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A Christian Perspective

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COMMENT

From the Editor

Embryos again

The weary Warnock debate is expected to be re-invigorated this autumn if, as we are led to expect, the Queen's Speech includes a commitment to introduce the comprehensive bill which protagonists on both sides have long demanded. deep parliamentary division on the central issue of embryo research is apparently to be met by the most unusual expedient of a free vote on alternative clauses – essentially, the Warnock majority recommendation (research allowed up to 14 days) *versus* the Powell Bill (none except in the interests of the embryo concerned). Whether the substantial majority in favour of Powell will be maintained remains to be seen: it is a new parliament, with many new faces; and opinion has had plenty of time to shift – and to be shifted, not least by the goalpost-moving coinage of the term 'pre-embryo', which enables staunch supporters of Warnock to put their hands on their hearts and say, 'we're against embryo research, too; these are just pre-embryos'.

Well, as Professor Ian Kennedy pointed out some time back in a *Times* letter, that 'pre-embryo' is a neologism is evident from the fact that the Warnock Report does not use it (it would certainly have been convenient to them had it been around at the time). Indeed, the Government consultation paper had the decency not to either. It's hard to avoid the conclusion that the definition of the term is not really 'a pre-14-day embryo' but 'an embryo we would like to have permission to experiment on'.

We need to keep our eyes on the ball. I was once a zygote and so were you, and if we license experiments on pre-14-day humans we are licensing experiments on the likes of you and me. We are denying that it is our *being* that makes us *human.* But if not that, then what? This is the big question: if membership of *Homo sapiens* is not what really counts (what Peter Singer has written off as ' speciesism'), who is to decide what does? We all have our own ideas about what makes people important and worthwhile, whether it is reason, the capacity for relationships, creativity, or some other criterion or set of criteria. It is not just that Christians, and others who wish to stand beside them, take as their point of departure the basic Christian understanding of man as made in the image of God; such that the image of God himself is recognised wherever man is seen (as in the zygotic Jesus; God himself was once a pre-embryo). The case is strong that in an increasingly pluralistic society only such a starting point will do. There are many theories about when life begins, or begins to matter, or should be protected in law.

May we not argue that the way in which such conflicts should be met in our society involves (a) a cautious and conservative approach to fundamental change; (b) a recognition that certain courses of action are ruled out, since they are profoundly offensive to many people (majority? substantial minority? – so much depends on how the question is framed); (c) an awareness that there are arguments unconnected with Christian religious and ethical convictions which tend to support them, or (to put it another way) to show that they are reasonable (in this case we are working with a concept of human rights and human dignity as co-extensive with *Homo sapiens*)? That is to say, it is those who favour the deleterious research use of the embryo who must make a case. It is not enough for them to say, 'how can you be sure this is a human person?', it is enough for them to be unable (as they plainly are) to demonstrate why it is unreasonable of us *either* to believe that the early embryo is ontologically 'one of us', *or* even to believe that this may or may not be the case; that we don't know. The widely held and specious position 'we don't know so it's all right' has to be shown up for what it is. If we really don't know, we do nothing; in case our ignorance cloaks a truth which would make our action monstrous.

The main practical outcome of a Warnock bill would be the establishment of a quango to administer its small print. If the invention of the pre-embryo was the first plank in the medical-scientific establishment's defence of Warnock, the second was the establishment of the Voluntary Licensing Authority, a conscious foreshadowing of the 'Statutory Licensing Authority' proposed by the committee. This was an astute exercise in PR, seeking both to reinforce the image of IVF as a responsible business, and to prepare the way for the SLA to come. Well, readers of *Ethics & Medicine* who observe the political process – and, especially, those who are actively engaged within it – will need no reminding that the composition and remit of the SLA are crucial to the whole future development of bio-technology. In its consultation document, the Government (no doubt at the suggestion of some clever civil servant in the DHSS, as it then was, maybe himself encouraged by a friend in the medical establishment . . .) slipped into the list of proposed responsibilities for the SLA a capacity to advise on future developments; in other words, to add to its administrative function that of being a 'standing Warnock'.

These functions are fundamentally distinct, and they require different kinds of members. The intention, no doubt, was to establish an authority essentially well-disposed to IVF in all its aspects which would offer congenial advice when, say, it becomes possible to sustain the embryo well after the 14th day; and, all of a sudden, the possibilities of research demand the re-definition of the 'pre-embryo' stage as lasting until 21, or 28, or 35, or whatever number of days is required. Whatever the outcome of the vote on embryo research, it is essential that the SLA have no such advisory function (indeed, if there are the votes it would do no harm to seal the lips of the authority by statute, and ensure that it is a thoroughly modest venture with no opportunity to aggregate to itself bioethical authority). Moreover, the authority's membership must not be a carbon copy of the membership of the present voluntary body. In broad terms, it should reflect the spread of public feeling on the issues, with (say) initial membership representative of the Commons vote on the embryo research question, and including figures known to be unhappy about the whole IVF enterprise. Only in this way shall we be able to put the brakes on the bioethical revolution.

With this issue Ethics & Medicine takes on more of an international flavour, as our first two associate editors join the team (see the column opposite). We are pleased to welcome Dr Pekka Reinikainen, from Helsinki, Finland, and Professor D. A. du Toit, from the University of Stellenbosch, South Africa, and look forward to their contributions to this Comment section in coming issues. The Editorial Board hopes to invite several overseas figures to be associated with the editorial work of the journal.

Love, Justice and the Allocation of Resources

DR RICHARD HIGGINSON, Ridley Hall, Cambridge

One of the things that keeps me interested in the study and teaching of ethics is the fact that the world is forever throwing up fresh topics for ethical debate. While certain issues like war, abortion and divorce have been discussed almost *ad nauseuam,* important subjects which have hitherto received relatively little attention keep thrusting themselves forward. The allocation of resources in health care is one such subject. It is a crucial background issue in medical ethics, an issue whose resolution impinges on most of the more concrete topical and controversial issues in medicine. As such I welcome the chance to address the question, though partly because there is a lack of tried and tested wisdom on this subject (and I am an unashamed parasite on other people's good ideas!) what I have to say will necessarily be tentative and sketchy.

When asked for a title a few months ago, I chose 'Love, Justice and the Allocation of Resources'. The reason is that I have argued in print (to be precise on p. 169 of my book, *Dilemmas,* Hodder & Stoughton, 1988) that the two pivotal principles which should lie at the heart of all Christian decision-making and action are those of justice and of love. In saying that, I do not mean to suggest that correct decisions can be read off with slide-rule simplicity from these two great principles; but I do believe they should be at the heart of all we do, and often it is possible to work out second-order principles which are consistent with love and justice in different areas of ethical inquiry. When I gave the title I had no idea what my commitment to love and justice as a starting-point would lead me to say on the ethics of allocating resources in health care; but I felt it would be an interesting mental exercise to find out.

Obviously, a lot depends on how one defines love and justice. I take love to be a disposition which delights in other persons and wills the best for them. Love speaks both of a warmth of relationship and a commitment to seek another's welfare when he or she makes such affection difficult. some might scoff at these as sentimental ideals which have no relevance to health care. But I beg to differ. Love in health care means showing the personal and thoughtful touch. This will mean 101 different things in 101 different situations. Often it involves personal qualities exhibited by health service employees in particular relationships; and the love which is shown neither demands centralised decision-making nor costs money. But where that personal concern is lacking, this can sometimes be linked to questionable administrative decisions. For instance, many hospitals give a host of outpatients the same appointment time. This leaves some individuals waiting a long time, wasting a lot of time and feeling extremely frustrated. A system of staggered appointments might be slightly more complicated and expensive for a hospital to run, but would be significantly more considerate and loving to the patients concerned.

Allow me to share another example from recent personal experience. Our two-year-old son has recently had a couple of operations in a leading Newcastle hospital. He and most of the other young children on his ward have required the presence of their mothers day and night. Very few of those mothers are provided with a bed. Those that are (about one in five) are given a bed some considerable distance away from the children's ward. The remaining mothers spend the nights sitting in chairs either by their child's bed or in the parents' room on the ward. The choice is thus one of either not being easily accessible when their child needs them, or of being accessible and having an extremely uncomfortable night. To my mind there is an obvious solution to this problem, *viz,* the provision of a supply of fold-up beds in the parents' room. the cost of this would be offset by the benefits rest would bring to the mothers, in turn making them more able to play their crucial part in nursing their children. Without the presence of mothers, hospitals would have to employ extra nursing staff. If hospitals showed just that extra measure of loving concern in treating the mothers of sick children well they could take a significant amount of pressure off their own hard-worked employees.

Love in health care also means a commitment to the welfare of the unlovely, a readiness to go on treating the patient who may in some way be offensive. Patients who abuse their bodies, whether through a surfeit of tobacco, alcohol, drugs, sexual promiscuity or in other ways, must often cause their doctors extreme irritation. The latter may be tempted to feel: if they won't help themselves, why should I? But an important part of the meaning of Christian love, as of the traditional medical ethic, is that doctors persevere with their patients. They keep on seeking the best for them. In this respect AIDS constitutes a major challenge to medicine and to society as a whole. I have noted a disturbing tendency in reporting on AIDS for homosexual and drug addict sufferers to be set apart from the 'real' victims of AIDS, as if the former were not genuine patients about whose plight we should be seriously troubled. True, some AIDS patients who have contracted the illness through involvement in a gay or drug culture have acted irresponsibly and reprehensibly. But that should not stop us loving them – which means being ready to treat them, finding the resources to treat them, and not treating them as paraiahs in the process!

The imperative to love, then, constitutes a perennial challenge to improve standards and maintain commitment to patient welfare in the health service. But precisely because the call to love is a call to love everyone, it sheds limited light on who should take priority when there is an issue of allocating scare resources. Where resources are scarce, some are liable to end up the gainers and others the losers. If love degenerates into sentimentality it may prove incapable of making these hard decisions. Hence the need for love to be supplemented and permeated by a concern for justice.

