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Second Opinion

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health, faith, and ethics

Questions at
the Edges
of Life



Norman Cousins Interview • Doctors & Suffering • Euthanasia • Use of Nazi Data

Cover

***Ex Nihilo* ("out of nothing"). Magna on canvas by Kenneth Noland, 1958.**

Collection of the artist. Courtesy of the Salander-O'Reilly Galleries, Inc., New York.

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Second Opinion

health, faith, and ethics



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Second Opinion, as its name implies, recognizes that the complexities of modern health care make it increasingly difficult to find the single “correct” action, thought, or method. Each situation is open to a variety of apparently legitimate and appropriate interpretations and applications. But such confrontations with ambiguity need not lead to discouragement. They can instead elicit greater research, discussion, and thought.

By inviting contributions from a wide range of perspectives, *Second Opinion* stimulates interdisciplinary conversations between members of fields relating to health, faith, and ethics. While other publications deal with one or two of these concerns, *Second Opinion* distinctively seeks to address all three. The Park Ridge Center created this publication in the hope that it will help form one public out of a number of related constituencies. This public will not only wish to relate ethics and faith to health issues, but should also, through lively and enlightened interchange, be better equipped to do so.

Second Opinion

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Shifting the Conversation

When *Second Opinion* first appeared in March 1986, the Park Ridge Center hoped its fledgling publication would stimulate “interdisciplinary conversations between members of fields relating to health, faith, and ethics.” Now some 14 issues have appeared in its still young life, and more than 115 articles. It’s time to see what has happened to the conversation we initiated and where it has carried us.

We can begin our assessment by considering the topics covered to date: the social meanings of illness, hospital chaplaincy, the professionalization of nursing, anorexia nervosa, madness, aging, religion and medicine in other cultures, AIDS, organ transplantation, the interactions among law, medicine, and religion, surrogate motherhood, rural health care, psychiatry, informed consent, the relationship of faith and healing, human experimentation, economics and medicine, suffering, death and dying, Alzheimer’s, human sexuality, abortion, alcoholism, the American hospital, the role of religious communities in health care, euthanasia, human personhood, Nazi medicine.

This incomplete list suggests the scope of the conversation we set out to host. Our fields of inquiry constantly lured us toward new topics; to fail to attend to them would have fostered an irresponsible tunnel vision. Following the lure meant not going as deeply as we would have liked into topics that merit books and shelves of books in their own right. Whether future issues keep probing new subjects or revisit old ones,

there will be no shortage of topics as this conversation matures and deepens.

We could also mention types of contributors. There have been leading public figures like President Jimmy Carter, religious leaders like Cardinal Joseph Bernardin, editors like Dr. Arnold Relman and Norman Cousins, noteworthy scholars like Renée Fox, Richard McCormick and Daniel Callahan. But right next to these “notables” have been people we’ve never heard of before: the father of a long-term patient in a neonatal intensive care unit, the recipient of a transplanted heart, a doctor whose medical mistakes led him to a new career caring for the homeless, a husband who chose to let his wife die, a survivor of 20 years’ experience with cancer. This journal aspired to more than simply speaking in secondhand ways about human experience. It wanted to bring voices of reflection and voices of experience into dialogue.

Alongside these voices from the school of suffering were those of journalists, attorneys, ethicists, historians, sociologists, theologians, and a variety of health care professionals. The conversation we wanted to nurture required many participants; we hoped that it would cross conventional conversational barriers, that new interchanges would occur. We were wary of solitary perspectives, so we placed physicians’ viewpoints next to sociologists’, patients across from ethicists, journalists alongside theologians.

And these contributors used a number of genres.

Second Opinion has featured opinion pieces, scholarly articles, interviews, journal entries, poetry, photo essays, point and counterpoint arguments, a drama excerpt. We wanted analysis, opinion, artistic expression, and candid commentary to remind us of the many dimensions of human reflection and action. We sought a full, richly human conversation.

Has the conversation taking place in *Second Opinion* made any difference? We think so. Other conversations have been interrupted as we have pulled people away to talk with us. From time to time we notice others bringing *Second Opinion* into conversations they are having or articles they write. Occasionally an author tells us how writing for us helped to clarify something, sometimes in surprising ways. Earlier this year, for example, Harry Cole published *One in a Million* (Little, Brown), the book-length version of his and his wife Jackie's experience with a decision to forgo life-sustaining treatment. He had taken a trial run at telling this story in our pages (Volume 7). Near the end of his book (p. 262) Cole describes how theologian Donald Shriver's response to his article changed his understanding of his own experience. The impact of a second opinion isn't always as clearcut as in this case, but Cole's experience demonstrated that the interchange we were nurturing was making a difference.

Our enterprise has rested on a fundamental conviction that new perspectives on modern health care issues were needed. We kept adding new and often contradictory perspectives in the hope that the existing conversation would begin to shift toward greater responsiveness to the deep beliefs and values present

in every health care situation. We hoped to open the conversation to the faith dimension; we wanted to bring religious perspectives to the bioethics table. Just how well we have done remains to be seen. Not every article was a hit. Much remains to be said on all the topics explored. But we do sense a growing interest in the type of conversation we are fostering, and for that we are grateful.

The conversation changes constantly. New topics demand attention. New people seek to add their voices. And existing conversation partners assume new roles. As I move to new responsibilities as Program Director in Religion at the Lilly Endowment, my place in this conversation changes, and *Second Opinion* is now handed over to other conversation shapers. In this case it is easy to change places because colleagues familiar with our project are ready to continue the work. The people who have shared difficulties with me and celebrated the successes will sustain this conversation. I will not name them all here, but I encourage you to review our mastheads and join me in thanking each person named there for starting the conversation and keeping it going. They will be joined and energized by Martin E. Marty as he assumes a new editorial role in the Center he has led and shaped. And I will enjoy watching their work from the Associates' side of the table—a place populated by a faithful and encouraging group of readers and supporters.



James P. Wind



The Doctor. *Painting by Sir Luke Fildes, 1891.*

Courtesy of the Tate Gallery, London, and Art Resource, New York.

Medicine and the Question of Suffering

Richard B. Gunderman

*As sickness is the greatest misery, so the greatest misery of sickness is solitude; . . .
Even the Physician dares scarce come.*
—John Donne

DURING THE EARLY PART of my medical training, over the course of a week or two at a certain hospital, I had become acquainted with a man about my age, whose name I have since forgotten. He suffered from a rare form of bone cancer. Before his illness he had worked as a tradesman and had recently graduated from apprenticeship in his craft. While horsing around with his kids one weekend, he bruised his right arm, and later a persistent pain developed deep in the bone. He gave it little thought until several months later, when he noticed a swelling at the site, which gradually grew larger. He decided to see his family doctor, an unusual circumstance for this robust man. After a series of referrals, he was admitted to our tertiary care center for definitive diagnosis and experimental therapy.

In the hospital, it was his habit to roam the halls late at night after his wife and small children had gone to their lodging. I never asked him whether it was pain that kept him moving or perhaps loneliness and a simple desire for conversation. One night, having completed my work for the day, feeling too tired to read on my own, and facing no other prospect but to give in to sleep, I felt like talking.

On that night, and on other nights following, we discussed nothing in particular. Our conversation might turn to his aspirations at work (he hoped someday to start his own company) or to my thoughts about medicine. For a time he would talk about his plans for the future as though they were still foremost in his mind, but before long he would lapse into the past tense

Medicine tends to ignore suffering. Doctors know that patients suffer, of course, but many doubt that suffering is a problem about which physicians could claim to “know” something.

and grow sullen. In retrospect, I think that a part of him was looking for encouragement, but what little I knew of his condition made medical reassurance nearly impossible. I hid from his pain by focusing on the bright side of things. It was a kind of dishonesty, though at that early point in my medical training I did not recognize it as such. What we had was better than silence, but we never really talked.

Two images concerning this man have remained in my mind. One night, after I had been away for several days, I met him again in the semidark hallway near the nurses' station. He was asking a nurse to bring something to his room, and I was coming to ask her a question. For some reason, she proceeded to introduce the two of us—a rare event by hospital standards. Equally strange, neither he nor I spoke up to say that we already knew one another. I put out my hand to shake his, and he started to do the same; then it hit me: his arm was missing. It had been amputated as part of his treatment.

I should have anticipated the amputation, but somehow, in my naiveté, and as I was not involved in his care, it came as a surprise to me. In the instant before my hand withdrew and I looked down, at a loss for what to say or do, I caught in his eyes a look of sorrow, perhaps even shame. I begged his pardon, but we did not speak further. The nurse had time to accompany him back to his room, and in the meantime I was called away. We never met again.

The second image, more disturbing, concerns an in-

cident that occurred only a week or so later. Early one morning I was attending a routine autopsy seminar in the basement of the hospital. In this ritual, a brief description of a case is written on a chalkboard, which the small audience studies before the pathologist makes a presentation. I read the entire history and clinical course, and even heard the presentation of the case, without the slightest hint of recognition. Only when the pathologist emphasized the rarity of this cancer—he wanted us to know that we would never see another like it—did I realize that I knew this patient.

I remember little else about the presentation, but one statement snapped me back to attention. Pointing to a number of metastases on the surface of a section of lung he was holding, the pathologist paused to express amazement at the speed with which the cancer had spread. Surgery, chemotherapy, radiation—nothing had slowed its relentless growth. The image of that tissue in his gloved hand remains with me. Like the arm that had unexpectedly disappeared, now the patient himself was gone.

