

# ETHICS & MEDICINE

## An International Christian Perspective on Bioethics

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58 Hanover Gardens, London, SE11 5TN  
Tel: 071-735 6210 Fax: 071-587 0595

**In the USA:** Trinity Evangelical Divinity School,  
2065 Half Day Road, Deerfield, Illinois 60015  
Tel: 1-708 945 8800 Fax: 1-708 317 8141

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From Stuart Hornett, a London barrister and Member of the Editorial Board of Ethics and Medicine.

# LEGAL COMMENT

## THE LEGAL ADVANCE OF THE ADVANCE DIRECTIVE

*Stuart Hornett examines recent developments in the law and the latest English High Court decision on the refusal of treatment and advance directives.*

While it might be overstating matters to suggest that recent decisions in the English Courts have rendered academic the debate over whether advance directives should be 'legalised', it is now clear that, in principle at least, advance directives are already legally valid. On no less than three occasions over the last year or so the Courts have impliedly or explicitly recognised that advance directives do carry legal force and should be obeyed. The first was *Re T (adult: refusal of medical treatment)* [1992] 4 All England Reports 649 which concerned the refusal of a blood transfusion by a Jehovah's Witness. The second was the seminal House of Lords decision in *Airedale N.H.S. Trust v. Bland* [1993] 2 Weekly Law Reports 359 (see Autumn 1993 *Ethics & Medicine* Vol. 9.3 at 34). The third and most recent, decided in October 1993, gives the clearest indication yet that the Courts will give effect to patient's wishes as expressed in an advance directive.

*Re C* (1993) *The Independent*, October 15; 143 *New Law Journal* (1993) 1642, concerned a 68 year old male patient confined to Broadmoor for nearly 30 years who for most of that time had been diagnosed as suffering from chronic paranoid schizophrenia. His condition afflicted him with two delusions: the first was that he had once been a great doctor who, among other things, had been and was able to cure damaged limbs; the second was that the Broadmoor staff had on occasions tortured him. C's foot became damaged and thereafter developed gangrene. He was removed to a general hospital where the consultant surgeon decided that C would soon die if his leg was not amputated below the knee. C refused to have his leg amputated and, moreover, trenchantly stated that he would not allow it to be amputated in any circumstances then or in the future. Alternative treatment was provided which temporarily eased his condition but it was understood by all that there remained a serious risk of gangrene returning and proving fatal. Although the hospital abided by C's refusal in the first instance, it refused to undertake that it would not amputate the leg in future circumstances, notwithstanding C's oral directive to that effect. C applied to the Court for an injunction to restrain the hospital from amputating his leg then or at any time in the future without his express and written consent.

Two issues pre-occupied the Court. The first was whether C was in fact competent to refuse the treatment in the first place; if he was not, then his refusal would not be valid and the hospital would be at liberty to treat C in accordance with his best interests and good medical

practice. The second issue was whether the Court could injunct the hospital from treating C in the future which, in turn, rested on whether C's oral directive on his future treatment had to be recognised and respected.

While C was suffering from a mental illness capable of falling within Section 1 of the Mental Health Act 1983, that in itself did not render him incompetent. He had, after all, issued proceedings without a Next Friend (the legal term used for a person by whom those who are incapable of managing and administering their property and affairs must bring a court action). C's condition and his attendant delusions meant that serious doubt was cast over his ability to reason and make a rational choice. The question was, however, did that mean C lacked legal capacity to refuse a treatment which, on the face of it, he understood and did not want?

Mr Justice Thorpe approached the issue by recalling and applying the comments of Lord Donaldson M.R. in the previously noted and very important case on the issue of refusal and advance directives, *Re T*. There, Lord Donaldson set out a number of legal propositions which form the basis of the current law:

- (1) *Prima facie*, every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal are rational or irrational, unknown or even non-existent. This is so notwithstanding the very strong public interest in preserving the life and health of all citizens. However, the presumption of capacity to decide – which stems from the fact that the patient is an adult – is rebuttable.
- (2) An adult patient may be deprived of his capacity to decide by long-term mental incapacity.
- (3) If an adult patient does not have the capacity to decide at the time of the purported refusal and still does not have that capacity, it is the duty of the doctors to treat him in whatever way they consider in the exercise of clinical judgment to be in his best interests.
- (4) Doctors faced with a refusal of consent have to give very careful and detailed consideration to the patient's capacity to decide at the time when the decision was made. It may not be a case of capacity or no capacity; it may be a case of reduced capacity. What matters is whether at the time the patient's capacity is reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health; others may not.

Adopting Lord Donaldson's principle of a presumption in favour of capacity, Thorpe J. was 'completely satisfied' on the evidence that the presumption that C had 'the right of self-determination' had not been displaced. The judge found that although C's general capacity was impaired by his schizophrenia, it had not been established that C did not sufficiently understand the nature, purpose and effect of the treatment he was refusing:

**'I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice', *ibid*.**

In coming to that conclusion, the judge considered helpful the analysis given by Dr Eastman, one of the medical experts in the case, who divided the decision-making process into three elements: first, comprehending and retaining treatment information; second, believing it and, third, weighing it in the balance to arrive at a choice.

One might pause at this stage to consider the merits of this analysis. It appears to attempt to encapsulate the notion that the evaluation of treatment information is either an essential element to, or a pre-requisite of, capacity to consent to or refuse treatment. This would seem to be both logical and correct: how can someone possess the capacity to make decisions about their healthcare without also possessing the ability to assess the relative merits and demerits of that healthcare? The only criticism that might be levelled at the posited test is the need for a patient to *believe* what he is told. In *Re C* itself, the evidence was that C countenanced the possibility that the gangrene might kill him, but (partly because he thought he was able to cure himself) he simply did not believe it would, despite every indication to the contrary. As *Re C* is one of the first cases in which a Court has attempted to formulate a general approach for determining decision making capacity, it should not come as any surprise that the test eventually employed is open to criticism. No doubt, however, the approach as stated will be improved on in time.

Having determined that C was capable of refusing treatment and had validly exercised his liberty to refuse the amputation, the next issue for the Court was whether an injunction should be granted to restrain the hospital from treating C in the future. In other words, should the Court recognise the validity of C's refusal, not only in respect of its immediate effect but also on its effect on C's treatment in the future.

In *Re T*, Lord Donaldson effectively acknowledged the validity of future declarations on treatment when he stated in the context of T's refusal:

**'If there is a distinction between a failure to consent and a refusal of consent, it is because a refusal can take the form of a declaration of intention never to consent in the future or never to consent in some future circumstances', *ibid*, 661c.**

Further recognition of this principle was provided in the now famous (or infamous) *Bland* case. In the Court of Appeal, Butler-Sloss L.J. stated:

**'Counsel all agree that the right to reject treatment**

**extends to deciding not to accept treatment in the future by way of advance directive or "living will". A well known example of advance directive [sic] is provided by those subscribing to the tenets of the Jehovah's Witnesses who make it clear that they will not accept blood transfusions; see, for example, *Malette v. Shulman* (1990) 67 D.L.R. (4th) 321.', *ibid*, at 342d.**

In the House of Lords, Lord Goff said:

**'Moreover, the same principle [that a person can refuse life-saving treatment] applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred . . .', *ibid*, 367h.**

There was therefore ample authority to found Thorpe's J. decision in *Re C* that, in the light of those decisions, injunctive or declaratory relief could be given to C to prevent the hospital operating in the future. In the event, the judge made an injunction order preventing the hospital then or in the future from amputating C's leg without his express written consent.

There would seem to be no doubt, therefore, that as a matter of common law, advance directives have legal effect. If a doctor treats a patient in the face of that patient's refusal, he will commit a civil and possibly criminal battery and that applies even if the refusal takes the form of an advance directive.

Nevertheless, while the Courts have in principle upheld the validity of advance directives, they have not yet fleshed out their precise scope and legal limits. One of the consequences of applying logical common law principles to refusal of treatment cases is that the law will develop in an *ad hoc*, ramshackle way: no comprehensive legal framework is likely to emerge for some considerable time. This may well create difficulties.

For example, in his haste to protect C's right to self determination, Thorpe J. overlooked one potentially important point. The hospital was enjoined from amputating C's leg in the future unless C gave his express and written consent. That, presumably, will be fine so long as C remains competent (as determined by the Court). But what if the gangrene returns; C lapses into incompetence and *then* changes his mind? His subsequent consent to the operation will not be valid. Let us say, for example, that C becomes quite irrational and deluded. He becomes convinced, quite irrationally, that he needs the operation in order (say) to save the world from disaster. On this basis he demands that the operation should go ahead. His doctors also believe that the operation should go ahead because, without it, C will die. However, if C is not competent, the operation cannot be performed: C might demand, even plead, that the operation be performed, but because his consent will be invalid (as he is incompetent) and therefore he cannot give his express, written consent, his doctors will be bound by the terms of his previous refusal to operate, even in the face of



everybody's current wishes – including C's. In other words, the effect of Thorpe's J. order was to lock C into his refusal. This was partly due to the fact that the order was final and the judge did not give the hospital liberty to apply to the Court to vary it in the future. Therefore, if C becomes incompetent, there is no way in which the doctors can perform the operation – C's fate will be sealed.

This apparently unforeseen consequence of the order illustrates well the fact that the recognition and enforcement of advance directives by the Courts is fraught with potential difficulties and conundrums. Advance directives are certainly not the panacea that some claim them to be. Nonetheless, and very probably irrespective of future legislation, it would seem that they are here to stay.

Jerome R. Wernow, University of Leuven, Belgium

# THE LIVING WILL

## ABSTRACT

*A compilation of commonalities derived from a variety of 'living will' texts has been used to form a description of the living will's content. A living will document can be described as a medical care declaration issuing from the exercise of a person's right to self-determination. The declaration is an expression of the person's wish to refuse or demand further medical treatment. The document directs the appropriate person(s) to execute the declarant's request statements, if the conditions of the document are met.*

*The current content and legal acceptance of these documents is largely a product of what once was known as the Euthanasia Education Council, now called Concern for Dying. A scrutiny of their rationale for the use of the living will exhibits a presuppositional strain of thought similar to that espoused by the proponents of suicide throughout history. Tenets like self-determination and primacy of health as life's essential value are similar to the bases for advocacy of suicide found in Seneca, the Stoics, the Humanist Movement and Social Darwinism.*

*Four basic arguments are given for the living will: (1) Death is to be seen as a normal process which should follow a normal course. (2) The fear of deterioration, indignity, suffering, and the burden of dependence outweighs the fear of a 'premature' death. (3) Euthanasia is justified upon the grounds that each person has the right to exercise self-determination and the right to privacy. (4) A desire exists to minimize the guilt feelings of those involved in the process of deciding and executing terminal choices. Some major issues raised in this treatment of the living will are based upon presuppositions, semantics, and structure.*

## I. INTRODUCTION

### A. Statement of Purpose

The purpose of this paper is three-fold. The first is to propose a working definition of 'living will' derived from a summary of the study of various living will formulations. The second is to situate the current state of the living will discussion through a summary of its historical development. The final is to raise and categorize issues surrounding the living will discussion.

### B. Method of Study

#### 1. Inductive study and gathering of current living will formulations

The initial stages of this study began with a search for books and articles which contained the phrase 'living will' in their title. The greatest amount of material regarding this clause was found in periodicals. The search was then broadened under the rubric 'euthanasia.' This heading produced a large amount of material in both periodicals and books. The amount of research material was reduced by again applying the descriptor 'living will'. The table of contents and indices of books were searched for this phrase. In doing so, it became apparent that this phrase was being used as a technical term. The descriptor was also found as a secondary or tertiary 'key term' section of some publications, rendering the topic searchable through applications of commercial data-base-search services. The primary search term often found in conjunction with living will was 'euthanasia.' The amount of data found in current periodicals and through bibliographic aids was sufficient for the depth of study of this paper, and thus a data base search was not necessary.

#### 2. Definition formulation

The formulation of the definition was derived by a comparative analysis of nine sources. These references represented a balance of antagonists, centrists, and protagonists of euthanasia. Common strands were culled out to form a descriptive definition.

### C. Limitations of Study

There are three major limitations to this study. First, it is limited to the languages of English and Dutch. Second, the study is done from the perspective of a North Atlantic-western cultural base, predominantly in the milieu of the United States. Third, certain resources were inaccessible in the time allotted to write this paper.