Justice, according to Aristotle (and his definition has been echoed by many since) means 'giving someone his due'. But what that 'due' is considered to be is open to a variety of interpretations. One model of justice is thoroughly egalitarian. Because all human beings are fundamentally equal, they should all be treated in the same way. Another model recognises that not all human beings are in comparable situations, so there is just reason for treating them differently, while insisting that those in similar situations should be treated similarly. This model thus enshrines a concern for equality within a system of differentials. A third model is more meritocratic: justice is about proportioning reward or penalty to work, achievements or the lack of them. A fourth model contains a bias to the poor, the

needy, and the deprived. Recognising that people start from situations of varying advantage – some privileged, others anything but – for which they are not responsible, justice seeks to remedy these imbalances and so devotes a major share of resources towards helping those most in need.

I believe that all these models of justice have something important to offer. In *Dilemmas* (pp. 174-5) I have pointed to elements in biblical teaching which provide backing for each of the four emphases: the egalitarian, the differential, the meritocratic, and the redistributive. Each emphasis has its proper place. What is not always so easy to decide is when it is appropriate to focus on which model.

Interestingly, a modern theory of justice which has attracted a good deal of attention and support, that proposed by John Rawls, draws either implicitly or explicitly on each of these models. Rawls' first principle of justice requires equality in the assignment of basic rights and duties, while the second holds that certain social and economic inequalities (*e.g.,* inequalities of wealth and authority) can be incorporated into a just system but only if they result in compensating benefits for everyone and in particular for the least advantaged members of society.

Let us now turn to the issue of resource allocation in health care. This problem occurs both in terms of micro-allocation, with regard to a particular group of patients competing for the same scarce resource, and in terms of macro-allocation, where there are different categories of patient competing for much larger but still limited resources.

First, the allocation of scarce resources where small groups of patients are concerned. The lack of sufficient beds for all the mothers on the children's ward provides an example of this. Assuming that most mothers would prefer a bed (albeit at the cost of not being so accessible to their child) how should a hospital decide which mother in every five should get one? My wife was given a bed the second time our child was in hospital but not the first. I hope that the reason was because on the second occasion she was seven months pregnant (*i.e.,* a good medical ground) rather than because after our first experience we wrote a stroppy letter (*i.e.,* kowtowing to the articulate middle class!). A just hospital policy would appear to be one of establishing where there are sound medical criteria (both on the child's part and the mother's) for granting priority and, after that, treating all mothers equally (which could mean apportioning beds either on the basis of first come-first served, or by deciding by lot).

A more important, and certainly much more widely discussed micro-allocation issue concerns the choice of patients for kidney dialysis where demand exceeds supply. Should the one available dialysis machine go to Alison, a 20-year-old unmarried student, Brian, a 30-year-old professional man with two children, Cheryl, a 40-year-old housewife with four children, or Denis, a 50-year-old unemployed divorcee who has completely lost contact with his children? Describing the four would-be recipients in this way immediately raises the question of whether age, marital status, number of dependents, and professional status are data relevant to a decision of this kind, but that is not where doctors should start their evaluation. Doctors should start with the criterion they are best able to judge, that of medical need. But medical need can be interpreted in two different ways. It can mean giving priority to the patient who is in the most desperate condition, whose life is most immediately threatened. (This might, incidentally, mean giving priority to Denis, the oldest patient, if age has rendered him the most run-down patient, but not because he is oldest *per se.*) Such a choice could well be justified if there was the possibility of providing care of a more interim kind for the other patients until more dialysis machines become available, but becomes a questionable use of resources if the first patient's desperate condition means he is less likely to benefit from dialysis, *i.e.,* he may well die soon anyway. This consideration points towards the second interpretation of medical need, which is to give priority to those for whom treatment has the highest chance of medical success, *i.e.,* of extending life significantly. (Conversely, this might mean giving Alison, the youngest patient, priority if her all-round condition is the fittest, but again not because she is the youngest *per se.*) Sometimes medical criteria may establish a clear order of priorities. But there again they may not. The more tried and tested a medical procedure becomes, the greater the likelihood that all patients will stand to gain by it. All four of our patients might be in immediate need and likely to survive for a significant period of time if put on dialysis. So further criteria of selection require consideration. Even among four people who share a common plight, that of being desperately in need of dialysis, can we identify significant differences in their situations which suggest a preferential order of treatment?

The fact that some patients are married and/or have dependent children and others do not could be one such factor. If Brian or, probably even more so, Cheryl die through lack of dialysis, there will be partners and children mourning as a result. But unmarried people also have relatives and close friends who will mourn their loss. It is not self-evident that the extra *closeness* of the marital or parental relationship constitutes a decisive criterion for putting individuals fortunate enough to be involved in such relationships ahead of others who are not. To put Brian or Cheryl first might display a special concern for one vulnerable group in society (young children) but at the expense of a bias against another (single people).

Again, what is one to make of individuals' social status? Brian, the one individual who is employed, might claim that he thereby makes a greater contribution to society. This would be the more likely if his profession is a high-status one like doctor, barrister or company director. But counter-claims might be made on behalf of Alison, of the grounds of the potentially brilliant career that lies ahead of her, Cheryl, because of the invaluable role housewives play as a bedrock of our society, and even Denis, if his past record before being made redundant includes some notable achievement. One can see that giving priority to an individual with special skills (*e.g.,* medical ones) might make sense in an emergency created by a disaster (since once restored to fitness, a doctor can play his part in helping others). But it is difficult to argue the case for this in more routine circumstances. If Brian's profession is that of a doctor, society is hardly likely to be significantly worse off through the loss of a single member of the medical profession. Overall, the task of assessing individuals according to their social worth appears to be an invidious one – extremely subjective and highly dubious. Granted that there is a case for giving individuals different financial rewards for the contributions they make to society (though that should not be taken to mean an uncritical acceptance of the *status quo*) the

allocators of health care resources should not be in the business of apportioning rewards – especially when it is the ultimate price of continued life at stake. Those who have been in high-status jobs or served society well have, to use a biblical phrase, 'had their reward'; the hospital is not the place to expect or confer further advantages.

My inclination is, therefore, to set the second and third models of justice (the differential and meritocratic) as inappropriate to this particular context. Once one has attended to the fourth, the criterion of greatest need, one is driven back to the first, the egalitarian model. Here, one accepts that all patients in medically comparable situations have an equal claim to treatment, and so it is better to decide between them randomly than evaluatively. Such a decision should not be construed negatively as an abdication of responsibility by resource allocators. It can and should be regarded positively, as an affirmation of human beings' fundamental equality. We are all of equal value before God. As for the way the random decision is made, two possibilities arise. One is acting according to a 'first come, first served' procedure, *viz,* everyone should take their place in a queue. But this assumes that people are able to enter and progress through the health care system at the same rate. Some individuals may use their power and influence to jump the queue. A purer system of chance (*i.e.,* some sort of lottery) seems preferable. Interestingly, there is good biblical precedent for the occasional use of lot (*e.g.,* the choice of Judas' replacement as the twelfth disciple). It testifies to the inappropriateness of human beings making judgments about their fellow-humans in certain contexts.

I turn now to the area of macro-allocation. It is, of course, this area which the advocates of the now (in)famous QALYs are concerned to address. There are certainly positive things to be said about the notion of QALYs. Here we have a coherent attempt to bring a discriminating overall perspective to the allocation of health care resources. It represents a concern to get beyond and adjudicate between the rival claims of competing groups demanding as big a share of the cake as they can obtain. QALYs embody a desire for rationality and efficiency in a sphere which too often appears arbitrary and inefficient. Furthermore, QALYs pose legitimate questions about whether in health care allocation we are apt to funnel too many resources towards the desperate and the unusual at the expense of more mundane and widespread types of suffering. While public attention and support is easily attracted for costly operations transplanting kidneys and (even more so) hearts, some patients wait years for a routine hip-replacement operation,. But hip-replacements are for more cost-efficient on a QALY scale of reckoning than kidney transplants or, for that matter, dialysis. The QALY notion raises a valid question: are the glamorous high-tech areas of medicine claiming a disproportionate share of resources?

The answer may well be that they are, though I am not entirely convinced; after all, the fact that not all patients who need dialysis machines can get them indicates that this is far from being an over-resourced area. The problem with the QALY approach is that it could lead to a practice of medicine which totally neglected patients in acute or even troublesome need because it concentrated all its resources at an earlier, preventative stage. Apparently, a BBC television programme calculated that from a budget of £200,000 a health authority would get ten QALYs from dialysis of kidney patients, 266 QALYs from hip-replacement operations, and 1197 QALYs from anti-smoking propaganda. I am surprised to learn that the effects of such propaganda can be quantified so precisely, but accepting that this is true, what is to stop the QALY advocate from devoting all the available money in the anti-smoking direction? He has adopted a thorough-going utilitarian line, and considerations of utility supply him with a clear answer. The figures show that the quality and length of a great many people's lives can be improved by the cheap, simple measure of anti-smoking propaganda. Nevertheless, we are right to recoil against the prospect of completely abandoning patients needing kidney dialysis or a hip-replacement. Is this not because we see Alison with her failed kidney or Zoe with her arthritic hip as representative of a group deserving justice? To opt one-sidedly for anti-smoking propaganda is to promote the interests of those in danger of succumbing to the temptations of smoking (a sizeable group, certainly) at the expense of other significant groups in society. To be just to each of these groups, some allocation of resources must be given, even if a measure of inefficiency according to the QALY yardstick creeps in. True, not every individual in every group will benefit, because the quantity of resources will be limited by their very dispersal. But they will at least have the consolation of knowing that their type of condition has not been forgotten, that the wider group of which they have become a part by dint of their illness is being assisted by society.

When we categorise individuals as members of a particular group in medical need, it is important to be aware of the social context in which medical needs arise. Some ailments and illnesses strike people equidistantly right across the social spectrum. Others have definite links with particular social groups – even in some cases with particular occupations as I have discovered in visiting miners with lung disease in a Durham hospital. An important principle which should underlie health care allocation is the maintenance of a roughly equal provision of health care between different social classes. No one class should feel that it is the object of discrimination.