In the days that followed, I could not make sense of what had happened. How could God subject this honest man and his young family to such torture? Explanations and justifications rang false. Could I have done anything differently? I wanted to write to the man's family, whom I had only seen at a distance, but I could find nothing to say. How could I comfort them? What words of appreciation or condolence could I offer, when I had no answers for myself? Lack of understanding,

detachment, and blindness had prevented me from recognizing and responding to the man's pain while he lived. Now that he was dead, I was more in the dark than ever.

OVER THE SIX INTERVENING YEARS, my questions have brought me back to a novel I first read in high school, Albert Camus's *The Plague*. As I thought about the man with bone cancer, I was being pulled in opposite directions—a situation dramatized in the novel by the conflict between two characters: Rieux, the physician, and Paneloux, the priest.

The novel takes place during an outbreak of plague in the Algerian town of Oran in the 1940s. At a crucial point in the story, the doctor and the priest together witness, minute by minute, the excruciating death of a child. Through the victim's wails, the priest cries out to God to spare the boy. Days later, and shortly before his own death, the priest preaches his last sermon. In it he agonizes over what he has seen. He tells the congregation that we must accept such agony, even though we do not understand it. In his eyes the sufferings of children are our bread of affliction: without that bread our souls would die of spiritual hunger. "My brothers, a time of testing has come for us all," he preaches. "We must believe everything or deny everything. And who among you, I ask, would dare to deny everything?" (Camus [1947] 1972:208).

Dr. Rieux, faced with the possibility of a deity who

could cause the suffering of innocent human beings, concludes that he must deny God. He is sick of the world, though he likes his fellow humans. Alone under the vast indifference of the sky, he has no choice but to be human, which for him means to fight against creation as he has found it. "Mightn't it be better for God if we refuse to believe in Him and struggle with all our might against death, without raising our eyes toward the heaven where He sits in silence?" (Camus [1947] 1972:121).

The arguments are familiar, perhaps all too familiar. We must deny human suffering, or we must deny God. If God were all powerful and all good, then innocent human beings would not be put to torture. Perhaps, then, we do not understand God? Perhaps we, with our limited vision, do not know what the good of creation really is? Perhaps we convict ourselves of the sin of pride the moment we presume to say what God would (or should) do? And yet, can those of us who have known suffering deny its reality? Can we face squarely the ravages of a person's death from cancer and convince ourselves that at some higher level it did not happen? Can we pretend that such agony is for the best? Shall we deny the human experience, or shall we deny God?

I have no theodicy to promote, no explanation or justification of why bad things happen to good people. Like Father Paneloux, I find it impossible, finally, to deny the reality of God, however inscrutable. Like Dr. Rieux, I cannot deny the reality of human suffering—

If I wanted to be a doctor, and not, say, a chaplain, I had to learn to think in terms of the facts.

human beings suffer, and we are the worse for it. The path of saintliness appears closed, but so, too, the path of humanity, at least if to be human means to turn one's back on God. In short, I have found no comfortable posture in wrestling with these questions. What I failed to do on the ward and what I saw in the morgue still haunt me.

Yet I have learned something since then. Perhaps I am no closer to definitive answers. But I have evolved an approach, however incomplete and provisional, to caring for patients (literally, "those who suffer"). Looking back, there are things I could have done differently.

I have become suspicious of the place typically accorded suffering in medical training and practice. Medicine tends to ignore suffering. Doctors know that patients suffer, of course, but many doubt that suffering is a problem about which physicians could claim to "know" something.

Pain, disability, decay, and death are medical facts of life. Even the most aggressive of clinicians will admit that medicine cannot cure every disease. Nor does it provide a remedy for senescence—at least not yet. What, then, can the doctor do? Technical know-how in recognizing and fighting disease does not necessarily provide insight into the personal experience of suffering. What can medicine do when it cannot cure—when there is no disease, or there is too much disease, or, as often obtains, the disease is only part of the patient's need?

It is curious that, in an age when medical science can

do more than ever before in the diagnosis and treatment of disease, patients express increasing concern about the humanistic qualities of physicians. Patients complain that doctors do not talk to them or take the time to get to know them. Amid the technological triumphs of modern medicine, patients sometimes feel they are being treated as machines.

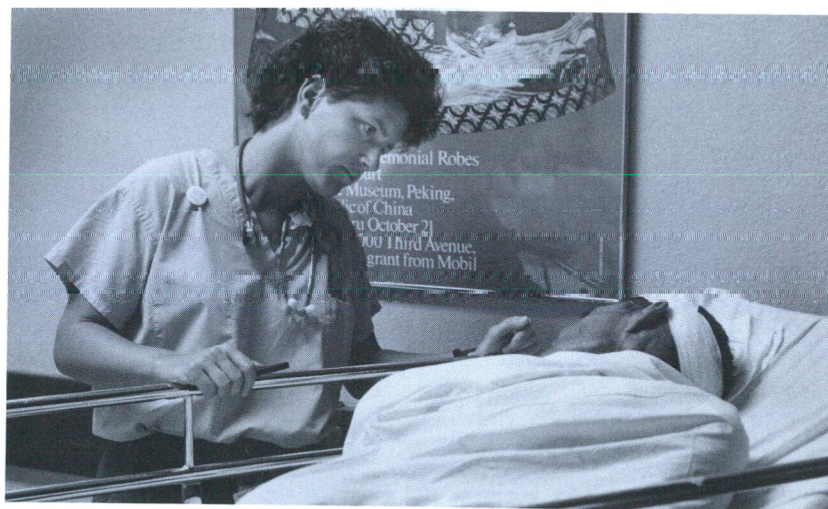
To some extent, I think, the patients are correct. Physicians are taught to think of human beings as machines. Physiology textbooks, for example, often employ the word *mechanism* in their titles, as in "the mechanisms of body function." Respectable therapies have "mechanisms of action." Physicians learn to think of the body as a machine—an integrated system of parts, each of which can be removed, repaired, and in some cases, replaced.

Physicians are certainly not trained to think of their patients as mere machines. Every doctor knows that illness involves suffering and that machines do not suffer. In the human case, suffering is more than mere malfunction. Yet physicians are taught to feel most secure when they can offer a mechanistic explanation for the patient's condition. Psychiatry notwithstanding, a "real" disease is one that involves an anatomic defect, whether at the level of molecules or organ systems. Where there is no broken part, the disease is referred to as "primary" or "functional." In the case of the man with bone cancer, the pathologist pointing to the metastases on the lung was displaying the disease. He held it there in his hand. Yet I was overcome by the intense disparity

between the patient I had known and the diseased organ before me. This monstrous object most emphatically was not the suffering human being I saw, or had failed to see, before. So long as I concentrated on the corruption of the tissue, I overlooked the suffering of the whole patient.

To suffer is not merely to endure physical pain, although severe or chronic pain can overturn a patient's life. The doctor must attend to that pain but see beyond it as well. Beyond the reach of the hypodermic needle is a human being trying to cope with affliction. The disease has touched not only pain receptors but the patient's whole being. The patient suffers from loss of competence, loneliness, lack of understanding, anxiety about the future, shame; where are the receptors for these very real forms of suffering? Those aspects of human suffering must be attended to.

I failed, somewhat willfully, to understand what the man with bone cancer was going through. At the time, I was learning to think of health and disease in terms of molecular biology and the like. When the discussion turned to his illness, I thought of lab values and radio-



Head attending physician on the night shift talks to a patient lying in a bed in the hallway. Bellevue Hospital emergency room, New York City.

Photograph by John Griffin, courtesy of the Image Works, Woodstock, N.Y. All rights reserved.

graphs. These were medical facts—facts that a doctor could know, and know for certain. They could be precisely quantified and diagrammed. I could find them in the medical record, the official version of the patient's story. If I wanted to be a doctor, and not, say, a chaplain, I had to learn to think in terms of the facts.

What did I know about the patient's suffering? It was painful to me—painful in ways my medical textbooks never addressed or explained. To understand his suf-

Because of my excessive attention to the “right” thing to do, I failed to hear what the man was saying.

fering, I would have had to put myself in his place and thereby open myself to his pain. I, too, had a young wife and a promising career. I, too, found it difficult to conceive that all of it might be cut short. I, too, had doubts about a world in which an honest man with a wife and young children could be cut down in the prime of life. “But what was this?” I asked myself, “mere emotion—sentimental drivel, really. The work of medicine is to diagnose and cure the body, not to succor the soul.” I had my hands full with the science of medicine. Perhaps later, when I had more time to think, I would reflect again on suffering.

In learning to think like a medical scientist, I was forgetting the whole patient. To help the patient in times of suffering, the physician must know the patient: not only as a case but as a person. Each patient has a history, a unique story to tell, which goes beyond the information in the medical history. Different patients have different senses of what makes life important to them, what they want out of life, and how far they are willing to go to preserve it. The patient’s full story, like any person’s story, includes his or her cultural background, childhood circumstances, career, family, religious life, and so on. It includes the patient’s self-understanding, appearance, manner of expression, temperament, and character. In short, it includes those attributes that make the patient a person—and not only a person, but this particular person.