## II. A SUMMARY OF RATIONALE, SIMILARITIES, AND DISSIMILARITIES IN SELECTED 'LIVING WILLS'

### A. Rationale

Four basic reasons were given as rationale for the existence and legislation of the living will.<sup>1</sup> The first argument proposes that death is to be seen as a normal process which should follow a normal course. The second argument asserts that the weight of fear of deterioration, indignity, suffering, and the burden of dependence outweighs the fear of a 'premature' death. The third submits that euthanasia is justified upon the grounds that each person has the right to exercise self-determination and a right to privacy.<sup>2</sup> The final argument is grounded in 'mitigating feelings of guilt' in those involved in the process of deciding and executing terminal choices.<sup>3</sup>

### B. Similarities

Some common features found in various living will documents issue from the preceding rationale. The self-determination aspect of the directive was manifest with the 'I' statement.

Those implored to carry out the directive included at least the physician. Some earlier texts allowed for a broader participation of people concerned in the decision-making loop. In contrast, fewer people were invited into the decision-making loop of the legal texts. In most cases the decision-making loop was restricted to the physician(s).<sup>4</sup>

Common characteristics found in the conditional clauses of these texts include: point in time of the onset of the disorder, conditions of incurability and severe suffering, and a prognosis of imminent death.

The request statements have similarities including a request for an uninterrupted process of death, a request to withhold or withdraw artificial life-support, and to withhold heroics.

Finally, all documents had some means by which the individual's freedom of choice to make the decision was protected.

I utilized these characteristics to describe the living will as:

*The living will is a medical care declaration issuing from the exercise of a person's right to self-determination. The declaration is an expression of the person's wish to refuse or demand further medical treatment. The document directs the appropriate person(s) to execute the declarant's requests once the conditions of the document are met.*

### C. Dissimilarities in Content of Statements

Dissimilarities among documents are mostly seen in the following four categories: (1) The statements of the early 'grass roots' movements included family, lawyer, clergy, as well as the physician in the decision making loop, while the more legal documents tend to focus on the physician. (2) Some declarations, such as the Calvin

Center's and McCormick's, have structural differences. One striking example came from Spring and Larson's book where they suggest the durable power of attorney through a surrogate as the most flexible method of declaration.<sup>5</sup> (3) Most living will documents appear to be directed toward the populace prior to the onset of any disease or toward those who are not aware of conditions of present terminal illness. Other documents, such as 'do not resuscitate' orders and 'withdrawal of life-support' directives, are used by health care facilities to address terminal choices after the onset of the terminal condition. (4) One of the greatest areas of dissimilarity among documents is that of the statements of request. These range from options of active euthanasia, as seen in Holland, to a cautious 'imminent death' and emergency room stabilization request, as seen in the Oregon Bill and Calvin Center formulation, respectively, to a clause in legislature which requests maximum treatment and life prolongation (e.g. Indiana Living Will and Life Prolonging-Procedures Act).<sup>6</sup>

This sort of diversity brings us to the basis of dissimilarity, that of rationale. The root of the variety of opinions expressed can be best understood through a brief reflection which situates the various positions historically. By doing so, issues and presuppositions begin to unfold which allow for a better understanding of the reasons for differing opinions.

## III. Historical Considerations

### A. Brief Historical Reflection

Two opposing strains of thought regarding suicide by those suffering physical maladies co-exist throughout the early history of Western culture up to the Renaissance. The proponents of suicide, such as a majority of the Stoics, Epicureans, and Cynics, based their positions on the right of self-determination in living a painless, healthy life. Opponents to suicide, such as many Neo-Platonists and Christians, founded their notions on the primacy of deity in determining life's end. The Christian tradition of Augustine played a role of paramount importance in the rejection of suicide for generations. Life was viewed as valuable regardless of one's physical circumstance, and to destroy it violated Divine Law. Thomas Aquinas agreed with Augustine on this issue and added the Aristotelian notion of community worth as well as a sophisticated concept of natural law to buttress rejection of suicide.

The winds of change came during the periods of Renaissance and Reformation. At least three factors contributed to the change. First was the surfacing of a pessimistic humanism fuelled by the fires of human autonomy. Much of this thinking was founded on notions gleaned from Greek philosophy, such as that of the Stoics. Truth became verified through nature and reason rather than the old foundations of tradition and Scripture. Suicide was advocated by a few as a proper exercise of self-determination for the good of the community. Another important factor must not be ignored. The period of Renaissance found itself in the dilemma of the



beginnings of more effective medical care and thus, in some cases, the prolongation of life and suffering. This author believes that the seeds of the passive euthanasia quandary were sown here. The Romanticists of the nineteenth century viewed endurance of suffering as a quality in one's character in a fashion similar to writers found in early Christianity. The semantic difficulties of 'ordinary' means are first noted here along with Hufeland's introduction of the roots of the wedge argument.<sup>7</sup>

The twentieth century became a time where self-autonomy flourished, as various forms of Darwinism and Humanism were more widely accepted. Liberal organizations, based on self-determination, anthropocentric humanism, and non-traditional forms of Christianity, proposed euthanasia legislation. They met resistance largely from those holding presuppositions of the conservative Roman Catholic and the conservative Protestant communities. These groups opposed active euthanasia as set forth by its advocates. They proposed that such action was a violation of Divine Law, human community values, and, surprisingly, the right to self-determination.

In contrast some of the members of these groups, who were in one accord in their stand against active euthanasia, differed regarding the treatment of passive euthanasia. The problem of passive euthanasia left this group divided. Their positions depend upon the meanings attributed to words like heroics, artificial life-support, as well as theological views regarding maximization of life-prolonging measures. Their positions regarding quality and sanctity of life, also, provided points of divergence.<sup>8</sup>

## B. Study of the Historical Development of the Living Will

### 1. Overview

The living will is a relatively new development (d. ~ 1969).<sup>9</sup> Three movements were responsible for the development of its content, form, and power. They appeared in the beginning as social movements. Development toward institutionalization in the United States accounts for the second movement. The third is the incorporation of the content of the living will into the policy and procedures of that country's medical sector.

### 2. Social Movements Toward Institutionalization

The first indication of modern organized support appears to have been attributed to C. Killick Millard. He desired to submit a euthanasia bill to the British Parliament. In order to garner support, he aided in the founding of the Voluntary Euthanasia Legalization Society, which began on December 10, 1935. Russell states that the objective of the society was:

to create public opinion favorable to the view that an adult person, suffering from a fatal illness for which no cure is known, should be entitled to the mercy of a painless death if and when that is his expressed wish: and to promote this legislation.<sup>10</sup>

Russell names some supporters of the Society and the bill: H. G. Wells, Julian Huxley, F. W. Norwood of the

National Free Church Council, and Rhondda Williams chairman of the Congregational Union.<sup>11</sup>

Russell cites numerous reasons given by Millard for acceptance of euthanasia. Perhaps one of the most important was the emphasis made regarding the quality of life. He intimates that in certain circumstances it is more important for the physician to prevent suffering than to promote life.<sup>12</sup> Other reasons for acceptance included mental anguish of a lingering death, mercy toward hopeless idiots and monstrosities, the progressive nature of truth, biblical silence on the issue, and the necessity for government regulated administration.<sup>13</sup> The bill was defeated after its introduction to the British Parliament in 1936.

Not long after the organization of the British Society came the formation of the Euthanasia Society of America (January 16, 1938). The founder, Unitarian minister and later a New Humanist, Rev. Charles Potter, formed the organization with goals similar to those of the British Society. Russell states,

Its purpose was to conduct a national campaign of education so that bills might be introduced in state legislatures and in Congress. It subscribed to the belief that with adequate safeguards, the choice of immediate death rather than prolonged agony should be available to the dying.<sup>14</sup>

Advocates of this group included members of the British Society, like Julian Huxley and H. G. Wells, as well as H. E. Fosdick, W. Somerset Maugham, and Margaret Sanger. Three reasons were submitted in support of their advocacy of euthanasia. The first was based on necessity according to their experience of the need. The second was the need to be merciful to the sufferer. The third proposed that Scripture permits such action through its silence on the subject.<sup>15</sup> Russell quotes Potter's view which assails the use of the fifth commandment in regard to opposition to euthanasia.<sup>16</sup>

On January 26, 1939 these advocates of euthanasia sponsored a bill to change the euthanasia laws of the state of New York similar to those proposed to the British Parliament. The bill was defeated.

The strength of the organized movement waned during World War II. Two reasons can be offered. First, most were more pre-occupied with the war effort than in issues of social controversy. Second, the genocide programme of the Nazis lessened the public's willingness to discuss the subject.<sup>17</sup>

During the period of the 1950's there was a continuous flow of petitions for legislative change regarding euthanasia, as well as a flurry of opposition against the action. A notable example is the address of Pope Pius XII to a Symposium of the Italian Society of Anesthesiology in 1957. The magisterial position was clarified by the Declaration on Euthanasia, which clarifies the teaching of the Church regarding the use of narcotics.<sup>18</sup>

The introduction of the *living will* term proper is attributed to Luis Kutner in 1969. He 'first proposed the concept of a testimony-type document with the intent to prevent or cease extra-ordinary means to prolong existence.'<sup>19</sup> Its contents contain four basic commonalities found in the contents of the Voluntary Euthanasia Bill,

introduced to the House of Lords, England by C. Killick Millard.<sup>20</sup>

Kutner, a member of the Illinois and Indiana Bar Associations, suggested that the **living will** could address four perceived needs. First, there appeared to be a need to resolve the disparity in the 'judicial process which treated mercy killers differently than murderers with malice'.<sup>21</sup> Second, there appeared to be a legal need to allow the patient 'the right to die if he so desires'.<sup>22</sup> Third, there was an apparent need for the patient to express his desire to die, though he was 'incapable of giving consent'.<sup>23</sup> Fourth, in order to address the first three needs, one must address the need to provide the patient with the 'necessary safeguards' without being 'cumbersome in application'.<sup>24</sup>

Kutner's solution was based on the legal precept that 'a patient has a right to refuse to be treated, even when he is *in extremis*, provided he is an adult and capable of giving consent'.<sup>25</sup> Upon this precept he proposed that a document indicating that, if the condition should arise in which an 'individual's bodily state becomes completely vegetative and it is certain that he cannot regain his mental and physical capacities, medical treatment shall cease'.<sup>26</sup> He suggested six possible names that could be attached to such a declaration, one of which was the 'living will'.<sup>27</sup>

From this starting point, Kutner proposed at least six characteristics in his concept of the document. First, the living will can 'only be made by a person giving his consent to treatment'.<sup>28</sup> Second, 'the living will is analogous to a revocable trust with the patient's body as the *res*, the patient as the beneficiary, and the doctor and hospital as the trustees'.<sup>29</sup> Third, the categories of patients in the living will can be expanded to include the mentally ill, in certain circumstances.<sup>30</sup> Fourth, the living will may not be used 'as a means for directing a doctor or another individual to *act affirmatively* to terminate his life'. Fifth, the patient's living will can be used in court to affirm action in the terminating of a patient's life when the 'hospital board on euthanasia may decline to assume responsibility'.<sup>31</sup>

The Euthanasia Education Council applied Kutner's observation of the patient's right to refuse treatment and combined it with content common to the British Bill which predated Kutner's proposition, as well as to Millard's early propositions. The result of this synthesis was the 'preparation and distribution of over a quarter of a million copies by the Council in 1973'.<sup>32</sup>

### 3. Legal Movements Toward Institutionalization

The legal context of Kutner's proposal provided the beginnings of a format viable for legislation in the United States. The content common to the living will was circulated by the Euthanasia Education Council in 1972. Eventually, this content was adopted by at least thirty-eight states as of 1990, with California being the hallmark example.<sup>33</sup>

The California 'Natural Death Act' of 1976 became the first legislative act providing for a legal directive which demands termination of medical treatment. The act incorporated the content of the living will common to that

disseminated by the Euthanasia Education Council, The phrase 'DIRECTIVE TO PHYSICIANS' at the beginning of the text demonstrates this assertion early on.<sup>34</sup> Larson remarks that the rigidity of this directive has been followed by other states.

All but three of the thirty-eight living will states provide form documents which should be at least substantially followed, with four states (California, Oregon, Idaho, and Georgia) requiring that their form be precisely followed.

### 4. Medical Movements Toward Institutionalization

The medical sector provided the forum where the movement toward national institutionalization and legalization has taken place. National control is exerted by the policy mandates of the Joint Commission on Accreditation of Health Care Organizations (JCAH). The following observations are used to support this assertion.

