrumental way and should be protected by law, not meaning that they must be treated with the same respect as adult humans.[6]

In order to assess the moral implications of this fact, Sawai quotes the distinction between *moral status* and *moral value* made by Steinbock,[11] according to which *moral status* can be ascribed only to sentient beings, since only sentient beings can have the required interests. On the contrary, *moral value* is the moral rank corresponding to a broader class of entities, such as human embryos or the American flag for American citizens, entities to which humans feel some kind of respect, hesitating to treat them as mere things.[6]

Sawai concludes that, since hiPS cells can be regarded as *germinal human life*, they have *moral value*, and thus they should receive the same respect as the human zygote, which does not mean, for this author, that they should not be used in investigation. Their use should, though, be regulated.[6]

But we wonder how realistic it is to use the sentience criteria to determine the moral status of an individual life. In our opinion, the fact of existence is the most relevant criterion to determine the moral status/value of an entity. We think that prior to the question about sentience life it is the question of the level of autarky of that life, because sentience may come and go without causing death. On the contrary, biological autarky determines the difference between life and death. That means that autarky is determinant on defining the type of life we are considering (i.e., whether it is an alive individual or just a group of living cells). We will return to this topic below.

However, we believe that the human embryo is not a precursor of human life, but a human individual itself, since it is able to develop to the fetal state, childhood, adulthood, and old age in a vital continuum. In this way, adult life is the same life that long ago was in its embryonic state, and it is also the life that over time reaches the state of old age. HiPS cells, on the contrary, are not totipotent. They must be injected in a preexisting embryo (i.e., tetraploid embryo) in order to take charge of its development into a fetus and the later vital stages. Thus, hiPS on their own are more comparable to human gametes than to human embryos. Neither hiPS cells nor gametes are human individuals: they are *human life*, not *human lives*, that is, they are not yet human individuals, but only certain biological precursors of human individuals. HiPS cells can be considered precursors of individual human life as gametes, which are human life but not complete human individuals, that is, human organisms whose biological structure makes them able to grow, develop, and reproduce. Therefore, their use in research does not pose ethical problems, similar to what happens with the use of gametes.

In this regard, we agree with Devolder when she states that "just because something has the potential to become something different, we should not regard it as if it has already realized that potential,"[12] and gives as an example that every living being is potentially dead, but we ought not to treat it as such. It is important to consider that the potential which Devolder attributes to hiPS cells is not of the same nature as embryonic potential, taking into account the distinction between *indirect possibility* and *direct* or *real possibility.* The totipotency of hiPS cells can be seen as an indirect possibility, that is, a possibility that is necessarily dependent on an externally induced alteration, which is biotechnologically generated, so that without an external human intervention that possibility would never be activated. By contrast, embryonic totipotency is a direct or real possibility of reaching the different stages of development; it is a naturally constitutive possibility of this biological entity, so that it naturally produces its effect, that is, without external intervention. In other words, a human embryo is a person with potential, while hiPS cells have the potential to become a person if injected in a human tetraploid embryo. Here it is important to notice that the tetraploid embryo is a person whose potential to develop has been biotechnologically inactivated (i.e., destroying its life). This fact is an unbridgeable ethical difficulty of the application of the tetraploid complementation technique, regardless the moral value of hiPS cells.

Relevance of Autarky in Determining the Moral Value of the Cell Type Resulting from in Vivo Culture of HiPS Cells

In any case, we must wonder about the moral rank of the new cell type obtained by cultivation of tetraploid embryos injected with hiPS cells. These cells have a fully totipotent character, which is not the virtually totipotent character that hiPS cells had, from which they come.

It seems appropriate to define the nature and value of these cells in their capacity of self-development and self-government, what makes them capable of generating a complete individual. The totipotency of the aggregate of cells resulting from in vivo culture of hiPS cells is similar to that of the blastocyst resulting from the fusion of gametes. Therefore, it can be said that the totipotency of this type of hiPS cells is indicative of a human life, since they will divide and differentiate in a vital continuum, giving rise to the different stages of human development. Therefore, they are worthy of the same respect due to the human embryo.

However, it is important to notice that we are determining the moral rank of the aggregate of cells as a whole, not individually. It is again the difference between *mere* human life and *a* human life, that is, the difference between biological structures not in process to develop into a human individual and biological structures that may be considered as complete human individuals as far as they are able to grow as such and reproduce as such. The life of a human skin cell has no individuality, because if separated from a human individual it is denatured and dies. It is not sufficient itself to live. By contrast, the living human individual represents an organic system able to manage its own life; it does not need to be part of another organism in order to live, although it depends on its environment, which in its early stages of development is the maternal organism.

Once it has been explained that the moral rank of this cell aggregate is the same as that of the embryo, it seems appropriate to make some specifications in this regard. To our knowledge, statute (statūtum, law) indicates how something should be treated according to its nature. Therefore, the *moral status* of an organism is a determination that will accompany it until it is denatured and stops being what it is. The *moral status* of the human individual will accompany it from the beginning of its life until its death. On the contrary, the *moral value*, unlike the moral status, suits to adjective realities, not to substantive ones.

Therefore, it seems more appropriate to say that the human zygote and the aggregate of cells cultured in vivo has a certain *moral status*, while its precursor biological forms—gametes/hiPS in vitro—have a *moral value*. In conclusion, cells resulting from in vivo culture of hiPS cells are worthy of the same respect due to the embryo resulting from fertilization, and that is due to their real and direct capacity—the same as an in vitro human embryo—to develop as a human individual. These cells would have, so to speak, a moral status biotechnologically induced.

Endnotes

1. Takahashi K, Yamanaka S. Induction of pluripotent stem cells from mouse embryonic and adult fibroblast cultures by defined factors. Cell 2006;126:663-76.
2. Takahashi K, Tanabe K, Ohnuki M, et al. Induction of pluripotent stem cells from adult human fibroblasts by defined factors. Cell 2007;131:861-72.
3. Grskovic M, Javaherian A, Strulovici B, et al. Induced pluripotent stem cells — opportunities for disease modelling and drug discovery. Nat Rev Drug Discov 2011;10:915-29.
4. Tiscornia G, Vivas EL, Izpisúa- Belmonte JC. Diseases in a dish: modeling human genetic disorders using induced pluripotent cells. Nat Med 2011;17:1570-6.
5. Zhu H, Lensch MW, Cahan P, et al. Investigating monogenic and complex diseases with pluripotent stem cells. Nat Rev Genet 2011;12:266-75.
6. Sawai T. The moral value of induced pluripotent stem cells: a Japanese bioethics perspective on human embryo research. J Med Ethics 2014;40:766–9.
7. Zhao XY, Li W, LV , et al. iPS cells produce viable mice through tetraploid complementation. Nature 2009;461:86–90.
8. Kang L, Wang J, Zhang Y, et al. iPS cells can support full-term development of tetraploid blastocyst-complemented embryos. Cell Stem Cell 2009;5:135–8.
9. Condic ML. Totipotency: What It Is and What It Is Not. Stem Cells Dev. 2014 April 15; 23(8): 796–812.
10. Meskus M, de Miguel Beriain I. Embryo-like features of induced pluripotent stem cells defy legal and ethical boundaries. Croat Med J 2013;54:589-91.
11. Steinbok B. Moral Status, Moral Value, and Human Embryos: Implications for Stem Cell Research. In: Steinbok B. The Oxford Handbook of Bioethics. Oxford: Oxford University Press 2007:416-40.
12. Devolder K. To be, or not to be? Are induced pluripotent stem cells potential babies, and does it matter? EMBO Rep 2009;10:1285-7.
13. “When I saw the embryo, I quickly realized that there was no difference between it and my daughters. I thought that we cannot afford destroying embryos for our research. There must be another way.”

Corresponding author: justo.aznar@ucv.es

Gloria Casanova, PhD, is currently a member of the Bioethics Observatory and Professor of Bioethics at the Catholic University of Valencia, "San Vicente Mártir," and at Pontifical John Paul II Institute for Studies on Marriage and Family at its Spanish Section. Her dissertation focuses on the ethics of human relationships and its biotechnological context. She currently resides in Valencia, Spain.

Lucía Gómez-Tatay, MS, is currently a PhD student and member of the Molecular and Mitochondrial Unit and the Bioethics Observatory, Catholic University of Valencia, "San Vicente Mártir." Her dissertation focuses on the ethics of Synthetic Biology. Her other areas of interest include ethics of mitochondrial replacement, iPS cells and practical application of Personalism to ethical analysis. She currently resides in Valencia, Spain.

Justo Aznar, MD, PhD, is currently director of the Institute of Life Sciences at the Catholic University of Valencia, "San Vicente Mártir." He is a member of the Pontifical Academy for Life. He is former head of the Department of Clinical Pathology at the University Clinical Hospital La Fe, Valencia, Spain, and director of the Biochemistry Research Unit of this hospital. He currently resides in Valencia, Spain.

The infertility industry has a dirty little secret.

eggsploitation

A FILM by THE CENTER FOR BIOETHICS AND CULTURE

Thinking about donating your eggs? Think again.

The infertility industry in the United States has grown to a multi-billion dollar business. What is its main commodity? Human eggs. Young women all over the world are solicited by ads—via college campus bulletin boards, social media, online classifieds—offering up to $100,000 for their "donated" eggs, to "help make someone's dream come true." But who is this egg donor? Is she treated justly? What are the short- and long-term risks to her health? The answers to these questions will disturb you...

