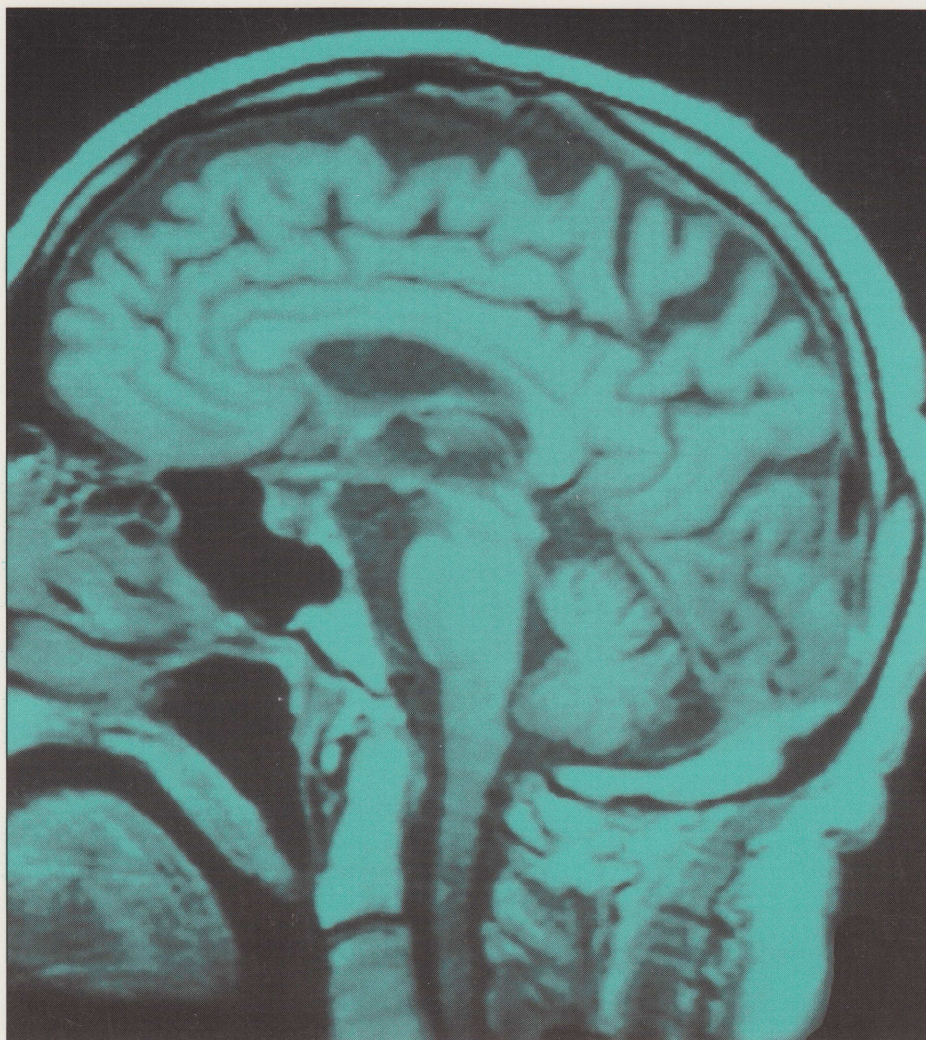


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THE UNEXAMINED TECHNOLOGY IS NOT WORTH DEVELOPING

C BEN MITCHELL, PHD

In the face of the ethical challenges before the ever-expanding litany of biotechnologies, it is important for us to remember that biotechnology is not inherently wrong. In fact, technology, generally speaking, is a human good. Humans are technologists by nature and by vocation. After all, we remain under the covenantal obligations to “Be fruitful and increase in number; fill the earth and subdue it” (Genesis 1:22). Stewardship of the created order requires some form of technology—even if it is no more sophisticated than a sharpened stick with which to plow a small furrow for planting seed. From paradise past to paradise future we can assume that technology will be with us always. What began in a garden, will end in a city.

In the mean time, however, we face a significant challenge, one which is most acute in the developing biotechnologies. Biotechnologies are not developed in a moral vacuum. Nor are they developed by amoral automatons (at least not yet). In the pursuit of a truly human future, technologies in general and biotechnologies in particular must be developed in morally responsible ways. We can no longer afford—if we ever could—the leisure of pushing the scientific envelope without at the same time exploring the ethical justification for and moral implications of any new biotechnology.

In this regard the ELSI (Ethical, Legal, and Social Implications) component of the Human Genome Project was genius. The tax dollars devoted to ELSI research arguably have been well spent. I would not want to relive the first 15 years of the Human Genome Project without the ELSI funding. Ethically myopic genetic science could be monstrous.

The good work of the President’s Bioethics Advisory Council notwithstanding, we need more funding for ELSI research, not less. We should be encouraging our elected representatives to fund an ELSI component under the auspices of the National Institute of Nanotechnology. We should have an ELSI component in the National Institute of Biotechnology. Taxpayers should be as willing to fund these projects as they are to fund the development of the technologies themselves.

One of the ancients famously said, “the unexamined life is not worth living.” The 21st century gloss on that axiom is, “the unexamined technology is not worth developing.” Technology will be with us always. As technologists, let us do our best to be certain it is morally responsible technology.

CLINICAL ETHICS CASE CONSULTATION¹

ROBERT D ORR, MD, CM

Question: Nurses in the Pediatric ICU requested an ethics consultation asking “Is it fair to this child to continue painful experimental surgical procedures?”

Robbie is a 9.5 month old boy who was somewhat small at birth, and required repeated early re-hospitalizations for pulmonary problems. He has now been hospitalized continuously since 3 months of age and has required full time ventilatory assistance during that time. He has been found to have Jeune syndrome (asphyxiating thoracic dystrophy), an autosomal recessive condition causing a very small chest cavity with diminished lung capacity. It often leads to death in infancy from respiratory failure or accompanying renal failure, but some with a lesser degree of involvement do survive. Some affected infants also have early liver dysfunction from biliary dysgenesis, but this often resolves with growth.

Because his condition was of lethal severity, his parents sought experimental options. At 6 months of age, he was transferred to another medical center several hundred miles away for surgical implantation of titanium expandable ribs on his left side, with plans to return to do the same on the right side 4 months later (about 6 weeks from now). It is anticipated that these devices will have to be adjusted (minor surgery) every 4 months, and/or replaced (major surgery) periodically until adolescence. These devices had been used in 33 patients prior to the beginning of this research study 18 months ago. Non-fatal complications developed in 11 of the 33, including breakage of the device requiring repeat surgery in 7. The current research protocol has been approved by the Institutional Review Board at the center doing the procedure, allowing enrollment of 50 subjects over a 2 year period.

This patient is currently in the Pediatric ICU, in isolation (because of colonization with antibiotic-resistant bacteria). He is on ventilator support, is fed via gastrostomy tube, and he requires frequent adjustment of sedation. He often becomes very agitated leading to a drop in oxygen saturation, requiring additional sedation and temporary augmentation of ventilation with a hand-held bag. However, he is now using less sedation than 3 weeks ago, and he can be more easily comforted by his parents and his primary nurse. He occasionally smiles and will spend quiet time looking at stuffed animals, etc. Apart from mild liver dysfunction, it appears that he is physiologically intact, but may be developmentally delayed. He has been evaluated for on-going care in a children’s rehabilitation facility, but his condition is felt to still be too unstable.

His parents are very committed to doing whatever is necessary to improve Robbie’s condition and preserve his life. They visit each evening (Dad works as a landscaper during the day and Mom does not drive). They are Roman Catholic. Robbie is their only child, but Mom is pregnant.

Assessment:

This infant has a condition which is lethal if left untreated, for which his parents have sought and consented to experimental treatment which has turned out to be quite burdensome to him.

Discussion:

Our society has mandated that handicapped newborns receive full standard treatment for life-threatening conditions except in 3 narrowly defined circumstances (“Baby Doe Regulations”). However, this mandate is not felt to extend to the use of experimental treatment.

Parents are expected to make treatment decisions for their children based on recommendations of their professional caregivers. In broad terms, they are expected to seek the patient’s best interests, but because this is not objectively definable, they are given some latitude to pursue a “reasonable construal of the patient’s best interests.” For example, professional caregivers would be expected to challenge a parental decision which is clearly not in the child’s best interests (e.g. to forgo antibiotics or blood transfusions for reversible conditions), but are encouraged to accept a parental decision which might not be their first choice but which is nonetheless within professionally accepted boundaries.

When therapeutic options include the use of experimental therapy, professional scrutiny and protection of the patient’s best interests should be even greater. While an Institutional Review Board is expected to approve only those experimental endeavors which have a reasonable likelihood of accruing benefits for some patients, the enrollment of a particular patient as a subject in a particular research study requires an individual assessment of the balance of potential benefits and burdens for that child.

In this case, the patient’s parents have chosen to enroll their son in a study for which he is qualified, and for which there is a reasonable hope of achieving sufficient benefit to prevent early death. While it appears to some of his bedside caregivers that he is experiencing significant burden, he does appear to be consolable, and there is hope that further surgery will allow him to come off the ventilator, thus decreasing his burden. The question then becomes whether months of vent support with discomfort and agitation are outweighed by a reasonable chance of long-term survival.

Recommendations:

- (1) Since there is no objective evidence that this patient’s condition cannot improve, and since the burden of his chronic care may decrease with subsequent surgery, the current plan would appear to be within a reasonable construal of his best interests.

- (2) If his condition should deteriorate, or if his parents should become convinced at some point that the burdens of his current and/or future care exceed the expected benefits, it would be ethically permissible for them to withdraw from the research protocol and pursue comfort care instead.

Follow-up:

Robbie had implantation of the experimental expandable ribs on the right side at 11 months of age. His chest condition did well, but at 15 months of age he developed progressive liver dysfunction and is not a candidate for liver transplant while still requiring ventilator support. His condition stabilized sufficiently that he was transferred to a children's rehabilitation facility on a vent at 16 months of age.

He has been transferred via air ambulance to the distant medical center every 4-6 months for adjustments to his artificial ribs. In addition, he has required re-admission to the primary medical center on several occasions for treatment of sepsis and liver failure.

At 3 and 1/2 years of age, he remains in the rehabilitation facility and is on a ventilator most of the time. His pulmonary situation has improved gradually so that he is now able to tolerate about 1 hour off the vent each day. Ascites (accumulation of fluid in the abdomen) from the liver failure has aggravated his pulmonary situation by pushing up on his diaphragm and causing further respiratory compromise. This ascites requires infusion of IV albumin twice a month. His parents remain committed to his care and improvement. They visit almost every day and bring their 2 year old daughter frequently. Robbie is interactive and appears to be content most of the time, but has begun to demonstrate breath-holding spells.

Reference

- ¹ The cases discussed in this column are based on real cases. Some demographic and clinical information has been altered to protect the privacy of patients, families, and professionals.

THE INSTITUTIONAL REVIEW BOARD: A CRITICAL REVISIT TO THE PROTECTION OF HUMAN SUBJECTS

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On May 14, 1997, President William Jefferson Clinton offered a public apology for the infamous Tuskegee Study. The 40-year U.S. Public Health Service study followed 399 African-American men with syphilis without either treatment or informed consent. During follow-up, partners were infected and subjects progressed through a spectrum of preventable complications dramatically increasing the human toll. As if he was a herald, during the same month as the President's apology, Duke University's license to conduct federally-funded research was revoked for insufficient Institutional Review Board (IRB) oversight.¹ Enrollment of research subjects at the University of Illinois, Chicago was also recently halted, allegedly because study participants were inadequately appraised of risks. Despite high profile bioethics educational programs directed at the conduct of death and dying (such as the Robert Wood Johnson Foundation Program) and curricula at multiple levels addressing subjects as diverse as cloning and euthanasia, it appears that the protection of human subjects in research has been relatively neglected. This neglect seems all the more untimely in light of the June 1998 Department of Health and Human Services Inspector General's "overarching conclusion is that the long-established system for protecting human subjects has vulnerabilities that threaten its effectiveness."²

Mere Coincidence or Dangerous Increase?

Justification for this revisit to human research subject protection begins with an essential question. Are recent IRB oversights mere coincidences, or do they in fact represent a significant increase in danger to human research subjects? In addition to Duke and the University of Illinois examples, other academic institutions, including Rush and the University of Pennsylvania, have undergone similarly motivated suspensions. On a potentially more insidious level, however, two recently published research "mishaps" should focus needed scrutiny on the ethical conduct of human research studies.

Eighteen-year-old Jesse Gelsinger—afflicted with the rare disease called ornithine transcarbamylase deficiency—died in 1999 of a severe allergic reaction, four days after experimental gene therapy.³ In response to his death, the Federal Drug Administration (FDA), citing numerous violations of research regulations, temporarily suspended all clinical trials involving human gene treatment. The FDA alleged that the researchers involved in Jesse Gelsinger's gene therapy trial did not report two prior adverse events in patients with serious reactions to the same treatment; and did not notify the FDA that two monkeys died earlier from gene therapy. Furthermore,

already agreed upon enrollment requirements for gene studies were altered and consent forms were deemed inadequate. Finally, more generally, overall standard operating procedures were suspect to the FDA. For perspective, gene therapy trials have included some 5000 patients in 350 clinical trials.

Secondly, a recent *New England Journal of Medicine* human subject study warranted substantive editorial comment aimed at ethical conduct rather than scientific merit.^{4,5} The design of the experimental study in question included 10 clusters of rural villagers in Africa (415 couples) in which one partner was HIV-1 positive and the other partner was at least initially HIV-1 negative. The research study included pregnant females. The incidence of transmitting HIV-1 infection to the seronegative partner in relation to multiple variables (including types of sexual contact, utilization of condoms, the presence of other sexually transmitted diseases) was followed for 30 months. During the study period, spousal notification of positive HIV status was optional; only five of the ten clusters were vigorously treated to reduce the prevalence of other sexually transmitted diseases; no accepted retroviral agents were used to treat HIV-positive individuals. The design and results led Dr. Angell to comment, "I believe, as I have argued elsewhere, that our ethical standards should not depend on where the research is performed . . . that would mean treating illnesses, even if they are not directly caused by the research . . . in practical terms, any other position could lead to the exploitation of people in developing countries in order to conduct research that could not be performed in the sponsoring countries."⁵ It appears that national IRB oversights are occurring concurrently with an increased laxity in research ethics in general.

The *Raison d'Être* for IRBs: A Historical Primer

Is it not ironic that a historic primer initiates this discussion in a post-modernistic age? Does a mistrust of metanarratives obviate the value of the historic genre? Such a facile disregard of history would come at great price. The disturbing similarities between "peri"-Nuremberg research and recent FDA-sanctioned behavior justify a historic review of past mistakes in the context of the present. Santayana's caveat regarding the ignorance of history and the danger of repeating it is no more prescient than when it applies to IRBs.

In the past, medicine had allowed the judgment of individual practitioners to determine the conduct of human experimentation on an ad hoc basis. Defining "past" leads to an interesting observation. Although the volume of human subject research has increased exponentially in the last two decades, protection of human subjects has been an issue for a very long time. Both Maimonides (1125-1204) and Roger Bacon (1214-1292) counseled care in any research performed on humans. But human experimentation actually began in earnest in the eighteenth century. Edward Jenner inoculated a number of humans against smallpox including his eldest son and the children of other physicians. Louis Pasteur administered a dozen inoculations to Joseph Meister, a nine-year-old bitten by a rabid dog. He survived. Finally, Claude Bernard, professor of medicine at the College of France, said . . . "The principle of morality consists in never performing on man an experiment which might be harmful to him to any extent, even though the result might be highly advantageous to science. (1865)."⁶

The ad hoc approach seemed to suffice until Nuremberg in 1947. After the Nuremberg prosecution of doctors accused of conducting immoral and gruesome experiments in Nazi concentration camps during WWII (the so-called "Doctors'

Trial”), a Code was formulated to protect human patients during any experiment.⁷ The code explicitly enumerates the responsibilities and duties of physicians to patients as subjects of human research. The following rules were unequivocally established and called the Nuremberg Code:

- 1) The voluntary consent of the human subject is absolutely essential.
- 2) The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
- 3) The experiment should be so designed and based on the results of animal experimentation and knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.
- 4) The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
- 5) No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.
- 6) The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
- 7) Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
- 8) Only scientifically qualified persons should conduct the experiment. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
- 9) During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
- 10) During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of good faith, superior skill, and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

The Nuremberg Code evolved in 1964 under the aegis of the World Medical Assembly, in Finland, when international medical leaders drafted the Declaration of Helsinki. This declaration listed a series of principles to guide physicians in research involving human subjects. However, the principles may be essentially unenforceable, leaving the criminal, civil, and ethical responsibilities to the laws of individual countries.

In the early 1970s, the U.S. Public Health Service began to promote the creation of review committees (IRBs) as a mechanism for ensuring the protection of human research subjects⁸—a natural corollary of the Declaration of Helsinki. These committees were intended to use the principles set forth in the Declaration and were to guide

decision-making in human experimentation. The following examples, however, demonstrate that experimentation repeatedly and egregiously violated the principles as set forth in both the Nuremberg Code and the Declaration of Helsinki.

The Tuskegee Syphilis Experiments

In 1932, the U.S. Department of Public Health promised 399 black men living in Macon County, Alabama, free treatment for “bad blood,” which was the common term for syphilis at that time. Although penicillin was not yet available, another treatment, arsenic, was being used with some success. However, these men never received standard treatment. In fact, the decision completely to withhold treatment was enforced, and the men were merely observed in order to compile data on the effects of spontaneous evolution of syphilis in black males.¹⁰ Informed consent was not part of the experiment.