The same is also true of different ethnic groups, which are also prone to different illnesses to varying extents. For instance, sickle cell disease (the collective term for a group of blood diseases resulting from inheritance of sickle haemoglobin, which produces symptoms of severe pain, fever, jaundice and anaemia) which is found mainly in the Afro-Caribbean population: it affects about one in 200 West Indian and one in 100 West African babies. Despite considerable pressure emanating from groups like the Sickle Cell Society since 1980, NHS provision in terms of specialist medical training, systematic screening and counselling services remains scare. It certainly compares unfavourably with NHS provision in relation to haemophilia, which is a comparable disease both in type and extent. It may fairly be asked whether Government concern about sickle cell would be greater if it was an illness solely affecting whites as distinct from one solely affecting blacks. It is as important to guard against racial discrimination in health care provision as in any other area of society.

The claims of social justice, then, bid us to be especially alert to the needs of minority groups within society. These groups include the very young (including the unborn), the very old, the seriously handicapped, and the severely demented as well as racial and religious minorities. All may find themselves at risk if society adopts a purely utilitarian calculus when it comes to health care provision. This calculus is likely to find that it is much more

economic to treat Mr and Mrs Average (and their many look-alike friends), who have the nous to get their none-too-serious illnesses seen to before they become too intractable and too expensive. We cannot afford to ignore utilitarian calculations, because they remind us of the need for efficiency and register alarm in the unlikely event of Mr Average's needs being neglected. But utility needs to be tempered by, and may sometimes be at odds with, a concern for justice, which demands that medicine continue to operate on a broad front. This will involve responding to a great variety of types of human need. It will at times support expenditure on quite costly types of treatment, recognising this is necessary in order to save lives, to maintain medical progress and confident that with the passage of time such cost will be reduced. The model of justice I am commending remains that which I supported in the area of micro-allocation: prioritising those in special need but with an egalitarian thrust in its concern that members of different groups throughout society receive adequate medical care. Because resources are limited, this care will not always be the best possible. But it can still remain care, it should still be characterised by love, it should never signify abandonment of the patient. The hospice movement has set a fine example in this respect. The work of love continues when the work of justice – inevitably – has failed to give everyone maximum satisfaction.

Continued from Page 28

References

1. 'The first and most helpful criticism I ever received from a doctor', wrote an American nurse, Sarah Dock, in 1917, 'was when he told me that I was supposed to be simply an intelligent machine for the purpose of carrying out his orders'. (Quoted by M. Benjamin in the *Hastings Centre Report,* vol. 18, no. 2, April/May 1988, p. 38)

2. Royal College of Nursing of the United Kingdom, *RCN Code of Professional Conduct – A Discussion Document* (London 1976), p. 1.

3. V. Henderson, *Basic Principles of Nursing Care* (Geneva, 1977), pp. 4, 6. See also the account of nursing provided by Baroness MacFarlane of Llandaff and G. Castledine in their *A Guide to the Practice of Nursing Using the Nursing Process* (London, 1982), pp. 4-5.

4. Cf. A. MacIntyre, *To Whom is the Nurse Responsible?,* in C. P. Murphy' and H. Hunter, *Ethical Problems in the Nurse-Patient Relationship* (Boston, USA, 1983), p. 79.

5. S. Chater, *Operation Update: The Search for Rhyme and Reason* (New York, 1976), pp. 5, 6. The conception of health, which dates back at least to Aristotle (384-322 BC), is defended in Leon Kass's article 'Regarding the End of Medicine and the Pursuit of Health', in A. L. Caplan, H. T. Engelhardt and and J. J. McCartney (eds.), *Concepts of Health and Disease: Interdisciplinary Perspectives* (Reading, USA, 1981), pp. 3-30).

7. The W.H.O.'s definition reads, in full: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. this definition is the first of a series of principles which are stated in the Constitution and which, the W.H.O. declares, 'are basic to the happiness, harmonious relations and security of all peoples'. (The W.H.O. Constitution is reprinted in Caplan, Engelhardt and McCartney, *Concepts of Health and Disease,* pp. 83-4).

8. Cf. Kass, *art. cit.,* and also Kass's 'Teleology and Darwin's *The Origin of Species:* Beyond Chance and Necessity?', in S. F. Spicker (ed.), *Organism, Medicine and Metaphysics* (Dordrecht, 1978), pp. 97-120. Cf. also the remarks of J. J. Haldane in 'Medical Ethics – an alternative approach', in *Journal of Medical Ethics,* vol,. 12, no 3, Sept. 1986, pp. 145-150.

9. Cf. again Kass, 'Regarding the end of Medicine and the Pursuit of Health'. A recent book, David Seedhouse's *Health: The Foundations for Achievement* (Chichester, 1986) is entirely devoted to this problem. Seedhouse rejects some widely favoured definitions of health and proposes an alternative definition, according to which 'a person's health is equivalent to the state of the set of conditions which fulfil or enable a person to fulfil his or her realistic chosen and biological potentials' (p. 72). This account of health seems to me to be vulnerable to the same objections as those encountered by the W.H.O. definition, *viz.,* (1) that it enlarges the scope of health so widely that it would encompass absolutely everything that contributes to man's good, and (2) that it would justify a practically unlimited extension of the doctor's and the nurse's professional competence and authority. One severe weakness of Seedhouse's book is that he does not seem to recognise the somatic theory as one of the theories deserving discussion, and does not refer even once to Kass's important article which outlines and defends that theory.

10. C. P. Murphy, 'Models of the Nurse-Patient relationship', in C. P. Murphy and H. Hunter (eds.), *Ethical Problems in the Nurse-Patient Relationship,* p. 10.

11. I am indebted here to an unpublished paper by A. J. L. Gormally entitled 'Risks', which was originally read to a nursing conference in 1984.

12. C. Campbell, 'Growing Pains', in *Nursing Times,* vol. 83, no. 43, October 28, 1987, p. 18.

13. C. Webb, 'Speaking up for Advocacy', in *Nursing Times,* vol. 83, no. 34, August 26, 1987, p. 34.

14. R. H. Pyne, *Professional Discipline in Nursing: Theory and Practice* (Oxford, 1981), pp. 5-6. (I have modified slightly the wording of the first and fourth criteria, in order to make them even more precise than they are in Pyne's book.) Some other writers who set out criteria for professional status allow that not all such criteria need to be satisfied if a body is to count as a profession: 'In reality few occupations ever meet all the many criteria, but to the extent that they do, they can be placed on a scale ranging from most to least professional'. (M. S. Pernick, 'Medical Professionalism', in *The Encyclopaedia of Bioethics* (New York, 1978), vol. 3, pp. 1028-1034, at p. 1028.)

15. Pyne, *Professional Discipline in Nursing,* pp. 6-7. Some writers also see the professional status of nursing reflected in the increasing importance of various specialised nursing roles. Cf., *e.g.,* Monica E. Baly, *Professional Responsibility* (Chichester, 2nd edition, 1984), p. 12: 'Another pointer to the growing professionalism of nursing is that it is developing a number of nursing specialisms . . . as a response to various medical specialities. Good examples of 'nursing' specialisms are terminal care nursing, stoma therapy and infection control. . . .'

16. Cf. editorial, 'Withdrawal of service, a dilemma for nursing', in *The Canadian Nurse,* July 1968, p. 29: 'Although the past few years have brought great changes in attitude among a large portion of the CNA (Canadian Nurses' Association) membership, there still remain many nurses who are reluctant to become involved with collective bargaining to achieve goals. They take a negative attitude towards it, because they believe it to be incompatible with professionalism, or afraid of facing possible conflict with management'.

Nurses, the Nursing Profession and Ethical Problems

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The Linacre Centre in London have just published Dr Fitzpatrick's major volume, *Ethics in Nursing Practice. Basic Principles and Their Application,* which will be reviewed in *Ethics and Medicine* in due course. We are grateful for permission to reproduce the opening chapter here.

Ethics in Nursing Practice is available from the Linacre Centre, price £9.95 (Linacre Centre for the Study of the Ethics of Health Care, London, 1988).

How should a nurse face up to the ethical problems which she encounters in her work? In trying to decide what action to take, how should she analyse the problems she is facing so as to identify the moral issues at stake? Questions of this sort will be central to the investigation of this book. In order to begin getting to grips with them, let us consider a problem of a kind which arises frequently for nurses in hospital wards. The problem, as expressed by a nurse at a London teaching hospital, is as follows:

> It is often difficult to answer the questions of patients who have just had cancer diagnosed. In many cases they are not told the severity of the disease or the prognosis, and nurses are not supposed to tell them if the doctor wants the information withheld from them. We at ... hospital had a patient who came in for tests which disclosed that he had a cancer of the rectum. He was not told of his condition, but was simply informed that he was to have a colostomy. This news quite terrified him. We were not allowed to tell him why he was to have a colostomy, because he was already a nervous man and the doctors considered that the news would affect his condition. Even so, he kept asking us if he had a cancer, and insisting that he would rather know definitely than not know. We told all this to the doctors, but they still refused to inform him.

Likewise, it may happen that at a ward meeting the nurse in charge will state: 'Dr X instructs that Mr A (a patient) is not to be told about his condition'. Any nurse caring for Mr A would then, apparently, be required not to tell him the truth about his condition but to evade any awkward questions which he may raise. It may even be suggested that the nurse is morally obliged to lie to Mr A, to tell him, for instance, that he is suffering from some remediable muscular problem when, in fact, he has motor neurone disease. May a nurse accede to requests of this sort? Or is she obliged to answer the patient's questions truthfully, to tell him what she herself knows about his condition and his prospects?

Some people would suggest that in situations of this sort the nurse's proper course of action is to suppress her own convictions and to do as the doctor says. If the nurse herself thinks in this way, she may reason to herself as follows: 'I don't myself think it's a good thing to evade Mr A's questions, and if it were up to me I should give him the whole truth. But, unfortunately, it's not up to me. It isn't my place to tell him what he wants to know; it's the doctor's job to do this, and if I were to tell Mr A the whole truth I'd be usurping the doctor's role. I must be satisfied to do those things which are my own legitimate business and not try to take over responsibilities which belong to other people'.