EGGSPLOITATION spotlights the booming business of human eggs, told through the tragic and revealing stories of real women who became involved and whose lives have been changed forever.

www.eggsploitation.com

THE CENTER FOR BIOETHICS AND CULTURE presents "EGGSPLOITATION"
Executive Producer JENNIFER LAHL Directed by JUSTIN BAIRD and JENNIFER LAHL
Edited by JUSTIN BAIRD Written by JENNIFER LAHL and EVAN C. ROSA
COLOR | RUNNING TIME APPROX. 45 MINUTES

Human Enhancement, the Person, and Posthuman Personhood

GRZEGORZ HOLUB, STM, PHD

Abstract

This article examines the problem of enhancing human beings and the possibility of making them into posthuman persons. I begin by presenting the major ideas of the project and their corresponding implementations. Then I consider the significance of these ideas from two different conceptions of the person, namely the naturalist and the personalist. Finally, I review the ethical projects associated with naturalism and personalism in an attempt to determine the emergent moral questions that arise when the two confront the possibility of human enhancement. These positions differ substantially in terms of their assessment of various interventions as permissible or ethically praiseworthy. Despite the major advancements in genetic technology that can make such interventions possible, we are still divided by basic understandings of who we are, whom we want to become, and what human goods should be promoted. At any rate, we cannot sideline these important humanist considerations.

Key words: Human enhancement; Person; Posthuman person; Naturalism; Personalism

Introduction

Discussion of human enhancement is already well under way, as it raises the interest of both the general public as well as the professional scholar. Concerning the latter, there are a good number of philosophers presently engaged in the debates on human enhancement. As a consequence, many scholarly articles are published in an attempt to investigate the possible influence of such intervention on various aspects of human lives and wellbeing. Strangely enough, these papers are advanced even though very few of the discussed innovations can be successfully implemented in practice. Thus, the whole issue may seem a part of futurology. Even without considering their veracity, it must be said that many ideas constituting particular debates are worthy of serious attention. One such idea is that of prolonging and changing human life to the point of questioning whether the resulting creature is still a human being, or more particularly, a human person. For the sake of our inquiry, we can assume at the very outset that a kind of posthuman person is possible at a certain point in the process of enhancing members of our species. If in a well-established philosophy of the person there is a place for discussing non-human persons (e.g. angelic, divine), there should be also a place for talk about “more advanced” posthuman persons. What they might be like in their entirety is, to a considerable extent, a matter of speculation, although we can ascribe to them some characteristics right now.

After some preliminary remarks regarding human enhancement, I first will sketch out the views of several proponents of this activity concerning a prolongation and betterment of human life leading to a so-called posthuman personhood. Second, I will point towards some difficulties associated with these ideas. Third, I will consider two versions of personhood which possibly come into play, namely the naturalist and the personalist. Finally, I will draw some ethical conclusions from these scientific, metaphysical, and anthropological investigations.

Toward Making Better People

At the beginning of our investigation, we should classify the various enhancing interventions. From a general point of view, we must point to a certain kind of logic that operates in all enhancement projects, namely the move from "good" to "better," that is, the move from a good state of human existence to a better one. However, from a wider perspective, we must also include an earlier move from "bad" to "good." Thus the elimination of undesirable states of health, pathological states, and any improvements will fall within our range of interest. Torbjörn Tännsjö covers each of these moves: He points to *negative* interventions aimed at curing a disease or eliminating a handicap; *positive* interventions directed at improving "the functioning of a human organism within a natural variations"; and *enhancing interventions*, which concentrate on taking an individual beyond the normal functioning of a human organism (Tännsjö 2009: 316). Although only the latter two seem to have a clearly ameliorating character, there are also negative interventions which can overlap with, to some extent, positive as well as enhancing ones.[1] But let us accept Tännsjö's distinction for the sake of present analyses, because it seems sufficient for the issues we want to investigate in this paper.

What are technical ways to implement these enhancement-oriented goals? Let us point to some generally agreed upon standards which are typically included in the enhancement debate. Simply stated, given procedures can be applied at all stages of human life, but the earlier the intervention, the better. Thus, while gene therapy can be used successfully on adult individuals to modify their genetic makeup, gametes and early embryos are better candidates to implement desirable change via genetic engineering (reason: they are not particularly complex and are relatively easy to manipulate). These interventions consist in replacing a so-called "bad" gene with a "good" one, or a "good" one with a "better" one. The aim is to create the best possible chromosome, which will bring with it the guarantee of a desired phenotype. Moreover, it becomes possible to speculate the creation of an artificial chromosome with the genes required to obtain radical enhancement and add this new structure to an existing natural one (Stock 2002: ch. 4; Agar 2010: 29). Also, among other proposals, some bioethicists discuss transforming human reproductive systems in such a way that they secure production of desirable (upgraded) reproductive cells (Bostrom, Savulescu 2009: 10).

Further undertakings within human enhancement include regenerative medicine associated with manipulation on a genotype of cells and so-called nano-medicine. For instance, successful recreation of vital organs (reared from stem cells) combined with a switching-off of genes responsible for the aging process can substantially contribute to a prolongation of human life. It will be a clear sign that we have reached a stage of enhanced individuals if, due to this modification, we are able to live 300 years or more (Harris 2007: 52). Nano-medicine, stemming from the growing domain of nanotechnologies, is not yet available and so remains a project for the future. What we can tell about it now is that nano-robots the size of bacteria can be introduced into the human organism as devices that monitor and repair damaged cells and tissues. Thus, if successful, they too will contribute to longer and healthier lives (O'Mathúna 2009: 128-157).

Enhancing human beings also involves an attempt at changing the human psyche. Of course, we can expect that replacing genes will affect the human psyche as a side effect, but then we have very limited control over it. What is needed is a set of more direct interventions such as those already in use. There are a good number of various drugs that influence the human psyche, such as performance-enhancing drugs and mood- or attention-altering agents. Moreover, Julian Savulescu notes that our human psyche and mental attitude can be substantially affected through the employment of the fruits of neurosciences and computing technology. His reasoning is as follows:

> neuroscience, together with computing technology, offers radical opportunities for enhancing cognitive performance. Already, chips have been introduced into human beings for purposes of tracking and computer-assisted control of biological functions. Minds are connected through the internet and there may be no barrier in principle to direct mind-reading and thought-sharing across human minds. Uploading of human minds to artificially intelligent systems represents one of the most radical possibilities for human development. (Savulescu 2009: 214)[2]

An enhanced person—as it is predicted by adherents of the human enhancement project—will live longer and be healthier and more advanced in her mental and personality characteristics. We can easily imagine, for example, someone who lives longer and in better health because we are witnesses to such constant medicinal improvements even within our lifetime. It is harder to imagine someone who is much more advanced in psychological and personality traits. However, we may borrow some examples from the world of computers or robots to visualize such changes. Insofar as Ray Kurzweil presents his idea of uploading of the person, he assumes that the latter can be made first into a large bulk of information, and second, recorded to a computer hard drive, then refined and improved. Recognizing that new and improved generations of computers appear continuously,[3] we may imagine this bulk of information undergoing a consequent and continual refinement and perfection. This process can be greatly aided through the presence of artificial devices and chips in the human body. Replacing natural organs (e.g. the parts responsible for higher brain functioning) with artificial ones—which transhumanists consider both a natural and inevitable process—will result in a greater availability of information. Artificial organs, especially the brain, are easier to scan, and so the resultant creature-cyborg, made up of many such elements, is made more conducive to scientific investigation.

Finally, when the processing and perfecting of this human information reaches a level millions of times higher than the intelligence of present humans, it will be downloaded into a new vessel such as a silicon body. Such a creature is so far advanced that it must be considered to belong to an entirely different species. Kurzweil tries to show the gulf that separates Homo sapiens from those new posthuman creatures. He claims that it can be compared to the gulf between presently living humans and bacteria. Inasmuch as the latter are unable to understand us, neither can we comprehend the character of posthuman persons (Kurzweil 2006: 297ff).

The views presented above, however, are problematic not only from a scientific point of view but also from a philosophical standpoint. First, in this scenario there are many strong claims which are difficult to verify. For instance, we do not know whether the sciences will ever allow us to go so far as to radically improve the functioning of our bodies. We do not know whether a switching-off of genes responsible for aging processes will ever be possible and, if so, whether it will guarantee the longevity of the somatic cells.[4] Furthermore, doubt exists regarding the possibility of scanning the richness and complexity of personal life into a set of information. Even if we succeeded in scanning particular somatic cells (including neural cells), it would be much harder to acquire information concerning the more complex systems of our body, e.g. systems responsible for social subconsciousness (see Tonn 2011: 25-34).

Second, from a philosophical point of view, identifying the person with a bundle of information, regardless of its complexity, remains highly controversial. Information can be obtained about any entity, but information by itself does not constitute that entity. Scanned information on the human being can be stored on a huge hard-drive as a kind of data, yet this data may not by itself constitute a human person. Even a highly advanced computer cannot make it into a person, let alone a silicon body, by itself. There must be another factor, which organizes information, makes it into a certain configuration, and consequently sustains its functioning. Once we are aware of the complexity of the bundle of personal information, we also begin to realize that the factor governing this set must be even more complex. What is important to notice here is that such a factor must amount to a kind of dynamic structure acting either from the outside or inside of that bundle. The set of information itself does not possess such a structure, and it is hard to imagine what external reality does. In some philosophical traditions, such a dynamic structure has been identified with the soul. However, in transhumanism there is no place for the latter.