The Harold Blauer Experiments

In December 1952, Harold Blauer was voluntarily admitted to the New York State Psychiatric Institute for the treatment of depression. While an inpatient, Mr. Blauer was given mescaline derivatives, which were supplied by the U.S. Army Chemical Corps and were offered to him as an experimental treatment for depression. He reluctantly agreed to undergo treatment at first. However, he adamantly refused subsequent injections, which were administered despite refusals. After a total of five injections, Mr. Blauer experienced a grand mal seizure, followed by cardiac arrest, and he died.¹¹

Cancer Cell Experiments

In 1963, the U.S. Public Health Service funded experimentation at the Jewish Chronic Disease Hospital, during which 22 patients were injected intradermally with exogenous cancer cells. The purpose of the experiment was to determine how long foreign cancer cells could live in a non-cancerous host compared to patients who had a diagnosis of cancer. Investigators involved in these experiments claimed that every participant gave verbal consent to participate; however, documentation of this essential fact was never provided.¹²

Hepatitis Experiments

In 1964, at the Willowbrook State Hospital in New York, children with severe mental retardation were administered hepatitis A virus, with the hope that inducing a sub-clinical infection would prevent a more severe infection in the future.¹³ In this hospital, hepatitis was widespread due to poor toileting and frequent fecal-oral contamination. The parents of these children were required to sign a consent form upon admission to the hospital. The consent form, though, implied that the children were receiving a “vaccination” and not the actual virus. It was not known whether persons administered a small amount of the virus would actually develop immunity, so that this study would represent human experimentation misrepresented to the parents in order to obtain consent.

Cincinnati Radiation Experiments

As part of a Department of the Army experiment during the 1960s and 1970s, cancer patients seeking treatment at the University of Cincinnati were exposed to whole body irradiation. The patients suffered sequelae of radiation exposure: nausea, burns, and

even death, with the understanding that they were being treated for their disease.¹⁴ The U.S. government was sued by survivors, who were awarded \$5.4 million as settlement in May 1999.

The Doctor as Whistle Blower

In 1966, Henry Beecher, a clinical researcher himself, exposed numerous abuses in human subject protection. It appeared that U.S. research during WWII and the twenty years following was jaded by multiple ethical violations. David J. Rothman called that period in American history, the “Gilded Age of Research.”¹⁵

Dr. Beecher published his “exposé” in *The Journal of the American Medical Association* and *The New England Journal of Medicine*. Twenty-two egregious violations at venerable institutions across the country, including Beecher’s own institution, Harvard, were reviewed.¹⁶ In one instance, at bronchoscopy, a needle was inserted through the bronchus into the heart. The hazards of the procedure were unknown and Rothman called the responsible investigator and the other involved researchers a “roster of dishonor.”¹⁷ The researchers involved were not mavericks, but rather, mainstream, prominent investigators from 1945-1965. Names like Eugene Braunwald, Robert Zollinger, Sheila Sherlock, and George Gabuzda were involved. One other study included in the “roster” can be evaluated solely by its title, “Fatal Homotransplanted Melanoma, a Case Report.”¹⁸

A fundamental, almost paradoxical, issue must be confronted at this juncture. Note that all these aforementioned human experiments gone awry, including a substantial portion of the Tuskegee study, were performed after the Nuremberg code. Was the Nuremberg code written for the barbarians spawned by Nazi Germany or did it transcend those atrocities and apply to all research contacts for all time?

Numerous experts, including Jay Katz and Edmund Pellegrino,^{19, 20} have observed that the judges at Nuremberg had more in mind than the singularly horrific transgressions of Nazi Germany and intended to promulgate principles that applied to all human subjects research. In fact, the Nuremberg prosecutor, Telford Taylor wrote that the tribunal embodied classic principles for all civilized societies.²¹ The period of research after Nuremberg affirms Edmund Pellegrino’s belief that moral reasoning based on defective premises tends to recur in new settings.

Another important historic document from this era was the Belmont Report (1978). It is a statement of basic ethical principles that should assist in the conduct of human subject research. More specifically it addressed: the boundaries between practice and research; basic ethical principles (e.g. justice); informed consent; and selection of subjects.

Formal guidelines now exist for contemporary IRBs when studies involve human subjects.²² Note that the basic premises mirror the Nuremberg code with appropriate updates for contemporary research techniques. These guidelines include:

- The study is being conducted according to accepted scientific principles and is based on adequately performed laboratory and animal experimentation as well as a thorough review of the applicable literature.
- The individuals conducting the research are scientifically qualified and are supervised by a clinically competent medical person.

- The importance of the objectives is in proportion to the inherent risks to the subject.
- The study reflects a concern for the individual subject over the interests of science and society.
- The risks to the subjects are minimized.
- The subject (or legally authorized representative) is adequately informed of the purpose, methods, risks, and benefits of the research activity; the right to withdraw from participation at any time without penalty; and available alternatives to participating in the research study.
- The study is designed to maximize the chance that consent by research subjects will be voluntary, without coercive influence.
- In most cases, informed consent must be documented by having the subject sign a document that explains the essential elements of informed consent.

A study published in 1998, analyzing IRB participation in the process of human experimentation revealed that, even today, up to 24% of critical care research projects published in major medical journals might not have been reviewed by IRBs. Of those studies which did report IRB approval, 20% did not explicitly state that informed consent was obtained.²³ The apparent disregard for or ignorance of ethics related to human subject experimentation led to the following educational intervention.

Educational Objectives: Settings and Design

In a majority of training programs, resident physicians may either not serve on IRBs at all or may obtain limited exposure contingent on a single research protocol. The educational objective for this effort was to design an ethics rotation for internal medicine residents to provide exposure to important ethical dilemmas occurring in the context of IRBs. The protection of human research subjects was the primary goal.

The IRB of a University-affiliated community hospital (Evanston Northwestern Healthcare) serves as the site for the rotation. The IRB convenes monthly and reviews approximately ten new protocols with another 400 ongoing protocols. The board itself is comprised of 16 physicians and researchers as well as 4 members of the lay community.

Structured education requires introduction to IRB ethics via a movie, followed by small discussion groups and finally attendance at four IRB meetings. The HBO "made for TV movie," *Miss Evers Boys*, serves as an introduction to the protection of human subjects. The movie addresses the specifics of the Tuskegee Study and is approximately 120 minutes long. It may be purchased for less than \$25. The movie engages all the ethical failures of the Tuskegee Study including the lack of informed consent, the lack of standard of care in the placebo group, and the absence of adverse event safeguards. If time does not permit viewing the entire movie, shorter segments can be utilized maintaining integrity of content. The small or large group sessions following the movie or segments thereof are structured to attain two objectives:

1. To have the learners design a drug research study maintaining scientific integrity while at the same time fulfilling all the essential criteria for human subject protection.
2. To understand eight definitions fundamental to the protection of human subjects in research.

An example of the first objective might be a drug like pimagedine. Pimagedine is a chemical agent that blocks advanced glycosylation end products (AGE). Pimagedine's development was in response to a potential "final common pathway" for the myriad complications of diabetes mellitus. The hypothesis to be tested by study would be whether the diverse complications of diabetes (retinopathy, neuropathy, nephropathy, and premature vascular disease) might all be related to the same pathologic process. AGEs are permanent structural changes in essential proteins resulting from excess glucose. AGEs could potentially be the single alteration that leads to all the disability associated with diabetes (from blindness through kidney disease).

Although pimagedine safely reversed the complications of diabetes in rats, dogs, and normal human volunteers, prospective double blind testing in humans led to unforeseen complications. Specifically, in type II diabetics, complications of the active drug led the FDA to suspend the study. However, this was done after appropriate adverse event reporting alerted the safety monitoring committee.

During the group discussions, definitions of eight terms integral to human subject protection are discussed. These include:

1. Informed consent
2. Phase I, II, and III trials
3. Randomization
4. Safety monitoring committees
5. Placebo control
6. Adverse event reporting
7. Maintenance of "standard of care" for placebo groups
8. Patient and researcher compensation (e.g., money, free drugs)
9. Periodic review
10. Advertising for subject recruitment

Informed consent is an intimate, interactive process, not a stale document. Patients as potential research subjects voluntarily choose to enter a study only after being made aware of risks, ability to withdraw at any time, possibility of placebo use, and signs or symptoms to watch for. Informed consent has to be written in "eighth grade" language. It must be obtained without coercion. It is the essential element in the fundamental ethic of Nuremberg, Helsinki, and every IRB. Any hint of researcher bias must be absent during the presentation of informed consent.

A three part clinical trial process (Phases I, II, & III) is performed in order to judge the benefit and safety profile of a new drug.²⁴ The trials may take longer than ten

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years to complete and may cost hundreds of millions of dollars. On average, trials that fail to show a benefit are more common. In the mix are thrown patients who know very little about the trial or the science involved, but they may be asked to risk their health during trial participation. Furthermore, they may be coerced into believing the only way to qualify for expensive, possibly lifesaving medications is through trial entry.

Why does medicine require this risky, expensive time consuming process? If doctors really knew a drug was beneficial (as well as free of complications), the process would be unnecessary. Therefore the terms Phase I, II, and III trials; double-blind; randomization; and placebo become critical benchmarks for IRBs.

A Phase I trial screens for safety if prior to its inception, the drug in question has been tried successfully and safely in animals. The drug is then given for the first time to paid, healthy volunteers. Initial drug doses are very low, but as they are gradually increased the potential for harm increases. Multiple samples are collected and a safe dosing regimen is determined. Ten to one hundred volunteers are used for a period of approximately 1.5 years at a cost of \$10 million.

During a Phase II trial, 50-500 patients with the disease being treated are entered for approximately 2 years at a cost of \$20 million. Phase II introduces a control group who will receive placebo in a double-blinded fashion (neither they nor the investigator know which patients get active drug or placebo). This is the time where randomization should be defined. The patients in the placebo and active drug group have to be exactly alike. If "sick" patients got the placebo, the active drug would "test" better. In a sense, randomization is like a lottery assigning patients "by chance" not by severity to a group. The process sets the experimental conditions that will allow the final phase to produce a definitive result and identify a primary end point.

Finally, Phase III trials may be as large as 300 to 30,000 patients, last 3.5 years and cost as much as \$45 million. The patients recruited are expected to benefit from the drug and statistical methods document substantive differences between the drug and placebo.

If neither the investigator nor the subject know who is on active drug or placebo, what if the drug is dangerous? A safety monitoring committee is consistently informed of adverse events. If three patients in the study have heart attacks, that may be a typical complication of their disease. What if all three are on the active drug? The "typical" complication may be due to the study drug. The honest reporting of adverse events is critical to patient safety.

The safety monitoring committee may also stop studies early for positive reasons. What if the active drug is benefiting individuals compared to the placebo? Then all should be given the active drug and the study halted.

The discussion of reimbursement is tripartite: patient, doctor, and drug. If a patient is reimbursed for study time, the amount should cover gas, meals, and transportation. Overly generous fees are coercive. Physicians however may be tempted to recruit based on reimbursement not ethics. If the drug works, study participants should be given it for free.

Another very important function of a well-run IRB is the duty to monitor the ongoing protection of human subjects by means of thoughtful and thorough periodic review of active research projects to ensure that no change has occurred in the conduct of research when compared to the original design.

Finally, all advertising related to the study must be approved by the IRB. The solicitation of subjects for recruitment has to be ethically scrutinized.

The time at IRB committee meetings will begin after the trial with the first meeting dedicated to observation. In advance of the following three sessions, the residents will be provided with copies of at least two protocols to be reviewed prior to attendance at the meetings. The residents' role and review will be to identify areas of concern related to human subject protection. The resident would then attend the meetings, participate in a discussion of protocols, and summarize conclusions in writing. At the end of the rotation, residents and the IRB director will meet to review performance in the context of each individual protocol particularly related to protection of human subjects.

Conclusion

As another millennium begins, human dignity has been under continual assault in multiple areas: through abortion, legalization of euthanasia, cloning, and transplantation ethics as well as, most recently, inadequate in research subject protection. Although efforts aimed at education have addressed most of these, research subjects seem relatively neglected. This neglect spans a period much longer than the time abortion and euthanasia have been hot topics. Since today's life saving drugs were in yesterday's research protocols, the benefits may be all-too-obvious. However, IRB function and education are essential to ensure protection to vulnerable and easily manipulated subjects. The IRB's time has come as an ethical sanctuary and can no longer be ignored.

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REVISITING REPRODUCTIVE TECHNOLOGY'S SLIPPERY SLOPE IN THE LIGHT OF THE CONCEPTS OF *IMAGO DEI*, CO-CREATION, AND STEWARDSHIP

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'And Adam knew Eve his wife; and she conceived and bare Cain, and said, I have gotten a man from the Lord' (Gn 4:1).¹

This passage together with Genesis 1:27, which states that we are created in the image of God, serve as the basis for the argument in this essay. The passage above makes it clear that the child born to Eve originated from God as well as from the union of Adam and Eve. It tells us that the child was a gift from God at the same time as he was the result of Adam 'knowing' his wife Eve. That is, the child was the fruit both of the man-woman union and of divine action, wherefore Adam and Eve jointly may be described as God's co-creators.

The subject of this essay is the moral relevance of the concepts of *imago Dei*, co-creation and stewardship for assessments of modern reproductive technologies, including cloning.² The first part of the essay begins with a discussion of the moral implications of the concept of *imago Dei* and co-creation in regard to parenthood as stewardship. It is argued that the first two concepts are linked to the third. Secondly, it is argued that, because the child is a gift from God, and because the *imago Dei* is passed on from one human generation to another, the child possesses the same human dignity as its parents and therefore should not be regarded as a human product and possession. In the second part of the paper the various reproductive technologies as well as cloning are examined in the light of the foregoing discussion.

Of course, there is already an impressive literature on the new reproductive technologies. This does not mean that the last word has been said. The technologies are steadily multiplying and forcing us to consider new possibilities. The debate must continue. The slippery slope of reproductive technology must be revisited again and again, as we seem to slide ever further down towards the ultimate commodification of human life.

In the Image of God

Stewardship

'So God created man in His own image, in the image of God created He him, male and female created He them. And God blessed them, and God said unto them, be fruitful, and multiply, and replenish the earth, and subdue it; and have dominion over the fish of the sea, and over the fowl of the air, and over every living thing that moveth upon the earth' (Gn 1: 27-28).

Only Adam and Eve are said to be created in the image of God. None of the other creatures are so described in the book of Genesis. While many commentators on the concept of *imago Dei* may have focused on those specifically human capacities such as self-consciousness and rationality in virtue of which human beings are said to be different from animals and resemble God, the focus here is on the responsibilities entailed by our likeness to God. It is noteworthy that the command to replenish³ and subdue the earth follows immediately upon the description of the human pair as created in the image of God.⁴ This is surely with the implication that it is because the pair are created in the image of God that they have been entrusted with the task and responsibility to subdue it.

Often the call to subdue the earth has been interpreted as a licence for humans to adopt an instrumentalist attitude towards the rest of creation. Aquinas, for one, argued that animals were created for man's use.⁵ Today, a similar instrumentalist attitude can be found vis-à-vis children in the context of medically assisted conception and in discussions about the utility of human cloning with a view to tissue transplantation. But the creation of man and woman in the image of God must be understood as a responsibility of stewardship over the rest of creation, including human children until they have reached maturity and are ready to assume their share of the responsibilities involved in the human stewardship. And stewardship entails a responsibility to vicariously care for those entrusted to one's care. As stewards we have a responsibility to care on behalf of God Himself for that over which we have been given dominion. Stewardship also entails representation. In other words, when Adam and Eve were told to have dominion over all the living things on earth, they were entrusted with the responsibility of bearing witness to and acting on behalf of God Himself before the rest of creation, not least before their own children.

Indeed, that human parents are to act as stewards in relation to their children—and as stewards respectful of their charges—is clearly stated in the Pauline *Letter to the Ephesians*, where we read: 'And, ye fathers, provoke not your children to wrath; but bring them up in the nurture and admonition of the Lord' (Eph 6:4). In more recent times, John Paul II and Karl Barth, who have both discussed the parent-child relationship at length, also have said—in line with a long Christian tradition going back at least to Aquinas⁶—that with biological parenting comes a responsibility to educate the offspring.⁷ Moreover, both John Paul II and Karl Barth—like St Paul—have pointed out that parental stewardship entails not only a responsibility to educate children by bearing witness to God (which for us Christians means bringing the Gospel news to our children as well as seeking to live in the spirit of the same),⁸ but it also entails a respectful attitude towards children. Thus, John Paul II says, speaking of the fourth commandment, that the respect owed to parents on the part of children implies that parents should act in such a way that they merit that honour.⁹ And Barth writes that 'the honour and obligation of parents is not to obtrude themselves as their guardians and helpers but rather to impart witness'.¹⁰

It is further to be noted that the letter to the Ephesians is speaking of the parent-child relationship in the context of married love—as does implicitly the Genesis injunction to be fruitful. For the latter must be understood as addressed to a couple joined together by God, since God gave Eve and Adam to one another and asked Adam 'to cleave unto his wife' for the two to 'be one flesh' (Gn 2: 24). It is as united in marriage, then, that man and woman have been entrusted with the stewardship of ruling over the earth.

In sum, the concept of the *imago Dei* is linked to the concepts of stewardship and divine representation, which in regard to our children entail a joint spousal responsibility to provide loving and respectful care.

Co-creation and the Child as a Gift

On the understanding of procreation as co-creation in the Biblical sense, each one of us originates both from a man-woman union and from God, and each one of us is created in the image of God. It follows on this understanding of the *imago Dei* as passed on from one human generation to another, that children and parents are equal before God. Not only must children be treated respectfully, then, by their parents and elders, but they must be treated as their equals in human dignity. They must not be regarded as human products or property.

That children must not be regarded as human products and possessions also follows from the understanding of the child as a gift from God received in human co-creation. In other words, viewed as a gift from God entrusted to our care as our neighbour, created in the image of God, the child cannot be viewed as an object that we may dispose of as we wish.¹¹ To treat children as products and properties is incompatible with that caring and respectful attitude towards the child called for by the parental vocation understood as delegated by God.

In short, as co-creators and stewards of children we must not treat them instrumentally. And therefore, the child should not come into existence as the result of actions treating him or her as a product and possession. He or she ought to be truly begotten, not made, of one being with its parents and flesh of their flesh.