A nurse who thinks in this way is evidently basing her moral judgment on a certain conception of her role precisely as a nurse. What is this conception? It is that of the nurse as essentially the doctor's handmaid, someone whose first loyalty is not to her patient but to the doctor who prescribes medical treatment for the patient: her proper role is precisely that of ensuring that this prescribed treatment is carried out and also of looking after the patient whenever the doctor is not around to attend to him personally.[1]

This conception of what nursing is all about has at times been widely held by nurses themselves as well as in society at large. Against it, however, there is the view of nursing which finds expression in many of the recently formulated codes of professional conduct. For instance, the code issued in 1976 by the Royal College of Nursing lays it down that 'The primary responsibility of nurses is to protect and enhance the well-being and dignity of each individual person in their care'.[2] If this is the case, it is arguable that no nurse may decide that she should not tell her patient about his condition simply because the patient's doctor has instructed her not to do so. Here we seem to have two incompatible conceptions of what nursing is and what the nurse should be doing.

These reflections lead us to draw the following conclusion: this moral problem raised by a doctor's instructions not to tell patients about their conditions or prospects, like many moral problems arising in nursing, can be intelligently handled only if one has first determined what the proper role of the nurse consists in. For, in general, people are often morally obliged, by virtue of their filling a certain role in society, to act differently from those who have not assumed that role. A parent, for instance, has obligations towards his children – *e.g.,* to provide for their material well-being and education – which no mere friend of the family could be said to have. Just as someone who becomes a parent thereby incurs a totally new set of obligations, so one who takes on a particular occupation is morally obliged (normally, at least) to perform faithfully the activities which that position entails. In some occupations the employee's responsibilities will have been either exhaustively described to him or enumerated in his contract, so that no detailed inquiry into their nature will be called for. But in other occupations, including nursing, the practical decisions which need to be made may vary enormously from one day to the next, so that no precise enumeration of 'dos' and 'don'ts' could ever be formulated. We need, then, to become as clear as we can about the proper role of the nurse.

There are all kinds of situations in which a nurse who finds herself morally impelled to act in a certain way may hold back, asking herself: 'Is it my *place* to do this? Do I, in my position, have the *right* to take the matter into my own hands in this way? Have I the *authority* to do so?' Such questions are essentially questions about the nature of the nurse's legitimate role, and about the sorts of acts and omissions which adherence to that role may license. So at least some of the moral problems which the nurse encounters will be soluble only if she possesses a clear-headed awareness of what is involved in being a nurse.

The role of the nurse

One traditional answer to this question about the nurse's role is that the nurse is engaged in *caring* for people who are either ill or disabled or (as in the case of some pregnant women) who require some fairly close and regular attention if certain dangers to life and health are to be avoided. According to this line of thought, the maintenance of health is a basic human need which people normally meet through eating and exercising, maintaining the right bodily temperature, and so on. This normal method of maintaining health may go wrong in either or both of two ways. First, the activities which normally maintain health and physical well-being may no longer be sufficient to do so. If this happens, because of illness or injury, and if, also, the patient cannot himself make up the difference, some fairly intensive and more or less prolonged caring may be necessary. Secondly, the patient, due to either illness or injury, may no longer be able even to perform those activities of eating and exercise which are essential for health, and in this case also someone else will have to care for him by helping to provide whatever he needs in order to have his health restored and maintained. The activity of helping or caring may require considerable skill and also a detailed knowledge of the workings of the human body, the nature and consequences of the patient's condition, and the complications which might arise from it, and so on. This task of caring for a patient, in the effort to maintain him in health or to restore him to health, is that which is proper to the nurse. In the case of those, such as terminally-ill patients, who cannot be restored to full health or anything like it, the nurse's role will be that of assisting the patient to retain (and, if appropriate, to regain) as much of his health and physical well-being as he possibly can, given his condition.

This conception is well summarised in the following account of the nurse's function, taken from one of the best-known general nursing textbooks, Virginia Henderson's *Basic Principles of Nursing Care:*

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him to gain independence as rapidly as possible. This aspect of her work, this part of her function, she initiates and controls; of this she is master. In addition she helps the patient to carry out the therapeutic plan as initiated by the physician. She also, as a member of a medical team, helps other members, as they in turn help her, to plan and carry out the total programme whether it be for the improvement of health, or the recovery from illness or support in death . . .
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> . . .the primary responsibility of the nurse is to help the patient with his daily pattern of living, or with those activities that he ordinarily performs without assistance; these are breathing, eating, eliminating, resting, sleeping and moving, cleaning the body and keeping it warm and properly clothed. The nurse also helps to provide for those activities that make life more than a vegetative process; namely, social intercourse, learning and occupations that are recreational and those that are productive. In other words she helps the patient to maintain or create a health regime that, were he strong, knowing and filled with the love of life, he would carry out unaided.[3]

How, in this case, does the nurse's role differ from that of the doctor? The answer is that the doctor has special knowledge and skills that enable him to diagnose illnesses, to give prognoses and to prescribe courses of treatment for the acutely ill - that is, for those illnesses which can be treated by radical intervention in the functioning of the body, *e.g.* by surgery or drugs. He is also able to prescribe similar treatment for the palliation of the symptoms of the disease in both the acutely ill and the chronically or terminally ill. The nurse's training does not give her the knowledge and expertise to carry out the first of these tasks, and so in the treatment of acute illness, and in some aspects of the care of the chronically or terminally ill, she helps to implement a programme of treatment prescribed by the patient's physician. Even so, provided that the nurse does, in these cases, faithfully carry out her part in the medical or surgical procedure, the nursing care which she provides is something on which she, and not the patient's physician, is the authority. So, on this view,whereas a doctor's priority is normally the *cure* of illness or disease, or at least the attempt to achieve as much in the way of a cure as can be reasonably hoped for, the nurse is concerned primarily with the *care* of patients. In some cases this nursing care will be used to assist the doctor in his efforts to cure, but in other cases (including, most obviously, those involving terminal illness) it will not.

This amounts to saying that a nurse's role can be seen as encompassing both an *independent* and a *dependent* function. That is, her work comprises both those activities which she performs as an independent practitioner and those other activities which she performs in helping to implement programmes of treatment prescribed by another health professional, usually a doctor. In her independent role, the nurse is concerned to assist and promote the patient's own bodily and mental resources so that he will recover his health to the fullest possible extent. This aspect of the nurse's role is perhaps most prominent in caring for mentally handicapped patients and also in community nursing and health visiting, where she is concerned, above all, not to do things for her patients but to educate and encourage them to promote their own health or the health of those (infants or aged relatives, for example) for whom they are caring. *Promotion of health* is therefore the central focus of the nurse's attention when she acts as an independent practitioner. But in her *dependent* function the nurse adopts, temporarily , the same perspective towards the patient as that of the doctor who prescribed the treatment, and she puts into effect a medical treatment aimed at directly attacking the disorder from which the patient suffers.

The role of the nurse is, then, a complex one, encompassing an independent as well as a dependent function. According to the condition of the patient whom she is treating, one of these two roles will become more prominent than the other. If the patient is acutely ill, his illness or injury will have to be combated before his natural powers of recuperation will be able to assert themselves. So here the nurse's independent role is to the fore. But once the acute condition has been rectified, the need is for the patient's own natural powers to be brought into play; and here the nurse's independent role becomes crucially important. This is also true in the case of chronic and terminal illness, where radical interventions in the workings of the body cannot benefit the patient.

The distinction between the nurse's role and the doctor's role should not be made too sharp, for the doctor is not concerned solely with counteracting illness and infections and repairing the damage to the body. He will realize that radical intervention in the workings of the body, through drug therapy, for example, or through surgery, will not be sufficient to restore the patient to health. The most crucial part in bringing about someone's recovery is played not by anything which a doctor prescribes but rather by the patient's own natural bodily resources. Medical and surgical treatment should be seen not as restoring the patient to health, but rather as removing certain

severe obstacles to the effective operation of the patient's own natural health-giving powers. The distinction between medical and nursing roles is really one of emphases or priorities. The doctor concentrates his attention on the effectiveness of therapeutic interventions in the workings of the body, but he will realize that such interventions are not going to achieve anything unless the patient's own health-preserving resources are sufficiently powerful to take full advantage of them. The nurse, by contrast, makes the patient's natural health-giving resources for preservation of health her central concern; but since she realizes that these resources can often be rendered ineffective by illness and injury, she sees it as part of her role to help in carrying out the medical or surgical treatment of the patient.

This fact of the complexity of the nurse's role may explain why some writers apparently fail to spot any unifying principle in nursing.[4] They tend to focus their attention on the notion of nursing essentially caring for patients, and then point out that many activities performed by nurses - the administration of chemotherapy, for instance, or the resuscitation of patients undergoing cardiac arrest - are in fact therapeutic interventions in the patients' bodies. They also point out that nurses now regularly carry out treatments involving complex monitoring equipment which were previously the exclusive preserve of physicians, and that these treatments are far removed from caring in the traditional sense. These difficulties disappear once we realize that the nurse's role is complex in the way described, that it contains a dependent an an independent function, so that no one type of activity will exhaust the nurse's role. We may, then, conclude that caring, in the sense described here, is the nurse's central activity, even though her work also encompasses other duties which are related more or less closely to this central function. Given that the nurse is concerned with the health of the whole person, it is understandable that part of her work will overlap with that of the doctor. So, as one commentator points out:

> Nursing is a process through which *care* is provide to individuals, families, or community groups *primarily* around circumstances and situations that arise from health related problems. Medical practice, on the other hand, is primarily cause-and cure-orientated. It is important in the above definition to stress the word 'primarily', for settings, numbers and circumstances can change the degree of overlapping functions between the nursing and medical professions. For instance, in remote areas nurses often come closer to practising medicine than nursing. Similarly, a physician may sit beside his patient in the recovery room caring for the subtle circumstances that arise during the post-operative course, practising something more akin to nursing than to medicine.[5]

A crucially important concept: health

The nurse's role has been described here as centred on enabling the patient to retain or regain health by encouraging and supplementing the workings of his natural powers of self-preservation and recuperation. With this description, have we arrived at a satisfactory account of nursing? No, not quite. For the very notion of *health,* which figures so prominently in the definition, is subject to differing interpretations. According as one adopts one or another of these definitions of health, one will understand the nature of nursing in differing and, indeed, incompatible ways.