Towards Making Better Persons

When we concentrate on personhood from within the context of enhancement, we must take into account its varied conceptions. I will limit my investigation to two such ideas. First, I will inquire into the significance of enhancement from the naturalist concept of the person. Second, I will do the same from the perspective of the personalist project.

The Naturalist Approach

Discussions concerning the naturalist concept of the person are very advanced. I will only sketch this pattern of thinking, which we need for our inquiry. In the naturalist approach to the person, the classical concept of substance is rejected. Consequently, no trans-empirical ground for personhood is accepted; rather, an examination of personhood in terms of substance must be considered from within the naturalist concept of the bundle.[5] Philosophers point to various sets of personal characteristics, which make a given entity a person. Some of them (e.g. Peter Singer), following John Locke's analyses concerning human identity,[6] concentrate on basic features like thinking, intelligence, and consciousness. Others, like Michael Tooley, John Harris, and Mary A. Warren, emphasize further psychological traits, which constitute the mature human personality. Joseph Fletcher presents a very advanced set of such factors pointing to intelligence, self-awareness, self-control, sense of time, sense of futurity, sense of the past, capacity to relate to others, concern for others, communication with other persons, control of existence, curiosity, change and changeability, balance of rationality and feeling, idiosyncrasy, and neocortical function (Fletcher 1979: 11nn). Thus we can point either to a minimal set of personal characteristics or a maximal one. Discussions concerning which set adequately describes the person is far from settled. One potential solution is that the minimal set amounts to a necessary condition of personhood, while the maximal one to a sufficient condition.

What is central to the naturalist approach is the conviction that only these characteristics matter. This means that while the characteristics do not appear in a void and must possess a kind of vessel, naturalists tend to focus on the bundle which gathers these personal traits together. A good example of this position is expressed by Robert Nozick, who writes that

> if the basic moral characteristic is shared by everyone, then it does not seem to have anything special to do with you. Your value would consist in being a bearer of this characteristic (for instance, rationality, ability to revere the moral law); you would not be valued for being yourself. . . . There then is the sense that any other bearer of the characteristic can equally well replace you, so that you are not valued or respected for being the particular person you are. . . . You are valued for your self but not for yourself. (Nozick 1981: 453-454)

From such an approach, it is relatively easy to separate the person from the human being and credit the former with a special importance and value. As Nozick put it, these personal characteristics are factors, which are of interest for ethicists. Thus the concept of personhood becomes also an ethical category.[7]

Enhancing the person as she is understood from the naturalist position will concern changing her personal characteristics. We can consider this from two aspects: empirical and philosophical. On the one hand, it consists in looking for the natural and empirical factors that condition her functioning and then a corresponding attempt to upgrade them. As we mentioned above, the latter can start with corrections brought about by psycho-stimulants. But it can also employ more radical interventions like regenerative medicine, nano-medicine, and finally, genetic manipulations. By strengthening certain somatic structures and processes, we bring about higher quality of resulting psychological traits. Of course, this way of reasoning leads us to the project of emergence (non-reductive naturalism). Thus the posthuman person in naturalism is understood in strict connection with the appearance of the creature that is in possession of higher quality emergent properties.

On the other hand, to enhance the person is to increase the quality of her expressions in every respect. Thus, we cannot confine these expressions to the realm of the physical or generally the material. They are multidimensional, which means that they cannot be fully identified with purely psychological processes. Rather, the latter should be considered as vessels, though what they contain—in many aspects—transcends the realm of the material and empirical. Thus, such traits as self-awareness and sense of time cannot be investigated with only empirical tools. They include reference to abstract realities, and in order to grasp them, we need methods different from those offered by naturalism. We can see these abstract realities emphasized in almost all of the characteristics presented by Fletcher (abstract ideas, intentions, projects). This brings about a serious problem: we do not know how to enhance this non-empirical content with empirical tools; it clearly goes beyond a simple issue of measurement and thus is not an easy subject of manipulation. Unless we subscribe to the view that they are fully products of material reality (and we have good reasons not to), we cannot sustain a thesis that, for instance, any upgrading of abstract intention (e.g. a resolve to be more just and tolerant) can be obtained with the application of regenerative medicine, nano-medicine, or genetic enhancement.

A Personalist Approach

The personalist approach to the person does not concentrate on particular personal characteristics. Rather, it has at the center of attention a whole personal reality. There are various personalisms and hence various approaches to the person. I am going to limit my presentation to one version of this position, namely to the so-called ontological personalism. Within this approach, it is assumed that the person exists as a multidimensional being and should be investigated accordingly. Following the personalist analysis advanced by Karol Wojtyla, we can describe the person as a subject who can be characterized by a metaphysical and personal subjectivity. The former is called *suppositum* and is understood as the metaphysical subject of existence and action, while the latter is a richer reality where human interiority and experience play vital roles. Of course, one is strictly connected with the other, and so, accordingly, we must treat them as one personal reality.[8]

Stressing the importance of the metaphysical subject, personalist philosophers aim to demonstrate that the human person constitutes something greater than a mere set of personal traits. The subject goes before its traits in the logical sense, and we cannot acquire an adequate understanding of the latter without the former. This is demonstrated in Thomas Reid, who critically discussed personal identity with John Locke. Reid emphasized that I am not this or that personal characteristic, e.g. I am not thought or action, but I think and undertake this or that action as a *self* or an *I*.[9] All personal activities must be possessed by and carried out by a doer or an agent.[10] Thus if John Locke inspired naturalist thinkers, so Thomas Reid strengthened the cause of personalist philosophers.

An analysis of personal characteristics, which are so important to the naturalist's apprehension of the person, can reveal two distinct aspects between these traits: exterior and interior. The former consists in a set of empirical processes that make manifest a given characteristic, thereafter available for observation. The latter, in turn, concerns the content, which transcends the realm of the natural and its set of epistemological tools. From the personalist perspective, these distinctions must be made with reference to the entirety of the whole person. Thus we can characterize the person as the entity who possesses both exteriority and interiority, each of which complements the other. As Wojtyla puts it, "I myself am for me not only interiority but also exteriority. At the same time I remain a subject of both experiences, namely from inside and from outside" (Wojtyla 1994: 55).

That the subject possesses a first-person perspective "I" is crucial to the personalist understanding of the person. Within the context of ontological personalism, this perspective cannot be identified with an extra-worldly reality *(res cogitans)* that is made manifest merely through the exteriority of the person, namely the body. Neither can it be comprehended as an epiphenomenon (or emergent) of material reality as may be the case in naturalism. Rather it is strictly connected with personhood understood as a way of existence.[11] As Roger Scruton rightly states, “Personhood is not a property that I possess, but my way of being me” (Scruton 2012: 62). Thus, although it is manifest in personal acts such as cognition, volition, or experience, the “I” is in a sense anchored in the whole personal being (in its existence). In the philosophy of the person as espoused by Karol Wojtyla, the subject with its first-person perspective also encompasses these aspects of the human being, which seem to represent pure objectivity (e.g. physiological states). And this is possible due to the fact that I, the person, have a reference to them and they belong to me, in a special way (i.e. not as pure objects), and co-constitute me as a complex subject.

Enhancing the person as understood in this way is rather difficult. When we take into account solely those personal characteristics, we can argue at most for enhancing some of her aspects. This is because these characteristics are not treated in the personalist position as a person’s constituent parts but as modes of her expressions; they are given on the level of the personal subject. A strictly personal way of existence cannot be a subject of empirical improvements. Changing some aspects of the personal being does not amount to changing her fundamental existence; thus, we cannot modify *suppositum* itself. And because the latter is present in the personal subject (as its core), also this one cannot be radically altered. Thus improving consciousness or ability to communicate we only upgrade channels through which the person makes herself manifest, and this can be done only in a limited degree, as we mentioned above.[12] This, of course, can increase the quality of personal life, but it cannot make her into a higher-level creature.

Ethics of Enhancement

Having examined both the naturalist as well as personalist positions, we can delve now into the ethical aspect of enhancement. Both perspectives of the human person are connected with specific conceptions of ethics and thus generate differing moral assessments of enhancement interventions. Naturalism is usually associated with utilitarian ethics, while personalism includes its own personalist ethics.

Even a general understanding of utilitarianism will allow us to understand that most enhancement interventions will be considered morally praiseworthy. They promise to increase a general wellbeing of groups and societies and specifically good consequences of various kinds.[13] Thus—according to Tännsjö’s typology—*negative* interventions that aim at the elimination of dispositions towards illness will be positive, at least in principle. They will eliminate all those factors which constitute sources of pain and suffering. Also, *positive* interventions will gain a positive ethical assessment, because they seek to intensify happiness and, consequently, increase a level of personal fulfillment. Thus “weaker” individuals will be given a chance to conduct their lives on a higher level. Finally, strictly *enhancing* interventions will be welcome because they bring with them the promise of the reduction or eradication of human limitations in many respects. A portrait of the posthuman person may summarize within itself all the positive consequences of enhancing interventions.

Of course, all attempts of betterment will be judged differently if they run a disproportioned risk for the present state of individuals (e.g. for their health). Thus risk assessment will be a necessary ingredient of such ethical considerations. What is interesting in the utilitarian approach is that very often we cannot determine with precision the consequences of our actions, especially in the case of pure enhancement. As a result we often deal with hypothetical consequences and hence various, and sometimes contradicting, ethical judgments.