Techniques of Artificial Reproduction

The term reproduction is apt enough in relation to technologies that treat nascent human life as if it were a product or commodity. If the term procreation suggests the creative involvement of God and so human co-creation, the term reproduction suggests that the child is the product of human action alone. It suggests that the child is man-made and solely the result of a human project. It is true, too, that the very fact that all techniques of artificial reproduction bypass the union in the flesh encourages the view that the child is a man-made product and solely a human project. The case is different with techniques such as repair of the fallopian tube, which allow couples to have children by normal intercourse. Thus it is significant that such techniques are not referred to as techniques of artificial reproduction or fertilisation.

In the Roman Catholic document *Donum Vitae* of 1987, issued by the Congregation for the Doctrine of the Faith, all techniques of artificial reproduction are condemned because they bypass the sexual act.¹² The reason for this is the same as the one stated against contraception in Paul VI's encyclical letter *Humanae Vitae* of 1968, namely that the unitive and procreative goods or ends of marriage must never be separated, because the connection between the two is established by God.¹³ This is with the implication that separating them constitutes a failure to procreate in the sense of co-create. However, several distinguished Catholic theologians have taken issue with the view stated in *Donum Vitae*, among them Richard McCormick and Karl Rahner.¹⁴ Those who, like them, argue against the position taken in *Donum Vitae*, say that what matters most is not whether the child is co-created in the warmth of the sexual embrace but whether it is co-created within the warmth of the spousal relationship and is the genetic child of both spouses.

One objection that may be raised against this argument which lays the emphasis on the relationship rather than on the individual act is that all techniques of assisted reproduction raise moral doubts in virtue of their manipulative nature. All techniques of assisted fertilisation are more or less manipulative and therefore encourage the view that procreation is a solely human project and the child a product, inherent in which view is a disrespectful attitude towards the child that is incompatible with true stewardship. And the more manipulative a technique is, the more it encourages a disrespectful attitude towards the child.

Artificial Insemination by Husband

The points just made about the more or less manipulative nature of the different techniques of assisted fertilisation raise the question whether artificial insemination by husband (AIH) respects the requirements of stewardship. Obviously, parents conceiving in this way fulfil their parental stewardship insofar as the child is conceived within their loving union, is their genetic child, and is brought up by them. The technique respects the view that the child should be conceived as the fruit of an exclusive, faithful, and loving relationship. Nor does it violate the requirement that the child should be of one being with its parents. But is the technique too manipulative? Does it involve treating the child as a product?

The Roman Catholic magisterium obviously takes the view that the technique is too manipulative and wrong inasmuch as it bypasses the sexual act. But the Church of England has expressed a different view. The authors of *Personal Origins*, the report of the working party on human fertilisation and embryology of the Board of Social Responsibility of the General Synod of the Church of England, argue on similar lines to McCormick and Rahner and say that what matters is that the child is conceived and brought up by parents living in a spousal union.¹⁵ Neither view is obviously unreasonable. AIH may be regarded as a borderline technique inasmuch as it involves giving nature just a little extra help.

As to the technique called GIFT, if it involves no gametal donation but simply the transfer of the gametes of husband and wife to the fallopian tube in order to enable fertilisation within the woman's body, then, arguably, it goes no more than half a step further down the slope of increasing degrees of manipulation than AIH. For in all other respects it resembles AIH. This makes it significantly less problematic than techniques involving donation, extra-corporal fertilisation or a-sexual fertilisation, the kinds of technique to which we now turn.

Techniques Involving Gametal Donation

Techniques involving gametal donation belong to a very different category than the two aforementioned techniques. In the case of gametal donation the child is not the fruit of a spousal union—or even of a couple union. Instead it is forsaken by one of its genetic parents—or even by both.

In *Personal Origins*, two different opinions are expressed about the relationship between the donor(s) and the receiving parents. According to some members of the working party who prepared the document, the spousal union is not violated by gametal donation, since no physical infidelity is involved.¹⁶ But other members of the working party, among them O'Donovan, have expressed the view that gametal donation is not compatible with the exclusiveness of marriage. To their mind, donation is an insult to the spousal relationship, precisely because the child does not spring from

the same, but comes into being through the intervention or intrusion of a third party, the donor.

Of course, no physical adultery is actually involved either in artificial insemination by donor or in egg donation—or in embryo donation, for that matter. But as commented by O'Donovan in his book *Begotten or Made*: 'Is the personal presence of the donor not itself a disruptive factor in the marriage relationship, analogous to the personal presence of an adulterous lover or a rapist?'¹⁷ The Congregation for the Doctrine of the Faith would certainly answer O'Donovan's question in the affirmative. In *Donum Vitae* techniques of medically assisted reproduction involving gametal donation are described as an insult to the spousal relationship of the parents who intend to foster the child: 'the fidelity of the spouses in the unity of marriage involves reciprocal respect of their right to become a father and a mother only through each other'.¹⁸

Both O'Donovan and the Congregation for the Doctrine of the Faith have also made the point that gametal donation constitutes a failure on the part of the donor to assume the parental responsibility of acting as a steward and representative of God. *Donum Vitae* refers to the child's need to be begotten and reared strictly within marriage for the sake of its wholesome psychological development. This is with the implication that biological begetting entails a responsibility to care for and educate the child within the relative security of the family founded on married love.¹⁹ But, of course, the child is abandoned by the donor. The donor abdicates his or her parental role as steward. And the fact that the child is forsaken by the donor implies, as observed by O'Donovan, that it is viewed as a commodity:

The notion that one might undertake to become a parent of a child in order to alienate one's parental relation to another, implicitly converts the child from a person to a commodity.²⁰

As O'Donovan says, the child created by donation is intentionally orphaned by the donor. The receiving parents take care of a child who has been abandoned by at least one of its parents. Their situation is therefore very different from that of adoptive parents. Adoptive parents also take care of an orphaned child, but they take care of a child who was not orphaned on purpose.

It also deserves emphasising that, contrary to what the term 'donation' suggests, the child received as a result of gametal donation is not received as gift, especially not as a gift from God received in co-creation. First, the donor's contribution to life, which involves a withdrawal of parental responsibility, cannot be described as generous, given his or her lack of concern for the child-to-be. Secondly, as O'Donovan points out, the child is treated as a commodity. Even if the donor is paid little or nothing, his or her transaction and that of the recipients involve an 'exchange of goods'. To treat the child as a chattel, rather than as our neighbour created in the image of God, is an insult to its human dignity.

In short, gametal donation is unacceptable from a Christian point of view for several reasons. The child is treated as a commodity and neither received as a gift within a loving parental union nor is it the object of that familial parental stewardship that it is owed by its biological parents.

Techniques Involving Extra-corporeal Fertilisation

The most often voiced argument against IVF is that it is disrespectful of embryonic human life because it exposes it to all kinds of harmful manipulation. However, this argument has failed to convince everyone. Many theologians, philosophers, and scientists have objected that the embryo is not yet a person and therefore does not need to be respected and protected as a person. Indeed, much of the debate relating to IVF has centred on the question of whether or not the embryo is a person. This question will however not be discussed here. For the present argument it is enough that the embryo is alive and biologically of human origin, since this means that it is nascent human life. That the embryo is nascent human life suffices to show both that it deserves to be respected as the *imago Dei* and that its biological parents have a parental responsibility to nurture and care for it.

However, the working party that produced *Personal Origins* was as divided on the issue of the morality of IVF as on gametal donation. Some members of the group could not support the practice because it involves destructive embryo research, but others had no problem with this.²¹ Thus some members of the group argued that since human life is a continuum, it ought to be treated as personal at all stages, whereas other members held that it is matter of judgement what human features should serve as a criterion of personhood and so as from what stage in its development the embryo merits protection.²² Both arguments hang on the question of personhood and neither argument has recourse to revelation.

But as Christians, we surely ought not to rely solely on human reasoning, which we know is fallible, but turn also to revelation for an answer to the question of how we should treat human life, be it at an early stage or approaching the end in old age. Having said this, it may be commented that if the Roman Catholic Church has sometimes prioritised philosophy and placed reason based on revelation in the shadow, John Paul II has turned the tide with his constant appeal to the Scriptures. Thus in his encyclical letter *Evangelium Vitae* he sought the answer to question of what respect we owe human life—at any stage—by recourse to the first letter of John (1 Jn 3:1-2) about our state in the resurrection. And he found that ‘the dignity of this life is linked not only to its beginning, to the fact that it comes from God, but also to its final end, to its destiny of fellowship with God in knowledge and love of Him.’²³ In other words, he found that human dignity derives both from the fact that life is a gift from God and in His image and from the fact that God has mapped out the road for the pilgrimage of human life, the destination of which is the Kingdom of God. This is important, for those who find it hard to recognise the *imago Dei* in the very first cells at the beginning of life, may nonetheless recognise the human dignity of embryonic human life in the light of its final end. For if the human embryo is destined to become (and will become, unless it succumbs to an accident or is intentionally destroyed) a mature person in the *imago Dei* meant for union with God, then it must surely already be our neighbour created in the image of God and meant for union with God. And if it is our neighbour created in the image of God, we ought clearly to treat it in a neighbourly way and protect it from harm and exploitation.

However, every IVF embryo is vulnerable to harmful exploitation. The technique normally involves the creation of more embryos than can be implanted in the maternal womb. That is to say, when IVF is used there are usually a number of spare embryos. Some of the spare embryos may be used for research. Others may be allowed to perish directly. Some may be frozen for future implantation, in which case

they may or may not survive the storing or thawing process. Indeed, the very fact that the embryo—our immature neighbour created in the image of God—is in the Petri dish exposes it to human caprice and manipulation. This is why IVF is an insult to its human dignity.

Some people object to this argument by pointing out that even in natural conception and pregnancy many embryos are lost. But this objection is irrelevant. For we have no responsibility for what is not under our control. Hence, we have no responsibility for embryonic losses due to nature. But we do have a responsibility for our own actions. Thus we do have a responsibility for how we treat human embryonic life. If our manipulations expose the human embryo to injury and death, we are morally answerable for it.

That the IVF technology is an expression of an instrumental attitude towards the child-to-be and towards nascent human life cannot be denied. It brings the embryo into being like an artefact—disposable artefact. The embryo is lucky if it passes the selection process. IVF embryos are always subjected to a selection process before implantation, even if this only means a study under microscope. The IVF embryo is never treated as our neighbour. Embryo research, in particular, epitomises the manipulative and instrumental attitude now widely adopted towards embryonic human life. And as O'Donovan has put it:

The practice of producing embryos by IVF with the intention of exploiting their special status for use in research is the clearest possible demonstration of the principle that when we start making human beings we necessarily stop loving them: that that which is made rather than begotten becomes something that we have at our disposal, not someone with whom we can engage in brotherly fellowship.²⁴

The instrumental attitude and manipulative actions exemplified by IVF cannot be reconciled with the attitude and behaviour of a steward. Stewardship entails a responsibility to care, nurture, and protect. But IVF is the intentional making of embryos in a manner that leaves them open to deliberate harm and injury. And when IVF is used in conjunction with gametal or embryo donation, nascent human life is doubly wronged. But whether or not IVF involves donation, it constitutes a failure on the part of parents and other adults involved in the creation of the new human life to act as its stewards.

Techniques Involving Embryo Donation

Exemplifying both gametal donation and IVF, embryo donation is subject to the objections raised to both kinds of technique—and the same is, of course, true in the case of egg donation. There is little more to add here other than the observation that in some exceptional cases we might consider embryo adoption justified. Exceptional, because obviously the word adoption is not appropriate when the embryo is subject to the kind of transaction involved in donation. But we might speak of embryo adoption, if women were to come forward offering to carry to term embryos who have been abandoned, such as embryos who have been stored up to the legal time limit and whose parents are not contactable for a parental decision about their fate. That is to say, in the case of abandoned embryos, vicarious parental stewardship might be envisaged as a kind of rescue operation.

Surrogacy

Surrogacy may take different forms. Often it involves artificial insemination by the male party of a commissioning couple. It may also involve embryo transfer (to the surrogate mother) using a commissioning couple's embryo. The technique is therefore similar to gametal and embryo donation and so subject to the same objections as these technologies. In the case of egg or embryo donation it is also subject to the objections that have been raised against IVF. Thus the technique raises questions about the obligation of stewardship. If artificial insemination is used and the child carried by the surrogate is her own genetic child, then she fails to assume her parental responsibility and stewardship in handing over the child to the commissioning couple. Indeed, the same is true in the case of embryo transfer inasmuch as the surrogate, as gestational mother, is a biological mother of the child, even if she is not its genetic mother.

Moreover, surrogacy is not only an insult to the child as our equal and neighbour in the image of God but also to the surrogate. It avails of the surrogate, as if she were no more than a hired prenatal incubator. In short, whatever the kind of surrogacy arrangement, the technique is an offence to human dignity and a failure to exercise respectful stewardship inasmuch as it involves a transaction that means treating both the surrogate and the child as commodities.

Non-sexual Fertilisation

Not the fruit of a loving man-woman union, not even the fruit of the fusion of male and female gametes, an embryo created by means of cloning (cell nuclear replacement) is not only the result of human manipulation but the result of tricking nature. In regard to cloning the following words of C. S. Lewis certainly ring true: 'man's power over nature turn out to be a power exercised by some men over other men with Nature as its instrument'.²⁵ Among all the techniques of artificial fertilisation, cloning—be it with a view to the creation of child or the creation of an embryo for the sake of harvesting its stem cells—must rate highest on the scale of increasing degrees of manipulation and commodification of the child.

Indeed, no treatment could be more disrespectful of the human embryo than so-called therapeutic cloning, that is, the creation and destruction of an embryo for the sake of cannibalising its stem cells in the hope of finding cures for certain diseases affecting adults. Reproductive cloning, that is, cloning with a view to the creation of a child, has been widely condemned, while calls for legal sanction of therapeutic cloning are coming from many directions. Yet it is the creation of an embryo in order to destroy it that represents the greatest failure to recognise humanity in the embryo and to exercise stewardship vis-à-vis nascent human life. The embryo created only to be destroyed for our use is treated as a consumable. It is devoured to sustain its elders. Again the words of Lewis are applicable. He writes: 'for magic and for applied science alike the problem is how to subdue reality to the wishes of men; the solution is a technique; and both, in the practice of this technique, are ready to do things hitherto regarded as disgusting'.²⁶

The situation is not much better in regard to the embryo created by cloning in the hope that it may grow into a mature human being. Obviously all the objections raised above to extra-corporeal fertilisation apply to any embryo created by cloning. But there are other additional objections.

First, as a way of reproducing, cloning is unlike any that has gone before it. The technique is more manipulative than any other technique of artificial reproduction hitherto invented. Cloning is a kind of budding artificially induced by human manipulation. From a genealogical point of view this means that an embryo created by cloning is a twin of the person who donated the cell nucleus for the procedure. Genealogically, the embryo belongs to the same generation as the person whose cell nucleus was used to create it, and its genetic parents are the parents of its twin. This in itself may not be too bad, after all twinning occurs naturally. But there is a significant difference between natural twinning and that brought about by cloning. In sexual reproduction there is always novelty and variation from one generation to another. In reproductive cloning the 'offspring' is produced as a copy of another individual.

It is precisely to the fact that in reproductive cloning the 'offspring' is a copy that most people take objection. This is either because it seems to detract from the individuality of the clone or because it means that the clone is totally subject to human design, since its genetic constitution is known and determined in advance by its makers. These objections may be rephrased in more explicitly theological terms. That is to say, the clone fabricated in the image of another person and thus made to measure is not received as a unique gift to be cherished as such.

Compared with other reproductive technologies hitherto developed, reproductive cloning is the ultimate commodification of the child, and so the ultimate insult to its human dignity as our neighbour in the image of God.

Should other techniques of non-sexual fertilisation resulting in embryonic human life with an inherent potential to develop into a mature human being be developed, similar objections as those raised to cloning—reproductive or not—must be raised to them.

Conclusion

Having revisited the field of reproductive technology, we have found it a slippery slope that has brought us ever closer towards the ultimate commodification of nascent human life. Increasingly, what God joined together at the beginning has been separated. With reproductive technology it is not only possible to separate the individual sexual act and the conjugal (or couple) relationship from procreation, it is also possible to remove the process of fertilisation from its natural environment, the maternal body. It is possible to create embryos outside the body and babies using gametes from strangers. It is possible to separate gestational motherhood from genetic motherhood. Our final feat is totally to separate human procreation from fertilisation.

But in the pursuit of adult quests for a child at any price and for embryonic human life for pure consumer purposes, the covenant of procreative stewardship has been broken.

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¹ All Biblical quotations are from the King James Version of the Bible.

² Cf. Brent Waters, *Reproductive Technology: Towards a Theology of Procreative Stewardship*. Darton · Longman + Todd, London 2001. Waters discusses the various reproductive technologies at length in the light of the concept of procreative stewardship. Several of his conclusions diverge from those presented here. Notably, in his view, IVF is compatible with the concept of procreative stewardship. That is not the conclusion reached here.