The concept of health is not an easy one to analyse, and there is an extensive literature in which the claims of various rival definitions are canvassed. In recent times there have been two leading contenders. (1). The idea of health as essentially *bodily well-being.* According to this conception, the word 'health' applies first and foremost to the proper functioning of the human body. Someone is healthy if his body is functioning as it should, free from disease and injury and from such other impediments as excessive fat levels, muscular flabbiness, high blood pressure and so on. The idea is not that a person is healthy only if his body is functioning *perfectly,* for if this were the case no-one at all, probably, would ever be healthy. Health is well-functioning, not perfect-functioning: it consists in an 'all-round satisfactory performance' of the body as a whole and of its individual parts and organs.

Supporters of this definition of health as bodily well-being do not deny that it makes sense to say that someone is healthy in mind as well as in body; nor do they dispute that a person's mental and emotional state often strongly influences, for good or ill, his physical condition. But they do maintain, first, that the primary use of the adjective 'healthy' is to apply to living bodies and, secondly, that although health professionals must take account of their patients' states of mind in planning their medical treatment or nursing care, the fact remains that mental and emotional influences on health are just that: factors which profoundly influence health one way or the other but are not actually part of a healthy or unhealthy constitution. I shall call this conception 'the somatic conception of health' (from the Greek word *soma,* meaning 'body').[6]

(2) The definition of health proposed by the World Health Organisation, in its *Constitution* of 1946, as a 'state of complete physical, mental and social well-being'. On this view, everything which contributes to the good of man is the legitimate business of the health professional. I shall call this 'the all-encompassing concept of health'.[7]

Those who reject the somatic conception contend that it involves regarding the patient as *just* a body, an organism made up of working parts, and not a human person. They may then object that any health professional who adopts such a conception may easily be led to 'depersonalise' his patients, to think of (and perhaps even treat) them as objects rather than people. But this objection evidently involves a misunderstanding. The nurse who accepts the somatic account of health will certainly guide her actions towards patients by her understanding of what will truly promote their physical well-being. But this is not to say that she ignores her patients' personal qualities and treats them throughout as mindless bodies or automata. Her professional concern is with their physical well-being; but she knows that wherever there is a living human body there is a human *person*, and that the body is not an entity in its own right but rather a 'part' or aspect of the whole person. She realises, then, that the point of all her activity is not to serve the body *as such,* but to serve the whole human being through promoting one important aspect of his total well-being, that of health. Admittedly, there is always a danger that health professionals will overlook their patients' individual and spiritual qualities and treat them merely as systems of physical organs; but the somatic conception of health cannot justly be charged with licensing that wrong outlook.

It might be thought that the definition of health as bodily well-being is undermined by the fact that we can speak meaningfully of people being healthy in mind as well as in body, about the mental health of patients, and about certain health professionals, such as pyschiatrists and psychiatric nurses, being concerned primarily with mental

rather than physical health. This objection is not conclusive, however, because a defender of the somatic conception can say that the primary meaning of 'health' is 'bodily well-being'. Nevertheless, the meaning of the word can be extended to cover man's mental functioning. Further extensions in the meaning of the word will make it intelligible to talk of the economic health of a nation, the moral health of an individual or society, the healthy or unhealthy state of man's spiritual life, and so on. Mental health is, then, on this view, conceived as the harmonious well-functioning of the mind, corresponding to the well-functioning of the body which is health if the strict sense of the word. The fact that it makes perfectly good sense to say of someone 'He's mentally disturbed, but so far this hasn't undermined his health' indicates that one is justified in viewing bodily well-being as what is primarily signified by the word 'health'.

What, then, of the roles of psychiatrists and psychiatric nurses? As health professionals their concern is obviously with health; but since it is mental, not bodily, well-being which they are trying to promote, their activities would appear to provide a living disproof of the somatic theory. Is this really the case? What makes this question difficult to handle is the fact that the status of psychiatry itself is a matter of dispute, so much so that either or both premises on which this argument against the somatic theory rests – (1) that psychiatrists *are* health professionals and nothing other than that, and (2) that psychiatry focuses its attention specifically on the patient's mental well-being – are questionable. A behaviourist psychologist, for instance, would certainly challenge the second of these contentions, since he would refuse to recognise any such thing as specifically mental health. If we reject behaviourism and insist that the psychiatrist, indeed, deals with mental, not physical well-being, this will be precisely a ground for saying that he is not concerned with the *health* of his patients, in the strict sense of the word 'health', and that he should not be regarded as a health professional. It has, indeed, been the accepted practice for psychiatrists to be medical practitioners, but one may doubt whether this is at all necessary; perhaps psychologists or others could do this work just as well. One could go on to argue that the work of the psychiatric nurse is implicated in this uncertainty of surrounding that of the psychiatrist, and that, insofar as she concerns herself expressly with the mental well-being of her patients, she is no longer focussing on their health, in the strict and primary sense of this word, and so is moving beyond the field of nursing as such. On this view, psychiatric nursing would be a sort of hybrid occupation, involving nursing *and* some other kind of work which expressly focussed on patients' mental well-being. This is one possible response which the somatic theorist may take. I do not wish to defend this or any other conception of psychiatric nursing here, but simply to point out that since the status of psychiatry and psychiatric nursing are subject to some dispute, it would seem unreasonable to overthrow our conviction that health in the primary sense is bodily well-being.

It can, however, be objected that the somatic account is too vague to be of much use, because the notion of bodily well-being is itself in need of clarification and cannot, therefore, be used to define health. What, after all, is bodily well-being? How do we measure it? To what extent, if at all, is it compatible with various illnesses and injuries? Is the standard of bodily well-being the same for all men, or does it vary from one person to another, or for different people in different societies? And can we define bodily well-being without first defining the opposed concepts of illness and disease? Clearly any attempt to defend the somatic conception of health by resolving these questions would involve developing a full account of human nature. It would have to be shown that all human beings do possess a common nature, and that the workings of man's body can correctly be described in a *teleological* way, as intrinsically geared to achieving an end or goal (Greek *telos,* 'end'), this goal being the bodily well-functioning which the somatic theorist takes to be identical with health. This sort of argument would be far too complex to be conducted here; but much valuable work in this area has been done, and it would be rash to claim that adherents of the somatic conception of health are unable to answer the sorts of question posed above.[8]

What about the all-encompassing definition of health proposed by the World Health Organisation? This definition does seem to be open to serious objection. If health is really 'a state of complete physical, mental and social well-being', and if the nurse's role is to promote the patient's health, then there are no obvious bounds to the nurse's professional competence and responsibility or, therefore, to her professional authority. She will embody, in her person, the roles of social worker, psychologist, and priest or spiritual adviser. But this, surely, is unreasonable. It is one thing to say that since the nurse's patients are human persons she must, in caring for them, take account of their mental and spiritual qualities; but it is quite another thing to claim that the patients' spiritual welfare (say) comes under her direct professional competence or that her advice and orders in that field have any professional authority. The nurse's competence and authority have definite limits, and she would act wrongly in attempting to usurp the roles of social workers and chaplains.

A comparison with the role of another kind of professional, a bank manager, may be helpful here. Any bank manager who regarded his customers solely as depositors and borrowers of money and who, in his dealings with them, never took account of their personal and spiritual qualities, would certainly be adopting a wrong attitude towards them. He should, instead, fully respect his customers as human persons and deal with their problems sympathetically, as befits human beings. Given that financial problems can impose a severe strain on families, it is probably not uncommon for a manager's attitude to be decisive in (for example) either sustaining a marriage or contributing to its break-up. But to say this is not to say that the bank manager's professional competence is all-encompassing, that he has a direct concern with his customers' personal fulfilment, with the quality of their intellectual, emotional and spiritual lives, and with the stability of their marriages. For he *is* a bank manager, not a priest or a marriage counsellor, and his direct professional concern is with those financial matters which his customers' entrust to him. It is only insofar as the more intimate aspects of his customers' lives impinge upon their financial position and, *vice versa,* that he can be justified in inquiring into them and offering his customers some limited guidance concerning them.

The question of the nature of health is more complicated than these very brief comments would indicate, and it would be a mistake to imply that the two theories discussed here, the somatic theory and the all-encompassing theory, are the only ones worth examining. On the contrary, there are several other conceptions of health which have been outlined in recent times, and any full treatment of this problem would have to take them into account.

While the reflections of these pages certainly do not establish the truth of the somatic theory of health – a task which would be impossible in such a brief compass as this – they do, I think, render suspect those theories which seek to go beyond man's bodily well-being and to define health in much broader terms. The least that can be said of the somatic theory is that it is reasonable in itself and that there is no obviously conclusive objection to it.[9]

The account of the role of the nurse which has been reached here is, then, as follows. The nurse's primary aim is that of facilitating the proper functioning of her patient's own resources for preserving and regaining health, to the extent to which that goal is attainable. And the notion of health which is used here is that of bodily well-being, not that of the comprehensive psychosomatic well-being suggested by the World Health Organization. The nurse realizes, of course, that her patients are not just bodies but persons, with mental and spiritual characteristics, and she is concerned to treat them always as persons. But her primary focus is on the bodily health which is appropriate to them as living beings. What has just been described is the nurse's primary and independent function; but insofar as her exercising this leads her to co-operate in her administering treatments decided upon by other health professionals she has another, this time dependent, function. However, the dependent function is subordinate to the independent, one, because it is the aim of enabling the patient's health-preserving or health-regaining powers to work unhindered which gives point to all the nurse's activities.

