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ETHICS & MEDICINE

An International Christian Perspective on Bioethics

Ethics and Medicine seeks to develop a Christian mind on the complex and fundamental challenges posed to society by technological advance in medical science.

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COMMENT

From the Editor

An Exciting Initiative: The Centre for Bioethics and Public Policy

The origins of *Ethics and Medicine* lie in the founding of Rutherford House in 1981 – as a centre for theological research and publishing with a conservative theological stance. Right from the start the special significance of developments in medical ethics was noted, and a modest study group established to discuss them (of which *Medicine in Crisis*, later published by the House, was the fruit). *Ethics and Medicine* first appeared late in 1984 in tandem with a series of conferences and some further books. The limiting factor was funding, and only in 1990 was sufficient secured to develop a centre for resources with part-time staff specifically appointed for its care. The international conference on 'The Christian Stake in Bioethics', was the first new initiative of this better-resourced project.

Yet this issue of *Ethics and Medicine* is the last to be published by Rutherford House. Responsibility for the journal and other initiatives has been passed to the Ethics and Medicine Trust (whose trustees are the chairman and secretary of our Editorial Board, and the Editor). The Paternoster Press of Exeter, England, take on publication on behalf of the trustees from 8:1. The embryonic centre moves to London to carry forward its work in a new Centre for Bioethics and Public Policy jointly sponsored by the Ethics and Medicine Trust and CARE Trust. While many – not least the Editor – will regret that the project is no longer connected with Rutherford House, developing the new London-based Centre is an exciting prospect which can only enhance our opportunities for developing a Christian perspective on bioethics. The Centre is anxious to secure fresh and, it is hoped, substantial new funding to exploit those opportunities to the full.

At the same time, the Editor is moving to a new appointment in the United States, from where he hopes to help further develop the international role of this journal.

Newstyle *Ethics and Medicine*

We hope you like the new design, though we are sure that some of you will not! We have been discussing a fresh appearance for some time now, and we believe this striking new look will help develop the work of the journal.

From the Very Revd Professor Thomas F. Torrance

Donor Insemination for the Single Woman: the animalisation of the human race

The Ethical Issue

It has been claimed that embryo research is being 'curbed by ethical guidelines', as if all ethical considerations have to be ruled out of court. All scientific activity that deals with the fundamental nature of nature in any area, needs stringent examination – this is very apparent to the whole world today in the way in which scientific research has so often ridden rough-shod over the in-built ecological balance of planet earth in the satisfaction of immoral human greed. Scientific activity affecting the essential structures of human life needs particularly rigorous controls and restraints to ensure that it is being carried out strictly in accordance with the nature of human beings. I do not believe we can avoid ethical considerations but care must be taken to work out appropriate ethical guidelines. As far as I can see, this is not being done in the field of embryo research, which is actually being governed by utilitarian ethics, that is, in accordance with what is thought to be for the greatest good of the greatest number. However, as we have found out this century, it is upon utilitarian ethics that all Communist and Fascist governments have relied for justification of their policies and practices.

The pursuit of embryo research in aid of donor insemination of the single woman seems to me to be determined by false hedonist and utilitarian ethics of a very damaging kind. Once scientific research is carried out within such a utilitarian framework, utterly revolting and damaging things get done, as we have learned to our cost in the researches of Communist and Nazi genetic and medical science. Hence the practice of donor insemination for the single woman on utilitarian grounds must be challenged and exposed as essentially anti-human and misanthropic. For scientists to brush aside ethical guidelines, is only to cover up the damaging nature of the utilitarian ethics within which they want to operate which allows them to do anything they want in experimental innovation, and then often only to increase their own kudos.

The Scientific Issue

No authentic or rigorous science operates in accordance with ideas or principles outwith its own field. All true scientific method, and all formulation of scientific theories, are governed by the nature of the realities being investigated and their inherent intelligibility, for science is concerned with what is intrinsically true and right, and will not allow external forms of thought to be imposed on it. This means that when moral issues arise they have to be tested by what is intrinsically true and right. Two basic errors have to be avoided here: external authority and naturalism. Care was taken to exclude the first error in the foundation of the Royal Society through its formulation of the principle that the only authority recognised by science, and on which scientific research can rest, is that which is internal to the intrinsic intelligibilities of its own field. It took longer for the second error to be detected, and set aside: that is the idea that

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what is found to happen is what must happen, that just because certain sequences are found to take place they are what ought to happen. This is the geneticist or naturalistic fallacy that no self-respecting scientist today in any field will allow himself to fall into. Science has now reached the point, argued Einstein, in which it can no longer be satisfied with describing how actual processes take place and formulating them into laws, but must penetrate into the reasons why nature is what it is and not something else. In formulation and justification for natural laws science is concerned with the ultimate reasons for them. It must be concerned with the **why** and not just with the *how*, with the *ought* as well as with the **is**. That was the reversal of the rational dualism that has split our culture introduced by the Enlightenment. This question has now become a primary one in the scientific world, in view of the fact that the expansion of the universe, from the ultimate singularity of the black hole, has given rise to ethics, art and religion, which are recognised to belong to the essential nature of nature. In its expansion the universe reveals a pattern of steady upward gradient of development in which richer patterns of order steadily arise under a latent thermodynamic imperative. Thus it is now recognised that there is an ethical imperative latent in the expansion of the universe, *e.g.* in biological development, which cannot be excluded from the basic structures of physical or natural law. Since all law points to and rests upon an ultimate ground of rational order, it is realised that there cannot be two grounds of rational order, that behind physical law and that behind moral law – they are ultimately one. This means that the deeper and more rigorous scientific research and formulation become, the more moral elements are found to have an essential place in the basic structures of all physical and natural law – otherwise science tumbles back into the old natural fallacy. Just as the ingredient of time cannot be treated as an external operator in physical law, so the ingredient of an ethical imperative must become an internal, not an external operator, in formalisation of scientific law. What does this mean for embryo research? It means that it must lay bare and formulate the fundamental moral elements *intrinsic* in its own field of intelligibility as a fundamental operator in research and theoretical formalisation. Until that is done, and internal ethical guidelines are brought to light within the constraints of which embryo research is carried out, error, serious error, will inevitably arise. That is the kind of error that is bound to be extremely damaging, for the slightest deviation from what is intrinsically true and right in the foundations of human genetic structures will inevitably lead into the most damaging and wide-spread deviations from authentic human nature. In short, embryo research in the field of donor insemination of the single woman, requires *scientifically*, to be carried out within the guiding constraints of intrinsic ethical truth, for that belongs to scientific rigour. It is rigorous medical science, not clever innovative technology, that we need. Technology divorced from the intrinsic constraints of what is true and right can become a monster.

The Religious Issue

In religion, especially in the Hebraeo-Christian tradition, it is the human *person* and not just the human body that is the centre of concern. Human beings are persons, not just animal bodies with a distinctive structure of their own differentiating them from other animals. Thus man is not just a male animal with a human shape, but he is a man in his inner personal being – difference in sex is not of the same order as a difference in the colour of one's eyes. And a woman is not just a female animal with a human shape, but a woman in her inner personal being. We have to do here with a profound interrelation in all essential human nature between the mind and the brain – this has been shown in book after book giving the researches of Sir John Eccles who won the Nobel prize for brain science. In the great work written by Sir John Eccles with Sir Karl Popper, on *The Self and its Brain*, he provides us with a more philosophical justification for this view, but in his recent book *The Evolution of the Brain*, he penetrates more deeply into the profound bearing of the brain and the mind on one another in human growth and development. Thus even from this quarter of research in brain science fundamental support is given for the treatment of human beings as centres of consciousness, rational agents, as persons, not just as highly developed animals. Unless embryo research takes this into account it restricts itself to the consideration of the human embryo as an animal, and not as a developing person, and gets trapped in the naturalistic fallacy. The danger facing us here is that genetic research and embryo research, pursued in this narrow reductionist way, lead to the *animalisation* of humanity and society, whereas what we should be concerned with is the *personalisation* of humanity and society. This is where Judaeo-Christian considerations come in: in the demand that human beings be treated as persons, and persons in relation to one another and the ultimate creative ground of personal being in God. On Judaeo-Christian grounds human nature is regarded as complete only in both sexes: it is man and woman in their interrelation who, we believe, are in the image of God (not man or woman apart from one another), and it is through and within the physical and personal interrelation of man and woman that the embryo comes into being and the personalisation of the unborn child into the born child takes place. Hence Jews and Christians with their intense respect for the personal nature of human beings cannot but object to insemination of a single woman apart from *personal intercourse*, for that would set aside the most all-important and most distinctive ingredient in human nature, and reduce human beings to the level of animals, treating them in the same way as people treat cows and sheep. In short, on religious grounds Jews and Christians alike protest against the *animalisation* of personal human beings and personal society that is threatened in pursuit of the insemination of the single woman.

Taken together, then, strict ethical, scientific and religious considerations force us to think more deeply and rigorously about the insemination of the single woman.

Professor Torrance, distinguished theologian and former Templeton prizewinner, has kindly given us permission to extract this Comment from a private letter.

COMMENT

From David S. Short, Emeritus Professor in Clinical Medicine, University of Aberdeen

The Persistent Vegetative State

The concept of 'brain death' has become widely recognised over the course of the last twenty to thirty years. We have become familiar with the idea that individuals who are unconscious and maintained on artificial respiration, showing signs of life such as a heart beat and a response to painful stimuli, may yet be dead in the sense that the brain stem has ceased to function. They will never recover to become independent of life-support apparatus. It is widely agreed that in such a state it is no longer necessary to maintain respiration artificially; so allowing the patient to die in the traditional sense. At this time organs such as kidneys, corneas, heart and liver may legally be removed for transplantation. Admittedly, there are some, both in the U.K. and elsewhere, who are still not satisfied that an individual who has been shown to suffer from brain stem death is really dead; though all would agree that he (or she) is beyond recovery.