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- ³ It has been argued at length by Karl Barth, with Paul's first letter to the Corinthians in mind, that 'the necessity to procreate imposed by the history of salvation prior to the appearance of the Messiah has now fallen away'. See *Church Dogmatics* (CD, III, 4, p. 143). But this kind of reflection need not concern us here.
- ⁴ Cf. Scott Bader-Saye, 'Imagining God through Peace with Animals: An Election for Blessing', *Studies in Christian Ethics*, vol. 14, no. 2, p. 2. Bader-Saye here points to this (con)textual link between the concept of the *imago Dei* and that of stewardship.
- ⁵ See St Thomas Aquinas, *Summa contra Gentiles*, III, 2. See also Scott Bader-Saye, *Op. cit.*, p. 3, where Bader-Saye notes that St Augustine, St Thomas Aquinas as well as Calvin took an instrumentalist view of animals, arguing that they were created for human use.
- ⁶ Cf. St Thomas Aquinas, *Summa contra Gentiles*, IV, 58.
- ⁷ Cf. Karl Barth, CD, III, 4, pp. 278-285; John Paul II, Apostolic Exhortation *Familiaris Consortio*, paras 25 and 36-41, and *Letter to Families*, para. 16.
- ⁸ Cf. Karl Barth, CD, III, 4, pp. 282-283; and also John Paul II, (FC), 36-41 and (LF) paras 15-16.
- ⁹ Cf. *Letter to Families*, para. 15.
- ¹⁰ Cf. Barth, CD, III, 4, p. 279.
- ¹¹ These points have been made very powerfully by Oliver O'Donovan in *Begotten Not Made*, Oxford 1984. See especially chapter 4, entitled 'And Who Is a Person?'
- ¹² Congregation for the Doctrine of the Faith, *Donum Vitae*, CTS, London, 1987, part 2, paras 4-6.
- ¹³ Paul VI, Encyclical Letter, *Humanae Vitae*, CTS, London 1968, para. 12.
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- ²⁰ O'Donovan, *Op. cit.*, p. 37.
- ²¹ Board of Social Responsibility, *Op.cit.*, para. 118.
- ²² Board of Social Responsibility, para. 133.
- ²³ John Paul II, Encyclical Letter, *Evangelium Vitae*, Libreria Editrice Vaticana, Vatican City, 1985, para. 38.
- ²⁴ O'Donovan, *Op. cit.*, p. 65.
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WHY NOT GIVE HIPPOCRATES A PLACE AT THE TABLE?

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There are four methods of doing bioethics in the United States today: deductivism, principlism, casuistry, and feminism.¹ The word Hippocratic is not mentioned, and the Hippocratic approach to medical ethics has been neglected. But does it have value, and if so, why not allow Hippocrates (c430 BC - c377 BC) a place at the table? The purpose of this essay is to 1) describe the prejudice against the Hippocratic tradition, 2) note the value of the Hippocratic ethic, and 2) suggest a place in contemporary bioethics where Hippocrates may be friend rather than foe.

Before we proceed further we will define Bioethics and the Hippocratic tradition.

Bioethics is characterized by the need for a civil ethic, or an ethic of a consensual reformulation of rights and obligations in the context of medical practice and health care.²

The *Hippocratic tradition* is a virtue based ethic that emphasizes personal competence and probity as well as a personal relation with the patient characterized by beneficence, non-maleficence and confidentiality.³

The fundamental difference must be noted. Bioethics is a civil ethic that is a normative relationship between social units such as physicians, the public, the government, third party payers, and professional ethicists. Medical ethics is a moral relationship between a physician and a patient, and may be extended to other health care providers such as nurses, psychologists, pharmacists, and many others. We will use the term medical ethics interchangeably with the Hippocratic tradition since the former encompasses the latter.

I. The Prejudice Against Hippocrates

Bioethics was officially born in 1971 when Potter popularized the term with his book *Bioethics: Bridge to the Future*.⁴ For some 2,300 years before that the regnant medical ethics was the Hippocratic tradition. The Hippocratic Oath had been the medical ethical standard in the western world, and has also influenced Moslem and Indian medicine.⁵ It has stood the test of time, and its moral dictums of beneficence, non-maleficence, and confidentiality have been above reproach, but it has been criticized as emphasizing professional etiquette and protecting the economic interests of physicians.⁶

Cultural changes, which begun during the Enlightenment Project, resulted in the 1960s concerns regarding several social issues. Two of these were a greater emphasis on personal autonomy and a moral concern about research crimes as exemplified by the disclosures of the Nuremberg Trials. Health care was particularly influenced by these two concerns. Autonomy was demanded in the areas of contraception and abortion, and public accountability was sought in the field of human experimentation. Additional variables impacting medicine included excessive subspecialization, the intrusion of technology, and the dominance of third party payers.

Concurrent with these concerns, and perhaps because of them, was a reaction against the distortions of the Hippocratic tradition by the arrogant and smug physicians who abused it. Much of the criticism was deserved, but some of the backlash may have been an over-reaction on the part of theologians and ethical philosophers who saw these issues as a means to promote a broader agenda.

The Hippocratic Oath has been variously criticized as being “pre-technical,”⁷ Simplistic,⁸ paternalistic,⁹ and irrelevant.¹⁰ However, the most vocal deconstruction of the traditional medical ethic probably came from Joseph Fletcher¹¹ and Robert Veatch.¹²

Fletcher, a theologian energized by the Vietnam War protests and civil rights marches, fought for patient autonomy and against physician paternalism. While promoting contraception, abortion, and euthanasia, he was not so much challenging Hippocrates as the Judeo-Christian moral tradition.

Veatch has been a more persistent critic, who considered Hippocratic physicians minor players in Greek medicine who were influenced by deviant Pythagorean beliefs and had little influence over early medical thought. Veatch has also suggested that the Hippocratic tradition did not influence Christian medical ethics and was incompatible with it.¹³

In spite of the bad press the Hippocratic medical ethical tradition has received we will argue that it still best serves a persistent human need.

II. Value of the Hippocratic Tradition

To appreciate the Hippocratic tradition one must understand the need it served for 2,300 years and ask the question “has the human condition changed?” The human person is inevitably heir to disease and suffering. The physician with his knowledge and empathy is able to mitigate this condition.

The Enlightenment Project, or the belief that science could solve all human problems, had hoped to eliminate disease and suffering, but even with our knowledge of the human genome these will always be with us. Restructuring health care delivery has not eliminated disease and suffering. These aspects of the human condition endure.

Because the physician understands disease pathophysiology and empathizes with the suffering patient, he may well be best able to mediate between the sick and distressed human person and his disease. This is best summarized by Leon Kass:

The physician, who is the knower of health and the numerous forms of its absence, who seeks to assist the healing power in the human body, also must tend particular, necessitous human beings who, in addition to their symptoms suffer from self concern and often fear and shame—about weakness esteem, and the fragility of all that matters to them.¹⁴

Assuming technical competence and probity of life on the part of the physician, it is this empathy, indeed love (in the Greek sense of *agape*), that should characterize his relation with the patient.

Far from removing the need for this medical ethic, the pervasiveness of science and technology requires it all the more.¹⁵ The rise of autonomy likewise does not

diminish the need for the Hippocratic medical ethic. Indeed the patient should not be free to choose impetuously, but rather to be informed appropriately, and then choose what is best.

How can this traditional ethic return to respectability in the era of bioethics? All in all, medical ethics, as heir to the Hippocratic tradition, is not much mentioned in the age of bioethics. This is unfortunate because human disease and suffering are as inevitable as the depression and anxieties that accompany them, and the contemporary emphasis on autonomy in the clinical relationship should in no way necessitate diminishing or eliminating the Hippocratic virtues. Indeed Pellegrino has reaffirmed the place of autonomy within beneficence in his concept of "beneficence-in-trust" in an effort to reemphasize the traditional and self-evident value of patient choice that resides implicitly in beneficence.¹⁶

If the Hippocratic medical ethic fulfills a universal human need where does it fit in the new world of bioethics?

III. Making Room for Hippocrates

Principlism¹⁷ is the regnant bioethical method in use today. It epitomizes the rationale for the rise of bioethics.¹⁸ As mentioned in the definition, bioethics fulfills the need for a civil ethic as a consensual reformation of rights and obligations.

Beauchamp and Childress enumerated the principles that define Principlism as 1) autonomy, 2) non-maleficence, 3) beneficence, and 4) justice. It is of interest to note that the Hippocratic medical ethical principles are 1) beneficence, 2) non-maleficence, and 3) confidentiality.¹⁹ Far from being in significant conflict, there would appear to be a significant convergence between these two traditions.

The point of difference would appear to be in the area of autonomy, felt to be primary in bioethics, whereas paternalism ruled in the Hippocratic tradition. While a paternalistic approach is neither always bad nor easy to eliminate, it is obvious that autonomy is here to stay. Even the Second Vatican Council acknowledged the primacy of individual conscience and choice in its document *Dignitatis Humanae*.²⁰ Pellegrino²¹ in his exposition of the Hippocratic Oath has explicated beneficence to include "beneficence-in-trust." This concept properly centers patient autonomy in the patient's desire to accept appropriate clinical management.

Given the similarities of the principles of principlism and the Hippocratic ethic and Pellegrino's integration of autonomy, it would appear that there is more compatibility than difference between the two ethics.

Callahan²² notes several areas to which bioethical methods can be applied: 1) theoretical, 2) regulatory or policy, 3) cultural, and 4) clinical. The Hippocratic medical ethic is self-evidently clinical. There would seem to be no good reason why the Hippocratic medical ethics could not be added to the four ethical methods mentioned in the opening sentence.

Summary

Bioethics and principlism define modern health care ethics. However, the Hippocratic ethic will not go away. It fulfills a human need in as much as it reflects a personal ethical relationship between a patient and his physician. Bioethics is more social and impersonal. Allowing for "beneficence-in-trust," Hippocrates is not old fashioned, but

is particularly contemporary. If so, why should Hippocrates not be allowed a seat at the table?

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VIEWS OF HUMANITY AND NURSING PRACTICE: AN ANALYSIS OF NURSING

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Introduction

The purpose of this essay is to address some of the issues in practice which arise for nurses as a consequence of their view of humanity and the model of nursing which they use, either consciously or unconsciously. The current development of models and theories of nursing present a wide range of philosophical assumptions from which models for nursing can be understood. The normally accepted paradigm of nurse, health, society, and person, although presenting a common domain of concepts for nursing, does not offer a common set of assumptions on which the understanding of these elements can be agreed. The nature and characteristics of the person and their relationship with society health and practice as identified in any model or theory will determine the response of the nurse and the focus of practice.

Within this essay three approaches to nursing are compared and the differences between them are highlighted. The analysis shows the differing views of humanity held by each view and provides contrasting domain concepts for the context of care. The essay illustrates the Christian view of humanity in Diaconal nursing emphasising the context of healing through relationships and responsibility focusing on human worth. The natural approach to humanity illustrated through historical medical nursing which is concerned with a context of repairing with a focus on disease, disease prevention, and curing, while the humanistic view of humanity described in the SAUC model for confirming nursing which points out the context of strengthening of the human being's self and self-relation and focusing on human development and growth. Human dignity in these three examples is respectively recognised through the value placed on relationships and to God, on statistical normality at the cell and organ level, and on individual potential to achieve dignity through the ability to rise above individual circumstances.

Views of Humanity

Professional nursing has developed from a Judaeo-Christian understanding of humanity and personhood and from Western thought expressed through the medical model (Bradshaw 1994). Following the Reformation, medicine developed largely within a philosophical framework, which saw technology, science, and modernisation as the dominant truths. The goal of medicine became the eradication of illness and disability through the effective utilisation of human knowledge. These values owe much to Hellenistic dualistic thinking, enlightenment rationalism, and empiricism (Schaeffer 1990). Theories of body are many. The medical model presents a functional view of the body within the context of community. It is seen as a health hazard to be repre-

sented in epidemiological terms. Social and political theories have largely ignored the body placing their emphasis more on social structures than on concepts of humanity. The suggestion is that this is because scholars in humanities and social sciences wish to avoid biological determinism and the medical model. The humanistic view of humanity takes into account the unique human being's subjective experiences, opinions, and experiential meaning of life situations (Taylor 1978). Humanistic models of nursing are described in the context of holism and interpersonal relationships. They thus view nursing as both an art and a science (Marriner-Tomey 1994).

A Christian View of Humanity Humankind as Primarily Spiritual Being

The Christian sees man as primarily a spiritual being (Sherlock 1996). There is a spiritual dimension to man's nature, which focuses the ultimate purpose of his existence towards a re-establishment of his relationship with God and so a state of wholeness with God as Creator and person. But this does not suggest that there is a separation between the body and the soul, rather man is identified as a psycho physical being, and psychical functions are bound closely to the physical nature. Man does not have a body, he is a body. The body is the soul in outward form.

Spirituality is thus something that cannot be separated from the whole person. Christian spirituality is 'whole person' spirituality. Christian spirituality embraces the world in all its fullness that includes suffering and pain as well as joy (Ryle 1979). The key element within any Christian concept of humanity is the recognition that man is made in the image of God. Being made in the image of God means that each person is a unique being (Sherlock 1996). Worth cannot be attributed to social status, gender, race, or colour. The unique significance about each person is his or her individuality. That individuality is framed within personal dignity and value. Human dignity is central to a Christian understanding of mankind, and the value of human life is in relation to the contribution that it makes to society. Human beings gain their dignity and value in and through God's willingness to enter into a relationship with them (Harries 1994). A significant part of the task of nurses is to enable people to actualise the image of God within themselves. That is, create the context or space where healing relationships can be built up and an individual can begin to experience themselves as truly human, loved and cared for by God and those who seek to image him.

Health and Suffering in a Christian View

Central to Christian thought on humanity within the context of health is the doctrine of original sin. Illness is sometimes equated with suffering and as a direct consequence of the sin of the individual. This view is contrary to the traditional and fundamental belief of Christians which upholds the view that suffering is not a direct penalty for individual wrongdoing, but it is a consequence of man's fall from grace (Ryle 1979). The belief that human beings are separated from God and that suffering is a common human experience has important implications for the ways in which people deal with their illness experience and the meanings that they place on it. The doctrine of original sin is essentially a relational concept. It was Adam's broken relationship with God that set in motion the process of relational reconnection of the human race with God and with one another. If this is so then Christian nursing seeks to image Christ in his mission to the world and find its focus in relational reconnection in all its forms.

The Christian response to suffering is not condemnation but compassion. Compassion and care lie at the heart of the human enterprise. As one cares one expresses who and what one is, and as one receives care, one is confirmed as a human person, worthy of the attentions of another. Relationships which reflect the image of God are thus seen to be fundamentally caring relationships. Care is thus seen to be central to a biblical theology. If this is so then the vocation of nursing with its focus on caring and enabling caring is by nature a deeply theological enterprise.

Values Made Relevant Within the Context of the Individual in the Community

The values which are inherent within a Christian paradigm of nursing are those which incorporate notions of justice as a means to ensure equality and tolerance. Love and compassion are recognised as both an attitude and behaviour. Self-respect results when we recognise that each person is made in the image of God, including ourselves. We also acknowledge that humans cannot live to satisfy their own individual or personal aims but are part of an interdependent community (Sherlock 1996).

An additional key value within Christian nursing is that of responsibility. Cusveller (1998) suggests that the wellbeing of patients is a moral concern because they are created in the image of God and fostering it is a moral practice. If this is so professional responsibility becomes a moral responsibility which is demonstrated by professional nurses whether they confess Christianity or not. In contrast Bradshaw (1994) points out that nursing care will change significantly when the ethos by which nursing has always been inspired, the ethical inspiration of the Christian gospel, is ignored in nursing theory and practice. Shelley and Miller (1997) see issues of responsibility arising out of a biblical concept of health focusing on restoration of a relationship with God as fundamental. A disrupted community represents ill health while healing involves its restoration.

A Christian Paradigm for Nursing/Diaconal Nursing

Marie Cederschiöld, a nurse and deaconess in Sweden, attended Kaiserswerth, Germany, in 1850 at the same time as Florence Nightingale. Cederschiöld started the first deaconite nursing education programme in Ersta Diaconal Society in Sweden in 1851 based on Christian ideals and values (Donahau 1985). The key concepts used to define the Diaconal nursing model are those of the triune God as creator of the unique spiritual person whose individuality is expressed with dignity and value through a relational community (Elmund 1973, Iversson 1988). The Diaconal nursing model emphasises that ultimate recovery is based on an unbroken relationship to God (Donahau 1985).

Key statutes held by the movements are:

- (1) *Missionaire nursing*. Imaging Christ by visiting the poor and caring for the sick.
- (2) *Spiritual nursing*. Providing the Bible and Christian literature, regular hours for devotion and worships with patients, and intercessions for patients.
- (3) *Person centered nursing*. Treating as individuals. Understanding the patient's experience of ill health from his or her point of view. Recognising the value of individuals and what they have to offer.

- (4) *Bodily nursing*. Respecting human dignity because the individual is of the Father and belongs to the Father.
- (5) *Interdependent community nursing*. Nursing practice based on a recognition form of interdependence in relationships and on “human meeting places” where both parties feel equal as human beings with self-respect.

For the Christian the main implication of using this approach is that the method of nursing is not the primary consideration. The primary focus is the importance of creating an environment that allows relationships to be mended and healed. This emphasis allows nurses to adopt a variety of approaches towards the delivery of care and accept a number of systems of care management. Community care is a central focus for the Christian paradigm and the community becomes a primary consideration when planning any care. Community models will be reinforced and collaborative teamwork by health care providers will be fundamental to the delivery of care (Parfitt 1998).

A Natural View of Humanity

The Human Being as Primarily a Biological Being

A natural view of humanity considers the human as a biological being. Biological normality and abnormality are described in functional, statistical, and epidemiological terms, with a focus on regularity, law, and generalisation. The two goals of medicine that are common to all organisms are survival and reproduction (Boorse 1981). The real threat to biological beings is disease, which gives disturbances at an organ level and prevents or interferes with the organ's normal contribution to achieving the desirable goals (Gustafsson 1996). Human dignity may therefore in a natural view be understood as the optimal functioning of the organs without abnormalities and pathologies. Diseases, in such reasoning, may be interpreted as defects that influence the integrity of the person and his or her dignity as a human being.

Health in a Disease-Oriented Perspective

In the natural view of human being described above health is identified as the absence of diseases (WHO 1978) while diseases, injuries, and defects are identified as abnormal. This disease-based health conception is a negative concept using bio-statistical theory to define the levels of normality. The bio-statistical health – disease continuum thus determines the degree of personal health of the individual. Pörn (1988) points out that in this kind of conception of health it is impossible to understand that a person may have ill health without organic disease or good health in spite of living with a chronic disease. The disease has the primary focus and is the key component in thinking of health. Medical knowledge is concentrated on the development of new methods for the examination and treatment of disease. Because health is defined in relation to disease, disease prevention, protection, curing, and repairing is central.