I see this most acutely in decisions to decline therapy. One elderly patient declined an operation because he

felt that his life had reached its natural conclusion, that he had lived long enough. To submit to surgery when he would inevitably die within the year would have been, in his mind, to fail to face up to his own mortality. The decision to decline treatment was *his*, not only in the sense that he made it, but in the sense that his character and history were reflected in it. His family understood and accepted his decision; they knew that it was compatible with his religious faith and the culture in which he grew up. Another elderly patient, by contrast, declined an operation for no apparent reason; he simply “did not want to be cut open.” The staff members were confounded, and questions began to be raised about the patient’s competence. Further probing, however, revealed that a relative had died during an operation when the patient was a child, and he had been afraid ever since of doctors and especially surgeons.

The fitting thing to say and do with one patient is not always fitting with another. To be true to the patient, one must know the patient.

Recently I have come to think that our focus on ethical and legal issues in medicine, intended to improve medical care, may have harmed it as well. We emphasize the principles that should govern the encounter between patient and doctor. What action on my part will maximize the patient’s autonomy? What is the beneficent thing to do in this case? How can I achieve a just resolution between the good of the patient and the good of society? At its worst, reliance on principles makes it seem as though the “right” thing to do were

floating up in some ethical stratosphere, to which only ethics committees and Ph.D.'s in philosophy or theology have access. Principles can get in the way. In fact, the appropriate response, if there is one, is right there in the case itself, in the mutual understanding of doctor and patient (and family, friends, nurses, and so on).

In my naiveté, I was reluctant to talk with the man who had bone cancer in part because I had no responsibility for his care. Would it be "right" to talk with such a patient about his condition and the care he was receiving? Because of my scrupulosity, my excessive attention to the "right" thing to do, I failed to hear what the man was saying. He was not looking for a second opinion, nor was he collecting ammunition for a malpractice suit against the hospital. He was a dying man, searching for understanding and compassion. I failed to discern the difference.

THE NOTION THAT THE HUMANE ASPECTS of medical care are separate from the good physician's clinical skill is mistaken. Good medicine engages the whole human being. The heart cannot feel if the eyes do not first see, and the eyes cannot see if the intelligence fails to discern. Better put, the physician cannot see the whole patient unless heart and eyes and mind are all working together. Discernment, caring, insight—in other words, the ability to see what is really at stake and to act accordingly—are at work in all three.

To put the point somewhat differently, there is no

dichotomy between fact and value in medicine. Health is good for us. To know health is to understand that it is good for us. So, too, illness is bad for us, and to understand illness is to know it as bad. Nature itself is not mute on these points. I suspect medical ethicists when they begin to talk as though the ethics were somehow independent of the medicine, as though it were a recent addition to the profession. To be sure, recent changes in medical science do pose novel problems, which have produced an explosion in biomedical ethics over recent decades. But the ethical dimension of medicine is not a twentieth-century invention.

The ethical concern for what is good or bad for the patient, the physician, and the community is there from the start. Matters of character have always governed the selection, education, and practice of physicians. Ethics is an integral aspect of good medicine, and there is no good medicine that is not ethical; that is, there is no good medicine which does not call upon the character and vision of the physician just as much as upon the physician's fund of knowledge and clinical skill.

Good medicine depends on the character of the physician. Excellence does not lie in adherence to standards, whether ethical, legal, or even medical. A signed informed consent form does not prove that the doctor has really talked with the patient or the family. The physicians who avoid malpractice litigation are not necessarily the best in their field. The "standard of care" does not correspond to the highest calling of the medical profession. Such standards represent a minimalist account of

There is no good medicine which does not call upon the character and vision of the physician just as much as upon the physician's fund of knowledge and clinical skill.

medicine—the very least that patients can expect from their doctors. Good medicine no more depends on informed consent and the like than good marriages depend on "prenuptial agreements."

Medicine is a job, but it is not a job like any other. It is first and foremost a profession. Current usage notwithstanding, doctors are not health care providers, and medicine is not a commodity. Doctors care for patients, suffering human beings. They attend some of the most poignant moments of human life: birth and death, decay and growth, injury and regeneration. To do this well requires mutual understanding, which is threatened by excessive reliance on ethical principles. It also requires a sense of trust, which is undermined by the built-in suspicion and antagonism of our litigious age. It requires above all that doctors treat patients as whole persons, and not as diseases, clients, consumers, adversaries, autonomous agents, children, or subjects. Trust, understanding, compassion, and respect are fragile things, whose cultivation requires excellence of both the individual physician and the profession as a whole. Neither excellence is sufficient (patients, families, and communities are involved as well), but both are necessary.

I am not saying that the more doctors become involved with their patients, the better the care they will provide. There is a tension in medical practice between the need to get to know one's patients and the danger of getting too close. Physicians must be mindful of that hazard. For one thing, excessive involvement can inter-

fere with sound judgment. I know of one physician who treated her own father, with whom she lived, for decades. She mismanaged medical problems that were beyond her own expertise and which, had they been diagnosed sooner, could have been effectively treated. As her father's condition progressed and he entered the last weeks of his life, she found it impossible to let go, to discontinue therapies that were clearly burdensome to her patient. The roles of daughter and doctor had become muddled in her mind, and she later regretted her approaches to both. Excessive involvement can also overburden the physician's own reserves. One cannot care for every patient as one would for one's parent, spouse, or child without becoming completely exhausted, of no use to anyone.

Yet I find that the danger of becoming too involved with patients tends to be overstated. Given the great technical and institutional demands on the time and energy of the contemporary physician, the most present danger is not that of becoming too involved with patients, but the danger of not becoming involved enough. Perhaps this is less true in private practice, but it certainly applies at many academic medical centers. Medical students and residents see medicine at its technical best, but at its humane worst. Time to get to know patients is short, and continuity of care is difficult to ensure. As a result, the contest between the doctor and the disease threatens to supplant the doctor-patient relationship as the benchmark of medical education.

Patients need and want to share their experiences

with their physicians. The need to communicate, to understand and be understood, runs deep in us all. Patients, who are going through especially trying experiences, are no exception. They need the right environment to tell their stories: sufficient time, a quiet place, privacy. They need a patient and attentive listener, who can help them to find the right words without taking over. They need someone who cares enough to let them know that their story has been heard and understood.

Many other hospital personnel can fulfill this responsibility, but it is one that good doctors do not shirk. The patient looks to the physician because physicians are the experts in the science of health and disease (*physician* originally meant "natural scientist"). The doctor is also the patient's teacher (from the Latin *docere*, "to teach"), the director and interpreter of the patient's medical care.

In part, the quality of the relationship between doctor and patient hinges on the doctor's ability to assume, at least intermittently, the patient's point of view. Socrates argues in the *Republic* that the best doctors are the ones



*Dr. Jordan Glaser checks on an AIDS patient who was an intravenous drug user.
Staten Island Hospital, New York.*

Photograph by John Griffin, courtesy of the Image Works, Woodstock, N.Y. All rights reserved.

who have been patients themselves. Having been sick, they know the patient's experience "from the inside."

Healers have been around for thousands of years—since long before aseptic surgery, radiography, antibiotics, molecular genetics, and the other mainstays of modern medicine. It would be unreasonable to suppose that healers have not been helping their patients all this time. They obviously helped their patients in some important ways, and they did so without benefit of the

I know doctors who say that the deepest and most rewarding moments of their careers occurred when they were caring for dying patients.

modern armamentarium. It would be equally unreasonable for medicine to lose sight of the benefits that have flowed from good relationships between healers and patients. Mere hand-holding will never suffice, but neither will mere technical skill, which might soon be provided more unerringly by machines. Good doctors do not choose between the science of medicine and the art of healing; they combine the best of both.

KNOWINGLY TO CHOOSE A CAREER IN MEDICINE requires courage, and so, too, does caring for patients. To care for the patient means opening oneself up to the reality of suffering, and thereby to the possibility of suffering oneself. The technician, the entrepreneur, and other false characters in medicine may have fewer cares; sometimes a beleaguered colleague may look upon them with envy. Yet a carefree life can also be a careless and shallow life, lacking in the human moment which makes medicine a genuine profession.

Caring for patients also involves recognizing that there is something bigger than we are. Even today, in an era of medical triumph, doctors work in the shadow of forces beyond the knowledge and control of both doctor and patient. Like the patient, the doctor must wait to see what happens. If we suppose that we are in complete control—that wounds heal because we make them heal and that patients decline because of our errors—then we fail to appreciate our true status as parts of a larger reality.

The need to understand and control, of course, is great. Part of the allure of a medical career is the special knowledge it seems to confer in matters of life and death. When knowledge and control are threatened, some physicians begin to disengage. On morning rounds, for example, some medical teams spend less and less time with the "terminal cases." Perhaps they reason that their time is better spent elsewhere, with patients for whom they can do some "real" good. Yet terminal patients need their doctors then as much as ever. Knowing that one could withdraw from the situation and avoid patients' pain, one needs courage to answer their calls—it is easier to pretend that one does not hear, to keep walking. On the other hand, I know doctors who say that the deepest and most rewarding moments of their careers occurred when they were caring for dying patients, in some cases relatives or friends. These doctors did not know what they would do beforehand, nor could they control the unfolding events, but they were there and they cared.