It has more recently been recognised that there is another form of brain death in which the patient remains unconscious for months or years without the need even for artificial respiration; simply requiring basic nursing care and feeding. The patient appears to be in a sleep from which he or she might be expected soon to awaken. The condition has been well described by Professor Jennett, who first drew attention to the syndrome twenty years ago, and designated it the Persistent Vegetative State (PVS). He vividly described their appearance as follows: 'Such patients spend long periods with their eyes open, but they show no voluntary activity or any meaningful response to the environment. Their spastic limbs may withdraw reflexly in response to painful stimuli, the face may grimace, the eyes may briefly turn to light or sounds, and groans and cries may occur.'[1]

The basis of PVS is not death of the brain stem, so that the standard tests for brain death are negative. Instead, the disorder lies in the bulk of the brain; the cerebral hemispheres. In most cases, there is severe and widespread severing of the nerve connexions which constitute the white matter of the brain. In others, damage to the cortical grey matter is dominant. About 40% have sustained a head injury. Most of the remainder are the result of some medical or anaesthetic misadventure, such as a cardiac arrest, or a prolonged fall in blood pressure, leading to a critical loss of blood and oxygen supply to the brain.

What is the prognosis? Of patients who remain in the PVS for three months, about a half die within twelve months; but some survive for fifteen years or more. One has been recorded as surviving for 36 years; sustained simply by basic nursing care and nutrition by nasogastric or gastrostomy tube. A few regain consciousness, but all remain very severely physically and mentally disabled and dependent.

The problem of PVS is the question whether such patients can be regarded as brain dead, and thus allowed to die in the traditional sense. The difficulty about this approach is threefold. Firstly, they do not fulfil the criteria for brain stem death. Secondly, they are not suffering. Thirdly, a few of them may regain consciousness, though never an independent existence. If they could make a rational decision, they might request to be allowed to die. But they have not the cerebral capacity either to make such a decision or to express it.

In a celebrated case in the United States, the parents of a young woman who been in PVS for four years following a head injury requested the removal of the gastrostomy tube to allow her to die. The hospital sought a legal ruling before acceding to the parents' request, and the state court found in their favour. The attorney general appealed to the state Supreme Court, which reversed the decision. The family then appealed to the US Supreme Court. This court decided that the state court should seek for any evidence of the patient's previously expressed views in recording its decision. At this stage, further witnesses came forward and testified that the patient had expressed wishes which favoured a withdrawal of treatment. So the decision was made accordingly, and Nancy Cruzan was 'allowed to die'.

How should such patients be managed? In the first place, it must be recognised that the diagnostic criteria for PVS are not as well defined as those for brain stem death, and neurologists do not yet agree as to what characterises a diagnosis as reliable. The diagnosis is one which, although it may be suspected at an early stage, only becomes reliable after several months of observation.

Even if the diagnosis is established, should the patient be regarded as dead, and nutrition be withdrawn? It must be remembered that the only special care these patients require is artificial feeding. This, however, makes considerable demands on the time of the nursing staff. It has been stated that it takes up to three hours a day to feed a patient adequately through anasogastric tube.[2] In the case of Nancy Cruzan, it was eventually decided to rely on evidence of the patient's previously expressed attitude to such a situation. This argument has been used to support the more widespread use of the 'Living Will'. This instrument was designed for just such a situation, in which a patient becomes permanently incapacitated and incapable of expressing a wish. Such a course could, howeverbe regarded as simply an extension of the concept of voluntary euthanasia.

Declarations by the Americal Medical Association in 1986 and 1989 specify that treatment, including artificially provided nutrition and fluid, may properly be withdrawn from patients in PVS, and most American courts agree with this principle. There is, however, still some debate about who should make this decision, and whether evidence is needed about the attitude and wishes of an individual patient.

The issue was debated at the Appleton Conference in 1988[3] convened to seek a consensus regarding guidelines for decisions to forego medical treatment. No consensus was, in fact, reached on this issue. Some delegates dissented from the AMA Declarations on the ground that, since these patients are not suffering, their quality of life cannot be characterised as 'harmful' to themselves, and withdrawal of treatment could be a dangerous step down a morally important slippery slope. This is clearly a subject which requires further careful consideration.

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Cystic Fibrosis: Screening or Cure?

Dr J. S. Elborn, Senior Registrar, City Hospita, lNottingham

Introduction

Cystic fibrosis, a disease affecting the lungs and digestive system, is the commonest autosomal recessive genetic disorder in caucasian populations.[1] In order to have a child affected by this condition both parents must be carriers and each contribute an abnormal cystic fibrosis gene. Approximately 3 million people are carriers of one abnormal cystic fibrosis gene in the United Kingdom (1/25 of the population) and this results in 1 in 2500 live births being an affected child with the disease. (300-350 children/per year in the UK).[2,3] There are approximately 6000 children and adults in the UK with cystic fibrosis.[4] Individuals with cystic fibrosis produce thick abnormal mucus in their lungs and suffer from repeated chest infections which causes progressive lung damage and death due to respiratory failure, usually in their late teens or early twenties.[5]

The prevalence and severity of this condition has resulted in intense research over the past decade to elucidate the exact nature of the cystic fibrosis gene and how the abnormal function of the coded protein causes the disease. This search culminated in the sequencing of the gene by two collaborating laboratories in North America by the process of 'reverse genetics' which uses chromosome markers to search the genetic material for a particular gene.[6,7] Developments subsequent to the sequencing of the gene have resulted in some surprises within the scientific and medical community and present many complex social and ethical questions concerning how this remarkable discovery might be applied for the benefit of patients.[8,9,10] The ethical dilemmas following the discovery of the cystic fibrosis gene are important in themselves and similar problems are likely to be encountered in other genetic disorders as their genetic basis is discovered.

The Cystic Fibrosis Gene

The cystic fibrosis gene is found on the long arm of chromosome 7 and is a DNA code for a protein called the cystic fibrosis transmembrane regulator (CFTR).[6] This protein controls transport of chloride ions across cell membranes.[11] The 'CF gene' and 'CFTR' refer to the gene and protein in patients who do not have cystic fibrosis. Individuals with cystic fibrosis have two abnormal genes (one on each chromosome 7) and manufacture CFTR which does not function normally. The commonest mutation of the gene has been called delta F508 which is genetic shorthand for a deletion of 3 base pairs in DNA which is code for a phenylalinine (an amino acid building block for the protein) at position 508 of the CFTR molecule.[6] The delta F508 mutation accounts for some 75% of individuals with cystic fibrosis in the UK but surprisingly more than 80 other mutations of the gene have now been described.[12] This is many more than was expected and has practical implications for potential screening programmes. A further surprise has been that these different mutations do not relate to the severity of disease. It has been known for many years that some individuals with cystic fibrosis have a mild form of the disease and it was thought by geneticists that different mutations would explain this. However, it has been shown by a number of groups that the genetic abnormality (genotype) does not predict disease severity (phenotype).[13] It is now clear that both genetic and environmental factors determine how severely an individual is affected.[12,14] It had been hoped that this information would be helpful in genetic counselling, encouraging abortion of more severe genotypes, but this is clearly not possible.

The discovery of the CF gene has been followed by much important basic research into the nature of the genetic abnormality at a molecular level. The practical application of this information has followed two paths.[12,15] Knowing the sequence of the gene and the ability to examine the DNA from cells will reveal if an individual is a carrier of the CF gene. This will make screening of the population for carriers of the gene possible with the option of testing 'at risk' pregnancies and the abortion of affected fetuses.[12] In contrast to this approach, is use of the genetic information to implant the normal CF gene into the lung cells of affected individuals with the possibility of curative therapy.[15,16]

Screening for Cystic Fibrosis

Screening for cystic fibrosis in families with an affected child has been available for approximately five years prior to discovery of the gene.[17] This method uses markers of the gene on chromosome 7 from the child with cystic fibrosis, parental chromosome markers and a chorionic villus sample and gives a probability of whether a fetus has two abnormal genes.[18] The ability to now determine exactly which genetic mutations a couple carry is a more accurate test. However, unless all 80 mutations are tested for, only a relative risk of having an affected pregnancy can be given to prospective parents. The application of relatively simple technology to screen directly for mutations using a scraping of cells from the mouth has raised the possibility of population screening for carriers of abnormal cystic fibrosis genes.[22] Couples who both carry mutations would have the option of all pregnancies being tested by a chorionic villus biopsy to decide if the fetus had cystic fibrosis and then offered termination of affected pregnancies.[9,12] Similar screening programmes have been applied to other genetic diseases such as thalassaemia and Tay-Sachs disease.[19] For example, in thalassaemia, which occurs commonly in Greek Cypriot populations, screening of the population and subsequent abortion has significantly reduced the incidence of the disease.[19,20] However, the situation for cystic fibrosis is very much more complex. There are major problems due to the large number of mutations and cost will prohibit screening for more than five or six. For prospective parents who are carriers the concept of relative rather than an absolute risk of a fetus being affected is likely to be very difficult to communicate.

There are also major logistic problems in deciding whom to screen and when.[9,16] A number of pilot schemes are already examining this.[21,22] Carrier testing is being offered to pregnant women and in those found positive then also offered to the father. If both are carriers then the pregnancy is screened and if the fetus has cystic fibrosis, termination of the pregnancy is offered. The problem with this approach is that a couple with a 'wanted' pregnancy may be faced

with a pressured decision whether to have a termination or not during the second trimester. In another pilot study all fertile patients in a series of family practices are being offered a test and carriers offered follow-up counselling.[22] However, uptake of test after a postal invitation has been poor and less than 40% of women found positive said they would opt for an abortion. Other groups have suggested screening 15 year oldschildren in their last year of school. There are considerable ethical problems in deciding how to be sure of informed consent from 15 year olds (children and their parents) and how to provide follow-up education and counselling. Children found to be carriers may be stigmatised or may become unnecessarily worried about being a carrier of a genetic defect.