The importance of centring care on patients

Given that the nurse's primary task is to provide care for her patients, it follows that her overriding loyalty is to them. It is important to state this, because the fact that most nurses work in hospitals and spend much of their time carrying out orders can lead them to mislocate their primary loyalty. They can become preoccupied with satisfying the demands of consultants or of the hospital administration, rather than responding to the needs of the patients in their care. Admittedly, the opposition between these different viewpoints should not be exaggerated: the well-being of patients provides the *raison d'être* for the work of the hospital administration and the consultants just as it does for nurses; ideally, all three work harmoniously together to achieve a common goal. Nevertheless, administrative procedures in hospitals, as in other institutions, are liable to be seen and pursued as ends in themselves, particularly if a hospital is regarded as a sort of business, with efficient management of staff and resources the number one priority. And hospital consultants whose personal contact with patients is sometimes minimal, may tend to regard patients as interesting challenges to medical science rather than as *persons* whose health problems can be the occasion of profound mental and spiritual suffering. Take for instance, the following report:

> While working on a male surgical ward, I was not at all impressed with the consideration shown by the consultant for patients' feelings. On one particular ward round, he went to a patient's bed and said loudly: 'Uh, this is the carcinoma, is it?'. As it happened the man was Spanish and spoke little English, and so probably didn't understand what the consultant had said – which was just as well, because he had only just been admitted and knew nothing of his condition. However, several of the other patients must have heard, and I think this was very thoughtless. Unfortunately this was not an isolated incident, because this particular consultant habitually discussed cases with colleagues in the hearing of patients.

This consultant evidently viewed his patient primarily as a collection of physical organs, one of which was in an interestingly pathological condition. This lack of respect for patients is by no means characteristic of all hospital consultants because nurses, physiotherapists and others are also capable of treating patients in a degrading manner; but the fact is that nurses, because of their comparatively close relationship with their patients, are normally less inclined to behave in this way. However, the temptation to regard patients not as persons requiring considerate care but as (say) machines to be kept going may, nevertheless, often be present. All the more reason, then, why the nurse should not allow her attitude to her work to become doctor-centred (or, for that matter, hospital-administration centred) rather than patient-centred: she must always treat her patients as whole human beings and regard their well-being as the goal of her efforts.

Along with this attitude of overriding concern for the patient's well-being, there are certain qualities of character which appear to be important for any nurse. Her patients – whether she meets them in hospital, in a medical practice, or on health-visiting rounds – have genuine health problems which can affect them profoundly on an emotional and spiritual level. A nurse would prove herself insensitive and unfeeling if she were not aware of this fact and able, to some extent, to 'enter into' the minds of her patients and appreciate just what their condition means to them personally. Hence the attitudes of concern and compassion, of sensitivity to patients' deepest personal feelings and reactions, should be part of the nurse's conscious make-up.

Two features of current nursing practice can perhaps tempt the nurse to cease regarding her patients as the primary focus of her work and can also weaken her hold on these essential personal qualities. The first of these is the effect of modern technology. Much of a nurse's time nowadays is taken up with operating various pieces of equipment, especially those used in the intensive care of acutely-ill patients and almost total care of the chronically and terminally ill – as of secondary importance only. One nurse educator reacts to the recent changes in the following way:

> Prior to the miracle drugs and the rapid technological advances in medicine in this century, nursing and its caring functions were the main contributions to health care. The focus was on care of the hopelessly ill individual and not the instant cure of disease. As the practice of medicine became more enhanced in the cure of disease, the quantity and quality of caring on the part of nurses decreased and the nurse became an extension of the physician's technology. The nurse as a medical technician has led to a model of nursing care that is fragmented, dehumanised, and depersonalised. Loss of its caring identity and the abandonment of its caring functions has threatened the basic structure of nursing. A return to caring concern now offers hope for the future as nurses begin to value the types of caring services they are capable of rendering to those patients beyond the reach of medical technology – the chronically ill, the elderly, and the terminally ill.[10]

Is this a reasonable reaction to the technological orientation of modern nursing? Arguably it is not, because this technical orientation is an inevitable result of scientific advance and is evidently here to stay. Nurses need to react to these technical changes positively, by trying to handle the demands which they make without relinquishing their patient-centred perspective; they should not react (as, it seems, the author of the quoted passage would recommend) by wishing that the technology would go away and then concentrat-

ing on other things. Nevertheless, it certainly is true that the technological character of modern nursing can tempt the nurse to move away from her proper role *vis-a-vis* her patients, and to come to see herself instead as a medical technician.

The second factor which can tempt a nurse to abandon a patient-centred perspective; has to do with the mode of operation of hospital bureaucracies.[11] Bureaucracies are typically concerned above all with efficiency in achieving the ends for which they are working; but they cannot themselves determine what those ends will be, because the ends are set by other people or bodies, and the bureaucrats take those ends as 'givens' which are to be achieved as efficiently as possible. In a pluralistic society like our own, in which there is no public consensus on what sort of a good health is, or how it fits in with the ensemble of other human goods, hospital administrators will lack any coherent conception of the good of health and its place in the achievement of overall human well-being, and will, therefore, tend to run their hospitals along the same efficiency-conscious lines as any other business. The real end or primary purpose of health-care facilities will tend to be forgotten in the pursuit of efficiency – particularly, of course, money-saving efficiency. Such a policy may powerfully influence nurses working in a hospital or undertaking community nursing for a local health authority; and a nurse whose thoughts are centred on satisfying this demand for efficiency rather than on meeting the needs of her patients will herself be losing sight of the primary purpose of such institutions, with potentially harmful results both for her patients and for herself.

The nurse as an advocate on her patients' behalf

The fact that patients, not hospital administrators or other health professionals, are the primary focus of the nurse's activities has led may people to seize on the idea of *advocacy* on behalf of patients as expressing the proper spirit of nursing. The word 'advocacy' tends to be given different senses by different writers, and some of these senses are perhaps less appropriate than others; but all those who describe the nurse as 'the patient's advocate' hold the following viewpoint. The nurse should, in carrying out her duties, think first and foremost of the welfare of her patients. She should regard herself as an advocate on their behalf, in the sense that she will do everything in her power to obtain for them the care that they need; she will not be afraid to press for their genuine needs to be met if the actions or directives of hospital administrators, doctors, or other nurses stand in the way of their being met. In particular, while she will always respect legitimate authority in her hospital, she will not abandon her responsibility to act in her patients' best interests if, by doing so, she should come into conflict with mistaken directives given by a physician or a nursing superior. This idea seems plainly correct: given that the nurse's labours are orientated first and foremost to the patient's welfare, advocacy on the patient's behalf, in this sense of the word 'advocacy', is a duty for her.

Paediatric nurses have recently expressed concern about the possibility that some newborn babies are being admitted to surgery without having been given adequate anaesthesia. According to one adviser to the RCN association of paediatric nursing: 'Lots of ward sisters have asked for my support when they've felt that junior medical staff have failed to provide adequate anaesthesia'. Another paediatric nurse is reported as saying that 'it is now up to nurses to improve their knowledge to guide and advise junior doctors when necessary'.[12] Here we have an example of nurses acting as advocates for their patients in a way which is clearly justified – especially since the patients in this case cannot defend their own interests and need someone to advocate on their behalf.

Some nursing writers are inclined to present the nurse as *the* patients' advocate, but this is evidently untenable. For all health professionals, nurses, doctors, physiotherapists and others, should be advocates for their patients, in the sense of 'advocate' which is being used here: there is no reason for supposing that nurses monopolise this role. Nevertheless, it does seem that doctors, and especially hospital consultants, because they spend only a short time examining and talking to their patients, may be strongly tempted to treat them in a way which fails to respect their dignity as persons. By contrast, the nurse, who spends much more time in her patients' company, will not normally experience this strong temptation; and in this sense advocacy on behalf of her patients is likely to be a more prominent aspect of her work than of the doctor's.

The nurse-as-advocate viewpoint is sometimes understood as contributing to an adversarial, rather than a co-operative, relationship between nurse and doctor, and there is no doubt that a nurse who takes her role as advocate seriously may sometimes come into conflict with medical personnel. One issue which may generate such a conflict is that of the doctor's duty to obtain informed consent for treatment. If it becomes clear that a doctor has not adequately explained to a patient what his proposed course of treatment will amount to, a nurse may be obliged to intervene in some way so that this unjust situation will be rectified. As one author puts it: 'doctors have a legal duty to obtain consent to operations and other procedures and to do so in a manner which ensures validity of that consent'. Hence, she goes on:

> If a nurse is aware that consent is being obtained in a manner which invalidates the intention of the law, then there is a clear obligation to make this known to the relevant authority. Failure to do so implicates the nurse in an illegal act. . . .
> [Likewise] Giving information to patients is increasingly accepted as a major role of the nurse, and there is a huge and growing body of research suggesting that information can help patients by reducing stress and by teaching coping strategies, thus reducing pain, the likelihood of complications such as infections and length of stay in hospital . . . [But] it is not difficult to imagine circumstances in which a nurse giving information like this may cause a patient to question what a doctor has said, or to realise implications which the doctor has not made clear.[13]

But just as there is no reason in principle why advocacy on patients' behalf should be confined to nurses, there is also no reason why it should always be directed against the actions or omissions of doctors: for nurses, other health professionals, and hospital administrators can act in a way which threatens the genuine well-being of a patient, and a nurse who acts as an advocate for her patient will be concerned to defend the patient against all threats to his integrity and well-being, from whichever quarter they may come.

The nurse as a health professional

In affirming that the nurse has her own proper knowledge and expertise which is independent of (although often employed in order to assist) the doctor we are in effect affirming that the nurse is a health *professional*, that she belongs to the *profession* of nursing. This fact is commonly accepted, because the phrase 'the nursing profession' is in widespread use. But the point of calling the nurse a professional since the word 'profession' is difficult to

define, and different people understand it in different ways. Here I shall utilise one definition which would command widespread agreement, that given by R. H. Pyne in his *Professional Discipline in Nursing: Theory and Practice.* Pyne sets out seven criteria, all of which must be satisfied by any body which is to count as a profession. They are:

1. Its practice is based on a recognised body of learning which is proper to itself.
2. It establishes an independent body for the collective pursuit of aims and objects related to these criteria.
3. Admission to corporate membership is based on strict standards of competence attested by examinations and assessed experience.
4. It recognises that its practice must be for the benefit of the public and not primarily for that of its practitioners.
5. It recognises its responsibility to advance and extend the body of learning on which it is based.
6. It recognises its responsibility to concern itself with facilities, methods and provision for educating and training future entrants and for enhancing the knowledge of present practitioners.
7. It recognises the need for its members to conform to high standards of ethics and professional conduct set out in a published code with appropriate disciplinary procedures.[14]

Of these criteria, 1 and 7 appear to be the most basic. It is the possession of a body of learning, and concern for proper ethical standards in the application of that body of learning, which are central to the idea of a profession. Criteria 2-6 could probably be seen as implications of one or both of these two basic points.