Even courage and compassion, however, can be wrongly informed, as occasionally happens when the so-called behavioral sciences are applied to medicine. These days it is fashionable to talk about suffering in terms of "the coping process," "the stages of bereavement," and "grief therapy." Such formulations, however, imply a detachment from suffering which belies the human significance of the patient's experience. The very notion of behavior, as opposed, say, to experience, implies that one is observing from the outside. It tends

to discount the very real center of experience inside the patient—the experience that makes suffering human in the first place. As a result, compassion is undermined. It also implies that suffering is a stereotypical process: no different from one person to another and no different in principle from any other process, such as the process of excreting bile.

Like ethics and the law, the behavioral sciences can illuminate medical practice, but physicians must find their own way. Facing death is not a process or a behavior. It is a profoundly meaningful human endeavor that both limits and defines human life. Few things in medicine have disturbed me more than hearing colleagues emerge from a dying patient's room with the facile diagnosis that the patient was "in denial." To be sure, patients do have difficulty accepting their fates, but this is no warrant for the physician or anyone else to stop listening.

Nothing I have said here in any way blunts the difficult questions with which this essay opened; if anything, my approach only sharpens them. In a sense one form of suffering is being exchanged for another. When I failed to discern the needs of a patient, I felt remorse. Now when I try to answer such a call, I lay

myself open to sorrow.

Yet one suffering is very different from the other. One is the suffering of isolation; the other the suffering of communion. One entails denial; the other acceptance. One shuns human life; the other embraces it, in ample awareness of all its difficulties and ambiguities. The tension between the doctor and the priest is still there, especially as I continue to devote myself to medicine.

The pathologist's discussion of the man with bone cancer denied some things and accepted others, though in ways I did not appreciate at the time. He wanted us to know that we would never see another case like it. He was right. The man with bone cancer is gone. Viewing his lifeless remains only heightened the loss I felt, too late, at his passing. There could be no second chance. Yet the man with bone cancer was also a human being who suffered in a human way. From him I learned something about suffering; something that binds together doctors and patients as human beings; something in the eyes and in the outstretched hand. In a sense, each of us is a case like his. Only in awareness of this, it seems to me, can we truly be there for our patients. ☸

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Prisoner. Woodcut, softened by rubbing, by Christian Rohlfs, 1918.

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The Ethics of Using Nazi Medical Data

A Jewish Perspective

Mark Weitzman

DURING THE TIME OF THE THIRD REICH, Nazi medical and scientific personnel conducted numerous experiments using concentration camp prisoners as involuntary human subjects. In these experiments researchers studied the effect of extreme cold, extreme low pressure, and ingestion of seawater upon individuals; they gave some subjects injections of infectious bacteria and performed bone and limb transplants, castration, and sterilization on others. After the conclusion of the Nuremberg "Doctors' Trial" (Harris 1970:423–27), the experiments ceased to be an object of public attention, although their existence was generally known.¹ Researchers, however, have known about the existence of the data and have utilized it. In December 1984 a researcher reported finding at least 45 articles that cited

or drew upon the Nazi experiments (Moe 1984a:5). In 1988, research being carried on primarily in Canada and Minnesota caused the issues concerning the experiments to resurface.² Is it ethical to use data garnered from Nazi medical experiments, when these experiments are unanimously acknowledged to have been barbaric, cruel, inhumane, and murderous? Obviously, the question evokes passion and controversy, particularly among Jews sensitive to the issues of the Holocaust. For traditional Jews, this question must be answered with the help of the same sources and methodology that guide their inquiry into other medical-ethical questions. But that approach, used in this article, provides a useful model for those outside the Jewish tradition as well.

No questions were asked about the human guinea pigs—who they were, how they were selected—and certainly no protests were offered.

To explore the question, we must first understand the nature of the Nazi experiments. Those spurring the most recent controversy are the experiments that investigated the effects upon humans of exposure to freezing water (hypothermia). The experiments, begun in 1942, were the brainchild of Dr. Sigmund Rascher, a Luftwaffe (Air Force) scientist. Because Luftwaffe pilots faced such exposure when their planes were shot down over the Atlantic Ocean or the North Sea, the research was expected to contribute to the Nazi war effort. The knowledge gained would help save valuable skilled pilots for further use in the war. Rascher was able to obtain active support for his program from Heinrich Himmler, head of the Gestapo and Waffen SS. According to a Nazi memo of October 8, 1942, "the approval of the Reich Leader SS [Himmler] was obtained in making available suitable testing facilities through the SS" (Mitscherlich and Mielke 1949:20). The facility referred to was the Dachau concentration camp. The experiments began in early October 1942 and were initially kept secret. Nonetheless, after some internal debate and Himmler's intervention (upon Rascher's request), it was decided to present the findings at a conference on "Medical Questions in Marine and Winter Emergencies," convened by the Luftwaffe in Nuremberg on October 26 and 27, 1942. There, an audience of 95 German scientists learned the results of the experiments:

Only a limited number of investigations could be made on human beings recovered after extensive

exposure to cold water. . . . The speed with which rigor ensues is remarkable. It was established that increasing rigor of the skeletal musculature appears within five to ten minutes of immersion. . . . When rectal temperature declines to 88°, consciousness is impaired, and with a further decline to below 86° there is a transition to deep cold narcosis. . . . When temperature sinks below 82.5°, the arrhythmical heart action may lead to sudden heart failure. (Mitscherlich and Mielke 1949:24)

No questions were asked about the human guinea pigs—who they were, how they were selected—and certainly no protests were offered there.³ Other objections were raised. The SS felt that these experiments were not getting the support they deserved from the Luftwaffe, and an internal power struggle ensued. As a result Professor Erich Hippke, chief of the Air Force Medical Service, issued an endorsement of Rascher's work, insisting that "you are mistaken . . . in assuming that I, the responsible head of all medical-scientific research work, ever offered the slightest opposition to the freezing experiments on human beings, thus impeding their progress" (Mitscherlich and Mielke 1949:24).

An assistant to Rascher described the experiments as follows:

The dry freezing tests: . . . The first experiment was conducted in the following way: a prisoner was placed naked on a stretcher outside the barracks. This was in the evening. He was covered with a sheet, and every hour a bucket of cold water was

poured over him. The test person lay out in the open like this into the morning. The temperature of these test persons was taken with a thermometer.

Later Dr. Rascher said it was a mistake to cover the subject with a sheet and to drench him with water. This caused the wrong effect since the air could not reach the drenched person. In future the test persons must not be covered.

The next experiment was a multiple test on ten prisoners, who were exposed in turn, likewise naked. In one case temperature was measured by a galvanometer, in the rest by thermometer. I do not recall precisely, however, whether there were fatalities during these experiments and how many. I should like to state, with reservations, that about three victims lost their life at this time.

During one of the next days Rascher called up and said Grawitz [Ernst Robert Grawitz, chief SS physician] had visited him and demanded that at least 100 tests of this kind be conducted. . . . (Mitscherlich and Mielke 1949:30–31)

Rascher's experiments were enthusiastically supported by Himmler, who even made suggestions regarding methods of rewarming the human subjects. He wrote to Rascher in 1942: "I have received the intermediate report on the freezing experiments at Dachau. I should nevertheless arrange the tests in such a way that all the possibilities—rapid warming and warming by medication or animal heat—can be tried in turn" (Mitscherlich and Mielke 1949:22). The experiments continued into 1943, following the same pattern.

Before attempting to decide about the ethics of using data gathered in experiments like the ones on hypothermia, we must first ask whether the data is worth using. Is there such a thing as usable Nazi science, or did the corruption that extended into Nazi ideology and practice also infect Nazi science? Opponents of using the data have often argued this latter point. At the Nuremberg trial, Brigadier General Telford Taylor opened his prosecution of the doctors by stating that "these experiments revealed nothing which civilized medicine can use" (cited in Moe 1984a:5).

Certainly Rascher did rely upon the patronage of Himmler, whose endorsement of him had come about because Rascher had announced astounding results in increasing fertility among older women (he claimed that his wife had given birth to two children after she had passed her 48th birthday). For Himmler, who had a passionate interest in increasing the Aryan population, this was dramatic and important news. However, when Himmler found out that the babies had been kidnapped from orphanages, that there had been no births, his revenge was quick. Rascher's wife was sent to Ravensbruck concentration camp, where she was eventually hanged, while Rascher was imprisoned in Dachau. Just prior to the camp's liberation he was shot on Himmler's orders (Kater 1989:126). Thus even his Nazi superior found the chief figure in these experiments corrupt, not only as an individual but equally as a scientist. According to Benno Muller-Hill (1988:99, 204), Rascher even faked experimental data for his grad-

All of us are students of the Holocaust, and all of us must be involved in teaching its lessons as well.

uate thesis. These arguments can be used to question the credentials of at least this Nazi researcher.

On the other hand, Leo Alexander, the U.S. Army Medical Corps officer who evaluated the hypothermia experiments after the war, concluded that the experiments "appeared to have been conducted in a reliable manner" and "satisfied all the criteria of objective and accurate observation and interpretation."⁴ Alexander was no apologist for Nazi medicine; he called Rascher a man who "wallowed in blood . . . and in obscenity." He also felt that the Nazis never made "any original contribution" and that if they had never done these experiments, "science would be no different today." Alexander's report was declassified after the war and distributed with the Publication Board's hopes that it would be "of direct benefit to U.S. science and industry" (Moe 1984a:6). This declassified report has served as the most prominent source of citations of the Nazi medical data.