Population screening as outlined above is clearly going to be beset with many problems in organisation. In addition, to convince a population to take up such screening tests will require an enormous (and costly) education programme and follow-up counselling services. Even if a national screening programme is instituted a reduction in the number of children with cystic fibrosis of only 40% has been estimated.[12] Health care services for children and adults with cystic fibrosis will have to remain and so only limited financial savings could be expected. Population screening is therefore unlikely to be cost effective even within its own frame of reference.[8,9,10]

Genetic Treatment for Cystic Fibrosis

The second practical application of the sequencing of the cystic fibrosis gene is the potential for gene therapy. This approach to genetic disease has already been successfully applied to other less common diseases. Cystic fibrosis offers the opportunity to provide curative treatment for a relatively common condition. The normal cystic fibrosis gene can be placed within a virus carrier. The virus can then 'infect' cells and cause them to produce normal CFTR protein.[23] In laboratory cultures of cells expressing abnormal cystic fibrosis genes, insertion of the normal gene results in such cells working normally, no longer showing any biochemical evidence of cystic fibrosis. There is also research demonstrating that viral vectors can be delivered to lung tissues in an aerosol spray making it possible to 'infect' lung cells with a virus containing new genetic material such as the normal CF gene.[23] This mode of treatment should result in the lung tissues working normally, so reducing or eradicating the lung damage which causes most of the symptoms and mortality from cystic fibrosis.[5] There will be considerable effort and investment required to develop the biotechnology to make such a genetic cure a reality; experts in this field suggest a cure will be available within the next five to ten years.[12, 15]

Prognosis of Cystic Fibrosis

There are a number of other considerations which are relevant to the debate concerning screening. The prognosis of patients with cystic fibrosis has improved dramatically over the past three decades due to general improvements in medical care.[3,4,18] Current median survival for cystic fibrosis is about 24 years and if current trends continue, irrespective of any effect of gene therapy, children born this year with cystic fibrosis will have a median survival of 40 years.[3] Further improvements in survival may also accrue from heart-lung transplantation and other promising therapies for the lung disease.[25] The option of embarking on an expensive mass screening programme for a disease in which over 95% of those affected will reach adulthood and many will live beyond 40 years with good quality of life is clearly ethically questionable.

The Medical Dilemma

Medical researchers are faced with the paradox of pursuing dichotomous lines of research, one leading to pregnancy screening and abortion and the other to curative therapy for a severe disease. Even if curative therapy is not available for five or more years, the improving prognosis for cystic fibrosis questions the morality of population screening.[26] Many potential parents of a child with cystic fibrosis are likely to find the option of abortion unacceptable under these circumstances. Investment of financial resources in such a screening programme are therefore difficult to justify and should be directed towards advancing the research into curative therapy.

The psychological and social issues resulting from prenatal screening have been recently reviewed.[27] Investigations for fetal abnormality are normally carried out at 16 weeks of pregnancy and as results can take two or three weeks, abortions for genetic indications are unlikely to take place before 20 weeks. Abortion at this stage of pregnancy results in a high incidence of physical and psychological complications. In addition women carrying normal fetuses often suffer from considerable anxiety while waiting for the results of screening. This is worrying as there is evidence linking anxiety during pregnancy with poor obstetric outcome.[27,28]

A Christian Perspective

Genetic research raises many ethical questions which need to be considered by Christians and clear and realistic perspectives articulated. Although many of the scientific issues are complicated and some background knowledge is required, we should not be intimidated by the medical jargon which surrounds this subject with unnecessary mystique. In most research into single gene defects, there is a tension between a eugenic approach, which aims at the eradication of genetic disease through screening and abortion of affected children, and curative therapy using the gene to replace missing or abnormal proteins due to the mutation. As outlined above cystic fibrosis is a clear illustration of this tension.

To propose population screening for cystic fibrosis in order to reduce incidence of this disease is morally unsound and difficult to justify in terms of resource allocation and cost effectiveness. The application of such genetic information to population screening and consequent selective abortion is unashamedly eugenic, and so in principle must be argued against. As genetic differences causing other diseases and variations from an arbitrary norm are discovered it will be possible to be very selective as to the genetic make-up of our children. As has been noted above, an increasing number of patients with cystic fibrosis survive until adulthood and many are in full-time employment. Those in favour of prenatal screening argue that abortion is justified because of the morbidity from the disease and the expense to the health service. Care for one patient with cystic fibrosis costs about £3,800 per year.[29] No costings are available for a screening programme, but clearly a national counselling service will be expensive. The argument that screening and abortion will save the health service is not only false in this case, but is also pernicious. We must never let the costs of medical care drive us to destroy life.

The likelihood of curative therapy for cystic fibrosis further undermines the argument for screening, and is an example of the positive

side of genetic research. There are many practical problems to be solved before such treatment is widely available but with investment in the appropriate biotechnology it is possible within the next five to ten years.[30] There is nothing morally or ethically questionable about such treatment nor is there any conflict with Christian teaching. Gene therapy targeted at cells other than those involved in reproduction (somatic cells) should be positively supported in cystic fibrosis and in other genetic diseases. In contrast, genetic manipulation of reproductive cells or embryos to replace abnormal genes is likely to be technically very difficult and is scientifically unproven. Manipulation of the genetic material of embryos, ova or sperm is likely to profoundly influence the developing fetus. Such experiments using animal reproductive cells have resulted in unexpected and bizarre offspring as the implantation of genetic material at an early stage of development has unpredictable effects. This approach to therapy for genetic disease such as cystic fibrosis is therefore unlikely to be scientifically feasible. The tampering with genetic material at an early stage of development raises important moral and ethical issues. It is clear from biblical teaching that human life begins at conception and the genetic material of the embryo is all that is required for further development. Genetic manipulation of the human geneome in a 4 to 8 cell embryo is very likely to have unpredictable effects, even if only one gene is altered.

The insertion sites of artificially inserted genes occur at random and thus can effect the expression of other potentially important genes. This approach to gene therapy which has the potential of profoundly affecting the nature of a human being must be viewed with extreme caution.

Cystic fibrosis illustrates a moral paradox within medicine which on one hand seeks to screen and eliminate through abortion and on the other to treat and cure. Molecular genetic research is likely to uncover many more useful therapeutic interventions and these should be supported and encouraged. Prenatal screening with a view to termination of pregnancy, however, is a eugenic approach to disease and in cystic fibrosis as with many other genetic diseases, it is clearly difficult to justify from a moral perspective. Christians should be aware of this application of genetic research and seriously question it. It is important, however, to realise that not all genetic research is unethical. There are many helpful treatments for serious diseases to be uncovered by genetic research with the development of somatic gene therapy and this area of medical research should be supported.

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The Seamless Dress of Hippocratic Medicine

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We are pleased to have permission to extract this chapter from the author's book The New Medicine, *to be published by Hodder Stoughton on November 29th at £7.99 (and by Crossway in the United States next year).*

What *is* medicine? That may seem a strange question to ask, but answers from doctors and medical students tend to show that those who practise medicine not only disagree about medical values, but that they also lack any single, unifying understanding of what it is they are doing.

Perhaps this criticism is unfair. Medical students are not taught in these terms. They are not invited to reflect systematically on the nature of medicine as a discipline but to practise it. If there are deficiencies in a system of medical education that fails to provoke in its students that kind of reflection, then there is a reason. This lies partly in increasing specialisation, partly in the rising profile of technology in medicine, partly in the breakup of the ethical consensus. The medical profession has simply forgotten to reflect on the nature of the medical enterprise. It has no single governing concept of what it is doing. A fatal combination of technological advance and ethical flux has led to the progressive disintegration of the idea of medicine.

In the smorgasbord of contemporary medical-ethical debate, there would seem to be something for everyone. In all its variety, contemporary medical-ethical discussion has the effect of offering him a *prima facie* ethical justification for whatever research or treatment regime he may happen to favour.

To be fair, the combination of ethical flux and new technology has given rise to a remarkable growth in the discussion of medical ethics; from hospital ethics committees to government-sponsored reports as the basis for public policy. A parallel development in the academic world has led to the appointment of ethicists to university (and even hospital) staffs, though less so in the UK than in some other countries. Yet even in the USA, where legal and political factors have forced medical ethics into the front line of public concern, most medical education is carried on with only modest interest in 'bioethics'. And in the UK it is generally squeezed to the sidelines of the tightly-packed medical curriculum. Although there is some interest in expanding this limited provision in the light of a spate of reports on medical-ethical issues and an avalanche of books, one effect has been to stress the variety of ethical options available, to encourage an open-ended approach, and thus to hasten rather than slow the shift in values. Attention is focused on the challenge posed by new ethical options (especially as presented by new techniques), and there is little balancing interest in the values being displaced.

What is the clinician to make of all this? It leaves him confused, and rightly. In the smorgasbord of contemporary medical-ethical debate, there would seem to be something for everyone. In all its variety, contemporary medical-ethical discussion has the effect of offering him a *prima facie* ethical justification for whatever research or treatment regime he may happen to favour. The effective function of the bioethics enterprise – whatever individual writers and institutions may intend – is to offer ethical 'cover' for any and every proposed course of action. It is freedom from any specific ethical tradition – let alone that of Hippocratism – leaving bioethicists free to select whatever clinical option is favoured and, if they are so minded, to develop an appropriate apologia. To put it another way, there is no serious option in treatment or research which is entirely without an apologist in the field of academic bioethics.