In contrast to the naturalist position, the ethics of the personalist approach will be more restrictive. Only few interventions in the realm of improvement and enhancement will be judged morally praiseworthy. On the one hand, this is a result of the assumed concept of the person. As we mentioned above, the person is a reality who goes well beyond the realm of empirical and natural, and so employing the tools of the latter cannot bring about a radical change in the former. On the other hand, such a radical modification has a strictly ethical barrier as well. With personalism of any variety, the person is always considered as an end in itself and as such should never be treated as a means to an end (Kant 2002: ch. II, no. 32; Wojtyla 1981: 28). In Kant's thinking, which was partly undertaken by Wojtyla, to be an end in itself, the personal entity must be objective, that is, "valid for all rational beings irrespective of their inclinations" (Wood 2008: 86). Recognizing and respecting the person-end-in-itself presupposes that he precedes all desires and intentions associated with him, and in fact the former generates the latter, not the other way round. Furthermore, we can introduce a further distinction between the essential good of the person and goods for the person insofar as it appears in works of Wojtyla (e.g. Wojtyla 1981: 122). The former is associated with the fundamental structure of the person, and we can call it the ontological good. The latter concern various factors, which the person needs for her development, wellbeing, and fulfillment. Goods for the person cannot be identified with the essential good of the person, although they remain in a close connection.

Thus from within the personalist position we can easily justify negative interventions. They tend to remove those impediments which prevent the development of a person's potential. Unless they pose too great a risk to the person, particularly undesirable and illness-related characteristics should be the subjects of improvement. Ultimately, such an activity will amount to medical treatment that draws upon new discoveries in genetics and genetic engineering. One criterion for this negative intervention will be the traditional concept of human health, which includes freedom from disease and other maladies.[14] At any rate, we can rightly claim that goods for the person should be subjected to the essential good of the person, and moreover the former should strengthen the latter.

The problem arises when we consider positive interventions. They tend to upgrade the strength and the level of performance of personal characteristics but without an attempt to transgress what is yet available in the human family (e.g. a level of intelligence). Taking into account all prudential requirements, we can wonder whether such a move will serve the person herself, or—in other words—whether by upgrading certain goods for the person, we also promote the essential good of the person, or at least we do not diminish it. One possible response is that in strengthening goods for the person, we directly create more space for her expression, and hence we promote her ontological good (the essential good). The problem with such a solution is that only all relevant goods for the person bring with them a vital support for the essential good of the person, but not selective ones. However, it often happens that intervention to one personal trait occurs at the expense of others (Hauskeller 2014), and consequently promotion of one particular good happens at the expense of other goods. Imagine an increase of a person's intelligence without a corresponding improvement in her disposition to justice. This one-sidedness can be dangerous for the person and even more so for society. Thus, we need to promote all important goods for the person simultaneously in order to provide a better space for the essential good of the person, and how to do that exactly still remains unclear.

Pure enhancement, from the personalist perspective, brings with it serious moral controversies. For example, if such enhancement leads to a new state of existence, it means that the present state is unsatisfactory and even undesirable. The essential good of the person is then considered as something that must be bettered. Because we do not know now how to transform our entire ontological condition, we change what is within the range of our present abilities. Thus, instead of upgrading the fundamental value of our existence (the essential good of the person), we try to modify particular goods. But, as mentioned, we can modify only some of them, and because we do not possess perfect tools, even expected effects in this respect will be limited. If, however, we were able to modify all relevant goods for the person, would the latter substantially influence the fundamental good of personal existence? I venture that the personalist position is inclined to respond in the negative. Insofar as the person is not considered a mere bundle of personal characteristics, neither is she a bundle of personal goods. These goods are important but still secondary. The essential good of the person is strictly associated with her ontological structure and with her existence. Thus, if it is highly controversial whether we can change the human entity, it is equally doubtful whether we can upgrade its fundamental good. Moreover, it is clearly impossible to move from goods for the person to the essential good of the person, or to put it differently, even a radical enhancement of the former cannot substantially better the latter.

Conclusions

Discussions on human enhancement are inevitable in contemporary philosophy and bioethics. We as human beings are in possession of ever better and more powerful tools, and we want to use them to improve our human condition, provided they are safe. These claims seem to be shared by almost all the participants of these discussions. Nevertheless, there are also many contentious issues, which ultimately concern particular aspects of such interventions and their scope. Depending on how we understand the person and her good, approaches to human enhancement differ. The version of personalism I have been drawing on—which can also be called realist personalism—sustains that not all enhancing interventions are permissible because of the essential good of the person. One thing here is certain: the personalist position rejects radical enhancements and thus questions the possibility of transforming the human beings into posthuman persons. A different conclusion may be drawn from the utilitarian position. It will favor almost any type of enhancement, including radical ones. From this latter perspective, each and every enhancement must be assessed in the light of future consequences or general wellbeing. Thus, this position seems to be more open for further developments in enhancement debates, including a discussion on posthuman personhood.

However, even if we accept haphazardly the utilitarian approach, some requirements should be stressed here. First, many participants of human enhancement discussions tend to concentrate on positive and desirable consequences, playing down those negative and undesirable ones. Their voices thus amount to a utopian-oriented point of view. However, because of the many unknown factors, it is necessary to be realistic and even a bit skeptical in planning these activities. All in all, it is better to err on the side of caution.[15] Second, when we try to determine possible consequences, we ought to be prepared for unintended ones. Generally they will consist in negative side-effects and even negative after-effects. Finally, we should ask ourselves whether the awareness of the consequences is a sufficient guide for undertaking such a serious enterprise. Frances Kamm and other critical commentators draw our attention to what must be considered at the very beginning of enhancing activities, apart from consequences. That is, we should know at the very outset "whom we want to become" and "what constitutes a set of goods necessary for personal and postpersonal fulfillment."[16] At any rate, we are far from that.

References

Agar, Nicholas, *Humanity's End. Why We Should Reject Radical Enhancement*, (London-Cambridge (MA): A Bradford Book. The MIT Press, 2010).

Agar, Nicholas, "There Is a Legitimate Place for Human Genetic Enhancement," in *Contemporary Debates in Bioethics*, A. L. Caplan, R. Arp (eds.), (Malden (MA)-Oxford: Wiley-Blackwell, 2014): 343-352.

Bostrom, Nick; Savulescu Julian, "Introduction. Human Enhancement Ethics: The State of the Debate," in *Human Enhancement*, J. Savulescu, N. Bostrom (eds.), (Oxford: Oxford University Press, 2009): 1-22.

Fletcher, Joseph, *Humanhood: Essays in Biomedical Ethics*, (Buffalo: Prometheus Books, 1979).

Glover, Jonathan, *Choosing Children: Genes, Disability, and Design* (Oxford: Oxford University Press, 2006).

Goetz, Steward; Taliaferro, Charles, *Naturalism* (Gran Rapids- Cambridge: William B. Eerdmans Publishing Company).

Harris, John, *Enhancing Evolution. The Ethical Case for Making Better People*, (Princeton-Oxford: Princeton University Press, 2007).

Hauskeller, Michael, *Better Humans? Understanding the Enhancement Project*, (London and New York: Routledge, 2014).

Holub, Grzegorz, *Creating Better People? Some Consideration on Genetic Enhancement*, "National Catholic Bioethics Quarterly" vol. 10, no. 4 (2010): 723-740.

Holub, Grzegorz, *Karol Wojtyla on the metaphysics of the person*, "Logos i Ethos" vol. 2 (2015): 97-115.

Kamm, Frances, "Is There a Problem with Enhancement?" *American Journal of Bioethics* vol. 5, no. 3 (2005): 5-14.

Kant, Immanuel, *Groundwork for the Metaphysics of Morals*, trans. A. Zweig; T. E. Hill, A. Zweig (eds.), (Oxford: Oxford University Press, 2002).

Kuhse, Helga, *The Sanctity-of Life Doctrine in Medicine. A Critique*, (Oxford: Clarendon Pres, 1987).

Kurzweil, Ray, *The Singularity Is Near: When Humans Transcend Biology*, (London: Penguin Books, 2006).

Locke, John, *An Essay concerning Human Understanding*, K. P. Winkler (ed.), (Indianapolis, IN: Hackett, 1996).

Meilaender, Gilbert, *Neither Beast nor God. The Dignity of the Human Person*, (New York-London: Encounter Books, 2009).

Mulgan, Tim, *Understanding Utilitarianism*, (Stocksfield: Acumen, 2007).

Menuz, Vincent; et al., *Is Human Enhancement also a Personal Matter?*, "Science & Engineering Ethics" vol. 19 (2013): 161-177.

Nozick, Robert, *Philosophical Explanations*, (Oxford: Clarendon Press, 1981).

O'Mathúna, Dónal P., *Nanoethics. Big Ethical Issues with Small Technology*, (London: Continuum 2009).

Persson, Igmar, Savulescu, Julian, *Unfit for the Future. The Need for Moral Enhancement*, (Oxford: Oxford University Press, 2014).

Reid, Thomas, *Essays on the Intellectual Powers of Man*, (Cambridge (MA): MIT Press, 1998).

Savulescu, Julian, "The Human Prejudice and the Moral Status of Enhanced Beings: What Do We Own the Gods?" in *Human Enhancement*, 211-247.

Scruton, Roger, *The Face of God*, (London: Bloomsbury, 2012).

Smart, John J. C., "Utilitarianism," in *Encyclopedia of Philosophy*, vol. 9, D. M. Borchert (ed.), (New York: Thomson * Gale, 2006): 603-611.

Sorabji, Richard, *Self. Ancient and Modern Insights about Individuality, Life, and Death*, (Chicago: The University of Chicago Press, 2006).

Stock, Gregory, *Redesigning Humans: Our Inevitable Genetic Future*, (Boston: Houghton Mifflin, 2002).