Today, some researchers use only part of the data. As John Hayward, of the University of Victoria in British Columbia, said, "I use it with my guard up, but it's useful" (cited in Moe 1984a:5). Hayward has developed a "thermofloat jacket" now used by sailors the world over and has also contributed to U.S. Navy research on hypothermia (Eberts 1985). Dr. Robert Pozos, a University of Minnesota researcher whose recent use of the material helped open the controversy, believes that the only existing study on hypothermia that can really give such information to the extent needed is the Dachau

study ("MacNeil/Lehrer NewsHour," 1 August 1988). One of the most recent studies of medicine under the Nazis assesses the initial rationale for the experiments in a somewhat neutral vein: "The experiments were undertaken not out of sadism, but to gain knowledge about certain conditions faced by German military men" (Proctor 1988:217).

In conclusion, although no consensus exists on the scientific worth of the Nazi experiments, some experts have judged them to be of value, and therefore our opening question remains valid: are we justified in using these data?

As the primary victims of Nazism, Jews have a particular stake in questioning the morality of any profit gained from that system. Traditionally, Jewish law, the Halakhah, has dealt with such legal and ethical questions. However, since none of the post-Holocaust Halakhic sources deals specifically with this issue, the discussion offered here can be only a preliminary exploration.

The late Seymour Siegel, a Jewish theologian who specialized in medical ethics and was executive director of the U.S. Holocaust Memorial Council, believed that use of the research results "just compounds the felony" (cited in Moe 1984b). We become accessories to the crime. Dora Zaidenweber, an Auschwitz survivor interviewed on the MacNeil/Lehrer television report (1 August 1988), added another reason: use of these data could eventually lead to justification of Nazi actions, or even Nazism—"the Nazis will suddenly become good

guys because they found a cure for something." Use of the material could help relativize, possibly remove, the sense of absolute evil that we commonly associate with Nazism—in effect, a subtle form of Holocaust revisionism. A last objection is that by using this material we might encourage further inhumane experiments in other societies, or in our own future society.

Each of these arguments must be taken seriously. Nevertheless, we cannot seriously compare modern U.S. society and Nazi Germany. Thus we cannot accept Siegel's claim that using the data would make us accessories after the fact. Though the risks of the "slippery slope" are real, they are diminished by other factors: the open discussion that has surrounded the topic; the attempt to search for guidelines by considering the full range of ethical, scientific, and religious precedents; the concern shown by the researchers who initially broached the topic; and the interest of the press, who widened the range of discourse. Each of these factors is part of a process radically opposite from the Nazi process, which was marked by secrecy, charlatanry, and contempt for the rights of the experimental subjects.

Furthermore, every part of civilization is built upon past knowledge, whether it is positive or negative in our eyes. We cannot simply say that the data is corrupt and thus dismiss it. It exists, it has entered the literature, and it has been accepted by some experts in the field as being of value. The survivors' fears about eventual legitimization of Nazi actions are valid, as is the fear of relativization. But if we accept, or allow, any form of legitimization

of Nazi Germany, then we have failed to absorb any of the lessons of the Holocaust and to communicate them to the world.

With these cautions in mind, let us now turn to the resources offered by the Jewish tradition. During a MacNeil/Lehrer report (1 August 1988) devoted to this topic, Rabbi Herbert Yoskowitz of Minneapolis observed that "the book of Leviticus includes a statement that we are to pursue righteous ends *only if* righteous means are utilized to reach those ends. Data gathered by unethical means on humans should not be utilized." He could have been referring to "You shall sanctify yourselves and be Holy" (Leviticus 11:44), "Faithfully follow My Laws" (Leviticus 18:4), "You shall be Holy" (Leviticus 19:6), or similar verses. However, in all the literature I reviewed, including post-Holocaust responses dealing with medical issues from Israel and the United States, this was the only such statement drawing upon Jewish tradition that directly opposed the use of the Nazi research.⁵

I believe that an opposing argument can be made on much stronger grounds, from within Jewish tradition. Jewish tradition—in this case, Jewish law (Halakhah)—reflects what theologian Eliezer Berkovits (1983:19) calls "the priority of the ethical." Halakhah is "the bridge over which the Torah (the revealed Biblical Law) moves from the written word into the living deed . . . Halakhah is the application of the Torah to life . . . to a specific time in a specific situation" (Berkovits 1983:1–2). According to Berkovits, "the rabbis in the Talmud were guided by

Is there such a thing as usable Nazi science, or did the corruption that extended into Nazi ideology and practice also infect Nazi science?

insight: God forbid that there should be anything in the application of the Torah to the actual life situation that is contrary to the principles of ethics. What are those principles? They are Torah principles." Shalom Rosenberg, professor of Jewish thought at the Hebrew University in Jerusalem, describes how these ethical principles enter Halakhah: "The tension between ethics and Halakhah . . . comes to the fore when concrete Halakhot are formulated. The move from the ethical principles animating Halakhah to the determination of concrete norms is difficult and complex. . . . It may happen that one must perform actions that are morally repugnant, but then too, one is guided by moral principles that point out the way one must follow" (1987:202).

Without question, using anything that has the taint of Nazism is "morally repugnant." Yet an imperative based upon the well-known Jewish reverence for life suggests that the Nazi data may be used. The classic formulation of this imperative is found in the Talmudic explication of the verse "You shall therefore keep my statutes and my ordinances, which if a man do, he shall live by them" (Leviticus 18:5). The Talmud explains: "he shall live by them, but he shall not die by them" (B. Yoma 85b; B. Sanhedrin 74a). Thus the conclusion, reiterated throughout Jewish history, that (with the three exceptions of murder, idolatry, and sexual immorality) a Jew is required to do whatever possible to preserve life.

In God, Man, and History Berkovits (1959:122–23)

draws from such sources a basic description of the Jewish reverence for life.

The preservation of life is itself a fundamental religious commandment, which—(with the three exceptions)—takes precedence over all other religious laws. To preserve one's health . . . is itself a divine command. Unlike Plato, Judaism does not look upon the body as a "prison of the soul." The body is an essential prerequisite of human existence. . . . Man needs life, in the purely biological sense of the word, if he is to fulfill his God-desired destiny on this earth. Life itself is God-given and has meaning and worth in its material and organic manifestations.

Having established how traditional sources view the value of individual life, we can consider the issue of using knowledge to preserve another's life. Here we find an operative text in Leviticus 19:16: "Thou shalt not stand upon the blood of thy neighbor." Rashi, the authoritative medieval exegete, gives the fundamental interpretation: Your neighbor is dying, and if you can prevent it, you must do so. The Mishnah, the rabbinic commentary on Torah which was codified around 200 C.E. and has served as a fundamental Jewish legal source (with further commentary) ever since, offers a powerful example of the value of even one human life. Mishnah Sanhedrin (4:5) states that "whoever saves a single life [it] is as if he saved an entire world."

The towering medieval physician, philosopher, and jurist Maimonides also stresses these points. "If one person is able to save another and does not save him,

he transgresses the commandment: neither shalt thou stand idly by the blood of thy neighbor. . . ." He then gives examples of such an action, including "if one hears one plotting evil against another and he does not call it to the other's attention and let him know . . . he transgresses the injunction."⁶ Maimonides' example here is relevant and important: if we have knowledge that will save a life and do not use it, we are liable.

An objection, however, can be raised. Further on, Maimonides writes, "It is forbidden to buy medicine from a heathen unless hope of the invalid's recovery has been abandoned. It is forbidden to receive medical treatment from a heretic even if all hope has been abandoned, *lest one be attracted to his views*." This seems to mirror the earlier objection that usage of the data would somehow ultimately legitimate Nazi views. In the very next paragraph, however, Maimonides observes that "a heathen physician may be *consulted* on what drug or treatment is best, but the drug may not be brought from him."⁷ Thus we can, according to Maimonides, use such knowledge as exists, even that gained from the hands of heathens.

We find similar positions among the modern authorities. The Chief Rabbi of England, Sir Immanuel Jakobovits, has laid down the following principles: Human life is of supreme and infinite worth (based on the Talmudic statement "You shall live by them"). Thus any chance or method to save life must be pursued (even if success is uncertain). Furthermore the obligation to save life means that when "there is no risk

involved, the obligation is . . . unconditional. Hence, the refusal of a doctor to extend medical aid when required is deemed tantamount to bloodshed, unless a more competent doctor is readily available" (Jakobovits [1966] 1979:379–80).⁸

Another prominent modern authority, Rabbi J. David Bleich, addresses the issue of whether we can profit by knowledge gained through "morally unconscionable" experimentation ([1978] 1979:82). Quoting Daniel Callahan's observation that "the history of medicine is full of instances where things were done unethically, but led to benefits for people," Bleich states that "Jewish ethics knows of no Miranda Principle, which would bar the use after the fact of information obtained by illicit means." His conclusion, though drawn in the context of a discussion of test-tube babies, is nonetheless applicable here.

A more philosophical opinion has been recently published by Rabbi Irving Greenberg (1986:132). He quotes Rabbi Joseph Soloveichik (1965:14): "Man of old could not fight disease, and succumbed in multitudes to yellow fever or any other plague. . . . Only the man who builds hospitals, discovers therapeutic techniques, and saves lives is blessed with dignity." Greenberg amplifies this statement:

. . . contrary to the constant emphasis on how medicine or scientific power in general is manipulative and dangerous to human ethics, at its profoundest level, particularly in modern times, it is liberating and religiously inspired. In the process of freeing

“The history of medicine is full of instances where things were done unethically, but led to benefits for people” — Daniel Callahan

people from slavery to health factors, medical science is the ultimate fulfillment of the human dream, that of the human becoming more and more like God. Thus, we are living in the greatest elevation of dignity in human history, and doctors are at the forefront of that thrust. Properly understood, every moment spent in medicine is a moment of religious calling and ethical responsibility. (1986:132)

This commentary may reflect the wish more than the reality and indeed may well be an idealized view of modern medicine. However, as a statement of ideals it sets forth a goal to be reached, and its very articulation is important. The intent is not to give carte blanche to science but to point out the ideal which science, operating with religious and ethical guidance, can attain.