Such an approach to contemporary discussion may seem cynical, but there is little public or professional (or political) awareness of the fact that the function of much current work in bioethics is entirely different from that which is traditionally associated with the word 'ethics' in medicine – the trying of practices and proposals in accordance with established principles of conduct. By contrast, a major role of the new bioethics has been to devise new principles of conduct which will allow practices which had hitherto been forbidden. There is no real analogy between the traditional 'ethical committees' of medical associations, which sit in judgement on professional conduct, or hospital 'ethical committees' which sift research proposals, and national ethics committees like the Warnock Committee in the UK and its equivalents worldwide. These new bodies are established not to apply norms but to adjust them, and to draw up new ones if they wish. To say that is not to comment on the *bona fide* intentions of bioethicists, it is merely to set their endeavours in the context of the rapidly shifting values and uncertainty about fundamental norms which are the hallmark of these discussions in the 1980's and 1990's. The fact that some of the best-known figures in the bioethics world have defended extremely radical positions on substantive ethical issues is a much greater cause for alarm than is generally realised.

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In this situation of conflict and confusion at the level of academic and public policy discussion, the working definitions of most medical practitioners are increasingly guided by two interlocking models of medicine, both of them deeply flawed: medicine as technique, and medicine as satisfaction of consumer wants.

The self-conscious introduction of an 'internal market' into the National Health Service in the UK illustrates this second model well, with its terminology of 'suppliers' and 'consumers' and its concept of health care as a commodity. Of course, most health care has always been privately supplied, and there is nothing necessarily bad about internal or open markets within health care systems (though market-led provision will undoubtedly accommodate faster ethical change and discriminate against certain classes like the chronic sick). The dismay with which many have greeted these developments displays the threadbare character of our medicine, since there is little confidence that its ethics will hold up outside the state umbrella. The threads are hanging loose for all to see in the much freer market conditions of the USA. But the ethical character of Hippocratism has always precluded the reduction of health care provision into a mere market of consumer wants and health care providers.

This double model, with its conception of the physician as technician possessed of skills to dispense in the market-place, is probably the inevitable concomitant of the abandonment of the ethical consensus. But it is none the less a threat, so much so that it raises the question whether medicine in this guise will survive. We return to this question in a later chapter, when we have surveyed some of the alternative ethical commitments which have been taken up into the new idea of medicine and which currently underlie growing areas of its practice. For the present we simply ask: thus defined and understood, would medicine ever have developed as it did? Would there ever have been the organic, professional development which gave birth to modern medicine? Are these ideas of medicine not the hallmarks of that very different medicine which existed before the Hippocratic revolution? That is to say, does not the contemporary breakdown of the ethical consensus, with its accompanying retreat into technique and consumerism, signal a return to the pre-Hippocratic norms?

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The Nature of Hippocratic Medicine

There is little appreciation of the truly extraordinary character of Hippocratic medicine. We have already noted Jones' complacent regard for the Hippocratic values, as if, had Hippocrates not stated them, they would have emerged of their own accord as (in effect) self-evident. Jones could never have written that if he had been able to read some of the contemporary literature on medical ethics which is surveyed elsewhere in this book. The value of his comment is that it serves as an unconscious illustration of the degree to which, even as late as the first half of the twentieth century, the Hippocratic tradition had suffused western medicine. Hippocrates was so foundational that Jones found it impossible to conceive of any other kind of medicine.

It is strangely true that something which is taken for granted can be undermined with little conscious discussion of its merits. With the passage of time and the movement of opinion, the old tradition silently gives place to the new. In this case the evidence is striking in the paucity of literature on the subject. A computer library search is revealing in what it does *not* discover under the name of Hippocrates. And in the many general volumes which have been written on medicine, the lack of conscious reflection on the Hippocratic tradition is remarkable. Only very recently has Hippocrates been given more serious attention, and then as the target of critical comment from those who wish self-consciously to break with the tradition. Would-be defenders of Hippocrates have paid scant attention to what we have called the Hippocratic logic – the interplay of skills and moral commitments which make up the pattern of Hippocratic practice. At a time when flux and uncertainty in medicine have given rise to an unprecedently large volume of writing and publishing, it is strange that the name of Hippocrates should occur so rarely, and then almost invariably in formal, passing allusions.

It is not hard, of course, to find explanations for the contemporary writers' lack of enthusiasm for Hippocrates. There is plainly much in the Oath which cuts across contemporary *mores*, especially the Hippocratic perspective on the sanctity of life. By contrast, those who are most uneasy about abandoning Hippocratism have often failed to see the issue at stake in these terms. They have focused upon particular questions such as abortion, while it is the abandonment of Hippocratism itself which has prior significance. The final implications of departing from the tradition are of a different order altogether.

At the other end of the scale from Jones we have Ludwig Edelstein, who argued that since only a small minority of Greek physicians was sympathetic to Hippocratic values, the normative status claimed for them is groundless (however much we may happen to support them, as he did). One effect of his discussion was to give ammunition to those who would marginalise Hippocratic values, as is evident from the way in which his work was used by the US Supreme Court in the famous case of *Roe v Wade*, which in 1973 liberalised the US law on abortion.

Though it had not been offered any arguments based upon the Oath, the Court itself raised the question in the course of a survey of historical attitudes to abortion. Edelstein's conclusion, that the Oath was a manifesto of the Pythagorean school, and did not represent any general character in ancient medicine, gave the Court an opportunity to dismiss the relevance of traditional Hippocratic opposition to abortion. 'This, it seems to us, is a satisfactory and acceptable explanation of the Oath's apparent rigidity',[1] wrote the Court, having cited Edelstein's remark that the Oath is 'a Pythagorean manifesto and not the expression of an absolute standard of medical conduct'.[2]

Yet, as we have already noted, Edelstein falls into the trap of false dichotomy. He may be correct in arguing the Pythagorean character of the Oath, but that has nothing to do with its validity. Indeed, as Edelstein had himself argued, the story of medicine in the years following the composition of the Oath is the story of the diffusion of its influence far beyond the bounds of the Pythagorean sect. The other so-called 'deontological' writings in the Hippocratic corpus (that is, those chiefly concerned with ethics rather than clinical practice) themselves reflect different philosophical *milieux*. Yet they exhibit a substantial harmony with the Oath, and by their inclusion within the collection of books ascribed to Hippocrates, they show the enormous influence wielded by the medical tradition

that had long since broken out of its Pythagorean confines. 'Among the general practitioners of late antiquity, the teaching of the deontological writings of the *Corpus Hippocraticum* seems to have prevailed.'[3]

The conquest of ancient medicine by Hippocratism, through its powerful blend of clinical expertise and moral ideas, cannot so easily be dismissed, as if something which began life as a 'Pythagorean manifesto' is therefore not 'an absolute standard of medical conduct'. Indeed, the Supreme Court itself speaks of the Oath as 'the apex of the development of strict ethical concepts in medicine'; and Edelstein himself stated, 'I trust that I am second to none in my appreciation of this document.'[4]

If we assume Edelstein's Pythagorean theory to be correct, the diffusion of Hippocratism throughout Greek medicine suggests that it fulfilled the ambitions of its originator.

If we assume Edelstein's Pythagorean theory to be correct, the diffusion of Hippocratism throughout Greek medicine suggests that it fulfilled the ambitions of its originator. It is Edelstein himself who writes of the purpose of the Oath in the following terms: 'The Hippocratic Oath originally was a literary manifesto, a programme laid down by one who wished to set matters right in accordance with his own convictions.'[5]

The recognition that Hippocratism first emerged in ancient Greek society as a minority, reformist movement (which ultimately met with remarkable success) gives it new poignancy today. Its dominance of medicine is in question as it has never been since Hellenistic times. Hippocratism is in decline, once more the medical faith of a minority. In the process the Oath is returning to its original role – that of a manifesto for reform in medical values.

The Profession of Medicine

We speak loosely of 'the medical profession' as if the phrase were merely a collective term for doctors. Yet it draws our attention to the professional character of medicine. Of course, there are other professions; and an assortment of occupations seeks to be added to their number, to indicate the freedom of its practitioners from the simple market reduction of the work to that of the tradesman. Teachers call themselves 'professionals', and we are now accustomed to speak of the 'teaching profession'; social workers are called 'professionals' too, though some would hesitate to call social work a 'profession', skilled and responsible though it be. What these uses of the term 'profession' suggest is that the idea is in the process of extension. To put it another way, these responsible occupations, share some key aspects of what makes the old professions 'professions' – independence of judgement, confidentiality, round-the-clock commitment, and so forth. As traditionally understood, the 'professions' encompassed – alongside medicine – the law and (in a distinct sense) the church. The profession was a vocation, and its members were marked from the outset of their careers as the bearers of a characteristic set of responsibilities.

It is in this sense that medicine stands out as *the* profession, the profession *par excellence*. Even the other older professions, considered as professions, take their fundamental character from their analogy with medicine itself. It is in the values supplied in Hippocratic medicine that we have the template of all professional commitment. In so far as other human occupations approximate to the professional character of Hippocratic medicine, they may be judged professions themselves. There is no bar to the analogical extension of the idea of the profession to education and social work, and much besides. By the same token, there is no bar to the withdrawal of this accolade from those whose concept or practice of their discipline does not share in the fundamental 'professional' character of Hippocratism.