Tännsjö, Torbjörn, "Medical Enhancement and Ethos of Elite Sport," in *Human Enhancement*: 315-326.

Tonn, Bruce, "Will Psychological Disorders Afflict Uploaded Personalities?," *World Future Review*, Winter (2011): 25-34.

Wojtyla, Karol, "Osoba i czyn," in K. Wojtyla, *Osoba i czyn oraz inne studia antropologiczne*, (Lublin: Wydawnictwo Katolickiego Uniwersytetu Lubelskiego, 1994; English translation of the book: *The Acting Person*, trans. A. Potocki; A.-T. Tymieniecka (ed.), Boston: Reidel, 1979).

Wojtyla, Karol, "Subjectivity and the Irreducible in the Human Person," in K. Wojtyla, *Person and Community. Selected Essays*, (1993a): 209-217.

Wojtyla, Karol, "The Person: Subject and Community," in K. Wojtyla, *Person and Community. Selected Essays*, trans. T. Sandok, (New York: Peter Lang, 1993): 219-261.

Wojtyla, Karol, *Love and Responsibility*, trans. H. T. Willetts, (San Francisco: Ignatius Press, 1981).

Wood, W. Allen, *Kantian Ethics*, (New York: Cambridge University Press, 2008).

Notes

1. There are authors who point to interventions where a medical treatment, say within a preventive medicine, is also a kind of enhancement, e.g. vaccines (see Menuz, et. al 2013: 167; Holub 2010:

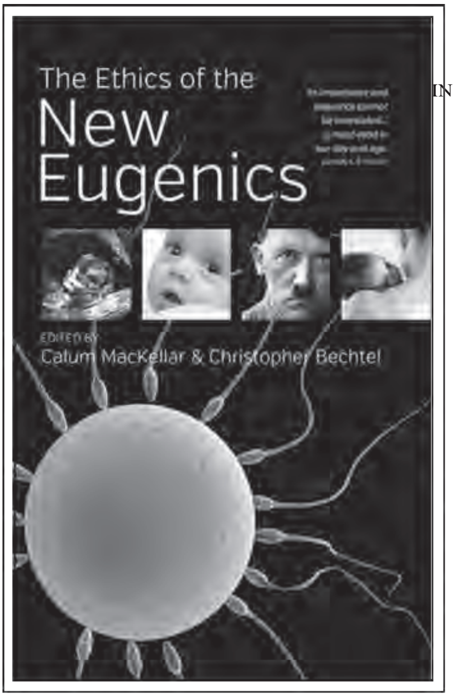
725-726).

2. Ray Kurzweil sets out an elaborated version of the idea of uploading of human mind and the human being in his book, *The Singularity Is Near: When Humans Transcend Biology* (Kurzweil 2006). The acute critique of the idea of uploading was advanced by Nicholas Agar (Agar 2010: ch. 3).
3. Kurzweil considers this process within a so-called law of accelerating returns.
4. The ongoing research tends to prevent the shortening of cell telomeres. The latter are thought to cause the aging process. How far we can go in this direction is now an open question.
5. Even if we accept the concept of substance in the naturalistic approach, its understanding is given by pointing to specific natural elements. Thus, the substance is here a bundle of such factors, and they can be investigated via empirical methods only. The person understood as a kind of substance does not possess any element, which goes beyond the scope of scientific explanation and, what is important here, "there is no enduring self or soul of any kind" (Goetz, Taliaferro 2008: 13).
6. Locke said that the person "is a thinking intelligent being, that has reason and reflection, and can consider itself as itself, the same thinking thing, in different times and places; which it does only by that consciousness which is inseparable from thinking, and as it seems to me essential to it" (Locke 1996: Book II, chap. XXVII, sect. 9). Although he was not to define the reality of the person, he nevertheless suggested some characteristics as person constituents.
7. For instance, Helga Kuhse declares as follows, "if one takes this approach, then one is not saying that human life has sanctity, but rather that rationality, the capacity to be self-aware, moral or purposeful, and so on, have 'sanctity.'" (Kuhse 1987: 212).
8. Wojtyla presented how one is connected with the other. And thus, on one hand, "the *suppositum humanum* must manifest itself as a human self: metaphysical subjectivity must manifest itself as personal subjectivity" (Wojtyla 1993: 225). On the other, the metaphysical subject does not exhaust a richness and complexity of the personal one. The latter must complete the former. He put it this way, "(…) the Boethian definition mainly marked out the "metaphysical terrain"—the dimension of being—in which personal human subjectivity is realized, creating, in a sense, a condition for "building upon" this terrain on the basis of experience" (Wojtyla 1993a: 212). For the concept of the metaphysics of the person in Wojtyla's thought see Holub 2015.
9. Reid's thinking goes as follows, "My personal identity, therefore, implies the continued existence of that indivisible thing which I call *myself*. Whatever this self may be, it is something which thinks, and deliberates, and resolves, and acts, and suffers. I am not thought, I am not action, I am not feeling; I am something that thinks, and acts, and suffers. My thoughts, and actions, and feelings, change every moment; they have no continued, but a successive existence; but that *self* or *I*, to which they belong, is permanent, and has the same relation to all the succeeding thoughts, actions and feelings, which I call mine" (Reid 1998: 341).
10. The subject also plays a role of the unifying principle of all personal activities, both within a particular activity and within a set of such elements. Richard Sorabji observes that, for instance, "if there is unity in one's self-awareness, the unity is supplied by the single owner of that awareness, not by the owner's using a single faculty" (Sorabji 2006: 260).
11. Gilber Meilaender writes about this complexity in an interesting way: "Human beings are strange, "in-between" sorts of creatures—lower than the gods, higher than the beasts. Not simply body, but also not simply mind or spirit; rather, the place where body and spirit meet and are united (…)" (Meilaender 2009: 4).
12. If we distinguish a moderate enhancement from a radical one, the former may be acceptable from the personalist standpoint. It can include boosting someone's IQ, say from 90 to 100 points, and extending his life span by a small number of years (see e.g. Agar 2014: 343ff).
13. There are very advanced discussions on versions of utilitarianism in contemporary philosophy (see e.g. Mulgan 2007), and I am not going to delve into them. A larger perspective of utilitarian thinking directs out attention at such important topics like social justice and wellbeing. Although human enhancement should be considered in this broader approach, in this paper I limit my remarks to a more restricted approach. Some philosophers claim that looking at two basic versions of this ethical stance, namely rule utilitarianism and act utilitarianism, we can point to a common thread. Thus, in opinion of John Smart, act utilitarianism can be viewed as "the doctrine that states that the rightness or wrongness of action is determined by the goodness and badness of

their consequences," whereas rule utilitarianism "considers the consequences of adopting some general rule" (Smart 2006: 603). Thus, what they have in common is the notion of the outcome of a given action, which makes that action good or bad. In my reference to utilitarianism, I primarily concentrate on consequences.

14. This is a minimalist notion of human health. It seems to accord with a common sense perception. There are also other definitions. We can point, for instance, to a maximalist notion provided by World Health Organization: a state of complete physical, mental, and social wellbeing. The latter is in tune with more radical interventions.
15. Scholars who promote human enhancement to a larger extent would incline to advocate a different rule. A good example is given by Ingmar Persson and Julian Savulescu, who claim that "it is probably better to err on the optimistic than on the pessimistic side" (Persson, Savulescu 2014: 3).
16. Kamm warns us, saying that "most people's conception of the variety of goods is very limited, and if they designed people their improvements would likely conform to limited, predictable types (…). In seeking enhancement people will focus on too simple and basic a set of goods" (Kamm 2005: 13). Jonathan Glove argues in a similar way (Glover 2006: 54).

Grzegorz Holub, STM, PhD, is Associate Professor of Philosophy at the Department of Philosophy of the Pontifical University of John Paul II in Cracow, Poland. His areas of research include bioethics, environmental ethics, and philosophy of the human person. He currently resides in Cracow, Poland.



242 pages, bibliog., index

ISBN 978-1-78238-120-4 **$120.00/ £75.00** Hb Published (March 2014)

ISBN 978-1-78533-202-9 **$29.95/ £18.50** Pb Not Yet Published (March 2016)

eISBN 978-1-78238-121-1 eBook

Paperback version to be released in March 2016!

THE ETHICS OF THE NEW EUGENICS

Edited by Calum MacKellar and Christopher Bechtel

"The book is clearly written, easy to follow, well-structured, and well-researched. A lay audience will easily access and understand the debate and realize what is at stake with the new eugenics. Medical procedures and technical concepts are well explained… [Its] importance and relevance cannot be overstated…a must-read in our day and age, especially when biotechnology and the new eugenics can be a threat to all of humanity." • **Johann A. R. Roduit,** Institute of Biomedical Ethics, University of Zurich

"Clearly written and highly informative about international and nations laws, as well as about past, current, and possible future eugenic practices and arguments for and against the same, this volume makes for valuable reading not only for students of medical ethics but can be recommended to anyone wanting to learn more about arguments for and against current and possible future reproductive selection procedures." •
Ethics & Medicine

Strategies or decisions aimed at affecting, in a manner considered to be positive, the genetic heritage of a child in the context of human reproduction are increasingly being accepted in contemporary society. As a result, unnerving similarities between earlier selection ideology so central to the discredited eugenic regimes of the 20th century and those now on offer suggest that a new era of eugenics has dawned. The time is ripe, therefore, for considering and evaluating from an ethical perspective both current and future selection practices. This inter-disciplinary volume blends research from embryology, genetics, philosophy, sociology, psychology, and history. In so doing, it constructs a thorough picture of the procedures emerging from today's reproductive developments, including a rigorous ethical argumentation concerning the possible advantages and risks related to the new eugenics.