Some social scientists have been reluctant to admit nursing as a profession along with medicine, teaching, law, accountancy, *etc.*, on the grounds that the first criterion is not, after all, satisfied. For, they argue, it is the medical profession which provides the theoretical and practical basis for nursing, and hence the nurse has no advanced knowledge or skills which are proper to her *as a nurse.* But it can be replied that the nurse has a proper role, centred on the provision of care for patients, which is distinct from that of the doctor, that the task of nursing differs from that of medicine, and hence that the knowledge and skills required by nurses will, in large part, be specifically nursing knowledge and skills. The fact that nurses often use those skills in assisting physicians or surgeons in no way overthrows this conclusion. The contribution of specialist nursing research which is all the time being conducted also tells against this objection: what is being built up here is precisely 'a recognised body of learning which is proper' to nursing.

Of the other criteria, 2 and 3 are satisfied by the fact that bodies such as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting exist and operate to promote excellence in nursing. The fourth is satisfied by the actual practice of nurses and by the provisions of the law in respect of their work. The fifth and sixth criteria, as Pyne points out, 'while always receiving some attention, have (perhaps) received less attention in the past than was deserved. Happily this has been changing for the better in recent years as more evidence of valid nursing research has been seen, as the increased membership of nursing and health service staff organisations has led to more articulate and comprehensive expressions of concern at any shortfall in both these respects, and as individual nurses have become more aware of the fact that their personal professional responsibility extends into these areas'.[15]

Finally the seventh criterion is clearly satisfied, since it is precisely the concern to maintain high ethical standards which explains the disciplinary regulations of the UKCC and similar bodies and which also underlies current debates about crucial problems of nursing ethics in numerous books and nursing journals.

Because nurses work not merely as individuals but as members and representatives of the nursing profession, one of their responsibilities will be to uphold always the standards of the profession, to conduct themselves in a way which observes and respects those standards, and to encourage and assist their fellow nurses to act likewise. It follows that one of the pitfalls faced by nurses will be that of acting in a way which directly betrays those professional standards or condones such action in others. One of the functions of the UKCC and equivalent bodies in other countries is to investigate cases in which it is alleged that a nurse has not observed these standards, cases in which there is thought to be professional misconduct.

While many of the ethical problems which arise in nursing can be discussed without any reference to the idea of the nurse as a health professional, there are some problems in which the professional or unprofessional character of a nurse's action occupies centre stage, so to speak. Much of the opposition to nurses ever going on strike, for example, is based on the claim that striking is at odds with the nurse's fulfilment of her obligations to her clients and is, therefore, unprofessional. It is interesting to note that some nurses have considered their professional status incompatible not only with going on strike, but even with engaging in collective bargaining on pay and conditions with employing authorities.[16] This attitude is surely unjustified: given that nurses have to earn their living through nursing, they are entitled to ensure that what they see as just demands for wages and working conditions are brought to their employers' attention. But the very fact that this aversion to collective bargaining has been widespread indicates the strength of the feeling that such action is unprofessional. Some brief attention will be paid to problems concerning industrial action in the final chapter of this book. All that need be said here is that this is an issue to which considerations of the nurse's professional status are highly relevant. In reflecting on issues like this we realise that the idea of the nurse as a professional, as committed to an ideal and a set of professional standards, does have important implications for nursing ethics.

Continued on Page 21

An Alternative to Condomania?

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I first became interested in sexually transmitted diseases (STD) when I saw the devastating results of neglected infections in Ethiopian women – infertility, ectopic pregnancy, puerperal infection, pelvic abscess and cervical cancer. it was easy to attribute these to child marriage, poverty, the male factor,[1] and inadequate facilities – but were they? The epidemiology of STD and cervical cancer is the subject of an ongoing research project.

Thirteen years later, as a gynaecologist in a Gulf state, I saw the same problems in a multi-cultural, affluent society with superb medical facilities. Many of these unfortunate woman shared two factors with their Ethiopian sisters – early sexual experience and the male factor. As in Ethiopia, obstetric haemorrhage was the chief indication for transfusion. Unlike Ethiopia, blood was imported from the USA – until we heard of AIDS.

> Ironically this disease (AIDS) . . . is essentially preventable. The abandonment of promiscuity, homosexuality, and drug abuse could eventually stop it in its tracks – though that is hardly likely to prove an acceptable solution.

These words were written six years ago by A. P. Waterson, a distinguished virologist from the Postgraduate Medical School, London.[2]

The Western, materialistic world has been progressively brainwashed to accept the Freudian concept that 'sex', interpreted as 'sexual experience' and synonymous with penetrative sexual intercourse, 'is the only reality in life – religion is merely an illusion'! This view has been promoted by advertising and has penetrated into television, radio, books, magazines, videos, pop music, and discos, and has resulted in life-styles in which coitus is taken out of its natural context and is made an end in itself, to be achieved as regularly and as frequently as possible.

Recent articles confirm how this view has taken hold. Seventy-five per cent of black and Hispanic New York inner-city teenagers, average age 17, are sexually active (22 per cent before the age of 13) and 25 per cent admitted to having had anal intercourse.[3] Some one million American adolescents run away from home each year, 36 per cent themselves the victim of physical or sexual abuse . . . many are at risk through i.v. drug abuse and prostitution . . . 27 per cent tested positive for HIV.[4] Four American and five Australian children infected with HIV as a result of sexual abuse have now developed AIDS.[5,6] Britain is now following the American experience. Fifty-three per cent of English sixth-form students are sexually active, 91 per cent before the age of 17.[7] Homeless street boys run the risk of HIV infection.[8]

Limitations of present AIDS education

While education has been shown to raise awareness of AIDS,[9,10] and fear of AIDS was a temporary deterrent to casual sex, for many the 'It can't happen to me' attitude still prevails.[11] Yet, in a plea for factual education, a 14-year-old wrote: 'And if it is loose morals and eagerness to leap into bed that is spreading AIDS then for God's sake say that. Do not be afraid that teenagers are all insensitive, sex-mad freaks who care about nothing but pop music and alternative comedy. Just stop the music and tell as the truth'.[12] Is it of significance that a medical graduate of the 'swinging sixties', said: 'While we did it ourselves, we are afraid for our daughters.'

With little knowledge of, or interest in, sexual practices or moral background in individual schools and regions, local and central governments have considered the only answer to the threat of AIDS is to promote 'safe sex' – specifically selling condoms to teenagers, by means of increasingly explicit sex education in schools. Teaching of the biology of sex has been extended to include instruction in the physical act of coitus and the use of condoms. The message that accompanies much of this teaching is not that coitus should take place within a stable, loving, caring relationship – 'marriage' – but rather 'This is how to do it, take precautions, be safe'. Trusting in condoms is like playing Russian roulette – condom usage has a known failure rate in preventing pregnancy in the best-motivated couple. 'It is difficult not to regard the British Government video, *Your Choice of Life,* as a 25-minute advert for the condom'.[13]

While some educationalists argue that knowledge increases safety and therefore should reduce the spread of STD and AIDS, others have challenged this. Already there have been reports that explicit sex education has resulted in increased experimentation and in certain schools unwanted pregnancies. There has been little mention of the adverse effects of sexual experimentation by teenagers, of the physical damage in terms of early and late complications of STD, including cervical cancer, and the emotional trauma following abortion. Only a very small percentage, 2 per cent of sexually active girls and 8 per cent of boys, in an AIDS-conscious city, do have 'safe sex' protected by a condom,[14] and as one said, 'if you're sexually aroused you don't care'.[15] The shock tactic used in the British Government's campaign to halt the spread of AIDS is failing to reach its target.[16]

Through antibiotic misuse gonococcal resistance to penicillin is widespread and its resistance to spectinomycin is increasing. Moreover, the woman whose (? bisexual) husband practices anal intercourse is likely to be infected with a 'pure faecal flora'. This not only causes acute salpingitis, a hitherto unrecognised association, but in the words of an American laser surgeon 'sure gums up the tubes'. Late sequelae of STD, such as peritubal adhesions, frozen pelvis, infertility and cervical neoplasia may be treated, in selected cases, using new technology – laser, *in vitro* fertilisation (IVF) and gamete intrafallopian transfer (GIFT) – but unless there is a change of life-style such infections will recur, thus undoing the good of the expensive treatment. Some of the most damaging and dangerous STD, however, are caused by viruses and until antibiotics are available to treat these – a virologist's pipe dream – is there an alternative?

The alternative

Many of the world's great religions teach the practice of chastity before, and faithfulness within, marriage, and forbid prostitution, adultery, homosexual practice, bestiality, and anal intercourse.

Chastity and celibacy, frequently confused, are not synonymous – celibacy (Latin *caelebs* single) refers to the unmarried state, especially under a vow; chastity (Latin *castus* pure) is sexual purity, or

virginity; a virgin being one who has had no sexual intercourse. The practice of chastity and virginity does not mean that a woman ceases to be feminine or a man masculine.

The Mosaic Laws

Over 3000 years ago Moses gave to the Israelites a moral code, later set out in the Pentateuch, the first five books of the Bible, in which teaching on sex and marriage was explicit. This defines the value of marriage and chastity. Today it continues not only as part of the religious teaching of Jews, but also of all Christians and Moslems, the three great monotheistic religions which respect the law of Moses.