Two items that came directly out of the Holocaust give further guidance. The first is a responsum (a legally binding answer to a question of Jewish law) by the noted Rabbi Ephraim Oshry, a survivor of the Kovno ghetto and author of *Sheilot U'Teshuvot Mi Ma' Amakim*, a five-volume account of religious questions and answers dealing with the Holocaust. Rabbi Oshry answers affirmatively a question dating from May 1942 about whether one can perform a caesarean section on a dead woman. He offers the principle that "when saving a life is involved, we are not concerned with the desecration of the dead (Oshry 1979, 2:53).⁹

The second is a short sermon given in the concentration camps by Rabbi Nissenbaum, who later died a martyr's death. It was Yom Kippur, the Day of Atone-

ment, and he explained to his listeners a difference between Halakhah in the Middle Ages and in his time. In the Middle Ages, rabbis taught that Jews should choose martyrdom because they were faced with religious persecution and coercion. Thus the commandment of Kiddush Ha Shem (religious martyrdom) was appropriate. But today, in the era of Nazism, in the Kingdom of Night, the Nazis didn't care about souls or baptism. They wanted to destroy the Jewish body, individually and en masse. Thus, according to Rabbi Nissenbaum, the commandment was now to save, in any way possible, the Jewish body (Rackman 1986:160–61).¹⁰

These points lead me to conclude that our obligation is to take the knowledge that we possess and to use it in a responsible Jewish manner. If we can save a life, therefore, we must, for we are commanded to do so. But I also believe that in the case of the Nazi medical experiments, the knowledge was bought at a terrible price, so I would add certain stipulations:

1. We must never forget the victims, and we must use the material with full acknowledgment of the moral flaws in its procurement. Dr. Albert Haas, a survivor of Dachau, Mauthausen, and other camps, states this position emphatically in his endorsement of the use of the data: "Should the results appear to be valid, and the decision to use them as the basis for new research be made, the scientist must take every possible opportunity to make clear where and how the original data was collected. By doing so, we do not have to repeat what is

already known, but neither do we absolve the Nazi physicians of the atrocities they committed, nor do we fail to honor the victims" (1988:63). (This was also the opinion of prominent ethicist Arthur Caplan, of the University of Minnesota, who was asked by one of the current researchers to comment on the issue.)

2. In the post-Holocaust era all of us, and particularly those in positions of authority, must continue to learn the lessons of the Holocaust and to teach others, so that as we grow more sophisticated in our power, we avoid repeating these crimes. We must condemn the corrupt medical establishment that trained and encouraged the perpetrators of these crimes. Robert Lifton (1986:302) suggests that the Nazi "experimental impulse" was consistent with the Nazi vision; the "removal of medical limits" was permitted by the Nazi image of "'life unworthy of life,' of creatures who, because less than human . . . can be studied, altered, manipulated, mutilated, or killed." The original experiments were not kept secret, yet at no time was there any protest. (Similarly, experiments were carried out on involuntary subjects in many other countries, including the United States, which also did not receive any notice.) Evidently, generations of medical researchers were trained with the idea that other human beings were nothing more than

laboratory fodder. Any training that leaves its graduates with such a vision has failed to inculcate the fundamental purpose of medicine—the preservation of human life.

3. Consideration must also be given to limiting the accessibility of the Nazi research. This is not censorship but a call for responsibility. Official censorship, whether institutional or governmental, is at the very least problematic—on moral, legal, and even practical levels. Yet with a sense of responsibility and an understanding of points 1 and 2 above, the specialist will be able to make constructive use of these data, while the teacher may choose to shun their use. Essentially this is a call for recognition of the nature of the Nazi experiments and for appropriate sensitivity in handling this research.

All of us are students of the Holocaust, and all of us must be involved in teaching its lessons as well. Although education did not prevent the Holocaust, it is the best tool we have for applying our knowledge and preventing a recurrence. Humanity has control over awesome powers, but if we are to achieve any therapy—for our bodies, minds, and souls—it will be only through learning from the lessons of the past, while heeding the words of Deuteronomy 30:19, "Therefore, choose life." ☸

NOTES

This paper originated two years ago when, as a representative of the Simon Wiesenthal Center, I was asked to take a position on this issue for CBS radio's "Newswatch" program (19 June 1988). My original reaction was repugnance at the thought of using anything, including scientific data, associated with the Nazis. That repugnance remains. The fact that I am here suggesting use of the data based on traditional sources is testimony to the deep reverence for the value of human life that exists within Jewish tradition. I must acknowledge, however, the clear tension between my emotional response and my intellectual position.

This paper could not have been written without the assistance of many people, including some who disagree with its conclusion. I would like particularly to thank Dr. Neil Rosen of the National Institutes of Health in Washington, D.C.; Dr. Harvey Bennett, Brookdale Hospital, Brooklyn, New York; Dr. Robert Berger of Harvard University; Holocaust survivors Clara Feldman and Ernie Honig; Rabbi Daniel Landes of the Simon Wiesenthal Center; and most of all my wife, Elaine Rosen Weitzman, Bronx Municipal Hospital Center, and Dr. Velvl Green, Ben-Gurion University, Beersheba, Israel, who have all given freely of their time and expertise in discussion of this issue. We are all indebted to Dr. Arthur Caplan, of the University of Minnesota's Center for Biomedical Ethics, for opening up this discussion of medical ethics and the Holocaust to the scientific community.

1. Specific works focusing on the Nazi abuse of science include Alexander Mitscherlich and Fred Mielke's *Doctors of Infamy* (1949), Max Weinreich's *Hitler's Professors* (1946), and most recently, Robert Lifton's *Nazi Doctors* (1986), Robert Proctor's *Racial Hygiene* (1988), Benno Muller-Hill's *Murderous Science* (1988), and Michael Kater's *Doctors Under Hitler* (1989). Sections of broader works are also devoted to this topic; see Raul Hilberg's *Destruction of the European Jews*, vol. 3 (1985), pp. 939–40, and Eugen Kogon's *Theory and Practice of Hell* (1980:163–67). Evidence from the Nuremberg trials on Nazi medical experimentation can be found in Whitney Harris's *Tyranny on Trial: The Evidence at Nuremberg* (1970:423ff.), as well as in the collected trial documents: *Trial of the Major War Criminals* (1947–1949), vols. 4, 5, 20.
2. For example, the "MacNeil/Lehrer NewsHour" of 1 August 1988 and CBS radio's "Newswatch" of 19 June 1988 dealt with this topic. "The Meaning of the Holocaust for Bioethics," a conference held in Minneapolis (17–19 May 1989) under the auspices of the University of Minnesota's Center for Biomedical Ethics, explored this issue but did so essentially from personal and secular perspectives. Only one speaker touched upon Judaic sources, and then only fleetingly.
3. According to Kater (1989:145, 328 n.54), one doctor present, the army pathologist Franz Büchner, did protest to his superior in Berlin with no result.
4. Combined Intelligence Objectives Subcommittee. 1946. "The Treatment of Shock from Prolonged Exposure to Cold, Especially in Water," Item #24, Report #250. Office of the Publication Board, Department of Commerce, Washington, D.C. Cited in Moe 1984a:5–6.
5. The article by Baruch Cohen (1989) came to my attention when this paper was ready for typesetting, but it did not affect any of my conclusions.
6. *Code of Maimonides, Book of Torts*, English translation, ed. Hyman V. Klein, *Treatise* 5, chap. 1:14 (p. 198).
7. *Ibid. Treatise* 10, chap. 11:9–10 (p. 232).

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8. Jakobovits's last statement rests on *Shulchan Arukh* (Code of Jewish Law) Yoreh De'ah 336:1. Rosner and Bleich, editors of the volume in which Jakobovits's article appears, present no opposing views to these assertions in their own remarks on the topic.
 9. An abridged English translation of Oshry's answer can be found in *Responsa from the Holocaust* (Oshry 1983:72–73). A discussion of Oshry's response is in Rosenbaum 1976:41–44.
 10. Nissenbaum's statement is also recounted, in slightly variant form (for example, as taking place in the Warsaw Ghetto in 1940–41), by Eliezer Berkovits (1979:99–100). Berkovits's source is Shaul Esh, Kiddush Ha Hayyim be Tokh ha Hurban (The Sanctification of Life amidst the Catastrophe) in *Molad* 5721 (1961).

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Germination (*Plate 2 from "Dans le rêve"*). Lithograph by Odilon Redon (French, 1840–1916), 1879.