Calum MacKellar is Director of Research of the Scottish Council on Human Bioethics, Edinburgh, and Visiting Professor of Bioethics at St Mary's University College, London, UK.

Christopher Bechtel holds a degree in philosophy and is a Research Fellow with the Scottish Council on Human Bioethics, Edinburgh, UK.

Book Reviews

Dying in the Twenty-First Century: Toward a New Ethical Framework for the Art of Dying Well

Lydia Dugdale, MD, Editor. Cambridge, MA: MIT Press, 2015.

ISBN 978-0-262-02912-4, 205 PAGES, CLOTH, $29.00.

We in the twenty-first century have forgotten how to die. The medicalization of the end of life has transformed dying from a process of fulfillment and closure to a decision regarding when to disconnect machines. *Dying in the Twenty-First Century: Toward a New Ethical Framework for the Art of Dying Well*, edited by Lydia Dugdale, MD, explores the plausibility of resurrecting the *Ars Moriendi*—the Art of Dying—for the twenty-first century, thereby restoring a more human approach to the process of dying in our contemporary society.

The ten essays by various authors are divided into three sections: the first explores the historical and philosophical aspects of death and dying; the second addresses the practices—the substance—of the art of dying; and the final section addresses special considerations involved when the dying are children, demented, or suffering from AIDS. A concluding chapter by the editor seeks to synthesize the essays into a coherent ethical framework.

The essays raise many significant issues for consideration and debate in development of any ethical approach to end-of-life issues, but one significantly recurring theme is the relationship of living to dying. Since dying is the final phase of living, any art of dying—especially the art of dying *well*—will be inexorably linked to the art of living well. This will require a framework of virtue ethics that focuses on cultivating character in the home, congregation, and community over the course of a lifetime. And as the term "art" implies, the realization of beauty and flourishing is believed to be possible even in the process of one's dying.

The essay by Dan Callahan, addressing issues in the process of dying in patients with dementia, was disappointing. In it, he registered suspicion of intergenerational obligations toward those with dementia and queried limits on the responsibility of spouses for such patients. Unable analytically to account for the motivation for self-sacrifice exhibited by spouses, he concluded simply, "human nature has its good side." The concept of an art form does not cohere well with the formal procedural logic that characterizes Callahan's intellectual commitments, and consequently he was unable to supply significant substance for any process of preparing for death among those afflicted with dementia or for their family members.

Ultimately, the book concludes that since the art of dying begins with choosing to live in such a way that one may die well, the resurrection of an *Ars Moriendi* may not be a plausible goal for bioethics in our pluralistic world lacking moral consensus. It may, however, be a project for development within strong moral communities where consensus concerning goods does exist. The holistic approach to the process of dying by many of the essayists is refreshing and inspiring, making it a commendable read for anyone interested in bioethics, end-of-life issues, or for those who wish to ponder what it means to die differently and to die well.

Reviewed by Susan M. Haack, MD, MA (Bioethics), MDiv, FACOG, recently retired from consultative gynecology at Hess Memorial Hospital and Mile Bluff Medical Center in Mauston, Wisconsin, USA.

Transplantation Ethics (Second Edition)

Robert M. Veatch and Lainie F. Ross. Washington, DC: Georgetown University Press, 2015.

ISBN 978-1626161672, 352 PAGES, PAPER, $39.95.

Author Robert Veatch is joined by Lainie Ross in this second edition of *Transplantation Ethics*. The second edition comes fourteen years after the original and has three new chapters (with one original chapter removed), as well as additional material throughout. The authors start with a short review of religious and cultural perspectives surrounding organ donation, then sketch a few general theories of normative ethics. While utility is not irrelevant, the authors clearly prefer the deontological elements of justice and respect for persons. The book is then divided into three major parts: 1) defining death; 2) procuring organs; and 3) allocating organs.

The authors begin by making an honest and much-needed admission: defining death is not merely a scientific question. “The choice among the many candidates for what is essential to the nature of the species, and, therefore, the loss of which is to be called ‘death,’ is a philosophical or moral question, not a medical or scientific one.” (42) While the idea of the soul leaving the body is mentioned, the focus is on three secular candidates for the definition of death: the whole-brain concept, the circulatory or somatic view, and the higher-brain definition of death. The crux of the discussion comes in the final two chapters of the section where the authors propose a new definition of death for public policy purposes—one which recognizes the diversity of our cultural beliefs and includes a conscience clause allowing the individual, within certain parameters, to choose their own definition. The authors believe that whole-brain death should be the default definition, but would allow a competent individual or surrogate to choose between “irreversible loss of consciousness” or “irreversible loss of circulatory function” instead. (126)

Next, the authors take up the topic of procuring organs. They insist that any donation model ought to be built on the pillars of respect and autonomy. In terms of efficiency, the models are ranked as follows: marketing (most efficient), salvaging (more efficient), and donation (least efficient). A discussion outlining the distinction between the idea of routine salvaging and “presumed consent” is also included. (154) Chapter 12 takes up the question of live-donor transplants including an excellent discussion of incompetents (i.e., infants, children, and others) and surrogate decision-making. After discussing high-risk donors—e.g., HIV, hepatitis B/C-positive donors—the authors suggest a policy change that would permit high risk donors to donate to negative recipients conditioned upon informed consent and willingness to accept. Ethical problems surrounding xenotransplantation (using organs from animals) is explored next. This part concludes with a new chapter examining the media’s impact on organ donation.

Lastly, the book explores the thorny problem of organ distribution. Again, to their credit, the authors insist that these issues are every bit as evaluative and moral as they are scientific and technical. This is especially illustrated in chapter 18, where the authors disagree on the extent to which alcoholism should factor into receiving an organ for transplantation. While justice is still considered the primary guide in working through these difficult issues, a careful intermixing of utilitarian and deontological principles is illustrated in considering how best to allocate the short supply of organs available to those in need. Various policy issues are discussed, critiqued, and suggested in this part of the book. The book then concludes with two new chapters on the topics of elective organ transplantation and vascularized composite allografts—e.g., hand, face, and uterine transplants.

This is a must-read book for anyone wishing to understand the complexities surrounding organ transplantation. Besides the thoroughness and depth of discussion, one of the many strengths found throughout this book is the authors’ repeated demonstration of the need for metaethical thinking and the underpinnings for the *practice* of bioethics, which is so often missing in discussions of biomedical ethics. "Practical ethics may turn out to be a two-way street. Not only do we move from ethical theory to practical problem solving, but we may also move the other way—from clear, considered moral judgments to a more sophisticated and precise ethical theory." (393) This book is well researched, broadly reasoned, and offers several proposals for advancement in a multicultural and pluralistic society. Written in a scholarly yet nontechnical manner, it is well suited for a diverse audience of professionals and non-professionals alike and could be considered "one-stop-shopping" for the study of the complex subject of transplantation. There is but one glaring hole in the subject matter. There is no discussion of the aftereffects of a successful transplantation—e.g., life expectancies, quality of life issues, side-effects of immunosuppression drugs, and alternatives to transplantation (to mention only a few issues relevant to the discussion). These topics are mentioned in a cursory manner only and deserve more attention. Nevertheless, I highly recommend this book for those interested in a solid evaluation of most of the relevant issues surrounding death, procurement, and the distribution of organs for transplantation. It is especially suited to the bioethics student, ethics committee member, and those interested in becoming an organ donor.

Reviewed by Michael G Muñoz, D.Bioethics, MA (Bioethics), MAR, MEd, who has worked in fire fighting for over 30 years, is adjunct faculty at Grand Canyon University in Phoenix, Arizona, and serves on the Ethics Committee at Phoenix Children's Hospital in Phoenix, Arizona, USA.

Embracing the Body: Finding God in Our Flesh and Bone

Tara M. Owens. Downers Grove, IL: InterVarsity Press, 2015.

ISBN 978-0-8308-3593-5, 256 PAGES, PAPER, $17.00.

Tara Owens is a certified spiritual director and founded Anam Cara Ministries in Colorado. In *Embracing the Body*, she explores how the body informs spiritual formation: "We shuffle away awkwardly when the subject of our physicality comes up, and we eschew the idea that this uncomfortable, sweaty, noisy, unruly body of ours might indeed by the vehicle for union with the God who loves us beyond anything we could imagine… That in them we might find the fullness of life in Christ that we've been longing for." (16) In part one, "Body Reality," Owens draws out the problem as she sees it: the fears and brokenness that characterize the treatment of embodiment in the church. Part two, "Facing the Fears," begins to address these issues by treating four dichotomies: angel or animal (ch. 5), beauty or beast (ch. 6), touch or temptation (ch. 7), and desire or destruction (ch. 8). Finally, in part three, "Becoming Whole," she maps out a path forward to correct the distorted vision of embodiment that reigns in the church and prevents Christians from living whole lives in relationship with God. She encourages readers to understand their fears, to be more comfortable in our own bodies, to enjoy the created world, and to understand God's design for sexuality.