It may be helpful at this point to refer to Edelstein's own discussion of the work of Scribonius Largus. Scribonius wrote at the beginning of the first century AD, so he gives us an opportunity to reflect on the character of medicine at the very outset of the Christian era but at a time when the influence of Hippocrates was already widely diffused in the ancient world. In his book *On Remedies* he writes of the 'sympathy' and 'humaneness' that arise from the 'will of medicine itself'. If the physician's heart is not full of these qualities, he will be despised by both gods and men. Scribonius goes on to spell out the obligations of the physician, who 'is not allowed to harm anybody, not even the enemies of the state ... since medicine does not judge men by their circumstances in life, nor by their character. Rather does medicine promise her succor in equal measure to all who implore her help, and she professes never to be injurious to anyone.'[6] Scribonius goes on to refer to medicine as a 'profession' (*professio*). Edelstein comments: 'This word, in the language of his time, was applied to workmanship in preference to the older and morally indefinite terms, in order to emphasize the ethical connotations of work, the idea of an obligation or duty on the part of those engaged in the arts and crafts', among whom the physician was placed. He continues: 'It approximates most closely the Christian concept of "vocation" or "calling" except of course that for him who has been "called" to do a job his obligations are ordained by God, while for the member of an ancient profession his duties result from his own understanding of the nature of his profession.'[7]

This same concept underlies our modern idea of a profession, although in twentieth-century discussion there is more interest in the sociology of the profession than in the values which underlie it, and finally explain the social standing of physicians and the organisation of medicine in society. Thus one objective way of defining a profession over against other occupations is with regard to its self-regulating character, and the fact that it 'has assumed a dominant position in a division of labor, so that it gains control over the determination of the substance of its own work. Unlike most occupations, it is autonomous or self-directing.' We quote here from the Introduction to Eliot Freidson's *Profession of Medicine*, sub-titled 'a study in the sociology of applied knowledge.'

Freidson goes on to make a simple connection between the sociology of a profession and its values by seeking to account for its standing. 'The occupation sustains this special status by its persuasive profession of the extraordinary trustworthiness of its members', a trustworthiness extending to both 'knowledgeable skill' and what Freidson calls 'ethicality'. And he continues: 'The profession claims to be the most reliable authority on the nature of the reality it deals with. When its characteristic work lies in the attempt to deal

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with the problems people bring to it, the profession develops its own independent conception of those problems and tries to manage both clients and problems in its own way. In developing its own "professional" approach, the profession changes the definition and shape of problems as experienced and interpreted by the layman. The layman's problem is re-created as it is managed – a new social reality is created by the profession. It is the autonomous position of the profession in society which enables it to re-create the layman's world.'[8]

It is interesting to compare Freidson's discussion of the 'formal characteristics of a profession'. He notes that the fundamental distinction between a profession and other occupations 'lies in legitimate, organized autonomy... it has been given the right to control its own work'. Indeed, unlike any other occupation, Freidson makes the point that: 'professions are *deliberately* granted autonomy, including the exclusive right to determine who can legitimately do its work and how the work should be done. Virtually all occupations struggle to obtain both rights, and some manage to seize them, but only the profession is *granted* the right to exercise them legitimately. And while no occupation can prevent employers, customers, clients, and other workers from evaluating its work, only the profession has the recognized right to declare such "outside" evaluation illegitimate and intolerable.'[9]

But if this remarkable autonomous status is a mark of the medical profession above all others, who grants it? Freidson observes that 'it is unlikely that one occupation would be chosen spontaneously over others and granted the singular status of a profession by some kind of popular vote. Medicine was certainly not so chosen. A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work.'
And Freidson continues by drawing attention to the reason why, in a high civilisation, the 'elite segment' should treat a profession in this manner: 'The work of the chosen occupation is unlikely to have been singled out if it did not represent or express some of the important beliefs or values of that elite... the work of the profession need have no necessary relationship to the beliefs or values of the average citizen. But once a profession is established in its protected position of autonomy, it is likely to have a dynamic of its own.... The work of the profession may thus eventually diverge from that expected by the elite.... It is essential for survival that the dominant elite remain persuaded of the positive values, or at least the harmlessness, of the profession's work, so that it continues to protect it from encroachment..[10]

If medicine is unable to ensure that the 'dominant elite remain persuaded' of its values and task, it is open to the profession to shift the emphases of values and task alike in order that they might approximate the more closely with those acceptable to the elite.

There are notable parallels between Freidson's analysis and ours, in respect of the nature of a profession and its relations with the society which through its elite accords it its status, and whose beliefs and values, as focused in those of the elite, it represents. Freidson's discussion of the need for and problem of professional survival is particularly illuminating. The threat of divergence between professional beliefs and values and those of the elite is serious, since it would undermine the standing of the profession in society. If medicine is unable to ensure that the 'dominant elite remain persuaded' of its values and task, it is open to the profession to shift the emphases of values and task alike in order that they might approximate the more closely with those acceptable to the elite. Of course, this would not be – has not been – a conscious ploy, since the leaders of the profession, who set the key of its self-understanding, are themselves members of the elite. Medicine is not quite a monastic exercise. It is closed but not impervious, autonomous yet not entirely isolated from the value-system of the society in which its own values are traded.

To some extent this is the price which the profession has paid for its very 'professional' status, in Freidson's terms. It has gained an unique recognition from society's elite, but in so doing has altogether lost any consciousness that its values were once 'peculiarly those of a small and isolated group' which had gathered around a radical and reforming 'manifesto'.[11] Ironically, it was in so doing that it played a major part in the development of the very idea of a profession.

We return to a number of Freidson's observations in due course. For the present, suffice it to note that in the nascent Hippocratic medicine of the ancient world we have the emergence of the physician's art as a professional enterprise. It is not merely that; indeed, the other historic professions of the law and the church are in important respects distinct from medicine, such that to speak of the 'idea of a profession' can be misleading. We do better to recognise that this idea is always relative to the particular character of the profession concerned. Some general observations may be made, along the lines of those we have cited from Freidson. Yet even they have a special application to medicine rather than to other professions, ancient or modern. It is interesting to note that while his study is of medicine, it is intended to be of medicine as an example, *the* example, of the character of a profession. So, in Freidson's own words, medicine is 'not merely one of the major professions of our time.... Indeed, in one way or another, the profession of medicine, not that of law or the ministry or any other, has come to be the prototype upon which occupations seeking a privileged status today are modelling their aspirations.'[12]
We have already suggested such a status for medicine, arising from the suffusion of the medical enterprise with moral commitments. We have also suggested that, historically, the beginnings of the idea of a profession may be traced to the rise of Hippocratism in medicine, though that is not to exclude other sources, Christian and pagan, from such a packaging of virtue and skill in society. What it does is to draw attention to the character of medicine as *the* profession. In his own analysis Freidson, like other modern writers on medicine as a profession, exaggerates the significance of those factors which have changed the character of medical practice down the centuries. From the perspective of those whose interest in medicine as a profession is sociological rather than ethical this may be inevitable, but in dividing modern medicine from its ancient progenitor such an approach fails to grasp the moral logic of Hippocratism which gave birth to the western medical tradition, and which today still underlies medicine in its professional character.

Medicine as Moral Commitment

The question which such a discussion inevitably raises is that of the inner character of medicine. How is it to be understood, in its essentials? Is modern medicine in real continuity with ancient practice – and, therefore, with medical practice today in primitive situations, where both modern techniques and the structure of the consulting and autonomous profession are absent? Freidson goes so far as to indicate the later part of the nineteenth century as the period when medicine developed as a profession in the sense which mosts interests him. Yet such an abstraction arises out of the field of interest of the sociologist, rather than the medical tradition itself. We must ask why medicine has developed as a marriage of skill and moral commitment, why it emerged in antiquity as a principled and philanthropic enterprise. The origins of the idea of medicine as a profession lie in the particular set of moral commitments which have from the start constituted the Hippocratic tradition.

The character of medicine as moral commitment has been nowhere better expressed than by Stanley Hauerwas, especially in his essays collected in the volume *Suffering Presence*, where he gives free rein to his thinking on a spread of topics which intersect with the questions of medicine and the handicapped.[13] He draws attention to the growing popularity of medical ethics. 'Confronted by issues that seemed morally troubling', he writes, 'physicians began to acknowledge that medicine must again touch base with ethics.' Yet, 'as a result, many failed to notice that medicine was first and foremost a moral practice constituted by intrinsic moral convictions that are operative even if not explicitly acknowledged.'[14]

As we have argued, the moral convictions which Hauerwas here suggests are intrinsic to medicine were, in fact, acknowledged most explicitly in the Hippocratic Oath. The Hippocratic physician lays his cards on the table; or, in terms of the Oath itself, before commencing his medical studies the would-be Hippocratic doctor picks up a set of moral cards at the outset. He knows, and his patients know, what his teacher, in passing on the tradition, insists: that the moral commitments of the physician are of the essence of medical practice. They are not some added extra, optional and a matter of preference. They are integral to the practice of the profession; to its very professional character. Of course, there were physicians before Hippocrates. But (and this is the point lying behind Hauerwas' statement) they were not practising what we have come to mean by medicine. At the heart of Hippocratism lies the conviction that medical values are intrinsic and not extrinsic to the medical enterprise. The plainest and most disturbing feature of contemporary medical-ethical discussion is the readiness with which even those who share the substantive values of the tradition are falling victim to the claim that these are mere super-additions to the technique which characterises and determines the nature of medicine. Most physicians, at least, remain men and women of integrity, working within the framework of their own moral convictions. But, in their view, the heart of medicine is not moral commitment, however important personal and particular moral commitments may be. Medicine is technique.