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Personhood: Current Legal Views

Edward J. Larson

THE MOSAIC LAW DECREED in Numbers 35:30, "If anyone kills a person, the murderer shall be put to death at the evidence of witnesses." Leviticus 24:17–18 drew a clear distinction between all human life and any nonhuman life: "And if a man takes the life of any human being, he shall surely be put to death. And the one who takes the life of an animal shall make it good, life for life." Yet potential ambiguity underlay these seemingly straightforward Hebrew laws because they did not define this "human being" or "person" entitled to special protection. So it is that after proclaiming the commandment "You shall not murder" and describing various violations for which a person should "be put to death," God is quoted in Exodus 21:20–25 as declaring merely that a man "shall be punished" for killing his

slave and that "if men struggle with each other and strike a woman with child so that she has a miscarriage, yet there is not further injury, he shall surely be fined." Although these passages may not necessarily establish different levels of personhood for slaves versus free persons or nonviable fetuses versus newborns, under current criminal procedure they would at least suggest a potential defense argument for reduced liability for killing a slave or causing a miscarriage.

Despite this latent ambiguity, Mosaic law offered a broad conception of protected personhood. In contrast, many ancient civilizations legally condoned abortion, infanticide, and euthanasia. Certain Greco-Roman philosophies idealized suicide as a noble form of death. Even murder was not universally outlawed, and the

Arising in a variety of bizarre circumstances, issues of ownership of human reproductive material are confronting courts throughout the world.

sick were often left to die or care for themselves without legal protection. Indeed, at the time of Christ, Roman society typically linked claims of human worth to an individual's social class, nationality, health, or personal virtue. With the spread of Christianity throughout the West, however, more laws protected vulnerable members of society, first in the Christianized late Roman Empire and then in medieval Europe.¹

These examples from ancient law give historical perspective to current issues concerning the legal concept of human personhood. Following the Judeo-Christian tradition, American law has generally protected human life and given a broad definition to personhood. But while ambiguity regarding the definition of personhood can be found in the Mosaic law, change and growing uncertainty mark current American law. This change and uncertainty stems partly from medical developments that have stretched traditional concepts of personhood by giving people unprecedented control over the beginning, continuance, and ending of human life. Is the legal status of the unborn altered by the existence of modern technology that allows, on the one hand, increasingly safe abortions and, on the other hand, earlier fetal viability? How does our power to conceive a human life in a test tube and alter its genetic composition affect our legal concept of personhood? Is a seriously ill human life that is being "artificially" prolonged with little chance of recovery treated the same under law as other human lives? An examination of several recent court decisions involving fetuses, prefe-

tal potential life, and the infirm will help us to explore developing legal perspectives on human personhood.

Fetal Personhood

Undoubtedly the most significant American court decision of the past quarter century addressing the question of human personhood was *Roe v. Wade*, the 1973 Supreme Court ruling that effectively overturned all state antiabortion laws. Writing for the majority, Justice Harry Blackmun dealt with the questions of whether a human fetus is a person and when human life begins. To answer the first question, Blackmun reviewed the references to *person* in the U.S. Constitution, concluding that "the use of the word is such that it has application only postnatally." Based primarily on this, he concluded that "the word 'person', as used in the Fourteenth Amendment, does not include the unborn." As such, the fetus does not possess a constitutionally protected right to life. Indeed, Blackmun went on to review the legal status of the unborn more generally (such as for tort recovery and inheritance rights) and concluded that "the unborn have never been recognized in the law as persons in the whole sense."²

Answering the question of fetal personhood, however, simply led to the question of when life begins, because states have an obvious interest in protecting human life even if that life is not yet a person for purposes of the federal constitution. Yet Blackmun

skirted this issue ("We need not resolve the difficult question of when life begins," he asserted) and instead addressed the issue of when states have a compelling interest in protecting potential life, which surely included the fetus. He concluded:

With respect to the State's important and legitimate interest in potential life, the "compelling" point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulations protective of fetal life after viability thus have both logical and biological justifications.

Relying on medical evidence, Blackmun placed the crucial point when the fetus could survive "outside the mother's womb, albeit with artificial aid" in the third trimester. States were allowed by *Roe* to protect fetal life only after this point. Further, states were prohibited from regulating abortion even to protect maternal health prior to the second trimester based on "the now-established medical fact . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." Thus, time limits for regulating abortion to protect either maternal health or fetal life, and to an extent the legal concept of when life itself begins, were tied to the current state of medical technology.³

Since issuing the *Roe* decision, the Supreme Court has repeatedly reaffirmed its technology-based approach to abortion regulation despite increasing dis-

sent. For example, even though *Roe* expressly identified a hospitalization requirement as a permitted type of second-trimester regulation, the Supreme Court in 1983 voided such a requirement on the basis of technological advances increasing the safety of nonhospital abortions performed after the first trimester.⁴ Justice Sandra Day O'Connor dissented sharply: "As the Court indicates today, the State's compelling interest in maternal health changes as medical technology changes," she observed. "Just as improvements in medical technology inevitably will move *forward* the point at which the State may regulate for reasons of maternal health, different technological improvements will move *backward* the point of viability at which the State may proscribe abortion. . . . The *Roe* framework, then, is clearly on a collision course with itself."⁵ Legal conceptions of human life, or at least constitutionally protectable potential life, are following that course.

The significance of viability as a point conferring enhanced legal status on human life has been carried far beyond the abortion debate during the past decade by various state courts. Three examples of this involve wrongful-death actions, child-custody orders, and the prosecution of murder charges.

Wrongful-death actions impose civil tort liability for wrongfully killing someone. Recovery traditionally was allowed only on behalf of a person who had been born alive. Now a majority of states permit wrongful-death actions for stillborn, viable fetuses. In adopting this approach, the Arizona Supreme Court wrote:

"She, as the patient, lying helplessly in bed...may consider her existence meaningful.

***She cannot be faulted for so concluding."*—California appellate court**

[T]he magic moment of "birth" is no longer determined by nature. The advances of science have given the doctor, armed with drugs and scalpel, the power to determine just when "birth" shall occur. We believe that the common law now recognizes that it is the ability of the fetus to sustain life independently of the mother's body that should determine when tort law should recognize it as a "person" whose loss is compensable to the survivors.⁶

Similarly, in 1982, a Connecticut federal court allowed an action to protect a viable fetus's constitutional rights against alleged police brutality, noting "the Court finds that recent and well-established trends in the state courts, including those in Connecticut, have expanded the legal rights of the viable fetus in a wide variety of contexts."⁷

Child-custody and protective orders, once reserved for children born alive, are increasingly being issued for fetuses. A textbook case occurred in Georgia, where Jessie May Jefferson refused a caesarean section for religious reasons despite medical opinion that it was needed to save her unborn child. Less than a week before the birth was expected in 1981, the state obtained legal custody of the unborn child for purposes of ordering the operation. Quoting from the trial court order, the Georgia Supreme Court decision stated, "[T]he Court concludes and finds as a matter of law that this child is a viable human being and entitled to the protection of the Juvenile Court Code of Georgia."⁸ *Jefferson*

was carried a step further by two subsequent New York decisions granting protective orders for pre-viable fetuses. The first order was issued to protect a four-month-old fetus from threatened assault by the father.⁹ The second order required a mother to undergo blood transfusions to protect her 18-week-old fetus. "In this case," the court noted, "the state has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds."¹⁰

Although many states outlawed abortion prior to *Roe v. Wade*, the crime of murder typically involved the killing of persons once born alive. Several states, including New York and California, have expanded the scope of their murder statutes to protect viable fetuses.¹¹ These statutes, and the common-law trends for wrongful-death actions and child-custody orders, indicate a definite movement away from a simple born-alive test for conferring all the legal rights of personhood in favor of a developmental approach gradually extending rights over time, with a major focus on viability and birth.



Prefetal Personhood

Just as medical science is challenging traditional legal concepts of personhood by pushing back the point of viability, medical developments involving prefetal stages of human reproduction are beginning to raise novel legal issues regarding the status of human ova, spermatozoa, and embryos. At present, these issues center on who owns such human reproductive material and what legal protection it enjoys.

A relatively early case involving the ownership of human reproductive material arose in 1973, when the chief of the Obstetrical and Gynecological Services in New York's Presbyterian Hospital terminated an experimental attempt at in vitro fertilization by destroying the ovum-sperm culture during incubation. This was done without prior notice to the patients, Dr. and Mrs. Del Zio, who filed suit charging a wrongful taking of their personal property, that is, the culture, as well as tortiously causing emotional distress. Even though \$50,000 was awarded for emotional distress, the federal trial court upheld a jury verdict denying liability for taking the culture on the basis that the amount of damages was too speculative. Although news of the first successful "test-tube" baby broke during the trial, it was kept from the jury; otherwise the trial might have had a different result.¹² The value of such a culture certainly would be less speculative today, making recovery of damages more likely.