Values Identified Within the Context of the Human Being Related to Disease

The traditional medical approach previously described has survival and reproduction based on statistical normality as the overall values. These values are central to the core knowledge of medicine and directed toward facilitating treatment and prevention of diseases in the body (Gustafsson 1996; Wulff, Pedersen, and Rosengren 1990). Care is seen as nomothetic, or legalistic, limited by its need to be evidenced based through

quantitative data (Boorse 1981).

Four prioritising goals for medicine are indicated as follows: (a) the prevention of disease and injury and the promotion and maintenance of health; (b) the relief of pain and suffering caused by maladies; (c) the care and cure of those with a malady, and the care of those who cannot be cured; and (d) the avoidance of premature death and the pursuit of a peaceful death. These have a number of shortcomings with consequences at a personal level. Primarily that the individual is forgotten and ceases to have value. The philosopher Toombs, who lived with multiple sclerosis (Toombs 1993), suggests that 'curing is a function limited to disease while healing goes beyond disease to the person'.

The Historical Medical Model for Nursing

Florence Nightingale is regarded as the founder of modern professional nursing. She learned her nursing skills, like Cederschiöld, at Kaiserswerth in Germany. Her nursing experience and her fame are especially linked to the Crimean War, diseases, surgical nursing, and the unsanitary conditions she tackled (Nightingale 1914). She started the Nightingale Training School for Nurses in 1860 (Donahau 1985). The students were called "Lady Nurses" and many later became important nursing leaders. She reinforced the historical medical model believing in the order of diagnosis and treatment as the focus of care but, in addition, she emphasised the environmental context in which a person is cared for as integral to its effective delivery. The key principle of her approach was that nature alone cures and heals the wound while surgical care removes the obstructions for nature to heal. This nursing model focused mainly on environmental control in order to prevent or suppress disease, damage, or death. The protection of the patient against emotional stress was also important. The role of nursing was to prevent the reparative process from being interrupted and to provide optimal conditions for its enhancement (Marriner-Tomey and Alligood 1998). Nightingale (1914) provided some general rules or guidelines for nursing covering different nursing areas as follows:

- (1) *Sanitary nursing*. A focus on the everyday management and manipulation of specific environmental conditions.
- (2) *Medical nursing*. Nursing care with an organ and symptom focus.
- (3) *Caring nursing*. This incorporated the handicraft of nursing that is closely involved in the observation of the sick.
- (4) *Advocated nursing*. The need for being "a devoted nurse" and a "confidential nurse". Nurses acting as moral agents not only receiving and holding confidences but also advocating on behalf of the poor for improvements in their health and living conditions.
- (5) *Observational nursing*. Daily observations of health status, measuring changes in the condition of the sick patient or the patient in convalescence.
- (6) *Public health nursing*. Concerned with the health of families at home. Bed and bedding, cleanliness of rooms and walls. Personal cleanliness was also important emphasising purity of body and mind, clean minds, clean bodies, and clean skins. Orderliness, time management and planning, pure, gentle, and firm instruction were also part of the overall approach.

Nightingale (1914) stressed that education and the development of a sound knowledge base were needed for practical nursing. She emphasised that nursing demands much more than a loving heart, it requires a good educational preparation.

Within the historical medical approach the primary focus of consideration is the management and control of disease and ill health within society and the importance of promoting order and maintaining an environment that resists disease. A key risk of this approach is that the person behind the statistics is forgotten and the total context for care delivery is ignored.

The Humanistic View of Humanity The Individual/Person Perspective of Human Being

Humanism focuses on the human dignity and creative powers of human beings, and a humanistic understanding of humanity emphasises the importance of the individual (Hume 1993). The heart of human tradition starts from the human being's existence, the human experience, and human relationships. The centrality is the individuals' own potentiality to achieve dignity, to strive for goodness or greatness, and to struggle for living up to what the individual is capable of (Skorupski 1997).

In Bullock (1985) Mill describes how humanism involves the human experience including the self-confidence, endurance, nobility, love, intelligence, sympathy, and courage to rise oneself from the sense of human incompetence.

Bullock (1985) describes three characteristics of the new modern humanism. Firstly, by contrasting the theological views of man as part of a divine order, as part of the scientific or natural order, and as part of the human experience. Secondly, he claims that humanism enforces the dignity of human beings in that every individual has a self value. This respect for human dignity is the real ground for human rights and for the latent powers of human beings in terms of creation, communication, and power to observe themselves, i.e., self-consciousness and self-reflection. Thirdly, he states that humanism points out on one hand the importance of ideas, and that ideas only can be formed or understood in their social and historical context, while on the other hand the tradition stresses that human beings never can be reduced to the rationalism of individual economic or class interests, or of sexual or other instinctual drives.

Health in an Individual/Person-Oriented Perspective

There are a wide range of theories and models which have different interpretations of the human being within humanistic tradition. Humanistic assumptions concerning individuals' health and wellness are described differently (Barnitt and Mayers 1993, Byrnes 1986). In general terms ultimate health is described as the individual's capacity for self-actualisation or self-fulfilment supporting a full and active life. Health is seen as the ability of individuals to fulfil their own basic human needs and to attain goals set by themselves (Nordenfelt 1987). Health equilibrium is obtained through the demands on individuals. Goals need to match their abilities in the different circumstances of the internal and external environment (Pörn 1993). Health is linked to the individual's ability to create his or her own life-goals, and reflect over this creation (Jacobs 1989).

Values Identified Within the Context of the Individual/Person in Creating One's Own Life

The humanist tradition refuses to accept a determinist or a reductionist view of human beings and focuses on inner development and freedom to make individual choices (Bullock 1985). Humanistic understandings of humanity emphasise the importance of the individual. Mill in Skorupski (1997) observed the value of relationships commenting that 'humans require sympathizing support' and that they are 'objects of admiration and reverence and need to pay (not just shall pay) attention of others' opinions'. Friedman (1995) has a similar view, reflecting on the permission or confirmation or the 'Yes, which allows him to be and which can come to him . . . from one person to another'. Buber (1957) points out that every human being is existing singularly in his situation and that there is struggle and strife for survival and becoming, for confirmation of human existence and understanding the meaning of life. The existential experience infers human awareness of self and otherness.

The SAUC Model for Confirming Nursing

The Gustafsson and Pörn action-theoretic nursing construction 'The SAUC model for confirming nursing' is developed in a humanistic tradition (Gustafsson and Pörn 1994; Gustafsson 1997, 2000). Within the SAUC model nursing is understood as care which focuses on individuals at the person level, spelled out in the term of acting subject, who is engaged in goal-directed actions and has a self-relation (Pörn 1981, 1988). The goals in the life-plan, abilities, and repertoire and the circumstances in the internal and external environment determine the goal-directed actions and self-relation. These three components constitute the wholeness of the individual, and if one of the components changes, the other will be affected (Pörn 1993). This unique state of adequacy and health are the consequence of the integrated approach and the relation between these three components. The available resources or lack of resources in the life-plan, repertoire, and environment enable or restrict the individual's possibilities for a good and fulfilled life.

The underlying philosophical system is system theory and existential philosophy with the central values of individual autonomy, freedom, and responsibility. Individuals have human powers for self-reflection, self-determination, and self-realisation (Gustafsson and Andersson 2001a, 2001b). The SAUC model demonstrates a systematic, confirmatory approach to self-relation support by strengthening the patient's positive or weakened negative self-assessment. A strengthened positive self-assessment, the internal environment, has positive consequences for the individual; it promotes the will and capacity to act. If will and courage are increased, individuals may be able to realise their goals in a life-plan; if that succeeds it strengthens the repertoire.

The SAUC model has a specific focus on support of the patient's internal environment and is a theory for practice. It identifies how to practice confirming nursing. The goal of nursing is to strengthen life-competence. For example, the challenging tasks accepted with strengthened self-assessment may result in the acquisition of qualified abilities to understand and manage the life-situation in a better way.

The SAUC model is described in four dynamic phases: S->A->U->C with specific goals and outcomes in the different SAUC-phases.

- (1) *S-phase*. Sympathy-expressing nursing has a goal to strengthen the patient's emotions of security and confidence by a "shared world" with nurses. The confirmation process in S-phase is aimed at strengthening the patient's self-assessment and his or her motivation and engagement in his or her own health process (or dying process) by involving each in the nursing.
- (2) *A-phase*. The goal of the acceptance-establishing nursing phase is to strengthen the patient's attitudes of openness and freedom by creating an "allowing climate". The confirmation process in A-phase is aimed to strengthen self-determination, autonomy, and responsibility.
- (3) *U-phase*. The goal of the understanding-acquiring nursing is to strengthen the patient's capacity to validate his or her own situation through individualised nursing by encouraging each to understand the meaning of his or her own life-situation. The confirmation process in the U-phase is aimed at strengthening self-integration and self-understanding, that is the patient's experiences of his or her own uniqueness and specialness as human beings.
- (4) *C-phase*. The goal of competence-manifesting nursing is to strengthen the patients ability to use his or her "own resources and potentiality" in ones life-plan, repertoire, and environment. The confirmation process in C-phase is aimed at strengthening self-realisation and self-reflection through a subject-subject relation and promoting trust in the individual's ability to develop and grow through his or her own resources. The SAUC model provides an opportunity for focusing on the self and on the potentialities as human being.

Discussion

Table 1 sets out the key components of each of the three views described in this essay. It illustrates the primary focus of the different approaches.

	CHRISTIAN/ DIACONAL NURSING Cedershiöld	HISTORICAL/ MEDICAL NURSING Nightingale	HUMANISTIC/ SAUC MODEL NURSING Gustafsson & Pörn
HUMAN	Spiritual being Whole person spirituality The value of human worth	Biological being Natural and functional view	Acting subject Holistic view of human potentiality for self-development
HEALTH	God orientated A relationship with God built on forgiveness. The meaning of suffering	Disease orientated Absence of disease and the struggle against death as the primary focus	Individual orientated Creating of life in relation to own goals, abilities, and circumstances in environment
KEY VALUES	Community responsibility Love, compassion, self-respect, obedience dependence, forgiveness, reconciliation Healing and sanctity	Survival and reproduction Statistical normality Pain relief Environment and prevention of disease and injury Repairing and curing	Self-realisation and growth Autonomy, freedom, independence, responsibility, human dignity, self-assessment Self-relation support

The Consequences of Nursing Within the Three Models

The nursing practice consequence of these different values is illustrated in Table 2.

MODELS	PERSON	NURSING IDEALITY & KEY COMPETENCIES	LEVELS
The Diaconal Christian model	Spiritual being	Nurses seek to create the space where healing relationships can be built up and individuals can experience themselves as truly human and loved by God. The primary role of the nurse is to serve. Key Nursing Competencies: Listening, praying, counselling, tending, comforting, supporting, and caring.	Father level
The SAUC model for confirming nursing	Acting subject	To encourage the life competence, to promote qualified abilities to realise the life-plan project in appropriate environment. The primary role of the nurse is to strengthen person's self, his or her resources and potentialities by self-relation support. Key Nursing Competencies: Sympathy & involvement, acceptance & influence, understanding & individualisation, personal competence, & subject-view & trust.	The person Level
The Historical Medical model	Biological being	To cure and prevent disease and its impact on individuals and communities. The primary role of the nurse is to provide optimal conditions for prevention, repair, and recovery to take place. Key Nursing Competencies: Technical ability, Assessment of health and disease, Observation and management of environmental conditions. Disease management.	The sub-personal level

Table 2 The Nursing Consequences of the Three Models

Modern nursing curricula ensure the development of a wide range of skills and abilities which nurses are required to achieve before registration or qualification as a nurse. Many of the values which are central to the views outlined above are included in a single programme, and students will learn to not only provide the technical and disease orientated care required in a modern health service but also to recognise the value of the person and his or her individuality. The key dilemma for modern professional nurses is to incorporate into practice the priorities that their view of nursing demands.

The differing understandings of humanity which are exemplified in the views described illustrate that although a common paradigm of nursing may be accepted, the values and beliefs which underpin it are often different and lead to other priorities in practice. The focus of the Christian model is on healing relationships, the historical medical model emphasises repair of the body, and the SAUC model focuses on restoring and maintaining the self. When planning nursing care using the skills and expertise promoted by each model the nature of practice will change. In practice there is an overlap between the models creating an opportunity for incorporating different approaches to a single care activity. The concept of Holism is fundamental to both the Christian model and the SAUC model. In the Christian model Holism is recognition of the need to take into account the individual's need of a relationship with God. The concept of Holism in the SAUC model recognises the integrated nature of the individual as an acting subject and the need for confirmation from others and oneself towards a development of personal potentiality. It is more difficult to see Holism in the historical medical model, but it is present and recognises that you must take all the functional parts of the body into account for healing to take place. Both the Christian model and the SAUC model emphasise the importance of relationships; the Christian emphasising the relationship of the person to God and ones fellow men while the SAUC emphasises the confirming relationship between the individual him-

self or herself and others. It may also include the relationship to God if the individual is seeking faith. Healthy relationships are necessary for the healthy person.

The dilemma for the nurse is how to express the holistic and relational parameters of care within what is often a strongly historical medical system. Is it possible to choose an approach? There are examples of institutions that have been able to free themselves from a medical model and offer a very different care paradigm; the hospice movement is a key example of this (Kellehaear 2000). Most nurses, however, work within health care systems they have little control over. If they are prepared within one model and then expected to give care within another, will this not have an impact on the quality of care provided? Conversely, nurses who are prepared without due recognition of the spiritual and humanistic values which strengthen their understanding of people and the affect of illness and death on them will be unable to provide an acceptable level of care. To propose then a model which requires a system approach rather than one where the individual can practice within a different framework but recognising the differences may lead us back to where we started, that is with a personal conflict of values.

Summary

The authors of this essay would argue that the first stage of solving this dilemma is to understand how the differences impact practice. Many nurses, whatever their background or values set, will be unaware of the conflicting values that are present within the care domain. In order to address these they need to understand them. The three views presented here illustrate examples, but they demonstrate how priorities might be set if the value system has total influence over how care is ultimately delivered. In reality this will not happen, for no system is entirely without either the spiritual or the humanistic dimension. However, these are often suppressed, denied, or simply ignored, and the nurse who recognises and demonstrates them will enrich practice and improve the quality of nursing that is given.

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WAYS OF APPROACHING NURSING ETHICS: SOME COMPARISONS AND CONTRASTS

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Nursing ethics, along with medical ethics, business ethics, journalistic ethics, and so on, is one of the particular areas of study and concern which come under the general heading of 'applied ethics'. This title, 'applied ethics,' has been widely employed in recent moral philosophies to mark out both a particular division of the subject matter of moral philosophy and also a particular way of doing ethics. The point of talking about applied ethics, and of marking off a branch of philosophical inquiry by the use of this title, is clearly to emphasise a distinction between ethical inquiry which is applied and that which is not applied. We might call this a distinction between pure or general ethics, on the one hand, and applied ethics on the other, by analogy with the distinction between pure and applied mathematics. According to this picture, philosophical inquiry first of all establishes and presents certain quite general points about the nature of morality, applicable in principle to all human activity and by no means restricted in application to any one area. Some of these results of the philosopher's inquiry will have to do with the meaning of words—actual meaning of terms such as 'good', 'bad', 'right', 'wrong', 'duty' and so on, and of what someone is actually saying when he asserts 'You shouldn't have done that' or 'It is your duty to do such-and-such'. The systematic philosophical treatment of these questions of meaning is known as meta-ethics. Such questions are of crucial importance in moral philosophy, and indeed some modern ethical theorists have concentrated their attention on them exclusively. Beyond meta-ethics, however, there is another part of general ethics which involves setting out a systematic ethical theory; that is, a rigorous account of the principles, which determine what it is that makes a human act morally good or bad, right or wrong. It is, of course, a controversial claim that such a list of basic principles of morality can, in fact, be set out and defended; here as elsewhere philosophers divide into distinct camps which may be strongly opposed to one another. Nevertheless, it is clear that if there is to be such a thing as applied ethics there must be something which is applied when someone does serious work in that field; and that 'something' must be certain principles of normative morality, which in themselves are part of general ethics. In this sense, then, general ethics comes first, applied ethics later. The distinction we are looking at can be set out concisely in the following couple of points:

Ethics or moral philosophy systematically considers the morality of human acts. It is a field of study, which can be divided into:

- (1) General ethics, the consideration of the morality of human acts in general, that is apart from any particular field of application, human occupation, or profession, etc. General ethics, in turn, comprises:

- (a) Meta-ethics: the study of the meaning of moral terms and the ways in which they are used in moral discourse.
 - (b) General normative ethics: a setting-out of basic principles, which determine the moral quality of human acts and the way in which our reasoning about moral matters should be conducted.
- (2) Applied ethics, in which the general principles of normative ethics are applied systematically to ethical issues which arise within a given specialised field of human endeavour; such as warfare, medicine, nursing, journalism and so on, in an attempt to resolve these ethical issues, and to show, in particular situations and circumstances, what would be the right course of action to take. Close attention is likely to be given to certain deeply perplexing situations in which every one of the available courses of action seems to be open to moral objection.

As set out here, the contrast between general ethical theory and applied ethics appears straightforward and unproblematic. It could, however, be misunderstood in a number of ways. One serious misunderstanding would be to suppose that a sufficiently gifted philosopher could establish genuine principles of right and wrong, the sort of principles which comprise the general ethical theory, by a sort of armchair thinking about human acts considered wholly in the abstract, without paying any attention to ethical problems that may actually arise in daily life or in certain specialised areas of human endeavour such as nursing. This clearly cannot be correct, because anyone who reflects seriously on the question of what it is that makes certain human acts right and others wrong, can surely proceed only by reflecting on the nature of *particular* good or bad human acts occurring in their full context. Human acts, then need to be clearly and carefully thought about in the concrete, as they actually occur in everyday life, if these thoughts are to be clear about what it is that generally makes human acts right or wrong. Nevertheless, the distinction between general ethical theory and applied ethics retains its point; for once an adequate account of normative ethical principles has developed in this way, these general principles can then be systematically applied to concrete problems arising in various specialised domains of human action. In this sense, then, there is a clear distinction to be drawn between general ethical theory on the one hand and applied ethics on the other.