The attraction of such a view of the essence of medicine is obvious. It enables those who wish to break with the moral tradition of Hippocrates to maintain their claim to be practising that same 'art' of which he was an exponent. They have merely shuffled the pack of moral cards. They maintain that Hippocratic values are subjective, arbitrary, claiming the opposite of Jones' unintentionally disparaging notion that they are really self-evident. They are time-bound and bound also by particular religious and philosophical commitments. This was in essence the case of the US Supreme Court against the claims of the Hippocratic tradition in *Roe v Wade*. Taking Edelstein's analysis as their point of departure, they moved on to relativise the moral commitments of Hippocratism as merely those of Pythagorean physicians in ancient Greece. There is no interest shown in the extraordinary Hippocratic marriage of value and technique which gave rise to the development of western medicine. Its implications for the significance of these 'merely' Pythagorean values seems to have escaped critics of the tradition. In current debate, this view is typical; and it enables contemporary apologists for the new medicine to lay claim to continuity with the old.

Of course they cannot altogether escape the overweening influence of Hippocratism. Every one of the modern re-statements of medical values has unconsciously or (generally) consciously cast itself in the Hippocratic form. The claim to stand within the great tradition of the old medicine is all but universal. Yet it is a claim which increasingly lacks credibility; the continuity is one of form, and can be claimed only by manipulating the substance of the tradition. The historical character of Hippocratism as a dissident, reforming movement which integrated clinical skill and distinct moral commitment gives the lie to such a claim.

What then is the nature of the Hippocratic tradition? Out of what inner logic is woven its seamless dress?

What then is the nature of the Hippocratic tradition? Out of what inner logic is woven its seamless dress? We have surveyed the text of the Oath and its history, and referred to the many contemporary versions which it has spawned in the twentieth century. It remains for us to gain a perspective on Hippocratism as a whole. The origins of modern medicine lie in the extraordinary moral power of the Hippocratic Oath and the ancient tradition which it represents. This conviction depends no more on the 'legend' of Hippocrates of Cos than upon the historical reconstruction of Ludwig Edelstein in his monograph of 1943.

There is no doubt that in Hippocratism we see the emergence in late Greek antiquity of a tightly knit body of moral thinking as the Siamese twin of effective clinical practice. If the 'legend' had graduates of ancient medical schools raising their right arm and swearing the Oath in full academic dress, it may be discounted with no loss. More exhilarating is Edelstein's realistic reconstruction of a vigorous, reforming minority, stemming from the disciples of later Pythagoreanism but soon diffusing into one philosophical school after another, until finally the legend could be written and believed. This analysis suggests a remarkable demonstration of the power of an idea. With the spread of Christianity throughout the Graeco-Roman world, the idea's time had come. Its ethics – as demanding as those of the Pythagoreans – could be undergirt with a theology of grace, and its moral power, already widely diffused in the different philosophical strands of the medicine of late antiquity, could be harnessed by the Christian church. Its influence even on post-Christian western medicine, struggling to free and re-establish

itself as a secular enterprise, testifies to its enduring power and the degree to which the warp and woof of medical values and skills are interwoven in the Hippocratic fabric.

The starting point of the tradition, first pagan and then baptised into Christian service, lies in its conviction that the physician is a healer. This underlies the scope of the Hippocratic enterprise. We may take that for granted, but its significance emerges in the prohibitions of the Oath which have so plainly stamped the Hippocratic tradition, ancient as modern, with the character of a healing tradition pure and simple.

Hippocratism is healing and not harming. The famous medical principle *primum non nocere* (first, or above all, do no harm) is to be found not in the Oath itself but elsewhere in the body of Hippocratic writings. Yet it could as well have been in the Oath since it is in the Oath that the two fundamental medical 'harms' are spelled out – together with the other more general harms in the power of the unscrupulous physician.

The prohibition of the medical harms, more than all else, sets the practice of Hippocratism apart from that of any other kind of medicine. For they are harms which might be done as readily by the scrupulous as by the unscrupulous, by the man of integrity as by the rogue. Their prohibition is the badge of the medical ethics of Hippocratism, as opposed to its medical etiquette. These harms are those of abortion and euthanasia. The Hippocratic physician forswears them. To be more precise, in the terms of the Oath – whether or not it was ever employed in such a fashion – the medical student, before taking up his studies, binds himself irrevocably to a medical practice which excludes participation in the taking of human life, before birth or after. And (in the formal stipulations of the Oath, which are intended to govern the passing on of medical knowledge) he will impart none of his expertise to any who will not swear likewise. The medical arts, whose supreme clinical, as well as ethical manifestation in ancient times was found in Hippocrates, could be revealed only to those who would hold these two together. It is in this clear, though negative, definition of the limits of the healer's task that we find the Hippocratic avowal of the principle of the sanctity of human life. The negative form which it takes is plainly deliberate. In place of a doctrine about the nature of human life we find practical provisions designed to protect it.

As we have already noted, the precise form of the prohibitions stands for a broader restriction on the practice of the physician. Abortions were procured in the ancient world by a variety of means. Apparently the most common method used a pessary. By the same token, suicides for medical reasons – not uncommon, we read – could of course be brought about in many different ways. But the administration of poison, either by the physician himself or by the patient, was the most usual, and although poisons were generally available it was evidently normal for the physician himself to supply an appropriate remedy. Since suicide-euthanasia and abortion were widespread in the Graeco-Roman world, and since the physician was generally involved in them both, the distinctive and radical character of Hippocratism is revealed in sharp focus as would-be arbiter of the ethics of the profession. A new and uncompromising moral agenda was set for medical practice.

Though these twin negations form the most significant clauses to be found in the Oath, they are to be balanced against its most significant omission. It comes as a surprise to many people – not least, to physicians – to realise that the Oath makes no specific reference among the responsibilities of the doctor to the relief of human suffering. This is plainly intended to underline the Hippocratic opposition to abortion and euthanasia, since their defence lay – as it lies today – in a relief-of-suffering ethic devoid of a commitment to the sanctity of human life. In ancient Greece even more than today the palliative role of the physician would have been central. Clinical management options would have been few – in a primitive culture, where drug therapies and surgery were severely limited, and long before the development of antisepsis and anaesthesia. The physician often must have faced no alternative to whatever palliative means lay at his disposal. Yet the Oath makes no reference to what for many physicians today would have pride of place in their ordering of medical commitments: while the prohibition of abortion and suicide-euthanasia is underlined, the duty to relieve suffering is left unmentioned. So what is the key to the moral medicine of Hippocrates?

We turn back now to the Oath to seek an understanding of the structure of the moral and religious commitments involved in Hippocratism. The first thing which strikes us is its sophistication: it is very far from the simplistic medical creed which some of its contemporary critics imply. There are different ways in which the Oath and its moral structure could be analysed. In the remainder of this chapter we draw out three interlocking principles which together determine the Hippocratic logic. First we examine its triple covenantal character, in which the physician is covenanted to his God, his master and his patient. Secondly, we turn to the double ethical principle which, within this multiple covenant, governs the physician's practice of his profession: a due regard for the sanctity of human life, and a general philanthropy in which his patient's interests are always paramount. Thirdly we focus on the single role of the Hippocratic physician: he is a healer.

1. The triple covenant

We suggested in our discussion of the ancient Christian version of the Oath that the excision of most of the covenantal features was a major impoverishment. The displacement of its covenantal structure leaves the Oath a naked ethical code, while its moral force depends precisely upon its being more than that. Other revisions have tended to have the same effect, though in almost every post-Hippocratic code there are the remnants of the original covenantal structure. The structure itself is highly complex.

We may outline it as follows. The pupil/physician who swears the Oath commits himself to much more than a code of practice. For the logic of that practice arises from a series of relationships. Chiefly they are three in number, though a fourth is referred to and others are implied.

The physician stands in covenantal relation to his master, who has inducted him into the medical arts (and also to his master's family); to his patient; and to his God, before whom he sets the whole conduct of his medical vocation as of his life. There is reference also to those who will in due time be his own pupils, in the solemn promise to impart medical instruction only to those who have already committed themselves to the Hippocratic values. This represents an adjunct to his covenant with his teacher, who is thereby assured that what he has imparted to his pupil will never be passed on, except on the same terms – to one who, like his pupil,

stands in the closed Hippocratic circle.

The implied relationships are themselves interesting, since just as the master shares a responsible concern for future pupils of the one whom he has taught, so he has a concern for his student's patients; indeed, it is out of this concern that the tradition is to be strictly maintained. Moreover, in swearing the Oath the physician is acknowledging that in his treatment of his patients he is treating those for whom he is accountable to God. The physician's God has his own interest in the physician's patients.

All of which underlines the complex nexus of covenant to which the Hippocratic physician commits himself by oath. His practice of medicine, and the moral commitments which underlie it, are no private matters in which he acts alone. The medical vocation draws him into a set of relationships which make fundamental demands on him and determine the character of the medical practice in which he engages. They oblige him, in turn, only to pass on his clinical skills to those who will first submit to the self-same covenantal ethical context. This is no self-seeking closed shop of a medical guild, as has sometimes been suggested; it is fundamental to the moral character of the tradition: only by refusing to pass on the medical arts to those outside the ambit of its values can the Hippocratic physician demonstrate his own moral seriousness. Here is a clear initiation of a medical-moral tradition: it is built into this understanding of the physician's responsibility to his teacher and his pupil, as well as his patient. It is in the nature of Hippocratism that it makes no claim to be merely sectional, or indeed sectarian. Its claim is objective, to represent the truth about human nature and to deny all other possible understandings as untrue. The exclusivity of the Hippocratic tradition is the result, and has been no small contributor to its influence.