Medical institutionalization of the contents of the living will appeared in hospitals as they began to adopt the legislative changes into their policy and procedure manuals. The large health maintenance organization (HMO), Kaiser Permanente, serves as an important example. This HMO is considered to be on the forefront of medical administration in the Northwestern United States. Three months after the Oregon Legislature adopted the living will format 'Senate Bill 438' in October 1983, Bess Kaiser Medical Center incorporated that precise format into their policy and procedure manual for *Terminating or Withholding Terminal Life Support Measures*. The Kaiser policy states on form 12777 (DIRECTIVE TO PHYSICIANS) that, 'This Directive is intended to comply in form with the "Death with Dignity" Law, Oregon Senate Bill 438, adopted October, 1983, Oregon Revised Statutes 97.050-97.090'.<sup>36</sup>

According to Wanzer institutionalization appears to be occurring at the national level in America.

In states with laws legitimizing living wills, hospitals have become responsive to patients' wishes as expressed in their advance directives and hospital accreditation by the Joint Commission on Accreditation of Health Care Organizations now requires the establishment of formal DNR policies.<sup>37</sup>

Institutionalization is demonstrated by the existence of a demand by JCAH that hospitals in states which have such legislative regulations have 'do not resuscitate' directives in their hospital policy and procedure manuals. The JCAH determines if the hospital meets government set criteria. If they do not, and lose accreditation, the hospital will not receive reimbursement for government-insured patients such as Medicare and Medicaid patients.<sup>38</sup>

### 5. Summary

The term living will was introduced by Luis Kutner in 1969. He used a legal format in the context of the legal right to refuse treatment. The Euthanasia Education Council synthesized Kutner's concept of living will with content common to Millard's pro-euthanasia propositions. In 1973 the Euthanasia Education Council prepared and



distributed approximately a quarter of a million documents of this formal declaration called the living will with the hope of changing legislation by another route.

In 1976, the California legislature adopted contents of this document as part of their 'Physician's Directive' in their hallmark legislation called the 'Natural Death Act'. Numerous states followed this precedent and utilized their living will format. This necessitated that risk management actions be taken by hospitals, which caused alterations in their policies and procedures to fit the new legislation. The policies and procedures became standards of community practice and were thus adopted by the Federal government as norms of practice. Then the Federal arm mandated that DNR (do not resuscitate) policies exist as part of the policy and procedure manuals of hospitals in states having living will legislation.

In conclusion, it can be seen that the current content and legal acceptance of the living will was largely a product of what was once known as the Euthanasia Education Council, now represented by Concern for Dying and the Right to Die organizations. A scrutiny of the rationale by advocates for the use of the living will exhibits a presuppositional strain of thought similar to that of proponents of suicide throughout history. Tenets like self-determination and primacy of health as life's essential value have commonalities with the thought strain of Early and Late Stoicism, Humanism, and some proponents of Social Darwinism.

#### IV. DISCUSSION OF ISSUES

The purpose of this section is to discuss some of the issues of the living will. Foundations for the following observations are based on the content, rationale, and historical development of the living will. The issues raised here appear to have some common relational elements which would allow them to be placed in the following categories described as: issues of presuppositions, semantics, and structure.

##### A. Issues of Presuppositions

Some important presuppositional issues may be categorized as self-determination, views regarding the existence of God, and hermeneutics. One's world view in each category, consciously or unconsciously, bears heavily upon one's view of the acceptability of content in the living will proposals. Probing one's warrants for justification of opinion in each category will bring the discussion to an essential level of personal epistemology.<sup>39</sup>

The issue of self-determination is foundational to the creation of the living will and to the ideas of euthanasia surrounding it. In Gruman's opinion, one of the two greatest themes in the euthanasia discussion is 'freedom of the will'.<sup>40</sup>

One's acceptance or rejection of particular content of living will formulations depends in part upon one's conviction(s) regarding man's freedom to choose and/or

God's sovereignty. For example, those forwarding active euthanasia will probably reject conservative beliefs of determinism. Norman Geisler exhibits this tension when he rejects the convictions of proponents of euthanasia, saying that

they are based on utilitarian presuppositions that deny deeply held Christian convictions about the sovereignty of God and the sanctity of human life made in his image.<sup>41</sup>

Positions promoting or limiting human autonomy must articulate their views of natural law. Views on autonomy based upon Thomistic notions of natural law may differ vastly from views rooted in the enlightenment, as is the case of Joseph Fletcher.<sup>42</sup>

Issues raised when describing suffering as 'useless' and intimating that worth of life is connected to the primacy of health seem bound to one's belief in the existence of God, or lack thereof, and his relationship to 'creation'. The historical contexts are replete with reports that some Greek philosophers and Christians found value in suffering. For example, some Roman Catholics and Calvinists found the experience of suffering preparatory for entrance into the future Kingdom of God, while some Neo-Platonists found it a matter of duty determined by a deity. This idea appears absurd and cruel to many humanists with Social Darwinistic tendencies. Likewise, active euthanasia as a compassionate act in the case of one who painfully suffers from a terminal illness, as suggested by some advocates of euthanasia, would appear criminal to persons holding that life is a gift from God (e.g. *Gaudium et spes*, n. 27).

Hermeneutics is another area influenced by presuppositions.<sup>44</sup> Differences in opinion flow from the following bases. Proponents of euthanasia, as early as the time of John Donne, have asserted that euthanasia is nowhere condemned in Scripture. Fletcher goes further, and asserts that it is supported as an act of compassion. He interprets the fifth commandment as condemning murder, not mercy killing.

Fletcher, as well as Russell, brings Augustine's position into question. Writers in antiquity, such as Bonaventura, Aquinas, Boudewijn, Calvin, as well as contemporary writers like May and Geisler, use the fifth commandment as part of their argument against euthanasia. The conflicting interpretations raise questions regarding how presuppositions are affecting the methodology and interpretations of similar passages.

Other Scriptural passages in dispute are God's intention in Romans 8:29ff, Samson's suicide in Judges 16:30, Abimelech's suicide in Judges 9:54, Job's apparent death wish in Job 7:15, Jonah's plea to be thrown overboard in Jonah 1, and Stephen's apparent choice of death in Acts 7. Assuming consistency in methodology (a rather big assumption), are presuppositions the root of the differences in interpretation? I suggest this is a strong possibility.

To summarize, probing our views on self-determination, natural law, the existence of God, suffering, being, historical interpretation, and hermeneutics will lead us back to a necessary and rudimentary level of presuppositional discussions upon which these opinions are based. Openness to discussion at this level might provide a basis for

understanding, evaluating, and discussing varying opinions.

### B. Issues of Semantics

The issue of semantics affects at least two components of the living will. The first includes quasi-technical terminology like 'life-sustaining procedures,' 'extra-ordinary means,' 'active euthanasia,' and 'imminency of death'. These in turn affect a second component, patient comprehension in the context of informed consent. For example, does the signatory really comprehend the phrase 'I understand the full import of this directive' in view of the ever shifting meaning of extra-ordinary or in the context of complex medical treatment? The question raised involves semantical ambiguity both in the face of a rapidly changing field of medical science and in the situational complexity of present day terminal care.

#### 1. Rapid Terminological Antiquation

Historical studies have shown terminological antiquation as a concern in the discussion of death and dying. One difficulty in formulating a rigid living will (e.g. *Natural Death Act*) is the rapid advance of medical technology. A rigid formulation does not allow for the semantical changes of the terms used when it was written, or, worse yet, the antiquation of the terminology altogether. An example of this problem was shown when McCormick found the terminology 'ordinary' and 'extraordinary' means 'increasingly confusing, ambiguous, and circular'.<sup>45</sup> His solution was to change the terms to 'reasonable and unreasonable treatment'.<sup>46</sup> Schaeffer and Koop raise the question with clarity.

On occasion, a physician may decide to withhold extraordinary means in the management of a patient. Is there ever justification for this? First of all, one must define the term *extraordinary* as it refers to medical care. Things which are extraordinary today will not be extraordinary next year, and things which were extraordinary last year are ordinary now. There was a day when the administration of oxygen and the use of intravenous fluids was extraordinary and so it has been with respirators, pacemakers, and heart-lung machines.<sup>47</sup>

The change in the meaning of this term is not an isolated example. A cursory study of the change in definitions of death and euthanasia will begin to add credence to terminological change as an issue. In light of this, can one express his or her desire for care in writing a living will with any degree of exactitude?

#### 2. Terminological Ambiguity Sourced in Situational Complexity

Historical observations demonstrate that Christoph Hufeland (1767-1836) was one of the first individuals to perceive the difficulty in determining the precise difference between what is now termed active and passive euthanasia. He recognized the complexity of varying situations of prolonging life through treatment or terminating life by withholding treatment. The abstruse

'border' between withholding of life-prolonging care and actively ending life led him to reject passive euthanasia. Medical technology has exacerbated the ambiguities of terminology. This can be seen through the ever increasing development of new life support technologies and procedures. These contributions greatly enhance the complexity of defining terms like passive and active euthanasia. Schotsmans suggests that the discovery of technology regarding the end of life procedures has rendered the distinction between active and passive euthanasia almost unusable.

The difference between passive and active euthanasia appears barely useable due to the discovery of end of life technology which has rendered mankind barely able to make the distinction.<sup>48</sup>

Both the rapid change in terminology and the ambiguity of terminology in complex situations raise the question of 'fullness in understanding' by the declarant of a 'living will.' Can a person signing a document of prescribed format, which may well contain antiquated terms and be a bit presumptuous in foreseeing complex situations, do so with 'full understanding'?

### C. Issues of Structure

The final issue raised is that of structure. The *desideratum* raised is two-fold. First, legislation of a living will creates a structural rigidity in a complex environment. Second, legislation reduces the choice of options in a pluralistic society by forcing compliance to an option decided by a particular group.

#### 1. Structural Rigidity

The adoption of a living will into governmental format often produces a rigidity in structure. This was suggested by Spring and Larson. They asserted that states such as California, Oregon, and Idaho had living will legislation which demanded that their format be used.<sup>49</sup> If their observations are correct, the right of self-determination has become unwittingly subservient to government determination. The consequences are astounding. Hospitals are required to develop policies which follow state laws in order to receive federal reimbursement (e.g. JCAH policy requirements). Physicians and nurses employed by these hospitals are required to follow the hospital regulations. It is not too difficult to speculate that such living will forms will be required as part of patient admission packets, similar to 'consent to treat' forms.<sup>50</sup> The structure eventually becomes dominated by policy and procedure, leaving out the original intention for its existence, the patient's right to self-determination. The patient, then, may experience less self-determination than in the days before the living will became an issue. Patient disputes with hospital policy will tend to end in some type of adjudication. McCormick once reacted to the scenario of government involvement 'in determining the best interest of desperately ill patients'.<sup>51</sup> He felt that

treatment and management decisions are not mere medical decisions; nor are they mere legal decisions.



They are human decisions. To shift them routinely to the courts undermines this fact.<sup>52</sup>

Should one ask in the same light if there is an element of de-personalization in shifting the right of self-determination to mandatory formulations made by legislative assemblies? This question introduces the final section for consideration, structural reductionism.

## 2. Structural Reductionism

The phrase 'structural reductionism' refers to a limitation of the choice of options by the structure of the living will document. Such a limitation forces a person living in a 'pluralistic society' to comply with an option chosen by a particular group.

A study of the contemporary period demonstrates that proponents of euthanasia question the rights of others to impose their opinions on them. For example, Russell demands that religion refrain from blocking euthanasia legislation.<sup>53</sup> Williams calls for civil law for euthanasia which is unaffected by religious opinion.<sup>54</sup> Toleration and dialogue regarding varying opinions seem to have been sacrificed for clever legal manoeuvring and alternative systems of belief.

The living will formats have come to reflect the opinions of those opposed to the right of religious groups to influence legislation. One will notice the omission of pastor and clergy in the later DIRECTIVE statements of euthanasia, whereas they were included in the earlier forms. This author questions the logic of this position, since history shows that one's religious position directly affects one's position on issues of death and dying. Can one really claim to have a religionless approach? Deeper questions follow. Does the 'religious' community that opposes active euthanasia have a right to legislate their perception of morality? Likewise, do the advocates of euthanasia have a right to legislate their perception of morality? Does one group have the right to overtly or covertly legislate a law which reduces the options of society to one option based on their presuppositions? If so, why? If not, why not?

## D. Conclusion

The present day contents of a legislated living will formulated upon the precepts of a particular presuppositional base leave this author pondering one question, a question which he now leaves with the reader: The living will, whose will?