Accepting the distinction between general normative and applied ethics, then, I propose in this article to focus on some crucial intellectual and pedagogical tasks involved in developing and applying in practice a consistent approach to one area of applied ethics, namely the ethics of nursing. This is no easy matter, because it becomes clear on reflexion that there are some formidable difficulties involved in any branch of applied ethics, both in the task of actually building it up and expounding it and in that of understanding and applying it in practice. First of all, consider the task facing someone who attempts to expound a coherent and principled approach to nursing ethics, by arguing that certain ways of acting are right and certain others wrong in a range of situations. To do this he needs to have a clear idea of what generally makes human acts right or wrong and also have a detailed knowledge of the range of ethical problems that can arise in the various fields of nursing. In addition, he has to be able to apply the higher-level ethical principles to those problems in a way which makes it clear which would be the morally right ways of responding and which the morally wrong ones. Each of these tasks presents formidable demands on

the ethicist. In the first place, the development of a normative ethical theory involves complex intellectual difficulties. One has only to reflect on the controversies in 20th Century English language moral philosophy between adherents of the different main tendencies—naturalism, ethical intuitionism, emotivism, prescriptivism, and so on—to realise that practically all the important questions of ethical theory are deeply controverted and that someone who takes a definite stand on any one of them is sure to meet opposition from other moral philosophers. There is disagreement even about what might be considered the most basic question of moral philosophy; whether people's moral beliefs and judgments are capable of being true or false: some ethicists (those who are said to adopt a 'cognitivist' viewpoint) answer it in the affirmative, but others (the so-called 'non-cognitivists') in the negative. A moral philosopher who labours in any field of applied ethics must somehow take into account the fact of widespread disagreement over essentials.

Suppose, however, that the moral philosopher does succeed in producing a principled, detailed, and well-argued account of basic moral principles and then applies those principles to issues in nursing ethics. It will remain for him to look at things from the point of view of his intended audience. This audience consists of practising nurses, who will have to understand and reflect on what he has to say, perhaps as part of a course of study. Any field of philosophy is intellectually difficult, and problems of moral philosophy may seem to be somehow even more elusive than those arising in other areas of the subject. Doing valuable work in the field, or indeed profiting from the work of others, requires not only intelligence but also a certain aptitude which few people tend to possess, no matter how highly gifted they may be in other respects. It would seem unreasonable to require that a nurse should be by nature suited to be a philosopher if she is to think profitably about ethical problems arising in the course of her work; if this really were the case, we may suppose, she should already have discovered her true vocation as a philosopher and abandoned her nursing career, or at least have attempted some mixture of nursing and philosophical work. Surely nurses with the required mixture of abilities and aptitudes must be rare. Are we to say, then, that even when an ethicist has succeeded in formulating a rigorous and coherent account of nursing ethics, it is not really profitable for nurses (apart, perhaps, from a small, philosophically gifted, minority) to bother acquainting themselves with the results of the inquiry?

These worries are, I suspect, inevitably felt by philosophers working in some field of applied ethics who wish to communicate their thoughts and conclusions to people who are practitioners in the field. The problems of communication will be especially acute if the philosopher is not himself a practitioner and so lacks any intimate acquaintance with the day-to-day character of that line of activity. He may, indeed, have a clear idea of how the ethical problems should be approached and resolved, but he is still bound to ask himself how he can expound his point of view in a way that will be intelligible and helpful for his students or for his readers. An experienced nurse, on the other hand, will have the required intimacy with the nursing situation but may lack any strong ability, aptitude, or inclination for dealing in a systematic way with moral problems that tend to arise. The problem of communication between the applied ethicist and professional nurses is therefore a pressing one.

Is there any way of overcoming this problem of communication? It seems to me that a number of different approaches are open to the applied ethicist, and indeed that each one of these approaches can be encountered in discussions of nursing ethics

published in English since the 1950s. I have identified five of these approaches in all, and propose now to discuss them one by one and to say something about each ones advantages and disadvantages. The first four of them are wholly philosophical in character, allowing no appeal to anything beyond what we can ascertain by reflecting on day-to-day nursing practice. The fifth one, however, involves an appeal to something extra-philosophical, something beyond what unaided human reason could work out; it therefore introduces considerations about traditional or revealed, and indeed specifically Christian, approaches to contentious ethical issues.

(1) *The strictly philosophical option.* This first line of approach is the strictly philosophical one of defending a rigorous normative ethic involving acceptance of certain fundamental moral principles, and applying these principles across the range of crucial ethical problems encountered by the nurse. In effect this option makes no concessions to the concerns just expressed about the admitted intellectual difficulty of philosophical argument about fundamentals in ethics and the demands, which it makes on both the ethicist and his audience. These difficulties and demands will have to be met head-on. The ethicist will naturally do his best to present his approach to nursing ethics as clearly and comprehensibly as possible, leaving out all unnecessary details and illustrating with appropriate case studies. Nevertheless the advocate of this line of approach will claim that there is really no alternative to the strictly philosophical option if one's outlook on nursing ethics is to be reasonable and justified. The nurse is, then, expected to examine, critically and in detail, the field of morality, the moral life and moral judgment, and to work out and be prepared to defend a rational account of the foundational issues which moral philosophers have traditionally tackled. In addition she has to be able to apply general principles of normative ethics across the whole range of moral problems arising in modern nursing practice. For her grasp of systematic moral theory, together with her intimate knowledge, as a practitioner, of the nursing situation, will enable her to work out reliable answers to questions about the morality of different responses to ethical issues, and to explain why this particular way of acting, in these concrete circumstances, would be justified or unjustified, right or wrong. Anything less than this—any reliance on inherited or traditional moral outlooks, for instance—would, on this view, render the nurse's moral judgments inherently uncertain and unreliable. For any approach to nursing ethics which lacked this decisive theoretical grounding would be vulnerable to some simple and basic questioning along the lines of 'But just why do you accept this account of what ethics is all about? Why do you hold to just these ethical principles and no others?'

Here we have, succinctly expressed, the argument for taking the strictly philosophical option. The argument against it, so it seems to me, is that the objections raised earlier to this strict philosophical option still present themselves with undiminished force. For, the objection would run, to expect the nursing ethicist and nurses themselves to carry out this whole range of tasks would be to impose on them an enormous intellectual burden. After all the task of establishing fundamentals in ethics is itself an immensely difficult one, on which there are long-standing disagreements between the professionals in this field, the moral philosophers. If the experts cannot manage to resolve decisively the philosophical difficulties involved, can we expect the nursing ethicist to do so? Is the nursing ethicist justified in accepting one particular approach to the foundations of ethics and rejecting the others, and then basing a complex investigation of ethical problems in nursing on the basis of that one approach,

all the time knowing that other reputable moral philosophers dispute it? Should he, in addition, try to impose his own way of approaching ethical foundations on his students, or on the readers of his book, as a basis for their critical thinking about problems in nursing ethics? If the nursing ethicist does try to do all this—to expound and defend an entire ethical theory as a basis for consideration of specifically nursing problems—he may find that few of his readers or his students may then be able to grasp the theory sufficiently well or to apply it to the concrete problems; or, alternatively, that they may be less than completely convinced of the value of his way of looking at the basic issues at stake and, therefore (reasonably enough) disinclined to base their nursing practice on it.

Perhaps I could enter a personal note at this point and say that considerations of this type were weighing on my mind while I was planning and drafting my volume *Ethics in Nursing Practice: Basic Principles and Their Application*, which was published in 1988 by the Linacre Centre for Health Care Ethics in London. I defended an approach to ethical reasoning in the natural-law tradition, relying closely on St. Thomas Aquinas and on some modern developers of this tradition, but added particular details or modifications when I thought it necessary. I wanted to show that certain basic ethical principles, which could be applied in practice, were rationally defensible and for this purpose devoted several chapters to evaluating rival accounts of ethical foundations and to developing an adequate approach to moral reasoning, before settling down to consider some standard issues of nursing ethics—issues of life and death, honesty and confidentiality, respect for persons, and so on. An important concern of mine was to keep the preliminary treatment of general ethics to modest dimensions, since if this were not done the book would become, in effect, a treatise of general ethics together with some additional chapters dealing with nursing problems, rather than a volume whose focus was precisely nursing and the ethical problems arising in modern nursing practice. But there was also, I thought, a danger of going too far in the direction of simplification: in restricting discussion of the theoretical ethical background to modest dimensions one could either leave out a good deal of argument, which is really necessary to make one's line of argument cogent, or one could compress the exposition so much that only the most intellectually gifted reader could fill in the gaps and succeed in grasping what one was trying to say. Serious philosophical work is difficult, and ethics is no exception to this rule; furthermore, the task of not only setting out a rigorous account of normative ethics but also applying it in a field where one is not a practitioner is even more onerous than that of tackling the key questions of normative ethics on one's own. Given the degree of difficulty involved, the philosopher who attempts the task may well be unsure about how successful he has been. It is to be expected that many practising nurses may become impatient with attempts to deal with moral problems in nursing in an explicitly philosophical way, by first of all setting out the ethical principles and then trying to apply them. She may well feel that there has to be some other way of dealing with the matter, some way that would be more practically effective, than this 'strict philosophical option'. The issue is open, but it could hardly be said that this feeling is unreasonable, given the difficulties, of an intellectual and a pedagogical nature, which arise for this option. The alternative approaches should at least be looked at.

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(2) *The 'cafeteria' approach* represents what may be called 'the easy way out' of the intellectual and pedagogical problems that arise for the strictly philosophical option. In effect the proponent of this view considers the philosophical issues at stake to be so complex and bewildering that any attempt to examine the field rigorously and defend one particular viewpoint would be a labour in vain. It may even be thought that in view of the extent of disagreement among moral philosophers themselves, the whole issue is at present inherently irresolvable even for a gifted philosopher, let alone for someone who, like a nurse, is largely preoccupied with another line of activity. The only way forward, according to the 'cafeteria' approach, is for practising nurses to be introduced to the essentials of the different points of view in normative ethics and be helped in working out the implications for the ethical problems that typically come their way. When an ethical problem actually presents itself and the nurse has to decide what to do here and now, the nursing ethicist can only encourage her to decide for herself which basic approach to ethical decision-making, if any, she wishes to adopt and apply in practice. The author of a nursing ethics textbook (or the lecturer/tutor in a nursing ethics course) therefore need only present the most widely-held ethical viewpoints, together with some of the standard arguments for and against each of them, explain how they work out in practice, and then (in effect) issue an invitation to the nurse: 'Take your pick: see which of these you are "comfortable" with accepting and working out in practice'. I say 'in effect' here because no author or teacher would be likely to express matters quite so bluntly as this; but I believe that the formulation given here expresses accurately enough the real tenor of the advice given. One finds textbooks of nursing ethics, for example, which centre their account of normative ethics on the standard distinction between teleological ('end-based') and deontological ('duty-based') ethical theories. The distinction, very briefly, is that according to teleological theories the right course of action is determined by some sort of calculation of the likely consequences of the different options available, whereas deontological theories hold that there are principles of right action which may hold independently of considerations to do with the consequences of actions. Once this basic distinction has been set out, the subsequent discussion of actual ethical dilemmas tends to run according to a standard pattern. The advice given is typically of the following form: if you (the nurse) follow a teleological ethical theory you will naturally decide to act in such-and-such a way; if, however, you adopt a deontological approach you will reject this option and instead do such-and-such.

The advantage of a 'cafeteria' approach is that it makes the communicative task of the teacher of nursing ethics comparatively easy, by removing from him any obligation to examine standard approaches to normative ethics rigorously and to say where he believes the truth of the matter lies. It is also this facile aspect of the 'cafeteria' option, its studied avoidance of hard intellectual work, which provides the decisive objection to it. Because it dispenses with any rigorous consideration of basic ethical issues, it tends to assimilate ethical decision-making to a choice of techniques for achieving a practical result, the latter being previously given in ways which resist the demand for rational justification. To approach the whole subject of nursing ethics in this way is surely to abandon any attempt to decide and act reasonably. When one is faced with alternative accounts of right and wrong, or of ethical decision-making, the crucial question is which, if any, of them is correct. If a particular philosophical approach to ethics is correct then it should be applied consistently in practice; if it is mistaken it should not be applied at all. For instance one of the standard objections to certain forms of teleological ethical theory, such as utilitarianism with its overall

criterion of the greatest good for the greatest number, is that they lead one to approve of acts which are in fact immoral because they involve acting unjustly against given individuals in order to benefit a certain group of people or society as a whole. If this line of criticism is cogent, the rejected ethical theory should not be acted upon. In that case, what is needed is not a mere acquaintance on the nurse's part with the theory as one of the available options but a reasoned grasp of the grounds for rejecting it and refusing to follow it in practice. In general, if a nurse is to approach the different options in normative ethics intelligently, she should be able not only to distinguish between them and their various applications in practice but also be able to offer a rational appraisal of them. To do this, however, involves considering the competing ethical theories at a much deeper level than bare acquaintance, which is all that the 'cafeteria' approach can ever provide. Rather than bother herself to get to grips with the philosophical issues in the strictly limited way encouraged by the 'cafeteria' approach, the nurse may well prefer to exclude general and principled approaches to moral decision-making and instead decide what to do by a situation-by-situation approach, based on what seems like 'a good idea at the time'.

(3) *A rejection of all ethical systems in favour of reforming attention to the nursing environment.* This option consists in directing the nurse's attention to removing, or at least improving, certain aspects of the contemporary nursing environment which are judged to be abuses, and certain features of the whole nursing or hospital organisation in which the proper relation between nurses and patients, doctors and nurses, or hospital administration and patients or health professionals are seen to be somehow distorted or disordered. It may, for example, be thought that the whole set-up in modern health-care facilities betrays a false emphasis on administrative priorities such as efficiency in throughput of patients, or minimisation of inconvenience for health professionals, which in effect invert the proper relation between health-care administrators or health professionals and patients. If such false emphases are, in fact, built into the contemporary health-care set-up, it could be argued that there is a basic injustice at the heart of things, and that the ethical issues commonly considered to be crucial—issues of life and death, of cooperation, of confidentiality and truth-telling, and so on—are not the central problems that she should be trying to deal with after all, but rather, very often, distractions from her really central concerns. Her first concern, on this view, should be to put right the basic injustices and imbalances that are claimed to exist.

On the surface, this idea is somewhat lacking in plausibility. Everyone is aware that systems of health-care, whether public or private, are far from perfect, that misjudgements and mismanagement of patients do take place, and that administrative and bureaucratic priorities can be over-emphasised to the detriment of attention to patients' individual needs. It is also well known that tensions between the different 'branches' of the health-care system—doctors, nurses, hospital administrators, and others—can be present, again adversely affecting care for patients. Nevertheless, most observers would also, I suspect, consider that the inefficiencies, imbalances, and tensions that do exist are very much what one would expect in an organisation that has to deal with very large numbers of patients and which, for purposes of efficiency and ultimately in patients' own interests, is run according to line-management principles. Because of this apparent implausibility I would not have mentioned this option here if I had not seen it, or something rather like it, seriously proposed in a recent publication dealing with ethical challenges in nursing, written by and for practising nurs-

es in a wide range of specialities. The viewpoint in question is expressed by Mr. Geoffrey Hunt in his introduction to the anthology *Ethical Issues in Nursing*, edited by him, and also in his own contribution to the volume, 'Nursing Accountability: the Broken Circle'.

Central to Mr. Hunt's concern is a fear that the nurse's commitment to caring for patients is rendered fruitless by her inevitable involvement with the hospital and health-care 'establishment'. In particular, the fact that the nurse's work in a hospital environment is subject to rules prescribing the performance of set procedures, these rules being enforced by her superiors, means that the nurse is largely robbed of her freedom of initiative to promote care for her patients as her first priority. Reinforcing the oppressive authority of set rules and procedures is the fact that nurses working in hospital wards, especially those caring for acutely ill patients, work in subordination to the medical profession and in the service of goals and targets laid down by physicians and surgeons. There are good reasons, Mr. Hunt believes, to doubt whether the responsible caring which the nurse exists to provide is really possible in an atmosphere like this in which freedom and initiative are denied to her and her role reduced to that of an instrument carrying out procedures set by others. He writes:

Nurses often express unease about a lack of freedom to care for patients and clients as they feel is decent, as they feel they themselves would like to be cared for or have their loved ones cared for. Many, but not all, of the ethical issues they raise come back to this unease in one way or another. More often than not discussions end up in an exploration of the constraints on their freedom to care. Two general and related constraints nearly always emerge: the way in which medicine defines health and illness, reflected in the way doctors think about and "approach" people in care (the "biomedical model"); and the way in which the whole business of health care, including nursing, is organised in a military-style command structure in which technical experts have the power (hierarchical technocracy).

Mr. Hunt's discussion of these two grounds for dissatisfaction with the current state of health-care provision and organisation deserves close attention and comment, which I am unable to devote to them here. It has, I think, to be conceded that some of his criticisms of (e.g.) the medical domination of health-care establishment are telling. But a critic could rightly point out that in the treatment of acutely-ill patients, the nurse's contribution to the healing process is inevitably going to be subordinate to and supportive of the medical specialist, so that here at least domination by 'the biomedical model' is only to be expected. With regard to the procedures imposed by hospital regimes, while Mr. Hunt may well be right in deploring the sheer pervasiveness of procedure and routine, once again he goes too far in the opposite direction. He argues:

. . . there is a strong general trend in nursing as a whole to keep an exaggerated quartermasterly discipline which runs counter to humane care. Every problem is conceived in terms of an appropriate procedure or sub-procedure or sub-sub-procedure. Procedure takes the form of uncritical habit and routine, excessive paper work and meetings, and unnecessary "tests", "obs" and "monitoring". Often it is tempting to slip into the rather dismal view that the nurse is simply there to follow instructions unquestioningly;

just as the soldier is not expected to ask why he has to clean boots which are not dirty—in fact he is expected not to ask.