Throughout the book, Owens does an excellent job of treating embodiment from different angles. She deals with sickness, suffering, and aging and the redemptive works God can do through these experiences. Aging, for instance, provides the opportunity to embrace vulnerability: "Instead of owning the vulnerability, pressing into the way aching knees and loosening muscles bring to bear the weight of weakness, we camouflage aging with dyes and devices. Out of our sight and mitigated by technology, the sometimes gentle and always difficult gifts of loss are ignored in favor of the fantasy of cost-free immortality." (111) Owens also considers embodiment from the angle of presence and attention to being a physical creature in a physical creation. Slowing down and experiencing life is important. Finally, Owens also provides a more positive reading of sexuality and intimacy than many would expect from a Christian perspective. While acknowledging the presence of abuse and the difficulty of touch for some people, she emphasizes that part of being bodies in relationship is to recognize the importance of touch. While sexual intercourse is reserved for marriage, Owens encourages her readers to realize that being embodied means that other forms of touch and physical connection are important as well.

Owens concludes each chapter with what she calls “Touch Points.” These include exercises, specific prayers, and other ways of encouraging the reader to take ownership of the material, to move beyond the theoretical to the practical. They are designed “to get you out of your head (where you process words on the page) and into your messy, unruly, complicated and oh-so-glorious body.” (17)

Like any book, this one is not perfect. Owens tells many helpful stories, draws on biblical texts in a helpful way, and knows the spiritual formation tradition well. However, the book does not interact much with philosophical or theological sources on embodiment. However, this book does exactly what Owens sets out to do: expose the problematic ways that many Christians think about and deal with our bodies, and point a hopeful, holistic way forward in forming more complete, embodied disciples of Jesus Christ. It is a helpful read for anyone considering how embodiment connects with spirituality, and the Touch Points and discussion questions make it an excellent candidate for a small group study or theologically oriented book club.

Reviewed by Jacob Shatzer, MDiv, PhD, who is assistant professor of biblical and theological studies at Palm Beach Atlantic University in West Palm Beach, Florida, USA.

Beyond the Abortion Wars: A Way Forward for a New Generation

Charles Camosy. Grand Rapids, Michigan & Cambridge UK: Eerdmans, 2015.

ISBN 978-0-8028-7128-2, 221 PAGES, CLOTH, $22.00.

Pointing to polling statistics, Fordham theologian Charles Camosy shows that a polarized view on legalized abortion, depicted by the American media, is false. He finds that few Americans are pro-choice and millennials as well as the growing number of Hispanics are the least pro-choice of all. He also notes that, although in the last decade American abortion laws have become more restrictive, abortion practices are lagging behind inasmuch as 33% of women have had an abortion and 20% of pregnancies still end in abortion. Given this situation, Camosy proposes a *Mother and Prenatal Child Protection Act* (MPCPA) that would protect the interests of both unborn children and pregnant women.

Having shown in his opening chapter that both Republicans and the Democrats have behaved in chameleon fashion, shifting colors to suit changing political climates, Camosy turns to philosophical and theological issues. He raises the usual questions about the status of the human fetus. After discussing questions about such things as viability and potentiality, he concludes that in view of its “natural” potential for typically personal traits, the fetus should be recognized as a person. Therefore, he rejects Peter Singer’s functionalist view that places the criterion of personhood as actual possession of certain intellectual capacities.

Camosy also discusses principles typically appealed to in moral debates within the Catholic tradition, such as the principle of double effect and the classical Catholic distinction between formal and material co-operation. With recourse to these principles, he makes a case for indirect abortion on grounds of rape. Thus, not only does he note that Catholic hospitals might provide a woman exposed to rape with pills aimed at preventing implantation in the womb, he also defends the use of the RU-486 which kills the embryo. Applying the principle of double effect, he argues that use of RU-486 is defensible provided the intention is not that of killing the embryo but that of separating it from the lining of the womb. This, then, would be indirect abortion.

The book closes with Camosy's MPCPA proposal, which partly reflects Catholic teaching and partly American public opinion and a legal trend away from the reasoning of Roe v. Wade, which legalized abortion through an appeal to privacy. Thus he notes that there is a shift towards the "undue burden" standard set by Planned Parenthood v. Casey, in which the Supreme Court of the United States in 1992 decided that a state may regulate abortion in defence of fetal life, provided this does not pose an undue burden on the mother seeking or needing an abortion. In Camosy's view the laws should not criminalize women who have had abortions; it should hold abortion providers guilty of a crime, though not that of felony murder. What Camosy wants is a law that protects women against enforced abortions, as well as a woman's right to indirect abortion in the case of rape or for other serious reasons such as her health.

Camosy's proposal and arguments constitute an important contribution to the abortion debate. His book therefore deserves to be widely read.

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

Political Illiberalism: A Defense of Freedom

Peter L. P. Simpson. New Brunswick, New Jersey: Transaction Publishers, 2015.

ISBN 978-1-4128-5574-7, 236 PAGES, HARDBACK, $69.95.

This book is not for the faint-hearted; it will not leave many dispassionate readers in its wake. It is a scathing and uncompromising attack on political Liberalism and the State. In fact, they come to much the same thing. The State is a modern Liberal invention. It is intrinsically, not contingently, despotic, having acquired a monopoly on coercion in the form of a centralized police force and professional army. It brooks no opposition to its ideology. Simpson's argument, worked out in relation to both Liberal theory and practice, covering fundamental principles and social institutions, becomes increasingly specific in its focus as it goes along. Thus, we encounter (a) an attack on the US Constitution and defense of the early Articles of Confederation in the service of the claim that political authority should be devolved, (b) a technically-formulated attack on the scientific principles that inform the music of Bach and partly account for its "impurity," and (c) a robust argument on behalf of traditional Catholic views of marriage and abortion. The whole is undergirded by a favorable exposition of Aristotle's political vision, the antithesis of John Rawls' Liberalism, which the author wishes to grind to dust. What Aristotle knows and Rawls refuses is that "politics is and must be about comprehensive visions of the good." (ix)

Were it not for one authorial comment, I should suggest that this belongs to that class of books of which the reader ought to resist making an overall assessment—a demanding proposal in the light of its strong tone and substance. On the one hand, Catholic readers of *Ethics & Medicine* will readily appreciate that the explicit anti-Protestantism of the volume will evoke Protestant disagreement. Simpson flattens out the diverse political thought of the Reformation and holds it responsible for the pernicious subordination of religious to political authority. Even if they reject the appeal to miracles and infallibility which ground Simpson's affirmation of Catholic truth, many Protestants will give sympathetic consideration to the author's reasons for an explicitly "theonomic" doctrine of social order. However, to claim that the resistance to this position expressed in Locke's First Letter on Toleration arises from Locke's conviction that "religion is not a matter of objective truth or falsehood" (196) is sheer prejudiced misrepresentation.

On the other hand, Simpson's argument that the evils of the Liberal State are embedded in its very idea and not accidental in its history will resonate with the experiences and conclusions of many observers. In contrast, Aristotle's profound humanitarianism certainly shines bright. However, there is one sentence that will cast the entire volume under a cloud for many otherwise sympathetic readers, including those in favor of most things said in it about abortion and marriage. Such is the author's antipathy towards marital attitudes which embrace divorce and contraception that he avers that marriage between members of different species, pederastic and homosexual marriages "are perhaps solutions worth adopting in the immediate and short term, because they will have the beneficial effect of shocking people into realizing how far they have departed from natural marriages in the unions they now call marriages." (207) The author apparently means what he says. This reviewer will refrain from saying what he thinks.

Reviewed by Stephen N. Williams, MA, PhD, who is a Professor of Systematic Theology at Union Theological College in Belfast, Northern Ireland and serves on the Editorial Board of *Ethics & Medicine*.

The Demise of the "Reasonable Man": A Cross-Cultural Study of a Legal Concept

Michael Saltman. New Brunswick, New Jersey: Transaction Publishers, 2015.

ISBN 978-1-4128-5591-4, 168 PAGES, CLOTH, $29.95.

Why bring to readers' attention a book now made available in paperback, first published a quarter of a century ago, containing little reference to anything in the last thirty years in a field where there has been plenty of development? The answer to that is that the passage of time has enhanced the significance of its thesis. That is why the volume has been re-published in its old edition. To review the detail of arguments advanced in 1991 would be futile, but to draw attention to their substance is profitable.

"Law," says Julian Rivers, Professor of Jurisprudence at the University of Bristol, "becomes [today] the medium in which we think about the good," and he quotes Jürgen Habermas' words: "Legal norms are what is left from a crumbled cement of society…" ("Good News for Law?" in *Ethics in Brief* (19.5) 2014) These two observations explain our interest in Saltman's study. In societies such as those in the West where public moral consensus is evanescent, the law both attracts to itself a moral authority and functions as a force for social cohesion in distinctive ways. In much public perception and rhetoric, religion and reason stand in tension with each other: religion is not rational and a society based on rational order may or should tolerate religion, but only as a private matter and not as a law-making force.

In this context, Saltman's argument has wide ramifications. The thesis is stark and clear: in societies which are not politically centralized, of which primitive societies are a type, judicial striving to determine what is reasonable is attuned to the shared values of the relevant culture. On the other hand, in politically centralized societies, the judges themselves determine what is reasonable. We may all applaud the idea of "the reasonable man" but diverse political arrangements affect what constitutes "the reasonable man" in the sphere of law. Saltman approaches his material with the ethnographic eye of an anthropologist. He considers different cases, cultures, and examples of legal reasoning, observing the uses of both the word and the concept of "reasonableness." "On examining the range of legal cultures referred to in this text, one conclusion has to be that the legal culture of small-scale, noncomplex societies addresses itself to the reasonableness of the substantive issues in its attempt to supply a remedy." (128) Compare the situation where "reasonableness is a qualifier of the judge rather than a qualifier of concrete reality." (120) Basically, in less centralized societies, the breaking of law is a breach of shared moral-cultural understanding; in centralized ones, it is simply flouting the objective legal order. This is the demise (to pick up the title of Saltman's book) of what is reasonable on the ground and its transposition to the pronouncements of the legal authorities.