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2. State of California: *Health and Safety Codes of California*: 'Natural Death Act: Directive to Physicians.' no. 7188 (1976): p. 147.

3. Russell, O. Ruth: *op. cit.* p. 296-297.

4. Compare the Euthanasia Education Council text found in Russell, O. Ruth: *op. cit.*, p. 296 with State of California: *Health and Safety Codes of California*: 'Natural Death Act: Directive to Physicians.' no. 7188 (1976): p. 149 and State of Oregon: Committee on Judiciary House Bill 2963: 'B-Engrossed,' July 6, 1983., pp. 2-3.

5. Larson, Ed, and Beth Spring: *op. cit.* pp. 137-154.

6. Redactie Team van de Documentatie en Informatie Centrum van de Horstink. *op. cit.* p. 95; State of Oregon: Committee on Judiciary House Bill 2963. *op. cit.* pp. 2-3; Walhout, Jan, ed.: *op. cit.* 284; Larson, Ed, and Beth Spring: *op. cit.* p. 169.

7. He asserts that if physicians begin hastening death for one particular reason soon no borders will be discernible to distinguish who lives and who dies. This concept will later reappear as the wedge argument. see Eijk, W. J.: *De Zelfgekozen Dood Naar Aanleiding van een Dodelijke en Ongeneeslijke Ziekte*. Brugge, 1987. pp. 216-217.

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10. Russel, O. Ruth: *op. cit.* p. 67.

11. The presuppositions of these members are as important as the individuals who were members. That however is beyond the scope of this paper.

12. *Ibid.*, p. 66.

13. *Ibid.*

14. *Ibid.*, p. 72.

15. *Ibid.*, p. 73.

16. *Ibid.*

17. The Nazis based their euthanasia policy partly upon the justifications of Binding. He proposed at least three conditions in which one could will his own death. First, those who suffered from a deadly and incurable disease or wound could choose death. Second, sufferers of untreatable mental illnesses could choose death. Finally, those who are sick could choose death. The misuse of this document by the leaders in Hitler's national-socialistic movement resulted in the death of at least 70,000 individuals. This included Hitler's 'kinder-euthanasie' plan implemented by government units such as *Actie Vier*. (Eijk, W. J.: *De Zelfgekozen Dood Naar Aanleiding van een Dodelijke en Ongeneeslijke Ziekte*. Brugge, 1987. p. 261-264.)

18. Walter, James J. and Thomas A. Shannon eds.: *Quality of Life: The New Medical Dilemma*. New York and Mahway, New Jersey. 1990, p. 262. Reprinted from *Origins* 10 (August, 1980): 154-157.

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20. Russell, O. Ruth: *op. cit.* p. 68. These commonalities were considered

in section two. Mlilard's bill had a directive to the 'practitioner concerned,' addressed one 'suffering from a fatal and incurable disease,' had a protection clause necessitating a license to die, and gave the rationale of 'protracted pain' as a reason for euthanasia.

21. Kutner, Luis: 'Due Process of Euthanasia: The Living Will. A Proposal,' *Indiana Law Journal*, v. 44, 1969, p. 549.

22. *Ibid.*, p. 543.

23. *Ibid.*, p. 550.

24. *Ibid.*, p. 551.

25. *Ibid.*, p. 549.

26. *Ibid.*, p. 551.

27. *Ibid.*, p. 551.

28. *Ibid.*, p. 552.

29. *Ibid.*,

30. *Ibid.*,

31. *Ibid.*, p. 554.

32. Russell, O. Ruth: *op. cit.* p. 181.

33. Larson, Ed, and Beth Spring: *Euthanasia: Spiritual, Medical, and Legal Issues in Terminal Health Care*. Portland, Oregon, 1988, p. 159.

34. see section two for content commonalities.

35. Larson, Ed, and Beth Spring: *op. cit.* p. 159.

36. Bess Kaiser Hospital Executive Committee, *Policies and Procedures for the Termination or Withholding of Die Support Measures*. Bess Kaiser Medical Center, Portland, Oregon, January 1984, form 12777 (rev, 11/ 83).

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38. Discontinuation of government re-imbursement would threaten the existence of most health care facilities.

39. It might be argued that to give warrant or defense to one's presuppositions causes them to become something other than what they are, presuppositions. I not only agree but assert that reflection and justification of presuppositions should serve as the *terminus ad quo* of the euthanasia discussion in a pluralistic context. That is to say, let presuppositions become something else, call it a basis or part of the meta-ethic of your will.

40. Gruman, Gerald J.: 'An Historical Introduction to Ideas about Voluntary Euthanasia: with a Bibliographic Survey and Guide for Interdisciplinary Studies.' *Omega*, v. 4, no. 2, 1973, pp. 91ff

41. Geisler, Norman L.: *Christian Ethics: Options and Issues*. Grand Rapids, 1989, p. 160.

42. Fletcher, Joseph: *Morals and Medicine*. Princeton, New Jersey, 1979, p. 215. Regarding Natural Law, he says, 'We need not repeat that the counter Reformation version of the classical Natural Law. which in its new form so consistently subordinates human values to the law of nature, is a perversion of a moral norm into a physical or material norm' (p. 222). He bases this on his interpretation of nature, whereby, 'there is no possible ground for supposing that a scrutiny of nature's ordinary and average phenomena can ever reveal either the will of God or a norm for men' (p. 215). His principle of personal integrity views a religious faith embracing determinism as reducing people to 'puppets' void of human agency (see p. 215).

43. Flannery Austin P. (ed.): 'Gaudium et spes 27.' *Documents of Vatican II*. Grand Rapids, 2nd printing 1978, p. 928.

44. I am using this term as defined by Mickelsen. '... hermeneutics designates both the science and art of interpretation.' (A. Berkeley Mickelsen: *Interpreting the Bible*. Grand Rapids, 8th printing, 1979 p. 3.)

45. McCormick, Richard A: *op. cit.*, p. 408.

46. *Ibid.*

47. Schaeffer, Francis A., and Koop, C. Everett: *The Complete Works of Francis A. Schaeffer: A Christian Worldview. What Ever Happened to the Human Race?* v. 5, Westchester, IL 1982, p.332.

48. Schotsmans, Paul: *En De Mens Schiep De Mens*. Kappellen, 2de druk, 1989, p. 219. Het onderscheid tussen passieve en actieve euthanasie lijkt ons dus weinig bruikbaar, omdat de ontwikkeling van technologie omtrent het einde van het leven zo immens is dat men dit onderscheid nog nauwelijks kan maken.

49. Spring, Beth and Larson, Ed: *op. cit.*, p. 159. These authors suggest the incorporation of durable power of attorney into the living will document. I think their suggestion is a solution for the Christian under the United States legal system. The addition will become critical as rigidity through legislation reduces the acceptable Christian options.

50. Wanzer, Sidney H., (et. al.): 'The Physician's Responsibility Toward



Hopelessly Ill Patients: A Second Look.' *The New England Journal of Medicine*. v. 320, March 30, 1989. Reprinted in Walter, James J. and Thomas A. Shannon, eds.: *Quality of Life: The New Medical Dilemma*. New York and Mahway, New Jersey, 1990, p. 284. Wanzer's article suggests patients sign such documents on admission, saying, 'In general, health care institutions must recognize their obligation to inform patients of their right to participate in decisions about their medical care, including their right to refuse treatment and should formulate institutional policies about the use of advance directives and the appointment of surrogate decision makers. Hospitals, health maintenance organizations, and nursing homes should ask patients on admission to indicate whether they have prepared a living will or designated a surrogate.' The scenario that causes greatest concern to

the author in this situation is a possibility of rationing of health care resources, which for the 'sake of society' becomes 'invisible thrift euthanasia'. This rationing becomes easier when documents exist that keep medical facilities immune from litigation for such action. May I be so bold as to suggest that it occurs even now. Even more stunning is the call for voluntary euthanasia as part of a 'living will'. Häyry and Häyry, ('Euthanasia, Ethics, and Economics.' *Bioethics*, v. 4 no. 2, 1990) argue for such a component in a 'living will' in the face of scarcity of medical resources.

51. McCormick, Richard A: *op. cit.*, pp. 377.

52. *Ibid.*, p. 378.

53. Russell, O. Ruth: *op. cit.* p. 234.

54. Gruman, Gerald J.: *op. cit.* p. 108.

## D. A. du Toit, University of Stellenbosch, South Africa

# ANTHROPOLOGY AND BIOETHICS

It is often said that we presently experience a serious crisis in morals. Undoubtedly there are sufficient grounds for this statement, and multiple illustrations from all spheres of life could be shown. Yet, there is good reason to consider whether the crisis is not much more of an anthropological kind, the assumption being firstly, that our view of man actually precedes our moral decisions and choices, and secondly, that there is a close relationship between the two. This paper intends to investigate that relationship and tries to point at some practical consequences with regard to bioethics.

### THE NORM PROBLEM

Traditional ethical methodology had no problem with the status and credibility of ethical norms and values. It seemed to be clear to almost everybody that it is wrong to steal, divorce, fornicate, murder, *etc.* To the modern mind this presents, however, a number of serious problems.

It has become a virtue of some kind to question existing norms and values. This can be done in an impertinent manner, sarcastically or even sacrilegiously, or it can be done in all honesty and sincerity. Whatever the case may be, the crux of the matter seems to be the question why these specific norms and values were chosen and how they came to be selected. And exactly this question points at the real problem in traditional ethical methodology, *i.e.*, the failure to explain why this specific selection of norms was made, and secondly, what the essential and logical connection between these consisted of.

Amongst others there seems to be an approach with promising possibilities for answering these questions. That is the approach that takes as its point of departure the main tenets of what can be described as a biblical view of man.

### THE ANTHROPOLOGICAL QUESTION

The perennial question *What is man?* can only be answered from an external source of knowledge: knowing yourself is not as easy as Socrates might have wished. Epistemologically speaking man has always been rather an embarrassment—it is simply impossible to be behind and under the microscope at the same time. Without an external source of knowledge about himself he could go on forever playing games with his own shadow. As Christians we firmly believe that source to be God's revelation. If the answer to *what is man?* is often a despondent *Heaven knows!*, then that is absolutely correct! For the purposes of this paper it is not necessary or feasible to try a hand at a complete biblical anthropology. We do need however an outline of the major issues relevant to our topic.

The creation of man in the image of God points at the least to the fact that there was some plan and order behind God's act of creation, as was the case with all of creation of course. However difficult we make it to reach consensus on the full scope of content to be included in the 'image', we may agree on the one fact, *i.e.* that God's will was expressed in that creation. What he created was 'very good' (Gen 1:31), and that word should be taken as referring in a comprehensive way to what good entails in both an ontological and ethical sense of the word. In that creation God expressed his will, *i.e.* the good, which at the same time is the true, the beautiful, the right, *etc.*

Why did God create? As far as it is possible to provide any answer to this question it must be in some way connected with God's own free will and being, *i.e.* love. This may be accepted as the reason for creation since it is explicitly stated also as the reason for the

redemption or recreation of the world in John 3:16 and also since love is the essence of his being (1 John 4:8). Therefore the expression of God's will in creation can only have the intention of providing what is best for his creatures. Anthropologically speaking the creation of man according to a certain plan is an expression of the norms by which the highest quality of life may be attained.

We may call it the *objective ontological given* of the anthropological structures of the human being. By these structures is meant the factual possibilities given to man by which he can attain his calling and destination in all spheres of life. Perhaps the word possibilities is ambiguous in the sense that it conveys something of an optionality. In fact it constitutes much more of a *sine qua non* for the realisation of true humanhood, which already points to another component of our argument.

This is the fact that the given objective ontological expression by God of the fundamental anthropological structures must be acted upon by man. The intended quality of life promised with the expression of these structures can be attained only through the *subjective ethical responsibility* of man. Acting positively and responsibly brings the structures to produce the quality of life God intended in his love and wisdom. Failure to do so (the fall in sin) is opting for an alternative realisation of these structures which contradicts their intention and own inherent functional law, and is therefore the choice for what is not good, not true, not right, not beautiful. Ethical and moral decisions have everything to do with the basic anthropological structures.

After the fall in sin God upheld both sides of this bipolarity, *i.e.* the objective ontological and the subjective ethical. But man, blinded by sin, needed more, and this God provided in his grace: he gave his people his law. Basically God's law, which of course comprises in detail much more than the Ten Commandments and is to be found right through the whole of revelation, is nothing else than a constant reminder of his original intention, and therefore also a constant reminder of our true anthropological structures, and thus also of the way to quality of life and a maximum realisation of total human potential.