We look in a later chapter at the signficance for medicine of a covenantal understanding of the doctor-patient relationship. As we shall see, this key concept has been recognised in contemporary debate, though it has not commended itself universally. Yet its grounding in this Hippocratic three-way covenant is not recognised. The vertical reference of the Oath – to God – is in both Pythagorean and Christian conceptions of medicine the crucial context of the human relationships involved. Otherwise the Oath, like some of its secular revisions, would present a mere formal code, a cold set of rules. By contrast, Hippocratic ethics are theistic. We have suggested that they might even be described as theological ethics, in however rudimentary a form. The human covenants are grounded in a divine covenant; the human obligations in obligations to God. That, of course, is the source of the self-confidence which gives rise to the claim of Hippocratic exclusivity. The Hippocratic physician is in no position to negotiate his ethical perceptions; he must do nothing which will encourage the development of clinical practice outside of the very special covenantal context in which he has been led to practise. This is not simply because he has so promised his teacher, or because he personally believes such practice to be wrong. It is because he has so promised his God and he is convinced that Hippocratism is the only basis on which his God would have him engage in the medical enterprise. The exclusivity of such a position is but the corollary of its internal logic.

In Chapter One we commented briefly on the contents of the Oath. What needs to be added is the broader perspective in which these individual commitments and injunctions should be understood. We must be grateful to Edelstein for the light which his work has thrown on the origins of Hippocratism in the Pythagoreanism of the later fourth century BC. We here add to our debt, since Edelstein's own argument demonstrates that the values of the Oath represent the outworking in the field of medicine of certain specific religious-philosophical convictions. The Hippocratic physicians swear their Oath before God since it represents the sum of what they believe he demands of them as physicians. The interlocking of the human and divine covenants is not arbitrary. In no other way could a 'pure and holy' life be lived, or a 'pure and holy' art practised. Because of the theistic grounding of the ethical injunctions of the Oath, the covenantal obligations to teacher, patient and God come to a single focus.

2. The two-fold obligation

We can sum up the ethical character of the Oath in the twin obligations of philanthropy and the sanctity of life. As we have noted, each of these could be held to entail the other. Yet it is convenient to distinguish those injunctions in the Oath which expressly forbid the taking of life from those in which the physician is enjoined to seek the well-being of his patient – and nothing else. It appears at first as if these represent the negative and the positive, in order to leave no room at all for doubt as to the character of the conduct required of the physician. In fact we see in the negative aspects of the Oath's moral injunctions (as in the Ten Commandments) sophistication that is born of realism. Hippocratism is no mere lofty ideal. We may well believe with Jones that the Oath (even in some earlier form) must surely have an historical connection with Hippocrates of Cos. He was no ivory tower ethicist but the greatest clinician in the ancient world.

But we note here that just as such questions as confidentiality and sexual continence are addressed directly and by prohibition, so is the sanctity of human life. In fact the Oath says nothing about the sanctity of life in so many words, it simply outlaws any participation in its destruction. In this respect there is a notable contrast between the Oath and some of its contemporary restatements, which focus on positive rather than negative viewpoints and thereby leave open possibilities of qualification and reinterpretation. Had the Declaration of Geneva followed the Oath in banning abortion instead of opting for a positive alternative statement, which had the same intention – 'utmost respect ... from the time of conception' – it would have been altogether more difficult to slip gears into ambiguity and revise the text, when liberal abortion was on the horizon to read '...from its beginning'. We return to this in Chapter Three.

3. The single role

It seems mere tautology to suggest that the role of the Hippocratic physician is that of a healer, but it puts some of the most contentious issues in contemporary medical-ethical debate into focus. Indeed, there is no more concise way of drawing attention to the contrast between the old medicine and the new. The anguish of contemporary medicine is that it finds itself locked in a conflict between the Hippocratic model of the healer and the attempt to set in his place a new physician whose chief task is to 'relieve suffering'. The dialectic of healing and the relief of suffering is the crucible of the new medicine; but it was also the crucible of the old.

That is a fact of central importance in any attempt to assess the relevance of Hippocratic values today. As we have seen in our discussion of the historical origins of the Hippocratic tradition, at a series of key points – and especially in its opposition to both abortion and suicide-euthanasia – Hippocratism consciously defined itself over against the contemporary medical *mores* of antiquity in which the 'relief of suffering' had pride of place. This is not, of course, the whole story; and the reforming Hippocratic manifesto had also its sights set on other abuses. But in repudiating both abortion and suicide-euthanasia, the Hippocratic physicians defiantly rejected a relief-of-suffering ethic, setting in its place the ethic which we know by the name of the sanctity of life.

The effect of ruling out these options, and especially that of euthanasia, is to channel the medical enterprise in one direction and one only. Medicine becomes synonymous with healing, and forswears absolutely the option of taking human life. To prevent all possible misunderstanding this conviction is underlined by the strangest of all omissions from the Oath. As we have already noted, many medical practitioners are astonished to learn that the Oath says nothing explicit about the calling of the physician to relieve the suffering of his patients. Of course, philanthropy runs right through the Oath. But in this regard its implications are not specified. Since this document details the calling and principles of the physician so fully, it is impossible to avoid the conclusion that there is a reason why 'relieving suffering' remains undiscussed. In the Oath itself we see recognition of the danger posed by the relief-of-suffering ethic, subversive as it is of the very Hippocratic idea, short-circuiting the healing task by putting the patient's life under threat from the doctor himself.

Even so perhaps some reference could have been made to relieving suffering as a subordinate task, secondary to the healing role of the physician. The omission is heavy with significance. Here, as in other matters, the Oath is characterised by a caution which speaks to our contemporary situation. For today we see what Hippocrates witnessed in Greek antiquity: a medicine in which healing is not paramount. Of course, healing remains *an* objective of the physician, but only if it seems the best way of 'relieving suffering'. For Hippocrates, the relief of suffering is incidental, assumed in the commitment to secure the patient's general well-being. Far from being merely semantic, this difference is profound, the touchstone of a medical tradition, the watershed in antiquity and the modern world between Hippocratism and primitive, pre-Hippocratic medicine.

The single-minded character of the Hippocratic healing commitment has successfully protected western medicine from the unresolved, double-minded tensions of a medical tradition in which both healing and the 'relief of suffering' vie for status.

The single-minded character of the Hippocratic healing commitment has successfully protected western medicine from the unresolved, double-minded tensions of a medical tradition in which both healing and the 'relief of suffering' vie for status. Yet this is how many physicians today understand their task, as a balancing act between the two in which, in every case, a fresh framework of understanding requires to be established. The result is to set at the heart of clinical practice an illogic which seems to deny any single mission for medicine.

The tendency is to give way to those pressures which have displaced healing from its paramount position in the tradition and to subsume it beneath the 'relief of suffering'.

The tendency is to give way to those pressures which have displaced healing from its paramount position in the tradition and to subsume it beneath the 'relief of suffering'. The physician may actually believe that he is working with two equal principles, while in practice subordinating healing to 'relief' on every single occasion – since, whenever they come into conflict, the one takes precedence over the other. We return to this theme in a later chapter.

1. 410 US 116 (1973).
2. Ludwig Edelstein, *The Hippocratic Oath*, (John Hopkins, Baltimore, 1943), p. 64.
3. Ludwig Edelstein, 'The Professional Ethics of the Greek Physician', in *Bulletin of the History of Medicine* 30 (1956), pp. 392-418; repr. in S.J. Reiser, A.J.Dyck, W.J. Curran, edd., *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*, MIT Press, Cambridge, Mass. and London, 1983, p.46.
4. *Ibid.*, p. 42.
5. *Ibid.*, p. 43.
6. *Ibid.*, pp. 44f.
7. *Ibid.*, p. 45. Edelstein goes on to contrast this 'ideal of medical humanism' with the 'spirit of Hippocratic ethics', suggesting that even Scribonius can make the connection only 'by implication'. But Scribonius, who called Hippocrates 'the father of our profession', plainly believed himself to be unpacking Hippocratic values.
8. Eliot Freidson, *Profession of Medicine: a Study in the Sociology of Applied Knowledge*, Harper and Row, New York, 1970, p. xvii.
9. *Ibid.*, pp. 71f.
10. *Ibid.*, pp. 72f.
11. Edelstein, *The Hippocratic Oath*, p. 38.
12. Freidson, *Profession of Medicine*, p. xviii.
13. Stanley Hauerwas, *Suffering Presence*, University of Notre Dame, Indiana, 1986; T.& T. Clark, Edinburgh, 1988.
14. *Ibid.*, p. 4.

REVIEWS

The Healing Spirit: Case Studies in Religion and Psychotherapy
Paul R. Fleischman
SPCK, 288 pages, £8.95, paperback, ISBN 0 281 04451 1.

As a practising clinical psychiatrist who also teaches in the School of Medicine at Yale University, the author has developed a particular interest in understanding 'how the threads of religious issues are woven into the fabrics of suffering, healing, and health'. Studying both the healing and destructive influence of the religious attitudes of his patients, he runs a seminar at Yale on the interface of psychiatry and religion. As a result, many patients whose psychiatric problem has a religious dimension are referred to him. A previous publication of Dr Fleischman's is 'The Therapeutic Action of Vipassana Meditation; and Why I Sit' (Buddhist Publication Society, Sri Lanka).

The case examples that the author describes involve fictitious patients, but are 'true in the sense that their human essence is something I heard and participated in during the practice of psychotherapy'. He categorises his subject under ten headings, which form the chapters of the book. He entitles these: Witnessed Significance, Lawful Order, Affirming Acceptance, Calling, Membership, Release, Worldview, Human Love, Sacrifice, and Meaningful Death. He distinguishes at least one of these themes in each of the case studies he describes, seeing the way to wholeness for his patients in the development of a proper outlook on these religious aspects of life. He recognises that some of his patients, as atheists, do not see their problem as having a religious dimension.