The importance of this volume for those concerned with medical ethics is that it impels us to scrutinize the relationship between political centralization and moral fragmentation in their effect on relevant laws, specifically by noticing what is happening to the vocabulary and concept of "the reasonable." Saltman's occasional remarks on religion and morality may not commend themselves to us, but we must heed his warning.

Reviewed by Stephen N. Williams, MA, PhD, who is a Professor of Systematic Theology at Union Theological College in Belfast, Northern Ireland and serves on the Editorial Board of *Ethics & Medicine*.

How I Changed My Mind About Evolution: Evangelicals Reflect on Faith and Science

Kathryn Applegate and J.B. Stump, Editors. Downers Grove, IL: InterVarsity Press Academic, 2016.

ISBN 978-0-8308-5290-1, 200 PAGES, PAPER, $16.00.

How I Changed My Mind About Evolution contains 25 short essays, or mini-memoirs, written by scientists, pastors, biblical scholars, theologians, and philosophers who have been "converted" from a biblical creationist view of the world to an evolutionary one. It emanates from BioLogos, whose mission is to present the harmony between science and biblical faith as they present an evolutionary understanding of God's creation. BioLogos' position is termed an "evolutionary creation position," which is in contrast to Intelligent Design theory, young earth creationism (which assumes the earth to be between 6,000 and 10,000 years old), and old earth creationism (which posits that the earth may be billions of years old by understanding the "days" of Genesis to be of a much longer period of time than 24 hours, enabling a literal reading). The focus of the writers is not on academic arguments for evolution as much as on personal testimony that they hope will impact other evangelicals who do not yet hold their position.

The essays focus on the reasons why people have changed their views and include the influence of a mentor (usually a teacher), books, science classes, and on a new non-literal hermeneutic for Genesis. They believe that all truth is God's truth, that theology/faith and science are not opposites, that we must approach truth with humility, and that while God did create the world, a literal reading of Genesis is not the only explanation of it. They do not have a problem with descent from modification, even for humans.

The book has a number of strengths. It is wonderful that it even exists because it demonstrates not only that there are evangelicals who believe that evolution is compatible with their faith, but that they also want to share this perspective with other evangelicals. These essays support the idea that knowledge and study can open up peoples' minds in new ways. A number of interesting books are mentioned in some of the essays. The major weakness of the book is that it is a testimonial in nature, and therefore does not focus much on the arguments for why Christian faith and evolutionary theory are compatible. It would have made the volume even stronger, and perhaps more persuasive to its intended readers. This book would be of most interest to other evangelicals still skeptical or rejecting of evolutionary theory; it is designed for this church-going group and is not meant as an academic text.

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

The Death of Humanity and the Case for Life

Richard Weikart. Washington, DC: Regnery Faith, 2016.

ISBN 978-1-62157-489-7, 348 PAGES, CLOTH, $ 27.99.

Reviews should probably begin with a description rather than an evaluation, but let such a noble procedure be ignored in this case in order to say that we are much indebted to Richard Weikart for this volume. He writes as both an intellectual historian and an advocate of traditional Christian beliefs on the value of life. This combination is skillfully managed so that the apology for Christian convictions emerges as a clear implication of the account on which he concentrates: a narrative and logical disclosure of what happens when life is devalued.

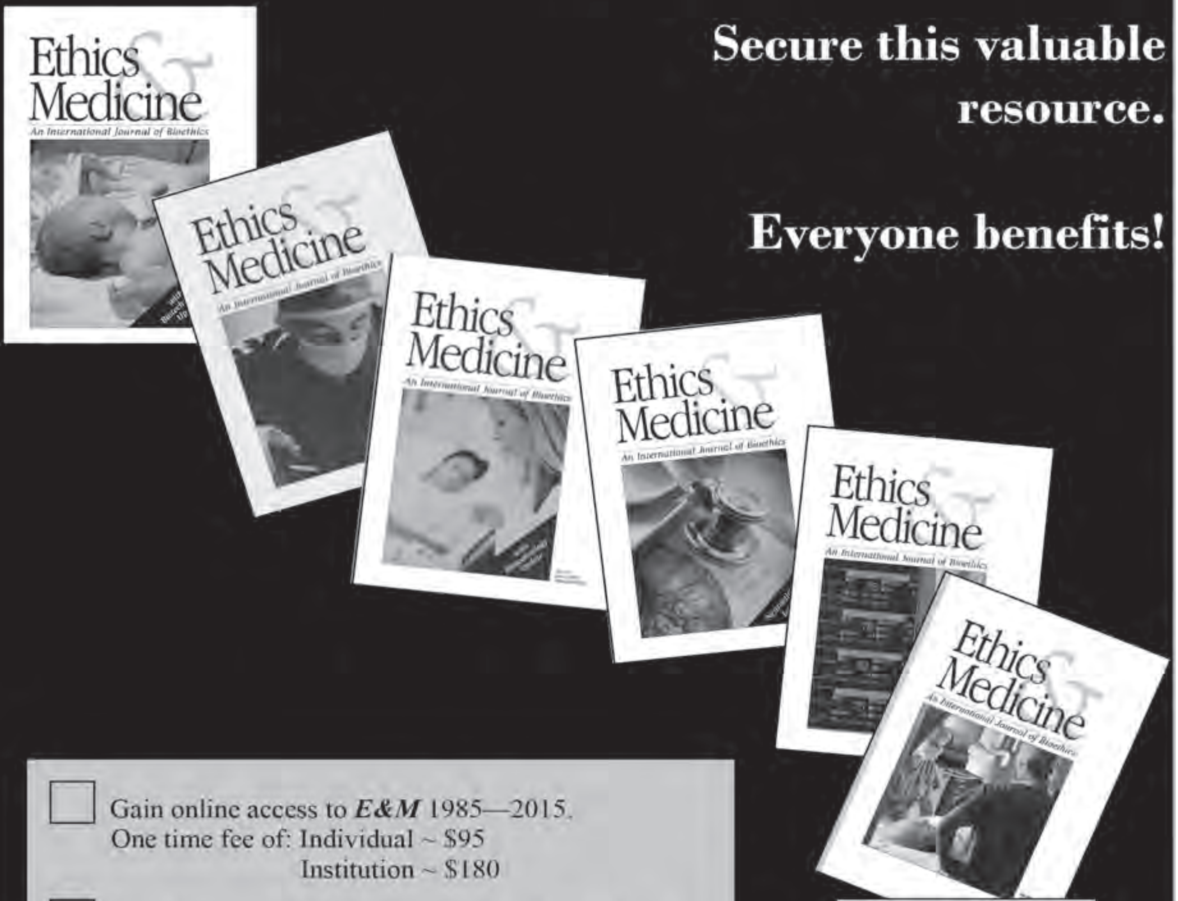
The author takes us through the principal figures in Enlightenment and post-Enlightenment thought whose understanding of humankind reduces humans to little or nothing more than machines or animals, so diminishing the worth of life. He frequently interweaves biography with intellectual history to show how their thought is related to the personal lives of the thinkers in question, and this can be a complex, multi-faceted matter. The terrifying dehumanization of our time is laid bare, not by scaremongering or through the medium of emotive prose, but by an objectively descriptive account of what is thought and said. In the last two chapters, the author turns to a thematic treatment of suicide, euthanasia, infanticide, and abortion before ending his volume with a chapter on “The Future of Humanity: Utopias, Dystopias, and Transhumanism.”

I warmly commend this volume. It is a solidly researched intellectual history made readable without over-simplification. While the tone is grave, the style is not manipulative. Where logical engagement is adjoined to historical account, it is clear and compelling, naturally emerging from the subject-matter without being intrusive. Given the huge quantity of literature being produced these days, it is with caution that we should talk of anything as a “must-read,” but this informative and sobering book lays plausible claim to such an assessment.

I have two general reservations. Firstly and briefly, the discussion of the reduction of humans to animal status runs the risk (unwittingly, I trust) of demeaning the importance of our proper care for and treatment of animals. Secondly, in dealing with Darwinism, the author’s opposition to Darwinian biology is apparently total, extending to a denial that there was death in the world prior to the existence of humans. It would be a pity if some readers seized on this to dismiss all that he says about Darwinism. I wish that Richard Weikart would have allowed for the position maintained by many who will passionately agree with the burden of his account in this volume, namely, that the problem with Darwinism is not necessarily the biology, but the interpretation placed on it by secular thinkers. Admittedly, this is to put things loosely, but those who are acquainted with the post-Darwinian theistic evolutionary position sponsored by a great number of orthodox Christians will know what I mean.

The last evaluative word, however, echoes the first, which is the acknowledgement of grateful, if sad, agreement with Richard Weikart’s analysis of this whole dire subject.

Reviewed by Stephen N. Williams, MA, PhD, who is a Professor of Systematic Theology at Union Theological College in Belfast, Northern Ireland and serves on the Editorial Board of *Ethics & Medicine.*



Ethics & Medicine

In Association With:
The Center for Bioethics and Human Dignity, Bannockburn, Illinois, USA
The Prof Dr G A Lindeboom Instituut, Ede, THE NETHERLANDS

CONTENTS

VOL 32:3, FALL 2016
HTTP://WWW.ETHICSANDMEDICINE.COM

bioethics PRESS

Ethics & Medicine An International Journal of Bioethics
Vol 32:3 FALL 2016 ISSN 0266-688X