## THE LAW OF LOVE

Perhaps the greatest tragedy in human history is our total misconception of love. In much of our religious understanding and practice it is unobtrusively shifted to the periphery, perhaps due to the connotations we attach to it, for instance those of sentimentality, emotion, infatuation, lust, a vague or general feeling of goodwill towards others, charity, *etc.* Somehow we shall have to restore the real biblical meaning of love.

What should be the strongest argument is undoubtedly the fact that the being of God himself is described as love, as we have seen, together with the evidence that both

creation and redemption find their bounds in God's love. Paul has no hesitation in pointing out love as the most important of all God's gifts, even more than faith or hope (1 Cor. 13), while Jesus himself explicitly stated that love is above all else the Great Commandment. There is nothing merely emotional, optional or subjective about this commandment. In the light of what had been said thus far it constitutes the essence of the law, which is a real form of God's grace, *i.e.* a reminder of the true anthropological structures and thus also of the maximum quality of life. To love God and the neighbour is to choose quality of life through the realisation of God given possibilities.

The realisation of these anthropological structural possibilities, created by God, happens within the relational functioning of man under the guidance of love. To understand the commandment is to translate it back in the language of the Ten Commandments. To love God therefore means in short 'to let God be God', to have unconditional respect for God, *i.e.*, not to take anything away that constitutes his being God. First of all, in terms of the Ten Commandments, the per definition uniqueness of God shall be upheld and no other gods must be had; the transcendence of God should be respected in not trying to make any image of him in this world; his name must not be misused in order not to intrude in his being, *etc.* That is simply the unconditional demand of love.

Similarly, to love the neighbour means to have unconditional respect for the human being, 'to let man be man', and not to take away anything that God bestowed upon him, in terms of the Ten Commandments: not his life, or his marriage, or the truth, or his good name *etc.* Again, this has nothing to do with sentiment, emotion, feeling or optionality. The reciprocity of the realisation of basic anthropological structures should be noted: to love God and the neighbour not only opens up new qualities of life for the one that loves, but also for the neighbour being loved.

The further development of this line of thought for the whole of Christian ethics is an urgent exercise which we in this context unfortunately cannot do. At the most we can only stipulate a few principles in addition to the above mentioned:

1. The indivisibility, unity, totality and wholeness of the human being. It is not possible to divide him into separate parts as for instance in the dualism of Greek philosophical anthropology, as H.-W. Wolff clearly showed in his *Anthropology of the Old Testament*. Of course there is a richness and diversity of dimensions in the human being, but these are cross-dimensions, overlapping, permeating and influencing each other in such a way that they cannot be separated.
2. The societary or communal anthropological structure (co-humanity). This is simply no incidental or optional issue, but vital and a *sine qua non* for the experience of true humanhood. We are still waiting for the final exposure of the extreme western individualism and solipsism as one of the most dangerous ideologies of all time.
3. The inseparable bond between sexuality, marriage



and procreation. There are numerous modern social and psychological problems that can be traced back to the breaking of this fundamental anthropological structure.

4. The almost baffling status of man in the eyes of God (Ps. 8). Physiologically he may be inferior to animals and a hopelessly premature birth, a featherless biped, a gypsy at the edge of the universe, a culture medium for bacteria, politically and ecologically speaking such a risk and disaster that he should rather be cancelled . . . but he still is the image and likeness of God, and therefore has a sanctity and inviolability bestowed upon him that demands unconditional respect. In the final analysis this is the very opposite of humanism, since it is first of all rooted in God's divine right to his creation.

These and other foundational anthropological structures form the frame of reference into which eventually all Christian ethical norms can be brought. For our purpose it will be sufficient to illustrate what is meant with a few examples from bioethics (also treated in a book to be published soon on the subject of genetic engineering).

## HONESTY AND TRUTHFULNESS

One of the really important norms on this basis and foundation, both in Scripture and in Christian tradition, is the ethical norm of honesty and truthfulness. It is firmly rooted in the divine demands with regard to the integrity and dignity of the human being—a dignity which according to the commandment of love is seriously threatened by the withholding of the truth. In our context this means several things:

*Firstly*, it means that everybody involved in the debate should give full recognition and support to the *facts produced and verified by science*. Honesty and truthfulness demand that such facts should not be falsified, reduced, selectively treated, ignored or concealed in any way whatsoever, that it should carefully and explicitly be distinguished from theories, conjecture or hidden value-agendas, and especially that the relation between the interpretation of such facts and any value-system should be pointed out in an honest, conscious and clear manner. Furthermore, this very same norm of honesty and truthfulness also demands that all reasoning and arguments in the debate should comply with the requirements and laws of basic human logic.

Let us now apply this to the issue of prenatal life.

The most important ethical issue in connection with the subject of genetic engineering, IVF, *etc.* remains the crucial questions about the moral value and status of prenatal life from conception onwards, in particular the value and status of the embryo during the first two weeks. The fact that scientists now seem to favour the option of germ line gene therapy as having the best possibilities for genetic manipulation limits it in actual fact to only the first few days after conception, since all engineering in this view would have to be completed

before implantation starts round about day five after conception. For people accepting the view that it still is only a 'pre-embryo', and therefore not worthy of full protection this presents no ethical problem. There may be quite a number of practical problems still which render the whole project not feasible, but once these are overcome they probably will go ahead. Whatever the situation may be, ethically speaking the demand will be upheld that we have to treat the embryo with the greatest respect from the moment of conception. Since the arguments on which this view bases itself have already been dealt with extensively elsewhere (Du Toit, 1991: 19–33) we now need only a short summary of the main arguments with regard to honesty and truth:

- Genetically speaking conception is the formation of a new, unique and completed genetic entity to which nothing is to be added for the next 70, 80 or 90 years (Iglesias, 1989: 58–73).
- Anthropology insists that the human being is a fundamental unity and totality which cannot be divided in independent parts and cannot be separated. What is important to take note of, however, is the plain and logical fact that such a unity must be present from the very beginning, or not be at all. Thus, an adding on at a later stage of 'something more', whatever it is called (humanity, personhood, soul, spirit, reason, sentience, *etc.*), is simply and logically ruled out. Whatever the 'essence' of the human being, it must be present from the start.
- The development of the conceptus through the stages of an embryo, of a foetus, a baby, a teenager, a young adult, an adult, a middle aged person, *etc.* into old age nowhere shows any unaccounted for leaps, gaps or 'magic' moments which can be interpreted as the moment of becoming a human being or person or soul. What manifests at any time must be seen as the normal growth and development of what had been present already in some form or another.

Arguments to the contrary naturally find it hard to refute the above mentioned reasoning, and in many instances it is simply ignored. Instead the attention is focussed on the presumed number of lost fertilized ova, the possibility of segmentation, the appearance of the primitive streak and the diversification of some cells into the placenta. One cannot escape the distinct impression that these eventually are all padded with less than clear philosophical speculation as well as with some quasi-theological attempts to prescribe divine providence (Shannon and Wolter, 1990: 603–626). That they are untenable attempts has been adequately and thoroughly illustrated by a mass of literature. It will suffice to refer readers to the overwhelming evidence gathered together by O'Mahony (1990: 9–17. Also see Iglesias, 1989: 58–73).

Over against philosophical speculation ethics will have to maintain the status and value of prenatal life from conception onwards, taking very seriously the scientific facts presented to us. Honesty and truthfulness, together with simple human logic, compel us to accept the fact

that if a human being has any moral value and status at all, he certainly has it from the very start, *i.e.* conception, or not at all.

*Secondly*, the norm of honesty and truthfulness means that participants in the debate should commit themselves to the honest and unambiguous usage of *words and language*. Of course it is possible to soften and almost totally conceal unpleasant realities behind carefully selected words. Perhaps we all do that in the normal walks of life, and doctors often do that with their patients. However, when medical, semi-medical or quasi-medical jargon is used to ethically sanitize an otherwise unacceptable reality we certainly have a case of severe ethical double-talk. Although we can be sure that doctors and researchers fully comprehend the meaning of their terminology and the realities to which it refers, it can nevertheless be abused in an ethical debate to further a particular brand of philosophy or value-system. In this way a new language evolves, based on medical terms, but which in itself rather functions as a kind of 'medicinese', and carries ethically speaking a very strong provocative nature. Iglesias calls it 'cosmetic semantics' (1989: 67).

There are numerous examples to illustrate this. The very use of the old word 'abortion' is a case in point, because it was a technical term borrowed from an ancient language, and as such therefore quite useful. It however in the end became obstructive to certain philosophies of man. So we have again been conditioned now for a long time by the use of 'termination of pregnancy', 'D&C', 'S&C' and others, by which the bloody and gruesome affair and reality of crushed baby skulls and torn-off limbs is being transformed into a safe, sterile, technical, clinical, formal and respectable medical practice. Another example would be the relative recent, but already infamous, invention of the term 'pre-embryo', which is really nothing less than a deliberate attempt to propagate a certain philosophical view of man, straight in the face of all known scientific facts. What it in fact says is that a certain category of human beings is quite disposable (*cf.* The Fifth 119 Report, 1990: 45).

With regard to the debate on our specific subject this term is not only objectionable, it is highly dangerous (Iglesias, 1989: 58–61). But it is not the only one. In the fight against disabilities and hereditary diseases new technology has made it possible to diagnose such at an early stage of pregnancy. Coupled with permissive legislation on prenatal life it offers the possibility of what is called (in medicinese) 'selection or treatment'. What it really is saying is rather 'kill or care', because that is exactly what it means. One practitioner in London has a patient who readily accepts this offer and is having a fifth pregnancy now after four successive 'selections' or abortions. Presently words and concepts are widely being used in research and medical practice, simply not saying what is being done: 'embryotherapy' and 'therapeutic experiments', for instance, are used for practices that are certainly not therapeutic in any sense, and rather point to the real status of those

embryos, *i.e.* as guinea-pigs, which are easily discarded and destroyed after the event.

The practice that developed in connection with 'prenatal diagnosis' and 'genetic screening and counseling' also led to considerable suspicion that in many instances it is used as an attempt to supply a cloak of scientific respectability to hide a procedure that more likely resembles a biased trial with a prejudiced judge and jury, with no defense allowed at all.

Cameron points to the same phenomenon when he shows how the age-old belief that medicine is all about 'healing' has now shifted to 'relief of suffering' and vague subjective notions like 'quality of life'. 'Sanctity of life' is being replaced by 'respect for life', again a subjective concept (1988: 1–13).

The simple fact is however that both medical doctors and researchers are being trained also in a certain vocabulary, and not everybody using this terminology necessarily has the evil intentions of double-talk and deceit. What also should be stressed is the fact that life sometimes provides real tragic circumstances and problems in which doctors are faced with very real ethical dilemmas and very difficult and painful decisions—decisions to be taken in those circumstances under tremendous pressure and often without much time to reflect. It is obvious that these doctors deserve everybody's understanding and prayers, and experience in general supports the contention that people actually do display this attitude. Therefore it is very dangerous to act in a way that causes suspicion, *i.e.* suspicion that we are indeed being deceived, that we are told things in a way, words and language that have the intention of trying to convince us that they are not really doing what they in fact are doing. But it is becoming extremely dangerous when 'medicinese' is deliberately used to try and convey a view of human life that is no longer acceptable within the ethical framework of respect for human beings and the sanctity of life.

The ethical norm of honesty and truthfulness demands that we should not abuse medical terms in an effort to put over dubious philosophical views and medical practices.

Neither should such words or language be used to deceive or at least create a distorted rendering of the reality. It is important to remember that there is a very close connection between creation, truth and the dignity of man. We have seen that the 'good' that God created is also the true, the right, the beautiful *etc.* Truth is not something theoretical but the factual, physical result of God's creational words. In the creation of man, *i.e.* in the anthropological structures, God expressed the truth about man. To hand out and receive the truth is therefore essential to the maximum functioning of the human being (whether doctor or patient). It is rooted in the structure of truth and man, as well as in the status awarded to man by God.

This relationship is aptly portrayed by the Afrikaans words for truth, value and dignity: 'waarheid', 'waarde' and 'waardigheid', in which the root in each case refers

to truth. Every human being is therefore entitled to the truth, while the whole society and the quality of life in that society, is in a fundamental way dependent on the way truth is handled.