Likewise, he says, all people have to come to terms with their own mortality, yet feel confirmed, not shattered. 'Every person is a piece, a fragment, that will die, pass on, disappear, lose everything and everyone'. He is dismissive of ideas of personal salvation, as advanced by Hinduism, Christianity and Mahayana Buddhism as a narcissistic fantasy of escape from the inevitability of death. 'People can touch, know, express, live out from the source of life itself, *which is in us*' (reviewer's italics). He quotes the twenty-third psalm as an example of our contact with the source of life:

'Yea, though I walk through the valley of the shadow of death,
I will fear no evil; for thou art with me...'

However, he goes on to say 'for each "I" that "thou" may differ'. The author moves easily between quotes from the Bhagavad Gita, the Koran, the Old and New Testaments, and Buddhist texts. It is assumed that a subjective acceptance of the more humane aspects of any of these religious traditions, while shunning their dark side, is a means to personal wholeness. There is no emphasis on an objective relationship with a personal God whereby such wholeness could become permanent. 'The denial of death...leads to absurd group fantasy inventions of inexhaustible and indomitable good human parents who live in the sky, presiding over a flawlessly, narcissistically gratifying reproduction of life on earth's ideal daydreams.' The author advocates an acceptance of eventual submergence in the environment of the universe as a whole. Our energy and virtue are not lost, but rather transformed into some other aspect of the world flow.

'I am a thousand winds that blow.
I am the diamond glint on snow.'

Dr Fleischman speaks of 'the calling' of such diverse individuals as Joseph Smith, Mohammed, a Sioux Indian, Mahatma Gandhi and Isaiah. Such psychological phenomena – induced by a yearning for significance – can be healthy if they result in human progress, or there may be malignant versions which result in a Nazi holocaust or a Jonestown massacre. Augustine's conversion is seen as a psychological release from the decadent paternalist worldview of Roman culture as represented by his pagan father, achieved by Augustine's willingness to change his worldview to that of his saintly Christian mother. Surrendering his will to the Christian God avoided any possible behaviour – including sexual behaviour – that would justify a beating by his father. He resolved his implicit Oedipal rivalry by uncritically absorbing his mother's worldview in a totalistic manner. This psychological resolution of Augustine's personal problem was historically significant, the author says, since 'individual changes in worldview, when expressed with the force of genius' can carry along millions of other people. Thus Augustine was a major influence in the shift from the Roman Empire to Christian Europe.

While accepting the contingent psychological aspects of a genuine religious conversion, this reviewer is left dissatisfied with a book that does not allow for the sovereign action of a personal and creator God in both history and the individual. In his introduction the author states 'I intend to create a matrix of understanding and action for clinicians that is neither blithely sanctifying nor cynically reductionistic. I hope to be complete, so that every major religious phenomenon that engages our work as psychotherapists is contained in these ten issues.' The reviewer is of the opinion that Dr Fleischman has achieved his intention but not his hope.

Allan Webster
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The Glover Report: Fertility and the Family
published by Fourth Estate, London, 1989, £7.95

The European Commission established a working party of seven members under the chairmanship of Jonathan Glover, to consider reproductive technologies. It published its findings last year under the title: *Fertility and the Family*.

The working party included several doctors of medicine and others with expertise in ethics, philosophy and theology, as well as a sociologist and a lawyer. Six nationalities were represented.

The Report is well written and very readable. It begins with a philosophical approach. It then proceeds to consider semen donation, the family and surrogate motherhood, the embryo and its status, the problem of infertility and the various forms of treatment available, including IVF. The final chapters are concerned with fetal handicap, selective abortion and the wider issues of genetic engineering.

The philosophical approach adopted is neither wholly utilitarian nor is it derived from any inalienable right of the parties involved. Instead, intuitively acceptable resolutions of particular conflicts are sought. Destructive human embryo research is therefore justified on the basis that 'acts quite acceptable at the start of development become increasingly hard to justify as later stages are reached'. Thus, the Report, whilst recognizing that the embryo or fetus is a human being ignores the fundamental commitment of the medical profession to respect for human life 'from the beginning' and the Helsinki Declaration prohibiting any research which is not for the benefit of the subject. The Report also perpetuates the extraordinary failure to appreciate any essential difference in status between an embryo (which is a complete new individual of the species) and the ovum and spermatozoon (which are part of the parents).

On the positive side, the Report rejects 'the technological imperative' – the view that if something can be done, it will and should be done. It also recognizes that research workers need to be guided by the values of the wider society.

The Report also expresses concern that the policy of eliminating the handicapped before birth may produce discriminatory attitudes towards those who are handicapped. Nevertheless, it appears to support pre-implantation screening, without seeing any difference in principle between such screening and selective abortion.

In the field of genetic engineering, the Report points out the potential dangers of sex selection, and endorses the European MRC's prohibition against germ line therapy, *i.e.* the insertion of genes into fertilized eggs, causing changes which may be transmitted to future generations.

(The reviewer wishes to acknowledge the help of Dr John McLean of the Manchester University Department of Anatomy.)

David Short
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The Misfortunes of Others: End-stage Renal Disease in the United Kingdom
Thomas Halper
Studies in Philosophy and Health Policy, Cambridge University Press, 1989, 219pp., £25, ISBN 0 521 35047 6

By selecting the policymaking process for the treatment of patients with renal failure within the British National Health Service, the author seeks to provide an illustration of the way in which 'a national health system in an advanced Western democracy confronts an affliction posing a life or death issue' (p.1). It is perhaps fortuitous for Professor Halper that the current reorganisation of the NHS with its radical changes in ethos and the criteria governing resource allocation, render this book of historical interest. It is otherwise difficult to know for whom, apart from serious students of health policy, it might prove relevant or riveting.

A review of the history and incidence of dialysis and transplantation in Europe, designed for readers with a non-medical background, precedes an examination of the biases claimed to be present in UK treatment patterns: bias against the elderly, those with other disorders and women. The focus of the study, however, is the relationship between the macro- and micro-allocation of resources, seen to echo the interaction between societal and political values and medical demands.

The major section on macro-allocation includes a critique of policy formation, the factors governing cost-effectiveness, the influence of bureaucracy and its relation to government and a detailed account of the workings of the DHSS and DHAs: all this together with an analysis of the effect of pressure groups and party politics on decision-making.

Micro-allocation is determined primarily by medical factors in Halper's view. The passive role adopted by patients, the negativism of general practitioners with a reluctance to refer patients and the tendency of medical consultants to follow their own moral and personal judgement rather than objective criteria for selection for treatment, all play a part. It is difficult to assess the accuracy of such claims since these chapters are peppered with unsubstantiated assertions and generalisations. The concentration on the English scene, though claiming to be a UK study, reinforces doubts about the validity of the conclusions drawn. Professor Halper concludes with an exposition of well rehearsed factors determining the right of the individual to health care.

Summaries at the end of each section are helpful together with an excellent and extensive bibliography.

As the title suggests, the author remains distanced from the health care system and operates out of a hitherto alien philosophy of health care provision. In many ways, these reflections exemplify the current conflict in attitudes to caring in Britain today.

Gillian M. Morton
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Ethics and Leadership: Putting Theory into Practice
William D. Hitt
Battelle Press, Columbus, Ohio, 1990, 236pp.,hardback.
$24.95; ISBN 0 935470 52 2

Ethics and Leadership is an exercise in raising ethical consciousness among leaders of organisations (notably business corporations, but its relevance is not confined to that sphere). Hitt argues that ethics and leadership go hand-in-hand and that a leader has a crucial role in creating an ethical climate which leads to trust and – in the long run – success. It is therefore crucial for a leader to: (i) achieve an understanding of ethics; (ii) serve as a role model in making ethical decisions; and (iii) develop and implement a plan of action for promoting ethical conduct on the part of his/her staff.

Hitt makes a very interesting correlation between levels of being, ethical systems and management types. He accepts the philosophical framework of Karl Jaspers, who sees human beings as existing on four different levels: empirical existence (seeking pleasure and avoiding pain), consciousness at large (acquiring objective knowledge), spirit (identifying with the key ideas of wider organisations) and *Existenz* (achieving authentic selfhood). Hitt argues that empirical existence corresponds to an end-result system of ethics (*e.g.* Mill's Utilitarianism) and the manager who is a manipulator; consciousness corresponds to a rule-based system (*e.g.* Kant) and the bureaucratic administrator; spirit to a social contract system (*e.g.* Rousseau) and the professional manager who adopts the company ethos uncritically; and *Existenz* to a stress on individual conscience (*e.g.* Buber) and a transforming type of leader who has strong personal convictions and inspires his followers to reach their better selves.

Hitt thinks that there is a place for all four ethical systems and leadership styles in his all-encompassing map, but not on an equal status: the higher levels of being should give direction to the lower. Thus his preference is for a transforming style of leader, but one who does not ignore the importance of results, rules and organisational objectives.

Hitt works this all out in an incredibly symmetrical manner. Every system or character-type is broken down into ten different aspects. It is all too neat and hardly does justice to the untidy nature of real life. But if the pun may be pardoned, Hitt does hit on some important connections. The clarity of his analysis makes it a very useful starting-point for ethical discussion even if one would like to make many refinements and qualifications. Some of his definitions are extremely helpful, *e.g.*, a value-system is 'an enduring organisation of beliefs concerning preferable modes of conduct or end-states of existence along a continuum of relative importance'(p.7).

Hitt's approach is purely secular, and naturally the Christian has things to say which go unmentioned in this book. In the Bible we find portraits of leadership which are of perennial relevance, not least those of the person of Jesus. We find paradigms, principles and perspectives which put ethics in a context and provide it with a theological undergirding far more secure than Jaspers' somewhat suspect anthropology. We find challenges (*e.g.* 'You cannot serve God and Mammon') which are extremely stark and which call into question Hitt's too easy assumption that what is good from a business standpoint and right from an ethical standpoint will almost always tally. But within these important limitations, this is a very useful book.

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