Time and effort is taken up with the constant search for the correct procedure; procedures are frequently checked and assessed to see that they are “correct”; students are for the most part still taught by *reducing* every aspect of nursing to a procedure, so that even having a chat with a patient becomes a special procedure of “communication” for which there is a science and a technique. (p. 3)

Mr. Hunt is careful to add ‘I do not wish to say that there is no room for procedures or principles whatsoever in nursing practice’, but it seems to me that the drift of his remarks tends towards favouring the abandonment of routine procedures except in some very few cases. This would surely be unfortunate for nurses themselves and especially for their patients, because many of the routines currently carried out, although often tedious for nurses themselves, may be vital for the health of their patients. An apt illustration of this point is provided by a recent incident at a private hospital in England, resulting in the death of a mother following childbirth, which, following an action brought in the High Court, is now to be the subject of an official inquest. The case involved a mother who died of a cerebral haemorrhage nine days after her twin sons had been delivered by caesarean section. A newspaper report tells us:

She had developed hypertension, which was not detected until more than two and a half hours after the delivery and then only because she complained of a severe headache. The coroner refused an inquest on the ground that she died of natural causes, but two judges overruled him yesterday after hearing the “tragic story” of the circumstances leading to [the mother’s] “extraordinary” death.¹

The report goes on to point out that the hospital has no ‘standard operating protocol for caesarean sections’; that is, no rules which require nursing staff to make regular checks on women recovering from the procedure. In arguing the need for a full inquest, the dead woman’s husband claimed that his wife’s ‘vital observations, crucially her blood pressure, were not monitored until two and a half hours after the operation’. By contrast, the report goes on, in National Health Service hospitals, which are governed by regulations agreed and imposed nationally, there are strict guidelines on monitoring mothers having caesareans, a time when high blood pressure can be expected. Women are put in a recovery room with monitoring equipment. They are checked every 15 minutes in the first hour, every 30 minutes for the next two hours, and then at least once every hour for the next three hours.

The importance of this for present purposes is that routinely checking blood pressure at regular intervals is precisely one of those pieces of more or less mechanical procedure in line with hospital regulations that Mr. Hunt would appear, in his article, to be deprecating. It is imposed unconditionally on nursing staff, who have to carry out the checks at rigidly-set intervals and record the results for consultants and other nurses to inspect. From the point-of-view of a nurse who is charged with carrying it out, it may well appear as an irksome duty, something imposed on her from above, without offering her any chance for thoughtful or imaginative nursing practice which she might prefer to carry out. Nevertheless, as the report of this legal case indicates,

there are sound reasons for the existence of the practice, since the checks are necessary to detect those rare cases where post-operative complications may have damaging and even life-threatening results.

I believe that cases such as this one make it difficult for one to sympathise with the apparent tenor of Mr. Hunt's argument, namely that we should divert our attention from the traditional problems of nursing ethics and instead concentrate upon formulating a quasi-political critique of the whole health-care set-up as it is found in contemporary society. There may indeed be basic structural and organisational faults, which characterise this set-up, but it surely cannot be maintained that the criticism and remedying of these faults should have to occupy centre-stage whenever we want to think about ethical issues in nursing. They deserve, rather, to take their place as problems along with the others. The traditional problems are of perennial importance and concern to nurses, no matter what additional problems might be raised by the managerial and organisational aspects of modern nursing. In many of those traditional problems a patient's very life is at stake, while in others, such as the questions of whether one may ever lie to patients or treat them without their consent or subject them to non-therapeutic medical or nursing research, there are issues of the utmost importance at stake. Even if there is something fundamentally awry, something radically at odds with the way things should be organised with the good of the patient in mind, about the way modern health-care is structured and administered, the task of critiquing and remedying this undesirable state of affairs cannot, surely, be as central a concern as deciding whether (e.g.) a nurse should co-operate in medical procedures which involve someone's death. Nor could it reasonably be thought that all the problems traditionally dealt with in nursing ethics—of life and death, of respect for patients in a clinic or hospital ward, etc.—would somehow vanish if only the important structural and organisational imbalances and false priorities affecting provision of health-care could be put right.

(4) *A reliance on principles specific to applied ethics.* The 'strictly philosophical option' is an attempt to treat nursing ethics by arguing from first principles; that is, by first defending a general account of what makes human acts morally good or bad, and then by attempting to derive, from this general account, conclusions about what would be right or wrong to do in morally problematic situations in nursing practice. The drawback involved in doing things this way has already been pointed out, and it has been argued that a 'cafeteria' approach to this question is no way to solve it. An alternative approach would be to base one's consideration of issues in nursing ethics on a rigorous application of certain substantive ethical principles—not, any longer, the absolutely basic and general principles proposed by ethicists as a foundation for general ethics, but rather something much more high-level, something which possesses a strong intuitive appeal, a strong sense of correctness about them. In this way it might be thought that we gain the best of both worlds—the intellectual rigour characteristic of the 'strictly philosophical' approach, but also the necessary pruning away of difficult foundational questions which is carried to such great lengths in the 'cafeteria' approach. This involves giving up any attempt to make the nurse, in effect, into a part-time moral philosopher or moral theologian. It insists only that she should be able to grasp the force of the substantive ethical principles—it being presumed that the intuitive correctness of those principles is clear to her—and able to apply them intelligently to the concrete ethical problems that come her way.

The key feature of this new line of approach to nursing ethics is, then, that we base our thinking about the subject on certain higher-level principles, some of which may be specific to health-care ethics. Because these principles are at a higher level than those dealt with in basic moral theory, they are very much more easily grasped by people who lack the ability or inclination to investigate moral beliefs and moral reasoning to their very foundations, and these higher-level principles may also possess a sort of intuitive correctness which is lacking in some of the key principles proposed in basic moral theory. Hence an approach to nursing ethics based on acceptance of these principles is much more easily grasped by a student of nursing ethics and can be much more straightforwardly presented, explained, and defended by the teacher, than can alternative approaches which base nursing ethics on principles of general ethics which have first to be set forth and defended. From a purely pedagogical point of view, then, it would seem that this approach definitely has something to be said for it.

As possible examples of the sort of higher-level, substantive moral principles which might serve the foundational role being set out here, I wish to mention four principles which have figured prominently in treatments of health-care ethics by Catholic philosophers and theologians. Despite their very close association with the Catholic tradition, their defenders would argue that they possess an inherent reasonableness which makes it possible to accept them with conviction without needing to support one's commitment to them by appeal to the Catholic Church's teaching authority. The examples are as follows.

(i) *The principle of totality.* This principle governs the morality of surgical and other interventions, such as amputations, which involve sacrificing some part or function of the human body for the sake of the whole. It states that the parts or organs of the human body acquire their value from the role that they play in maintaining the health and integrity of the body as a whole, and do not possess a value simply in and for themselves, as the body itself does. Hence they may be deliberately sacrificed for the sake of the body as a whole if there is a need to do so. (By contrast a man, although certainly fit for society in the company of his fellow men, is an individual being in himself and is not merely 'for' society. Hence he may not be sacrificed (i.e., deliberately killed) for the sake of society as a whole.)

(ii) *The principle of double effect.* This principle is commonly used to determine the morality of certain acts of warfare, but is applicable in all areas of applied ethics. It sets out conditions under which an action, that is chosen for the sake of a certain good effect but has one or more bad side-effects or after-effects, may nevertheless be rightly chosen. This principle presupposes that there are certain kinds of human acts which are wrong in themselves and are not to be chosen, even if good consequences may result from that wrong act. But there are certain other acts with some good effects but also some bad effects which may, in certain circumstances, be rightly chosen, depending on the purpose of the act or the intention which lies behind it. Because of this connexion with the purpose of an action it would cause confusion to think that the principle of double effect could be applied in a mechanical manner to human actions considered only as bits of bodily behaviour and in abstraction from their purposive or intentional character. If the distinction between killing and allowing someone to die is not to be misunderstood and misused as a licence for wrong acts such as euthanasia, then (so Catholic moralists would argue) this distinction

needs to be clarified in the light of this intentional 'side' to human action, and also in the light of the principles of double effect.

(iii) *The principles governing a person's cooperation in the wrong action of another human agent.* These principles have been formalised by moralists in terms of a distinction between formal and material cooperation, which again rests on the fundamentally intentional and purposive character of human action. They are applied to determine when the action of one person constitutes a morally wrong cooperation with the evil act of another and to distinguish them from cooperative acts which are not immoral and may, under the appropriate conditions, be justifiable. The basic point here is that if someone's act is in itself immoral (e.g., a surgeon performing some operation) then cooperation with the agent by other people, which necessitates the requirement that they share the purpose or intention of that act and guide their own behaviour in accordance with that purpose, is also immoral; this is called, in the tradition, formal cooperation. In cases where one's behaviour contributes in some sense to the evil act of another but does not necessarily involve one's sharing his evil purpose ('material cooperation'), there may be grounds for justifying that cooperation, depending on further aspects of the situation which would have to be weighed carefully. Clearly these principles can be applied in all walks of life, wherever there are cooperative ventures between men. But they need to be applied in the context of modern medical and nursing practice, especially in the hospital environment where problems regularly arise concerning cooperation in morally suspect surgical, screening, and pharmacological procedures.

(iv) *The distinction between ordinary and extraordinary means of preserving life.* The health professional's work is centred on the preservation of human life and health, and in normal circumstances there is an obligation for the nurse or doctor to do everything reasonably possible to protect the lives of her patients. There are, however, limits to this obligation, and the use of the qualifying phrase 'reasonably possible' signals this. The distinction between ordinary and extraordinary means of preserving life is an attempt to express this notion of 'reasonable possibility' in rigorous terms. An important ground for deciding whether a particular means of preserving life is 'extraordinary', and therefore non-obligatory, is the burden that it may impose either on the patient whose life is at stake or on other people, especially in relation to the likely effectiveness of the treatment proposed.

The suggestion being canvassed here is, therefore, that the nurse does not need any knowledge of the 'deep' structure of morality, of the basic moral principles which govern or should govern our judgments of the rightness or wrongness of particular practices. This knowledge is alright (so the argument would run) for professional philosophers or for those with the ability and opportunity to delve into such things, but for someone who, like the nurse, is 'on the spot' and has to decide, often with little time to think theoretical thoughts about what should be done in a situation that demands action immediately, something more down-to-earth, and more immediately applicable to the situation in which she finds herself and to which she has to respond, is necessary. It is surely not unreasonable to conclude that the higher-level principles instanced here are needed if situations needing immediate response are to be handled efficiently.

There are, then, reasons, both theoretical and practical in nature, for adopting this proposal and making the appeal to higher-level principles. Are they sufficient reasons? There is a very obvious argument to the effect that they are not, and this argument needs to be answered somehow if the position being defended is to be in any way tenable. The argument runs as follows. The nurse surely has to provide some justification for accepting the ethical principles she relies on in deciding how to act in a given situation. This remains the case whether she relies on the sort of higher-level principles instanced here or tries to get back behind them to something more basic. After all, even though the principles cited above do possess a certain intuitive sense of being right, this is a long way from saying that they are self-evidently true. They can be disputed, and people have in fact disputed and rejected all of them. If, then, a nurse is to accept them and base her nursing conduct on her understanding of them, her acceptance of them should not be a mere impulsive reaction. There must be some reason for her choosing to follow just these principles in preference to the many alternative ones. The critic therefore demands that the nurse should be able to indicate the reasons behind these principles that, in her opinion, justifies her acceptance and adoption of them. Whether the required reasons are good or bad, whether they amount to a convincing justification for her action or not is, of course, a further and distinct question; but the essential thing is that some reasons should be provided, because the nurse's choice should be grounded by reasons rather than a mere spontaneous reaction to events.

Faced with this demand for justification, the nurse has a number of options. She could try to defend her acceptance of the moral principles by identifying one or more characteristics, which render them acceptable to her. She could, for example, say that:

- (i) the principles have an immediate, intuitive appeal to her as being 'right' or 'fitting'; or that
- (ii) they are accepted practice in the milieu to which she belongs (this being either the nursing/hospital milieu with its particular ethos, or the range of attitudes widely accepted in society at large; or, finally, that
- (iii) the principles are an accepted part of the moral and/or religious tradition to which she belongs.

Only a little reflexion is needed, I believe, to realise that options (i) and (ii) are ultimately untenable. For in both cases there may be the acceptance of a moral viewpoint which ultimately has no rational basis. For what justification has the nurse for thinking that what immediately appeals to her, or what is accepted practice in the milieu to which she belongs, is actually right? Could it not be that her immediate reactions to situations, or the attitudes and practices accepted in her milieu, are misinformed or misguided? If she is to have any confidence on this score, surely, the argument will run, she has to do some serious thinking about these questions at a basic intellectual level. Moreover, this thinking will have to be, in large part, philosophical thinking about basic moral principles and their justification. If this is correct, the nurse has not, after all, escaped from the need for critical philosophical reflexion upon the issues at stake.

At first sight this verdict seems to apply also in the case of a nurse who chooses option (iii) above. For suppose that she justifies her acceptance of substantive ethical principles by appealing to some body or institution that she believes to be authoritative. Surely the question of justification arises in this case just as forcibly as in the other two? If the nurse accepts some moral authority and is prepared to base her professional conduct on rules that that authority lays down, surely this has to be because the authority is worthy of acceptance. But then the demand for justification surfaces again, this time in a form demanding reasons for considering that authority to be worthy of acceptance. Then the question arises: are they conclusive arguments or not? It may further be thought that the grounds for accepting that authority will in part have to be philosophical grounds, since the questions involved are obviously fundamental ones, including as they do the ultimate question of why one should follow any human authority at all.

It seems to me that this demand for justification is unanswerable so long as the authority appealed to is to some merely human and temporally-conditioned authority such as a government, hospital administration, or nursing association. All such bodies are only too obviously fallible and lacking in any power to speak authoritatively on matters of right and wrong. The only authority which should be considered utterly reliable would be an authority of a religious nature: either God himself or some earthly body or institution which can claim to speak with God's own authority. It seems, then, that the recourse to substantive ethical principles which can be applied directly in practice, implies the acceptance of some more-than-human authority in matters of morality. In effect it involves an appeal to God himself as the supremely good creator on whom all things depend.

Once God is brought into the picture, however, the whole character of this option is changed. The ways in which God's own authority is involved need to be set out clearly, certain clarifications need to be made, and some objections need to be anticipated and answered. The fourth option, now radically modified by the appeal to God's authority, therefore now becomes a new, fifth option and deserves consideration in its own right.

(5) *The appeal to a religious tradition.* The situation we are now considering is one in which a nurse accepts and acts on certain moral principles, not because those principles are currently fashionable or customary in her working environment, but because they are taught by a religious authority to which she is wholeheartedly committed. In this situation, it is argued, the practising nurse who accepts that religious authority as decisive may justifiably base her nursing practice on the moral principles which it proclaims and defends, without needing to inquire independently into whatever philosophical arguments there might be for those principles. For if the religious authority is authentic, so that ultimately it is God's own authority that is involved, it will provide, unlike any merely human agency, a reliable guide for moral choice and action. It follows that a nurse who recognises this authority will, both in her private life and professional nursing activity, act reasonably and rightly by accepting principles of right behaviour, which it has laid down. The important question is whether the claims of this religious authority are rationally justifiable. Are there good grounds for accepting that authority or not? If there are, those grounds may be largely non-philosophical; hence it cannot be shown that a detailed philosophical argument on fundamental issues in normative ethics is a duty for the nurse. She does not, after all, need to be a part-time philosopher if she is to accept and put into practice definite eth-

ical principles in her nursing activity. What she does need is an understanding of the nature of the teaching defended by the religious authority in question, of the grounds for accepting it as a genuine and reliable authority in matters of morality, and a reasonable facility in applying the basic moral principles contained in its teaching to the day-to-day problems of nursing practice. The case of a religious body or institution claiming to speak with divine authority amounts, therefore, to a special case here, in which there is a convincing reply to the argument cited above against the appeal to higher-level principles.

Since the viewpoint now under consideration differs markedly in character from the alternatives, it deserves to be described in somewhat more detail, and to have its implications carefully stated. We start from the fact that a nurse may already be a believer in God and adhere to a particular religious tradition: she will not, then, encounter ethical problems in her work lacking any settled convictions about matters of right or wrong. Her attitudes to these matters will already, in large measure, have been formed as a result of her adherence to a religious tradition. Included as an important part of this religious tradition will be a definite moral teaching, and as part of the moral teaching there will be certain substantive principles which can be applied to actual moral issues. The moral principles will themselves have been formulated and defended by philosophers and theologians who accept the guiding role of the religious authority and the legitimacy of the revelation on which it is based, but the nurse, while attempting, to the best of her ability, to understand both the detained tenor of the moral principles themselves and the independent justification for accepting them, may not be too concerned with the foundational questions which any detailed work in this area would need to tackle. Attempts on her part to act as an independent moral philosopher or theologian may, then, be strictly limited. Naturally, given her general attitude of being 'in tune' with the religious tradition and the revelation which is imparted to her, it is to be expected that she will find the moral principles involved—principles such as those of totality, for example, or those governing cooperation in wrong or morally dubious acts—to have a sort of intuitive correctness. But if she is asked why it is that she accepts and acts on the principles in question she will cite, not only this intuitive correctness, but also the authority of the religious tradition that backs them up. This appeal to a religious tradition will obviously not be decisive for someone who does not accept it; but that does not mean that the nurse herself is acting unreasonable in forming her conscientious beliefs in the light of the tradition, and in acting accordingly.