This of course also follows from the fact that language must be regarded as constitutive for the human being, as has been adequately stated by E. Jüngel (p. 124–153). We are being called into existence by God's word of creation. We are being addressed by God and have the essential structure to answer God, to communicate with our fellow human beings (thereby creating communion and society), and to exercise dominion over creation by naming it, signifying it, and in that sense even 'manufacturing' it. To demand and speak the truth is to imitate the 'very good' of creation, which is also the truth in worship, socialization and dominion. The radical devaluation of words and the truth it is suppose to convey, may very well be at the core of the crisis in anthropology and bioethics.

## JUSTICE, EQUALITY AND CHARITY

Love of the neighbour implies in a rather straightforward manner that we should care for each other, but in a very real sense for those in need (cf. Mat. 25). This is one of the most constant themes running throughout the whole of Scripture. It is also apparent that not a single aspect or sphere of life is excluded from this demand. On the very same basis we are called to exercise justice in our dealings with our fellowman, again in the same universal fashion. Behind all of this stands the clear principle of our human equality before God.

The interrelatedness of these three issues provides the background for the very real ethical conflicts and dilemmas arising in the face of the challenge to justly and equitably distribute limited resources. And of course, genetic manipulation is right in the thick of it. The very difficult choice confronting us is that between supplying basic medical services for the majority of people on a very broad base, thereby improving their quality of life, or, on the other hand, shifting the emphasis to specialized and expensive research and practice, benefitting a select few who finally can afford it. The parable of the rich man and Lazarus who had to subsist on the crumbs falling from the table is not totally inappropriate.

This is not an easy problem to deal with, and I do not think that there are simple solutions. On the one hand nobody can deny that expensive specialized research may finally benefit what we now call primary health care. At the same time there are prominent scientists who seriously question the broader benefits of research in genetic engineering. The opinions of Prof. Lejeune and others in this respect are well known, while it is accepted that at present there is very little relevancy of this research for the clinical practice.

In any society a final decision will be reached only after a careful weighing of the different factors involved. These are amongst others the available resources, the real probability of any future advantages of research on genetic manipulation for the broader and poor

masses of people, the existing, chronic, growing and immediate needs of those masses, the ethical evaluation of genetic manipulation and accompanying practices, and others.

From the ethical perspective serious questions will have to be answered: to what extent does genetic manipulation represents a selective caring for people, bringing into contention the principles of justice, equality and charity? What impact will a decision to either side have on the imminent and looming threat of the ecological and demographic trap? Should we not rather contextualize our medicine, accommodating the very real African realities, instead of trying in vain to universalize it according to the economically unattainable norms of the First World? And does that not imply that our available (*i.e.* severely limited) resources should rather be applied to the massive problems of primary and preventive medicine, population control and the like? These are some of the questions, and undoubtedly quite different answers will be supplied. However, ethically speaking, no decision will be acceptable which does not comply with the norms of justice, charity and equality, difficult as it may be.

From our anthropological background another issue in this regard emerges. The analysis above could be interpreted as playing off the interests of the individual against the larger community. Western society unfortunately is still under the sway of a liberal individualism which to a large extent rules the day also in bioethics, and is by and large a misunderstanding of 'personal'. Individual freedom and rights are stressed almost to the exclusion of anything else. The creational structures in which man was created presents us with the indispensability of all man's relational possibilities for the attainment of personal wellbeing and quality of life. Apart from the relationship with God, with oneself and with creation at large, the relationship with others is of extreme importance, and therefore the communal aspect of life receives great emphasis in Scripture (and surely, not only in a spiritual or religious sense). The impression remains that the modern bioethical approach to a large extent is firmly stamped by individualism, to the detriment of the quality of life and personal fulfilment.

## ELIMINATION OF SUFFERING

One of the strong arguments in favour of genetic manipulation is the possibilities it has for the elimination of future suffering. From an ethical perspective there can be no doubt about the merit of such intentions. Christian ethics in particular would maintain that

- all future suffering should be avoided where possible
- that all existing suffering and pain should be alleviated or removed, if possible
- that all unavoidable suffering and pain should be treated intensively in a medical, pastoral, clinical and material way.

However, the elimination of suffering and pain have



also been dealt with within the broader framework of contemporary phenomenological analyses of Western culture, and prove to be a rather complex problem. It has been pointed out that the drive for the elimination of suffering does not always come forth from a sincere compassion for humans in pain or suffering, but rather from an utopian desire to produce an immaculate and perfect, flawless society. The ideal is a new *Herrenvolk*, a super race built on the unconscious primitive desire for immortality, at last freed from the prescriptions and conditions of religions and moral codes, and solely dependent on the new exciting prospects of science.

Theologically speaking all this is nothing less than the sinful perversion of the original mandate given to man by God at the creation, *i.e.*, the mandate to govern, administer and develop all of creation to the glory of God and the benefit and well being of the human being. Sin transformed this divine ordinance into the desire to have absolute control—a dream in terms of which the whole of mankind's history may be read. That dream still today guides man's desires and actions, despite the disastrous results it has already produced (nuclear and other mass destruction means, ecological disasters, bureaucratic institutions, etc.)—in fact, the dream in more ways than one has become a terrible nightmare. Now it is pointed out that the desire to eliminate all suffering may just be one of the issues flowing forth from the ideal of total control.

In as far as people unconsciously cling to this ideal, and at the same time are still confronted with the reality of the impossibility of their dream, it inevitably leads to an alarming inability to acknowledge any possibility of finding any meaning in suffering. The realities of the humanising dimensions of suffering, the creation of quite unexpected elements of quality of life, co-humanity, service of love, and the equally unexpected and hitherto unknown possibilities of personal growth and development through suffering—all of these appear totally nonsensical and illusory in the blinding and fatal attraction of the unattainable ideal of total control.

This of course leads to an increasing inability to handle the issue of suffering, and could very well be at the bottom of

- the increase of suicide and family killings
- the sharp increase in abortions and infanticide
- the strong flow of propagation of active euthanasia
- the recent sensational slogan: 'let sick children die'
- the persistence in some circles that the terminally ill elderly should not be allowed in hospitals, *etc.*

It is easy to deny all this, but it is very hard to find an alternative and credible explanation.

For the practice of genetic engineering, euthanasia and others the ideal of the elimination of suffering should therefore be treated with circumspection, and several serious ethical questions will have to be dealt with first. Amongst others we shall have to answer in some way as to the priority of life itself above the elimination of suffering. Also we shall have to be positive about the motive for it in general, *i.e.* whether it is to create a

flawless society in accordance with the ideal of absolute control, or whether it is sincere compassion with the human being in his suffering. We also will have to be very clear about the issue of whose suffering we are eliminating, that of the patient, or that of other people, relatives for instance, who cannot cope with the phenomenon of suffering. There is almost no end to the issues that can be raised in this regard.

## REPARATION OR IMPROVEMENT

One of the major ethical issues in genetic engineering is the question about the acceptability of the full range of actual possibilities it presents, although only in theory at present. The very obvious and most talked about is the possibility to avoid or repair some kinds of deficiencies, hereditary diseases or disabilities. This is very much in line with normal medical practice, and ethics of any nature would be hard pressed to come up with objections of any fundamental nature. In fact, Christian ethics especially, together with Christian churches, should rather welcome this new option as part of God's general grace to modern humankind. Science and the responsible and ethically justified application of its findings can be seen as part of man's obligation in terms of his creational cultural mandate and calling. There are though some practical safeguards which would be requested by Christian ethics, and in conclusion we shall return to these.

However, it is also possible that some people would like to go much further than simply the therapeutic or eugenic possibilities of genetic engineering. What seemed to be pure fiction for a long time is now coming very close, especially against the backdrop of some far reaching experiments already been conducted with some degree of success on animals. That is of course the possibility, not only to restore normality and repair deficiencies and disabilities, but also to try and improve on the already normal embryo, thus creating either a specific human being with specified personal physical traits which he would not have otherwise, or in general a new 'improved' generation of human beings.

There seems to be a universal aversion to and repugnance against the very idea, and therefore an almost instinctive and immediate rejection of any such notion. Whether it still has something to do with the memory of Nazi-programmes is not sure, but Christian ethics for sure has no choice but to reject it resolutely and in the strongest terms possible. That would indeed be playing God, and is as unacceptable as another Hiroshima or Dachau. Human beings will be in control of not only the physical appearance but eventually also of the psychological make-up of another human being. There is no end to the questions raising themselves: who is going to decide what a new boy or girl is going to look like? The norms (desires, ideas, fantasies) will vary according to the decisionmaker: the musician will opt for musical talent, the frustrated would-be filmstar for a beautiful face and body in her offspring, the sporting coach for muscular giants, the industrialist for

a hardworking and not too intelligent labour force, etc. There simply is no general ideal type of human being. At the same time it is a serious ethical question whether this kind of action does not constitute an impermissible intrusion into the inviolability, integrity and autonomy of the human person.

This again would point to the dream of absolute control—control not only of nature but also of posterity. It also could be an indication of the outrageous dimensions of modern western selfcentredness, consumerism and egoism: parents would require that science and the doctors provide them with a perfect child according to preset conditions and requirements. Thus the child becomes a product and commodity, designed to satisfy the parents' desires and fantasies, available at a price on the market. Intensive preparation for this kind of mentality has already been done by many years of liberal abortion practices (cf. O'Mahoney, 1990:4).

In conclusion: this article was an effort to illustrate the importance of a solid anthropological basis for bioethics. The examples taken can, and must be, multiplied in the process of building up an evangelical framework. There remains, however, one danger that we should be aware of, and that is the possibility that we, in opposition to much of the provocative 'medicinese', can actually formulate the value and status of prenatal life in terms not less provocative. It has been pointed out repeatedly that the use of provocative language in ethics is a severe obstruction in the debate—from either side! Therefore, while we insist that human life begins at conception, that there is no point or stage during the continuous process of development which can be seen as the magic moment, and that we must treat that life with respect and grant it full protection from conception onwards, it still is a debatable point whether terms and words used mainly for adults would not be jeopardizing the case for defending the full status of prenatal life. It is perfectly understandable that people should feel that it is only logical to describe this status with the words human being, person or soul. It leads however easily to all kinds of caricatures and misunderstandings, the main problem being the fact that these words are loaded with different cultural, historical, sociological, and psychological meanings.

It is for instance not uncommon that many people, despite the fact that anthropological dualism has been rejected completely for a long time, still think of the soul as a massive, adult and completed packet of some kind of spirituality which is located somewhere in the body, like the famous 'black box' of modern aircraft. It is very difficult for them to accept that the soul denotes an unbreakable relationship which grows together with the rest of the human being (Yates, 1989:137). Keeping the unity of the human person and the unbroken continuous development since conception in mind (O'Mahony, 1990:33) we shall have to qualify the terms we use. Just as a child is a person or soul in the way of a child, and a baby is a person in the way of a baby (and not an adult), in the same fashion must we maintain that a foetus or an embryo is a person or soul in the way of a foetus or an embryo. At the same time however, this is also the

absolute minimum that we are allowed to say in the light of the available evidence.

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E. D. Watt, University of Western Australia

# HOBBES'S EQUAL THREAT: ARE SOME MORE EQUAL THAN OTHERS?

Leviathan xiii begins:

Nature hath made men so equal, in the faculties of body and mind, as that though there be found one man sometimes manifestly stronger in body, or of quicker mind than another, yet when all is reckoned together, the difference between man and man is not so considerable, as that one man can thereupon claim to himself any benefit, to which another may not pretend, as well as he. For as to strength of body, the weakest has strength enough to kill the strongest, either by secret machination, or by confederacy with others that are in the same danger with himself. And as to the faculties of the mind . . . I find yet a greater equality amongst men, than that of strength.

This is Hobbes's understanding of natural human equality, obvious, he suggests, to anyone not confused by 'a vain conception of [his] own wisdom'. Nobody is simply at the mercy of anybody else. Conflict is the inevitable outcome of equality so understood:

From this equality of ability, ariseth equality of hope of attaining our ends. And therefore if any two men desire the same thing, which nevertheless they cannot both enjoy, they become enemies, and in the way to their end (which is principally their own conservation, and sometimes their delectation only), endeavour to destroy or subdue one another (*Leviathan xiii*),

not out of any malice towards one another, but simply from everyone's exclusive interest in his own objects of desire. This condition of conflict ('War') is unrelenting, not in the sense that everyone would be fighting all the time, but in the sense that anyone could be fighting at any time, for

the nature of war consisteth not in actual fighting, but in the known disposition thereto, during all the time where is no assurance to the contrary (*Leviathan xiii*),

and in the absence of effective government, what assurance

could there be? There is nothing normative about human equality in this sense; it is put forward as simply descriptive. But it provides support for normative contentions of several kinds, including the existence of equal 'natural rights', and duties of impartiality both private and public. On impartiality, the ninth 'law of nature' requires

that every man acknowledge other for his equal by nature (*Leviathan xv*),

and the eleventh, that

if a man be trusted to judge between man and man, it is a precept of the law of nature that he deal equally between them. For without that, the controversies of men cannot be determined but by war (*Leviathan xv*).