The Bible in particular shows clearly that the plan outlined from the earliest days of creation was for a male/female partnership, for companionship, procreation and sexual intercourse – 'that two may become one flesh'.[17] The physical union was regarded as 'marriage'. This special and unique partnership was not for sharing. To protect it there was specific teaching regarding forbidden promiscuous sexual practices. There was to be no prostitution, at that time associated with the worship of the gods of Egypt or Canaan – such as Isis, Astarte, Molech and Baal, cults which included sexual practices and temple prostitution, both male and female.[18] Sexual intercourse with close relatives (incest and child abuse)[19] was banned, as was intercourse with another man's wife (adultery);[20] with another man (homosexual practice);[21] with a woman during her menstruation;[22] and neither sex was to have sexual relations with an animal (bestiality).[23]

Spread of HIV has already been clearly associated with lapses from these laws – with prostitution, with multiple partners including 'serial monogamy' (in biblical terms both are adultery), with homosexual practice and, more recently, with child abuse. Heterosexual spread of HIV (pattern 2) has been attributed to prostitution, associated with cervical ectropion, superficial cervicitis due to the 'Pill', and with STD causing genital ulceration, but, the potential significance of coitus during menstruation for HIV transmission has not been recognised. Many prostitutes have to work throughout their menstrual cycle in order to support their children. During menstruation, as the endometrium is shed, the uterine cavity becomes an open wound highly receptive to all infections – have we forgotten that acute gonorrhoea is most likely to occur immediately post-menstrually? Moreover, menstrual discharges of infected persons are known to contain HIV. Where does bestiality come in? Bestiality occurs worldwide, mainly as a juvenile aberration.[24] The origin of HIV is still the subject of speculation. The similarity between HTLV-III and STLV-III is well known. There was a massive trade in the African green (vervet) monkey, mainly to the USA, in the 1950s.[25] Could the initial transmission have been bestiality with subsequent transformation in *Homo sapiens*?

If the Mosaic guidelines on prohibited sexual practice were followed, not only would AIDS be contained largely within the presently infected population but STD could be brought rapidly to a halt. This teaching. which was to protect the marriage relationship, should be put alongside very positive teaching regarding enjoyment of marriage;[26] taking time to get to know each other in a loving relationship;[27] mutual self-respect, putting the other partner and the other partner's good, physically and emotionally, above one's own immediate demands.[28] Furthermore, it emphasises the need for mutual respect between husband and wife, and parents and children.[29]

In 1988, the Ugandan Minister of Education, the Hon. J. S. Mayanja Nkanki, at the launch of an official Basic Science and Health Education Syllabus, said: 'AIDS is not a medical problem but a spiritual one'.[30] If these Biblical principles were practised by all the members of the Christian faith, while Jews followed the teachings of the Torah and the prophets, Moslems the code of practice outlined in the Koran, and the Hindus, Sikhs and Buddhists followed the teachings of their holy books, *and* taught the practice and principles of these beliefs to their children, instead of allowing them to be brainwashed by pornographic radio, television, movies, books and magazines, not only would STD and AIDS be controlled, but we could have a return to the principle that the family unit is the strength of the nation.

The argument that people should return to the teaching of their holy books, the law, can only be first step as this amounts to a legalistic 'book of rules' approach, however commonsensical the Mosiac and similar laws may be. The Bible develops the way ahead from the Mosaic Law and Levitical Code. 'The time is coming', declares the Lord, 'when I will make a new covenant with the house of Israel.' The law was to be no longer a code on tablets of stone but 'written on the hearts' of individual people, whose sin and wrong-doing would be forgiven'.[31] Jesus came to bring the New Covenant with forgiveness, new life, and the power of the Holy Spirit to do what legislation and a code of rules could never do. This makes Christian teaching in AIDS unique in that it is the only religion that not only gives the right standards of personal behaviour but also the *power* for right living.

AIDS is now a problem for the general population. It is associated with particular aspects of our social behaviour which are related to the disintegration of our society as its social values and practices have moved away from a Biblical morality into a free-for-all. In 1972 only 8 per cent of children lived in single-parent families; in 1985, 13 per cent . In 1986 there were 158,000 illegitimate births compared with 61,000 in 1976.[32] In 1987 36 per cent of births to primigravidae were extra-marital.

Biblical principles and teachings on sexual morality cannot be taken out of context of the whole person. Patterns of sexual behaviour are part of a highly complicated socio-economic pattern. Failure to understand, and ignorance of biblical teaching, together with an attitude based on 'if it seems to be right then do it' have resulted in a form of *false religion* with all that follows in terms of injustice, oppression of the poor, wealth at the expense of the poor, sexual immorality, violence, murder, and stealing. In Europe and North America, the younger generation are disillusioned with the religion of their elders. As they turn to drugs, the occult, and prostitution their self-worth wanes, and the words 'love God and love your neighbour as yourself'[33] are meaningless.

'Sex' has become industrialised with large financial rewards, and promoted by advertising, pornography in all its outlets, the continued slave trade in prostitution, and the latest medical technology. We are in a battle between the forces of good and evil and, if we wish to fight on the side of good, we need the resources that are available, the forgiveness of God for breaking his laws and the guilt that so frequently ensues, and the power of the Spirit of God to change lives and life-styles.

In countries where AIDS spreads by pattern 2, there has been a

cultural revolution. Many of these are countries where old tribal practices and taboos prohibited pre-marital sex. But with the increasing education, 'travel to work', urbanisation and dislocation of the tribal system, tribal traditions were broken and prostitution increased. Permissive western culture has been imported, and HIV spreads along the long-distance lorry routes.

Yet, I believe there is hope. In many countries of Africa and South America 60-70 per cent of the population is under the age of 16, 75-80 per cent of their populations claim to be Christian. If Biblical teaching regarding sexual behaviour were taught and practised by the under-16-year-olds – a*s is already happening* – the heterosexual spread of HIV could be largely contained within a decade.

> It would seem that virginity and faithfulness will once again become fashionable along with the condom for those who are unwilling or unable to stick to one partner.[34]

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REVIEWS

Murderous Science. Elimination by Scientific Selection of Jews, Gypsies, and Others, Germany 1933 to 1945.
Benno Müller-Hill
Oxford University Press, 1988, £15, 208 pp. (English Translation)

This volume furnishes us in English with a most significant document, chronicling the rise of Nazi medicine in detail and offering fascinating and sometimes spine-chilling insights into the thinking of the men and women whose action or inaction ushered in this black period in the history of the Western medical tradition. The writer moves from historical narrative (in a first part entitled 'Identification, Proscription, and Extermination') to 'conversations' with surviving medical scientists and their children and assistants from the period. Unlike some which have appeared, this work is highly scholarly in its approach, and – for example – we are offered a most helpful note on 'German academic organisation' together with other important background information to enable us to enter into some understanding of the character of the extraordinary events which are unfolded in Müller-Hill's story.

At a time when euthanasia is once again on the political agenda, and the possibilities of 'eugenics' are far greater now than they ever were when the term was first coined, it is crucially important that the facts of what took place during the 1930s and 1940s in German medical science should be given their widest possible airing; so this English translation (of a German book published first in 1984) is to be warmly recommended. Recent publicity given to conservative legislation passed by the West German Parliament on 'Warnock issues' suggests that opposition to embryo research, and so forth, have their origin in the German memory of what went wrong 50 years ago. The Germans have not forgotten: but many do not know, or wish to know, what it is that they remember. Concluding his 14-page summary of the historical progress of 'Murderous Science', having noted the definition by Watson and Crick of the structure of DNA, the writer (himself Professor of Genetics in the University of Cologne) asks: 'has anything been learned from the outbreak of barbarism in Germany or will it be repeated on a world-wide scale in yet more dreadful form and to a yet more dreadful degree?'

This book is very deeply disturbing, most of all, of course, in the agonising factual detail which it presents of the atrocities themselves; but also in the connections which are plainly drawn between the 'murderous science' in Germany itself and eugenic and anti-semitic academic and other influences before the war.

We salute the scholarly researches and courage of Professor Müller-Hill and warmly commend his important book.

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Video: The Truth About Aids
Produced by Family and Youth Concern, Milton Keynes, VHS, 12 minutes, 1988

With so much morally questionable and even contradictory talk and information on AIDS over the last two years it is good to welcome this straightforward and helpful video which is not ashamed to proclaim chastity before and faithfulness within marriage.

The video is aimed primarily at 14 to 16-year-olds, though its message all need to hear. It is mostly taken up with the two presenters, Suzie Halewood and Michael Lams, giving simple, factual information about AIDS, HIV, and how they are spread. The language is clear and graphics are used to emphasise the main points. The producers intend the video to be used in classrooms and for discussion groups.

Having covered the various forms of homosexual and heterosexual transmission, and transmission in drug abuse, and having cast necessary doubt on the protection afforded by condoms, the programme concludes with the statement that AIDS can almost certainly be avoided by mutual faithfulness to one married partner.

But should a message of such life-saving importance be left to the end? With most of the programme given over to matter-of-fact and sensible information would the main message make sufficient impact upon those who have already heard so much from so many other sources? A problem for all of us who are concerned to advise young people on AIDS is immediately apparent here: how to be simple and factual and yet convey the horrific implications of the subject. The sometimes less than professional presentation on this video did not help here. But it is generally good.

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Brain Grafts. Parkinson's Disease, Foetuses and Ethics.
D. Gareth Jones
Grove Ethical Studies Number 72, Grove Books, Nottingham, 1989, 27 pp., £1.65

Professor Jones' writing in the area of medical ethics is well known and well appreciated. This topical booklet, on foetal brain cell transplants, is a welcome contribution to discussion. The writer helpfully surveys the historical background to this procedure and provides helpful clinical details so that the reader is left with some real understanding of what the technique involves at that level. Professor Jones also raises broader questions about the ethical context of such research and treatment projects.

His conclusions may not, however, commend themselves to many who have an uneasy conscience about these procedures. 'The discussion about foetal transplants, therefore, should be a discussion about the salvaging of tissue from a dead cadaver, that is, a foetus that is legally and morally dead' (p. 17). But why? In this journal, we have recently argued for a disanalogy between this technique and general cadaver transplants, and on grounds to which Professor Jones pays insufficient attention. He deals all too briefly with the question of the criteria of foetal death, and addresses the problem of consent with an acceptance that it may be improper for the mother to consent to such a use of the tissue of her foetus while suggesting 'consent . . . may not be ethically required for the therapeutic use of tissue'.

One reason for the thinness of some of this argument may be the writer's unfamiliarity with some of the literature. It is really very curious that he makes no reference to the standard volume in this area, Peter McCullagh, *The Foetus as Transplant Donor,* published as long ago as 1987; nor to McCullagh's article published in a recent issue of this journal (which offers a most helpful summary of the ethical problems which the procedure raises).

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