All this is, of course, stated in highly general terms. I have talked of adhering to a 'religious authority' and 'acting on the basis of a religious tradition' rather than of any particular authority and tradition. Nevertheless the examples given earlier of substantive moral principles were taken from the Catholic Church's tradition of ethical reflexion, and even though no appeal to specific Catholic teachings is being made here, it does seem to me that the Catholic moral tradition provides the clearest as well as the most detailed and coherent example available of the working out of an ethical teaching on the basis of what is taken to be God's revelation. Clearly the authority to which the Catholic nurse will appeal will be that of the Church itself, considered as the authoritative representative of God himself and as empowered to speak in his own name. In practice the Church's authority in moral doctrinal matters will be exercised by its magisterium in reflecting and judging decisively, over the years, on crucial issues as they come to light and demand attention: thus, all the substantive ethical

principles cited earlier were expounded and commented on in detail by Pope Pius XII in various letters and allocutions, particularly during the 1940s and 1950s. For a Catholic nurse these developments in the Church's magisterium possess a permanent value precisely as coming with the Church's authority and therefore ultimately by God's own authority. For that reason she will be convinced that she is acting reasonable and right in adhering to those principles, striving to understand them and the spirit that lies behind them to the best of her ability, and applying them in practice. When justifying her attitude, she may simply say that she believes and accepts the authority of the Catholic faith as sufficient reasons, that the Catholic faith is in many ways a 'package deal' and that part of the package consists in the moral principles in question. These principles, she may add, are both clearly true in themselves and in addition, are so closely bound up with the moral teaching of the Church that it is reasonable for her to accept them and would be unreasonable to do anything else.

I believe that this description applies, accurately enough, to the Catholic nurse who takes her religious belief and commitment seriously and is concerned to act on its implications for her nursing practice. An attitude that would come naturally to (say) a protestant nurse belonging to one of the reformed churches would naturally be very different. Admittedly, the substantive moral principles to which she would appeal might not be greatly different from those appealed to by the Catholic nurse; but her convictions, regarding the evidential basis for these beliefs and the grounds she has for accepting them, would differ markedly. For protestants tend to reject not only the claim of the Catholic Church to speak on doctrinal and moral matters with a divinely-granted authority, but also reject even the idea of the Church itself as a visible, structured association of baptised believers with authority to speak in the Lord's own name and pronounce judgment on matters of right and wrong in war, politics, health-care, or any other field. For protestants the sole authority in matters of faith and morals is God's own word in the Scriptures, and whatever can be learned decisively about what is right or wrong is to be gained ultimately by examination of and reflexion upon God's own word. On this view, some purely human authority could, in a sense, have a claim on this allegiance, but only through an individual Christian's holiness and spiritual insight and knowledge of and devotion to the Biblical faith. Such a person, steeped in the Scriptures, prayerful, and reflective in his personal life, could be reasonably trusted to judge about problems of morality and human conduct from the correct, God-centred perspective, but even so, his personal qualities of knowledge and insight would by no means prevent him from making mistakes in reasoning about ethical problems. Wherever there is a practical unanimity of view amongst committed orthodox Protestant believers—as there is, for example, in rejection of euthanasia—the individual believer could argue that he is acting reasonably, given his belief in the Christian and Biblical faith, in choosing to follow the advice which they thus offer him with a united voice.

It is naturally a matter for dispute as to whether, and to what extent, the Scriptures themselves are really capable of giving us everything that we need in this way, especially when it is, in principle, up to the individual believer to examine them for himself and try to work out the guidance which they provide on a particular subject. A critic could argue that the Bible is simply not the sort of book that one can use to 'read off' a systematic moral theory, because it needs to be read and interpreted in the light of genuine Christian tradition, and that even in a large part of the New Testament that contains concrete moral teaching, (e.g., the epistles of St. Paul) there

is still much that is obscure and fragmentary, much that needs interpretation and supplementation by appeal to that tradition. Clearly this is an argument that could be pursued a good deal further than I am able to do here. The crucial point that I wish to defend here is a matter of principle, which can be defended without having to enter into such controversial questions. It is that someone may act reasonably in following the prescriptions of an authority which he recognises as decisive; or at the very least, that an opponent could not, without a good deal of further argument, pronounce that option to be *unreasonable*. The Christian believer does not conceive his acceptance of a guiding authority in matters of moral judgment as a sort of irrational, blind choice of one option against another; he believes, rather, that there are good reasons for accepting the Christian faith. Suppose, then, that these good, sufficient reasons really are concrete because there are justifiable, rational grounds for choosing to accept the Christian faith. Then there is a rationally-justified system of religious belief which is offered for our acceptance, and which is rationally justified precisely because it comes to us ultimately with the authority of God himself. If the Christian faith, as thus conceived and accepted, involves a definite moral teaching, expressed in standards of right behaviour which are considered to be binding on human beings, then the believer's acceptance of those behavioural standards and actions in conformity to them will be justified. After all, if the believer is justified in accepting the Christian faith, he is also justified in accepting the moral teaching which is part and parcel of it.

One who takes this view of authority in ethical matters is surely not obliged, as arguably one would be on all the alternative views, to engage in rigorous philosophical argumentation about fundamental issues in ethics. One simply accepts, for what one believes are good (but largely non-philosophical) reasons, a whole set of religious beliefs and way of life, including the applied ethical teaching which is an integral part of that way of life. There are, of course, philosophical questions and difficulties that arise here, and the Christian believer may wish to investigate them from a strictly philosophical point of view. What is being argued here is only that the believer is not *obliged* to engage in this philosophical task. For the nurse facing ethical difficulties in her work, the position is very much the same: she can say that she is happy to leave the necessary task of philosophical argumentation to others and to take her stand on the moral teaching and tradition which is part of her faith. Of course she has to understand that moral teaching adequately and apply it intelligently in practice. But clearly there are limits to the amount of philosophical or theological involvement that she has to display. Depending on ability, temperament, and opportunity, nurses will vary in the intellectual depth to which they are able to penetrate the moral teaching, based on religious tradition, which they all accept; and this is surely as it should be.

1. Cf. The court report, "Father wins inquest on wife's death in childbirth", by Sandra Laville, in *The Daily Telegraph*, 23 June, 2000, p. 5.

BOOK REVIEWS

Ward Ethics: Dilemmas for Medical Students and Doctors in Training

Thomasine K. Kushner and David C. Thomasma, Editors

Cambridge: Cambridge University Press, 2001

ISBN 0-521-66452-7, 265 pp., paperback, \$30.00

Those of us who have followed medical ethics for a decade or two probably accept the recent division into 'Bioethics 1', covering for example the older issues of abortion and euthanasia, and 'Bioethics 2'—pre-implantation genetic diagnosis, cloning, nanotechnology, etc. But there is a third category of health care ethics which particularly interests current and former clinicians like me—the ethics of everyday practice, the ethics of the clinical world, or, as the editors of this collection of cases and commentaries have termed them: 'Ward ethics'.

Thomasine Kushner and David Thomasma are also co-editors of *The Cambridge Quarterly of Health Care Ethics*. They have compiled a series of more than 80 case studies from around the world and invited leading ethicists and clinicians to comment on them. They felt the need to do this after years of listening to medical students and trainee doctors and have, according to the blurb, produced 'an essential guide to coping with the ethical dilemmas of those embarking on their medical careers'.

But have they? In the first place, this book is marketed worldwide but is heavily dominated by examples and comments from the U.S. Of the 46 invited commentators, 33 are from the U.S. The others are from Argentina (1), Canada (2), Denmark (1), England (2), France (1), Israel (1), Italy (1), Japan (1), and The Netherlands (3). Although the case studies sometimes suggest a country of origin it is not usually possible to be certain, but a similar proportion of the cases seem to be from the U.S. While the fundamental principles of the ethical dilemmas in question apply anywhere, the precise problems are very culture-specific, and U.S. medical culture is very different from European medical culture. So much so, there has to be a glossary translating U.S. terms for us Europeans!

My second reason for suggesting that this book is not best aimed at 'those embarking on their medical careers' is that it is a heavy read. Although often human and even humorous, it is also an academic work, using the precise (and therefore cumbersome) language of social scientists and professional ethicists. In short, for students and doctors in training the book could have been a lot shorter.

But I think this book is excellent, so for whom do I recommend it? This is a book that should be read by those who teach students, by those who train doctors, and by those who oversee undergraduate and postgraduate medical education. Whilst I am grateful (I think) that I trained in London and not in the U.S., the sorts of abuses of students and juniors which are detailed in many of the case histories sadly take place wherever medicine is taught. And they leave their mark: the students and doctors 'often for the first time, reveal cases that continue to cause them discomfort and distress, even though in some cases years have passed'. The anecdotes illustrate pressures to perform procedures (often, unbeknownst to the patient, for the first time); problems in truth telling; setting boundaries; conflicts of socialisation in becoming a team player; argot, jargon, and questionable humour; questioning authority and the status quo; and observing peers or superiors commit an act deemed unethical. Reading these, it is impossible not to realise how ward ethics can in practice become the ethics of survival (for the student or trainee), and how bad habits can be perpetuated when that once idealistic student later gets into a position of power over others.

I found the section 'on becoming a "team player", searching for *esprit de corps* and conflicts of socialisation' the highlight. Three primary models of team operation are described—the military model (running 'a tight ship' in order 'to win the war'), the sports model ('playing by the rules'), and the repair model ('the body as machine'—'making patients as good as new') but are

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discarded in favour of the collaborative model ('everyone has his or her own contribution to make'). The interpersonal relationships within and without the team that flow from these different models have a considerable impact on ward ethics!

The nature of the advice from the experts is sound, and at once both radical yet conservative. Readers of *Ethics & Medicine* will feel comfortable with almost all of it, and occasionally there are pearls which are clearly Christian. Advocating a genuinely 'patient centred ethic', this challenging book will improve the ward ethics of any reader. Even so, I suggest the publishers target this one at teachers and come up with a shorter and more truly international companion for medical students and doctors in training.

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The Nurse Apprentice 1860-1977

Ann Bradshaw

Ashgate, Aldershot UK, Burlington USA, 2001

ISBN: 0 7546 0172 2, vii + 267 pp., hardback, \$79.95

This is a history of the rise and fall of the British apprentice model of nursing, which was initiated by Florence Nightingale and which was to gain not only national but international recognition before it had to yield to the more academic model of nursing developed in America. The tone of the book is somewhat nostalgic; one feels that Ann Bradshaw regrets the demise of the apprentice tradition fostering virtues characteristic of nursing understood as a call, almost on the model of a religious order.

The book begins with an examination of the Nightingale principles of nursing first implemented at St. Thomas's Hospital, in London, in the 1860s. It is argued that Florence Nightingale's Christian faith was of basic importance for her understanding of nursing as a vocation and also for her view that the nurse must be of good moral character; that is to say, temperate, sober, orderly, honest, trustworthy, cheerful, neat and tidy, and respectful of her superiors. It is shown that Florence Nightingale had a hierarchical and authoritarian view of the profession. The matron was at the top, seconded by the ward sisters; and, needless to say, the nurse was to respect the authority of the doctor. She had to obey and to learn from her superiors. Trained by her superiors in the work place, the nurse learned basic nursing skills as well as personal skills. She learned to take a genuine interest in the patient. She also went to lectures, and she had to sit a written examination in addition to her practical examination. Ann Bradshaw describes Nightingale's vision of nursing as a 'synthesis of art and science'.

On the basis of a meticulous study of documents, it is shown how the Nightingale's tradition gained ground worldwide. Textbooks written by matrons, ward sisters, and tutors from the late nineteenth century until the 1980s are examined in order to illustrate the nursing ethos dominating hospital wards for about a century. This, we are told, was an ethos characterised by sensitivity towards the patient and a great humility. No task was ever considered too menial. The human body was viewed as a temple of the spirit to be approached with respect. The nurse learned to be gentle and kind. And, so Ann Bradshaw insists, only the Nightingale apprenticeship method of training with its strong spiritual dimension could achieve this.

As amply illustrated by the author, the practice of registering nurses, which was introduced at the beginning of the twentieth century, was preceded by a lengthy and heated debate. Those who argued in favour of registration held that it was necessary to protect nurses from exploitation and also to standardise training and practice. It was also argued that registration would improve the status of nurses. Those who argued against registration thought that it would lead to an emphasis on technical skills, as opposed to vocational care. And they feared that this would enable morally unsuitable women to enter the profession. The opponents of registration also thought that the system would be difficult and costly to implement. But the profession was grow-

ing and regulation was inevitable. And, according to Ann Bradshaw, the registration of nurses did not threaten Nightingale's vision of nursing as the integration of art and science, although the standardisation of training and the introduction of a national training syllabus entailed a new emphasis on the scientific side of nursing.

It was not until the 1950s that the American influence began to be felt, we are told. Then questions were raised about the training of nurses. Thus it was increasingly questioned whether the British nurse should continue to be trained in the hospital according to the apprentice tradition or whether she should be trained according to a college-based degree programme, as her American counterpart. There can be no doubt about Ann Bradshaw's loyalties. One clearly senses a degree of hostility towards the American model when she writes that the American nursing model is nurse-centred, whereas the British Nightingale tradition was patient-centred.

But the American influence was not to be reversed. Increasingly there was a shift away from the apprentice model, as witnessed by nursing journals and parliamentary debates in the 1960s. Analysing the gradual change of attitude that can be perceived in the leading nursing journals, and other documents at the time, Ann Bradshaw shows that the Nightingale view that the nurse's moral character was fundamental to her professional practice was seriously challenged from many sides and that nursing was coming of age a secularised profession. Seeing herself as a professional, the modern nurse expects herself to assume individual responsibility in a way unheard of before. Lamenting this trend, Ann Bradshaw writes: 'increasing the professional status of the nurse meant decreasing the vocational ethic and attracting a differently motivated recruit, the implications of which have yet to be fully realised'.

In conclusion, the author's bias in favour of the Nightingale apprentice tradition of nursing as a vocation and service may irritate the advocates of nursing as profession, who may see the Nightingale tradition as vestige of the Victorian era. However, the richness of the source material and the perceptive analysis of the same make this book an important contribution to the history of British nursing.

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The New Medicine: Life and Death After Hippocrates (Revised Ed.)

Nigel M. de S. Cameron

Highland Park, IL: The Bioethics Press, 2001

ISBN 0-89107-645-X, 187 pp., paperback, \$17.95

At a recent bioethics seminar, I may have unknowingly picked up the last remaining copy of the previous printing of *The New Medicine: Life and Death After Hippocrates* by Nigel M. de S. Cameron. I was attracted to the book because of my interest in ancient history, and wanted to read the text of the Hippocratic Oath along with an analysis. I found both, and more than I had not expected.

A revised edition has since become available. This printing contains a new forward and the same text as the original edition. In the forward, Cameron addresses the changes in public health care policy and the privatization of biomedical research that have occurred over the last decade, setting the stage for the still timely content of *The New Medicine*. The rest of the book evaluates modern medical ethics in light of the over 2200-year-old tradition of the Hippocratic Oath. Cameron covers the origins of the Oath and the strength of its statement and practice. He then provides an example of medicine operating without the Oath and comments on recent views of the Oath. Finally, he discusses the potential of the Hippocratic tradition to remain in modern medical practice and a glimpse into two futures: medical ethics with, and without, the Oath.

The New Medicine asserts that the Hippocratic tradition is "a tradition of healing" (p. 129). Cameron traces its origins, history, and future. The book's thesis is that the Hippocratic Oath and

practice 1) hold the physician to the highest standards of medical practice, and 2) can provide the patient with the kindest care.

Let me relate a few of the ideas that I found most compelling in *The New Medicine*. The first two chapters cover the text of the Hippocratic Oath, the historical context of its origin, and how the tradition elevates the standard of medical practice. Cameron relies heavily on *The Hippocratic Oath*, a monograph by Ludwig Edelstein (1943). Edelstein identifies the Hippocratic Oath and tradition as a minority view that grew out of the Pythagorean School. Competing philosophies and ethics in this era accepted and promoted infanticide, euthanasia, and suicide. Modern advocates of abortion and euthanasia used the idea that Hippocratic medicine was a minority view to claim that ancient society accepted such practices. Cameron takes exception to this view, pointing to the rise of pre-Christian Hippocratism. The tradition was accepted by virtually all practitioners only a short time after its introduction; the unstated conclusion is that Hippocratic medicine expanded into an ethical vacuum.

The strength of the Oath lies in its covenant between physician, patient, and God, and its “obligations of philanthropy and the sanctity of life” (p. 64). Also significant is its language, the practices forbidden, and topics or practices that are omitted. Cameron asserts that the negative statements (against abortion and against giving poison to patients) lend strength to the ethic of the Oath.

Is there a recent example of medicine losing hold of its Hippocratic tradition? What does it look like? What are its practices? Chapters 3 and 4 offer a history of German medical practice over the first half of the twentieth century and the marginalization of parts of the human population under utilitarian, non-Hippocratic medicine. The disturbing example Cameron gives traces the lapse of medical practice concurrent with Germany’s involvement in World War I and continuing through World War II with the horrors perpetrated by the Nazis. The title of chapter 4, “The Margins of the Human Race,” aptly describes the rationale that tends to arise when the Hippocratic tradition is replaced. “Margins” refer to groups of people defined by a society as lacking worth or status, or even being non-human!

Cameron argues that the Hippocratic tradition is one of healing. If so, what has replaced healing in modern medicine? Not surprising are such things as managed care, procedures instead of care giving, and a disconnection between doctor and patient. Surprising is the ethic of relief of suffering. This is one of the notable omissions from the Hippocratic Oath. Not that the practitioner of the tradition is not compassionate, but this ethic (relief of suffering) is relative and redirects medicine from healing and “Do no harm.”

Is Hippocratism an outdated relic of history? The parallels between today and the ancient time of the original Oath, with respect to infanticide and euthanasia, suggest otherwise. The last chapter discloses Cameron’s ideas on the prospects of the Hippocratic ethic in the future of medicine.

In light of recent health care changes, medical advances, biotechnical breakthroughs, and current bioethical debate, *The New Medicine* remains a timely introduction to the history of Hippocratic medicine and a relevant critique of the modern movement away from that tradition.

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