On equal natural rights, every man is entitled, Hobbes holds, to take *any* steps which in his judgment will lead to his preservation. To do so is his natural 'right', not in the sense that he is entitled that anyone else assist him, or even refrain from obstructing him, in anything he does in seeking his own preservation; rather, in the sense that there is *nothing* he might do, in seeking his own preservation, which would be unjust to anyone else. He could, by his own consent, renounce his unlimited discretion, but he cannot rightly be compelled to do so, because he is under no obligation to renounce it. This is the only kind of *innate* right that Hobbes recognises. Understood in his way, to say that everyone has a natural right to everything is to say that no-one has a natural right to have his rights respected:

Every man has a right to every thing, even to one another's body. And therefore, as long as this natural right of every man to every thing endureth, there can be no security to any man (how strong or wise soever he be), of living out the time which nature ordinarily alloweth men to live (*Leviathan xiii*).

What Hobbes is doing here seems plain enough. He needs to show that in the absence of civil order *everyone*



would be imperilled, and therefore that everyone alike has the same interest in giving unreserved consent to a common arbitrator of any disputes that might arise between one person and another. A *Commonwealth* is

made by covenant of every man with every man, in such manner, as if every man should say to every man, I authorise and give up my right of governing myself to this man or to this assembly of men, on this condition, that thou give up thy right to him, and authorise his actions in like manner (*Leviathan xvii*).

Hobbes has constructed

a political theory which bases unlimited political authority on unlimited individualism. The conclusion requires the premiss; anything less than unlimited individualism would justify only limited political authority (Gauthier 1969: vi).

It must be shown to be in the individual interest of *everyone* to give this consent. But his account of natural human equality as (sufficiently) equal vulnerability has not been found satisfactory by all readers. Its shortcomings have been understood variously. One objection, which has enjoyed some currency in recent decades, is that Hobbes (whatever *he* may think he is doing) has in mind not men in general, but something called 'bourgeois men' or 'possessive individualists', denizens of a 'market society' (Macpherson 1962, 1968, cf. Strauss 1936). It is only such men, we are told, and not men in general, who have the kind of limitless desires that are inescapably in conflict with other men's limitless desires: what Hobbes has constructed is not an analysis of man and of society, but only of 'bourgeois man' and 'bourgeois society', where 'behaviour' and 'values' are 'largely shaped, directly or indirectly, by the requirements of the market' (Macpherson 1968: 11–12).

Hobbes needs 'the postulate of equality' if he is to 'demonstrate from the facts the need for a universal political obligation' (Macpherson 1968: 59). But his 'postulate of equality' is not 'the equal subordination of every individual to the laws of the market' (Macpherson 1962: 85). In support of that interpretation, Macpherson offers no reference to any Hobbes text, and it has all the marks of a view of the world with which he approached Hobbes, a rabbit that he could not have pulled out of Hobbes's hat unless he had first put it there himself. But he is right in thinking that there is something odd in Hobbes's account of natural human equality. The people Hobbes concentrates on pose a threat to one another's felicity, not merely as competing entrepreneurs, but more generally as competing agents, all engaged in 'motion', which carries with it the constant danger of collision. The images of human vulnerability are death and wounds rather than financial loss. And those who have the capacity to pose a mutual threat, also have the capacity to make covenants and so put an end to their mutual threat. The Great Leviathan protects his subjects, not from all the dangers that beset them—not from bacteria, or sharks, or storms—but only from dangers caused by other agents. And the Great Leviathan can remain in being from day to day only by the continued recognition

and support of those he protects, and their safety depends on their capacity to make covenants with one another:

To make covenant with brute beasts, is impossible; because not understanding our speech, they understand not, nor accept any translation of right; nor can translate any right to another: and without mutual acceptation, there is no covenant (*Leviathan 14*).

Though sometimes, for polemical purposes, Hobbes seeks to minimize the distinction between men and brute beasts, on the central question of covenant-making the distinction is drawn very sharply.

But it is not only brute beasts that are incapable of making covenants:

Over natural fools, children, or madmen there is no law, no more than over brute beasts . . . because they never had the power to make any covenant, or to understand the consequences thereof; and consequently never took upon themselves to authorise the action of any Sovereign, as they must do that make themselves a commonwealth (*Leviathan xxvi*).

And since

the definition of injustice, is no other than the not performance of covenant. And whatsoever is not unjust, is just (*Leviathan xv*),

it follows that there is no way of treating natural fools, children or madmen which would be unjust to them. (It might, of course, be unjust to someone else, if it were in breach of a covenant with that other person).

Even towards people capable of making agreements we have, Hobbes holds, no obligations *unless in fact* agreements have been made. Hobbes speaks of a situation, real or imagined, where no agreements have been made, as 'the natural condition of mankind' (*Leviathan xiii*). It is *natural* in the sense of being non-conventional. In the absence of any obligations undertaken by agreement, 'every man has a right to every thing; even to one another's body' (*Leviathan xiv*). To have a *right* here means not to have any obligations.

If I have no obligations, then whatever I do, I have a right to do it. This 'right to every thing' implies no obligation on the part of anyone else to respect my entitlement, for everyone alike has the same 'right to every thing, even to one another's body'. At sea, refugees and pirates have the same right to the refugees' money and their lives. In the 'war of every man against every man', no man is at fault, for all have the same right to all things. I acquire obligations only by exercising my 'rights of nature', hitherto unlimited, by making covenants which restrict my 'right of nature'. So all obligations are conventional, 'for where no covenant hath preceded, . . . every man has right to every thing' (*Leviathan xv*). Reasonable agents will be prepared to make covenants to restrict their 'rights of nature'. Each reasonable agent will do so for his own advantage, not for his neighbour's. Anyone who is not prepared to make a covenant is unreasonable, in preferring strife to peace, and in being content to live under threat from all his fellows, and to pose an equal threat to them.

A 'right of nature' in Hobbes's sense is not a right to

be treated in a particular way, but a right to *do* something, a right to act. If for any reason I am incapable of doing something, there seems no point in speaking of my right to do it. And it is those who have the normal adult human capacity for acting, and only those, who are capable of posing a threat to one another, or of making covenants with one another to avert that threat. But even healthy adults have spent part of their lives newborn and unborn, and still spend part of every day asleep. All these people, the sleeping no less than the newborn and the unborn, are entirely incapable of posing an equal threat, or any threat, to anyone, and entirely incapable of making any covenant of peace. For other people, the period of their incapacity will be the whole of their lives, or the rest of their lives. Those who, whether temporarily or permanently, can preserve themselves neither aggressively as equal threateners nor peaceably as equal makers of covenants, are wholly at the mercy of the remainder of the human race, healthy adults who have not fallen asleep.

Hobbes's equal mutual threat, and the equal hope of security for everyone through a mutual covenant of peace, direct our attention to the world of competent adults. This is the sphere within which Hobbes can speak of natural human equality, for his is an (approximate) equality in capacities, to act (and consequently to pose threats), and to make agreements restricting one's acts and threats by a mutual submission to the commonwealth. But because everyone for some of the time, and some people for all the time, are neither equal threateners nor equal promisors, they fall outside the scope of natural human equality as it appears in Hobbes's argument. If they are conquered, the victor is under no obligation to spare their lives even after they surrender:

Nor is a victor obliged by an enemy's rendering himself, without promise of life, to spare him for this his yielding to discretion; which obliges not the victor longer, than in his own discretion he shall think fit (*Leviathan* xx).

And if they are infants, their mothers seems to be under no natural obligation (in the absence of civil law) to spare their lives either:

Again, seeing the infant is first in the power of the mother, so as she may either nourish, or expose it; if she nourish it, it oweth its life to its mother; and is therefore obliged to obey her (*Leviathan* xx).

The child who is spared is even said to have *promised* to obey, for

every man is supposed to promise obedience, to him, in whose power it is to save, or destroy him (*Leviathan* xx).

Conquerors and mothers are under no obligation to treat as their equals those from whom they face no equal threat, and indeed, no threat at all.

Hobbes is not alone in insisting on a measure of competent agency if we are to speak of entitlements in justice. Hume likewise insists that it is only among approximate equals that talk of justice can even be intelligible:

Were there a species intermingled with men, which though rational, were possessed of such inferior strength, both of body and mind, that they were incapable of all resistance, and could never, upon the highest provocation, make us feel the effects of their resentment, the necessary consequence, I think, is that we should be bound by the laws of humanity to give gentle usage to these creatures, but should not, properly speaking, lie under any restraint of justice with regard to them, nor could they possess any right or property, exclusive of such arbitrary lords. Our intercourse with them could not be called society—which supposes a degree of equality—but absolute command on the one side, and servile obedience on the other. What we covet, they must instantly resign. Our permission is the only tenure by which they hold their possessions . . . (Hume 1949: 190–191).

Hume rejects what he calls the 'vulgar definition of justice' as 'a constant and perpetual will of giving every one his due' because, he says, it makes no sense to imagine an entitlement which is 'independent of justice and antecedent to it': rather, it is the rules of justice, which are conventional rules and nothing more, that *define* what is just and unjust (Hume 1949: 190–191). People are prepared to adhere to the conventions of justice in pursuit of their own interests, because they can see that those interests are constantly imperilled by everyone's pursuit of his own interests. The picture is restricted,

Human Rights Commissions and similar institutions are more at home with claims made by competent adults, members of the commonwealth, to be entitled to do something or other. They commonly have more difficulty in dealing with claims which have not enjoyed social recognition, and with claims made on behalf of those who, for whatever reason, are not able to speak for themselves; with the rights (if there are any) which we had when we were children, and will have in a few years when we become senile, and in a few hours when we are asleep.

then, to those who are approximate equals in Hobbes's sense of being equally capable of thwarting one another's plans.

Hume's interest here is in rights of ownership, but his argument, as is often the case with Hume, supports conclusions far wider than the subject of his original interest. When he turns from an imaginary to an actual instance of great inequality of power, in the contact between European settlers and Indians in North America,

Hume must be accused of drawing back from the full implications of his doctrine. Why does he say that European settlers were only 'tempted to imagine' themselves above justice? Surely, on his theory, they were above justice in relation to the Indians (Barry 1978: 221),

since the Indians, though far from helpless in the short run, could offer no effective long-term resistance to any policy imposed on them, and so had, on Hume's view, no rights. Barry's reply to Hume is that the chronicle of relations between very unequal groups is full of self-evidently 'monstrous injustice', more obvious than any reasons that could be given to show that it was unjust (Barry 1978: 222).

But Barry himself, while insisting against Hume that American Indians fall within the sphere of justice, is prepared to exclude from that sphere those *sufficiently* helpless. His difference with Hume or Hobbes, then, is over no more than a matter of degree. A similar approach is adopted in much of the recent talk of equal human rights. A *human right*, as that expression is now used, seldom denotes a right which is innate to the holder of it, something to which he is entitled because of what he is, and entitled whether or not his fellows recognise or respect his entitlement. Instead, it usually denotes a social entitlement, the outcome of convention, something he is entitled to as a member of the commonwealth he belongs to, so that if it is not recognised, he does not have

it. Human Rights Commissions and similar institutions are more at home with claims made by competent adults, members of the commonwealth, to be entitled to do something or other. They commonly have more difficulty in dealing with claims which have not enjoyed social recognition, and with claims made on behalf of those who, for whatever reason, are not able to speak for themselves; with the rights (if there are any) which we had when we were children, and will have in a few years when we become senile, and in a few hours when we are asleep.

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# BOOK REVIEWS

## Prenatal Diagnosis: Confronting the ethical issues

Agneta Sutton

The Linacre Centre, London, 1990, ISBN 0-906561-06-X

This is a useful and unusual book, bringing together information on the techniques and rationale of prenatal diagnosis and the ethical and legal considerations which impinge on this fast developing field of modern medicine.

The book is divided into two parts. In the first, Agneta Sutton provides an overview of diagnosable fetal disorders, followed by an explanation of prenatal investigations. These are linked with the abnormalities they are capable of detecting and the stage of pregnancy at which they would be carried out. There is a genuine attempt to assess objectively the utility of these tests,

in terms of risks and therapeutic potential, while recognising that the elimination of defective fetuses is usually the primary objective.

In Chapter 3 the discussion is taken further. A contrast is drawn between the usual aim of diagnostic procedures, i.e. the promotion of health and well-being of the patient, and the aim of prenatal diagnosis, i.e. of avoiding genetic illness or malformation. In the latter case there are two patients involved, and for the one whose condition is being diagnosed, namely the unborn child, there is no such intention of health promotion.



Agneta Sutton goes on to discuss briefly the cases in which there may be a therapeutic intention in prenatal diagnosis, i.e. in discovering fetal conditions which can be treated *in utero*.

Chapter 4 begins with a helpful discussion of the definition and history of eugenics, and the writer goes on to argue that prenatal diagnosis with a view to termination of pregnancy in the presence of illness or malformation is the logic of negative eugenics. The point is made that the cost-benefit analyses which have been applied to prenatal screening omit any estimation of costs and benefits to prospective disabled children and adults—who are as much a part of society as able-bodied people. The Tables presented clarify the basis of cost-benefit analysis, but the source of the information given is not clear, perhaps indicating a lack of research on parents' views of prenatal diagnosis.

Chapter 5 is in my view the strongest chapter in Part 1, offering a detailed consideration of legal perspectives on the issues around prenatal diagnosis. Although some statutory changes have taken place since the chapter was written, the discussion of 'wrongful birth' and 'wrongful life' cases is particularly useful. The case for a reconsideration of prenatal diagnosis, on the basis of its potential benefit to the child itself, is examined.

In Part 2 of the book Agneta Sutton discusses in depth the ethical dimensions of abortion and the moral status of the developing embryo. This begins with an account of the teaching of the Roman Catholic Church and moves into a philosophical analysis of personhood. The continuity of personal human life is presented as a claim for respect due to the developing individual from conception onwards, regardless of potential disability. The chapter on social reasons for avoiding the birth of a handicapped child gives a considered assessment of the burden of care imposed on families and on society by handicapped children. The quality of life argument is counter-balanced by a view of the intrinsic value of human life which refuses any justification for cutting short the life of a fetus. The central argument of this section is that 'the idea that some human beings may be sacrificed in order to promote the interests of others undermines the very concept of justice itself.'

Of particular interest and relevance to health care professionals is the discussion of the duty of care which requires health professionals to discuss with pregnant women the intentions and risks of prenatal diagnosis, with implications for informed consent. This leads on to an analysis of the midwife's moral responsibility with regard to participation in prenatal diagnosis where there is a conditional intention of abortion. Agneta Sutton's view is that, since the law allows nurses, midwives and doctors to withdraw from procedures causing abortion, logically they should also be permitted to withdraw from abortion-related procedures such as prenatal diagnosis.

The book concludes with a reiteration of its underlying philosophy, that the abortion of unborn children because they would be a burden to themselves or others is a denial of 'fundamental human equality and the basic human rights on which justice is based.'

Agneta Sutton is to be congratulated on her careful analysis of difficult issues which have as yet been inadequately addressed. She has taken on the difficult task of clarifying the questions and explaining the medical technology in a way which is accessible to the intelligent lay reader. Her unwavering defence of the rights of the unborn will be unacceptable to many in present-day society, but the argument illuminates the questions posed by this new technology in a way that is potentially helpful to those who are trying to work out their own positions. The readiness to be prescriptive, however, to parents and to health professionals perhaps reflects a theoretical approach which does not adequately recognise the painful complexity of real-life dilemmas.

My problem with this book was the question of the expected readership. The provision of an excellent glossary makes the technical sections readable by an interested lay person, but the subject matter is also relevant and important for health professionals. For this readership the text lacks depth, in some areas, eg. in discussion of pathological conditions and of psychosocial aspects, although legal issues are dealt with more authoritatively.

In such a rapidly developing area information is soon out of date, but there is much factual material in the first part of the book to inform anyone trying to make sense of the array of prenatal tests now available. The ethical discussion will be helpful for students and practitioners in the health care disciplines. The practice of prenatal diagnosis is gaining ground fast, and the issues highlighted in this book are so important that it should be welcomed and widely read.

University of Edinburgh

DOROTHY A. WHYTE

**Etats vegetatifs chroniques: Repercussions humaines: Aspects medicaux, juridiques et ethiques**

Edited by: F. Tasseau, M-H Boucand, J-R. Le Gall, P. Verspieren  
Rennes Cedex, France, 1991

The title of this book, produced by a multi-disciplinary group of twelve under the auspices of the Jesuit **Centre Sevres** in Paris, may strike, at least the Anglo-Saxon reader as a little curious. The subject matter is the moral and legal issues concerning patients in the persistent vegetative state (PVS). But the title translated into English is not 'The Persistent Vegetative State' but 'Chronic Vegetative States'. The plural in itself may raise an eyebrow, but what the authors themselves emphasise as significant is the use of the term 'chronic' as opposed to 'permanent'. The reason, they say, for choosing the term 'chronic' as opposed to the widely accepted word 'permanent' is to make it quite clear that the state referred to is an irreversible one.

The book is divided into four parts. Of these the first and the fourth parts are probably the most interesting from a bioethical point of view. Part one is about clinical symptoms and tests. Two of the papers concern the clinician mainly, while the third, by Patrick Verspiern SJ, the Director of the Bioethics Department at Centre Sevres, is of a more philosophical nature. Discussing the epistemological status of clinical interpretation of data, he asks whether one can ever be sure that a person who is unable to communicate and shows no signs of conscience or sentience, really is totally unconscious and non-sentient? Furthermore, rejecting the suggestion that a person in the 'chronic vegetative state' (CVS) is sub-human, Verspieren argues that a patient's humanity depends neither on the decisions of clinicians nor on his own ability to communicate, since we are not human solely by virtue of our capacities. Nor, he adds, would we be justified in declaring CVS patients dead. He especially dismisses the concept of 'neo-cortical death' on the ground that the death of a human being, a person, is not to be equated with the death or non-function of an organ—not even that of the neo-cortex.

The second and third parts of the book are basically of an empirical nature. The papers in the second part contain statistics relating to the number of patients in CVS, and the costs, nursing hours and types of treatment required for adequate care of such patients, whereas those in the third part are about the attitudes of doctors nurses and families towards CVS patients.

The fourth and final part of the book concerns legal and ethical matters. Jean Michaud, a member of the French National Consultative Ethics Committee, shows that French law has not yet caught up with the situation of CVS patients. Even if these

patients fall under the general category of incompetent patients, there are no regulations concerning them in particular.

The question of medical research involving CVS patients has, however, received considerable attention. And, the French National Consultative Ethics Committee, reflecting a certain public outrage, has come to the conclusions that CVS patients deserve 'the respect due to every human person' and that such patients should not be treated as mere means to scientific progress. Commenting on the Committee's recommendations that research on CVS patients should not be allowed unless it benefits—or at least potentially may benefit—the individual patient himself, Verspieren argues that it would have been better if the Committee had openly recognized that medical research of no benefit to the individual patient can be justified in the interest of society, provided certain other requirements are met. Amongst these, he mentions the following: informed consent has been obtained, if not by the patient, by his guardian or attorney; the research relates to CVS rather than to some other type of condition; and, it has been approved by an independent Ethics Committee.

In another paper, Verspieren, takes issue with Richard McCormick's view that the life of a PVS patient is not really human but a form of biological life which we are under no obligation to support. He describes McCormick's position as a kind of 'individualism', typical of much American thinking. According to Verspieren, instead of considering the social situation faced by the patient, his family and the doctors and nurses caring for him, thinkers such as McCormick, concentrate on the patient alone and his failing capacities. But it is not only the poor quality of life of the patient that is at issue. Rather, on Verspieren's account, what is primarily at stake is human attitudes and how we treat one another. In his view, the central question is whether we are justified in abandoning some patients. His answer is 'No'. In particular, he insists that the fact a patient is chronically in a vegetative state does not by itself justify denying him nutrition and hydration. If, on the other hand, a CVS patient succumbs to other illnesses on top of the CVS state, Verspieren argues, we should be prudent and restrictive in the treatment of these conditions. And, whatever decisions are taken must be taken by family and carers together.

Describing CVS patients as neither dead nor dying, Marie-Louise Lamau, the Director of the Centre of Medical Ethics of the University of Lille, argues that they remain members of the human family and that to withhold hydration or nutrition or deny them any other form of medical treatment would have serious consequences for those who care for them, for their families and for society at large. Instead, these patients should be cared for in the name of familial and social solidarity, avoiding aggressive and useless treatment but providing basic care including hydration and nutrition. Even artificial or medically assisted hydration and nutrition may be perceived as symbolising solidarity—a point of view more readily appreciated, she says, in the Latin world than in the Anglo-Saxon one. Indeed, she adds, in France the risk of desertion is often smaller than that of excessive demands for treatment on the part of the family.

This is a book of compassion. It ought to be read by every Anglo-Saxon bioethicist who reads French, and not just because it provides an insight into French thinking on these issues but because it expresses a 'Weltanschauung' emphasizing certain human values, in particular, those of charity and solidarity with the most needy—values often neglected by Anglo-Saxon writers on PVS who tend to be more concerned with the intellectual capacities and the quality of life of the afflicted individual.

### **Trapianto di cuore e morte cerebrale**

Antonio Puca

Edizioni Camilliane, Turin, 1993, L.18.000

This book deals with brain death and with heart transplants, from a Christian moral perspective. Before attempting a moral evaluation of the practices described, it gives a factual account of the criteria used for diagnosing death in different countries, and of what is involved in heart transplantation.

The scientific sections of the book, though they contain more detail than some readers will want, are clearly and helpfully set out, as are some, at least, of the more philosophical sections. It is argued that the brain is the organic control centre of the human being, so that loss of brain capacity signifies death in so far as it signifies the loss of the capacity to organize oneself as a living whole. For those who believe in the soul, brain death signifies the loss of the soul's vehicle for organizing the body. The author rejects the criterion proposed by some that all brain tissue be shown to be destroyed. A brain is dead when it ceases to function, not when every cell is dead. The author also rejects the use of brainstem-based criteria for determining death in favour of whole brain criteria, on the grounds that higher and lower parts of the brain are interdependent. In any case, the use of higher brain criteria alone is not sufficient; the functions of human beings cannot be reduced to their psychological functions alone.

The author notes that even advocates of the use of higher brain criteria may be reluctant to rely on these in the case of young children. Diagnosis of death is particularly difficult in the case of anencephalic infants, who have been used as organ sources despite the fact that whole brain death had not occurred. To regard anencephalics as 'brain dead' or 'brain absent' is justifiable neither on moral nor on scientific grounds. The dignity of the anencephalic baby must be recognized by the carrying out of tests on all existing parts of the brain, backed up by cardiopulmonary tests where necessary. The author rejects as '*di natura oltremodo disgustosa*' the suggestion that the humanity of anencephalic babies should be taken to indicate no more than 'an essential sensitivity in transplantation'.

In the section on heart transplants there is some discussion of problems concerning the assessment of likely benefits for the patient (heart transplants can, for example, have adverse psychiatric effects), problems concerning the allocation of organs and funds for surgery, and those concerning consent on the part of the donor. Some would require that consent be sought from the donor and/or the relatives, while others want the donor's consent to be assumed, at least if there is no evidence to the contrary. The latter group includes some who see donation of organs as a duty and the refusal of consent as a failure in human solidarity. While the author would accept the use of organs from corpses which had been abandoned, he wants in general to retain the status of organ donation as a gift, and hence to retain the requirement that the donor and/or the relatives consent to the transfer of organs. The author sees this requirement as a safeguard against abuses, including the commercialization of organ procurement. Human solidarity is best served by the education of potential donors. The author sees as regrettable the tendency—to be seen, for example, in Recommendation 29/87 of the Council of Europe—to regard the human corpse as a '*res communitatis*': at the disposal of the public.

This book contains much of interest; however, it suffers from a certain lack of structure, due in part to excessive use of quotations. Many of the passages quoted are very long; moreover, some raise questions of their own which themselves require discussion. For example, opponents of syngamy as a market point for the origin of the embryo will be dissatisfied with the use without comment of a passage from Serra.

The conclusion of the book examines the relationship between science, anthropology and ethics. The author ends with an appeal for science to serve the good of human beings; a good identified by natural reason, and further illuminated by Christian

ethics. This appeal may or may not be well-received by secular ethicists; it should be well-received by Christians.

The Linacre Centre, London

DR. HELEN WATT

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