Legal protection was extended to the product of

human in vitro fertilization by a 1981 Illinois statute, which was later amended. That law originally defined a *human being* as "the individual from fertilization until death," and prohibited the willful endangering of an in vitro fertilized human ovum except by a lawful abortion.¹³ A federal district court held that this law did not prevent the use of in vitro fertilization to produce children, except perhaps by techniques designed to produce multiple fertilizations where only one would be used.¹⁴ The court did not deal with the impact of the law on the in vitro fertilization of human embryos for research. As amended in 1985, the statute now bars experiments on any human fetus except to aid that fetus. Other states impose similar restrictions, and the National Institutes of Health (NIH) requires compliance with these laws for research that it funds in such states. Further, the U.S. Department of Health and Human Services, which includes NIH, will not fund research using a fetus unless the purpose is to help that fetus or the risk to the fetus is minimal.¹⁵ Government boards and commissions in the United States, England, Canada, and Australia have recommended that human embryos (or preembryos) used for research not be allowed to develop *ex utero* for long periods, such as beyond the initial appearance of primary embryonic organization at about two weeks following fertilization.¹⁶

In the U.S., the Department of Health and Human Services recently refused permission for federal funds to be used in experiments involving the implantation of human neural tissue from induced abortions into

"I am not prepared to accept...that the patient 'is a plant.' Why do we speak to, comfort, and hold such patients?" —New Jersey Supreme Court justice

Parkinson's disease patients to ameliorate the symptoms of this disorder. The department cited several ethical and legal questions concerning this procedure, for example, the relevance of the abortion being induced, the sufficiency of maternal consent alone for use of the tissue, and the desirability of prohibiting the donation of such tissue between family members, presumably because this might encourage pregnancies for the sole purpose of producing the tissue.¹⁷ These questions directly raise issues of who owns human reproductive material and what independent protection it enjoys. Such issues, arising in a variety of bizarre circumstances, are increasingly confronting courts throughout the world. For example, a man in France had deposited sperm at a special facility before undergoing cancer treatment likely to render him sterile. After he died of the cancer, his wife sought the sperm. A court granted her access but warned that any resulting child might not be treated as the decedent's descendant under French civil law because the child's birth would occur after the statutory 300 days following the decedent's death.¹⁸ Similarly, the Australian legal system has puzzled over the status of two frozen embryos of a wealthy California couple that sought in vitro fertilization treatment in that country but died in a plane crash before using the embryos. Although the embryos remained frozen after the patients' death, a government report recommended that the embryos be destroyed in such cases if the patients left no other directions. Finally, a Tennessee divorce court granted

temporary custody of seven frozen preembryos to "their mother" for the limited purpose of implantation. The father, who wanted the preembryos destroyed, faces the possibility of owing child support if implantation leads to a live birth.¹⁹ These isolated legal rulings and recommendations are insufficient to reveal clear trends in the law, but they suggest an attitude that gives human reproductive material a status higher than non-reproductive human tissue but (in at least the first two cases) lower than full personhood.

Personhood of the Infirm

Medical developments have spawned changes in the law regarding the ending of human life as well as its beginning. Perhaps the simplest such change occurred during the 1970s, following development of techniques to prolong respiration and circulation artificially. States quickly supplemented traditional legal definitions for death (or the ending of personhood) based on respiration and circulation with criteria based on the irreversible cessation of all brain functions.²⁰ Yet the ever-expanding ability of technology to prolong life with limited brain activity continues to raise new legal questions about when life-sustaining treatment may be terminated and who may terminate it.

The law governing the termination of life-sustaining medical care and treatment begins with a clear but fine distinction that opens the way to confusion and contro-

versy in many actual cases. That distinction pits an individual's traditional right to refuse medical treatment against society's traditional stance against suicide. Both of these legal principles are rooted deep in English common law and have long been recognized by American courts. Recent medical advances, which can radically prolong the dying process, have brought these two principles into a conflict that at least indirectly relates to the legal concept of personhood.

Statutes authorizing so-called "living wills" represent one relatively recent legal response to the development of life-sustaining medical technology. Using such a document, persons can direct in advance that certain medical treatments not be used if they become terminally ill and are then incapable of participating in treatment decisions. Living-will statutes do not directly define personhood, but typically they do define particular "terminal conditions" when some or all medical treatments (often including artificially administered food and water) may be terminated without that act constituting suicide, euthanasia, or murder.²¹ Yet the same act committed when the person does not suffer a terminal condition would often be suicide or murder. Thus, through living-will statutes, most states have recognized reduced legal protection for human life in certain

persons based on their infirm physical condition.

This conflict is illustrated in the 1986 California case of Elizabeth Bouvia. Only 28 years old at the time, Bouvia had suffered since birth with severe cerebral palsy and was quadriplegic. By 1986 she was com-



Futility. Drawing by Ben Shahn, wood engraving by Stefan Martin, 1960.

Courtesy of Bernarda Shahn and Stefan Martin.

“In certain, thankfully rare, circumstances the burden of maintaining the corporal existence degrades the very humanity it was meant to serve.” —Massachusetts Supreme Court

pletely bedridden and able to move only a few fingers and her head. Suffering continual pain from crippling arthritis, she lay flat in bed and was expected to do so for the duration of her life, possibly 20 more years. Despite her severe physical handicaps, Bouvia was intelligent and mentally competent. She had been married, but her husband had left her; she resided in a city hospital.

As early as 1983, Bouvia expressed a desire to die. Since she could not perform any act capable of killing herself, she resolved to starve herself to death by not eating. Fearful for her survival, her physicians inserted a life-saving feeding tube down her throat against her will. Bouvia then filed suit to have the tube removed. The trial court refused her request, ruling that Bouvia was illegally trying to commit suicide with the hospital's assistance.

The appeals court reversed this ruling in a decision that relied heavily on Bouvia's physical condition. Noting two earlier cases allowing the cessation of life-sustaining medical treatment, the appellate court wrote:

In part, at least, this was permitted because the quality of life during the time remaining in those cases had been terribly diminished. In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of helplessness, uselessness, unenjoyability, and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She can not be faulted for so concluding.

Given her condition, the court found Bouvia's request "is not equivalent to an election to commit suicide." Thus, because of her self-acknowledged diminished quality of life, the court lifted the statutory sanction against assisted suicide. "We do not believe it is the policy of this State that all and every life must be preserved against the will of the sufferer," the court concluded.²² Presumably within limits set by courts, individuals could determine if their life had lost sufficient quality due to infirmity to be freed from the full legal protection afforded human personhood.

Bouvia is an unusual case, however, because the patient could make her own choice. Terminally ill or severely infirm patients usually are unable to make treatment choices for themselves and, if they have no living will, are left under the emerging legal doctrine of substituted judgment. Under this doctrine, the law in some states empowers close relatives or other suitable persons to make terminal treatment decisions for certain incompetent patients based on evidence of what that patient would have wanted. This doctrine is designed to protect the right to refuse treatment (the right at issue in *Bouvia*) in those situations where individuals are no longer capable of exercising it themselves.

Patients qualifying for the substituted-judgment doctrine are usually in two categories. Some, like Claire Conroy in one case, are "conscious and can interact with their environment to a limited extent, but [their] mental and physical functioning is severely and permanently impaired and [their] life expectancy, even with treat-

ment, is relatively short."²³ Others, like Paul Brophy and Helda Peter in two other cases, are diagnosed as being in a "persistent vegetative state."²⁴ Courts have authorized the withdrawal of tube feeding in all three of these cases.

The New Jersey Supreme Court decided both *Conroy* and *Peter* and used the latter decision to distinguish between the two categories of patients. The court wrote, "Life expectancy analyses assume that there are at least some benefits to be derived from the continual sustenance of an incompetent patient. That assumption, which is usually valid, . . . is not appropriate in the case of persistently vegetative patients." This suggests that the benefits of human life, rather than life itself, is the proper subject of legal protection. Accordingly, the *Peter* court added that "we find it difficult to conceive of any case in which the state could have an interest strong enough to subordinate a patient's right to choose not to be artificially sustained in a persistent vegetative state."²⁵ Inasmuch as the state interests identified by the court included protecting the sanctity of all human life and preventing suicide, the court apparently saw Peter's diminished physical capacity as reducing her personhood. Focusing on this point, one dissenting justice wrote:

I am not prepared to accept the description cited to us by one expert that the patient "is a plant." Has anyone ever seen a nursing professional who did not treat a comatose patient with the deepest respect?

Why do we speak to, comfort, and hold such patients? Because we realize that they are no less human than we.²⁶

The Massachusetts Supreme Court's decision in *Brophy* reflected similar reasoning. The court wrote:

[W]e must recognize that the State's interest in life encompasses a broader interest than mere corporal existence. In certain, thankfully rare, circumstances the burden of maintaining the corporal existence degrades the very humanity it was meant to serve. . . . The duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity.

Humanity, or human personhood, is distinguishable from life itself at the fraying edges under this analysis. Applying this standard to *Brophy*, the court observed, "he is left helpless and in a condition which Brophy has indicated he would consider to be degrading and without human dignity."²⁷ This analysis, like that in *Bouvia*, involves the court and the individual (or his or her substituted judgment) in determining when humanity is lost. Three of the *Brophy* court's seven justices dissented, with each dissenter filing an opinion denouncing the majority for condoning suicide by individuals with diminished quality of life. In one, Justice Joseph R. Nolan bluntly described the ruling as "but another tri-

Increasingly, in the eyes of the law, full human personhood attaches over time and can detach over time as well.

umph of the forces of secular humanism (modern paganism) which have now succeeded in imposing their anti-life principles at both ends of life's spectrum."²⁸

Conclusion

Whether or not this is secular humanism, Nolan correctly perceived that courts are applying developmental views of personhood to the beginning and ending of human life. Increasingly, in the eyes of the law, full human personhood does not attach to life at any one instant, be it birth, viability, or conception, and does not detach from life at any one instant, such as the cessation

of circulation, respiration, or total or partial brain functioning. Responding at least in part to changing medical technology, the law supports the idea that humanity attaches over time and can detach over time as well. Given public opinion surveys indicating both widespread approval of allowing a right to die in certain circumstances and persistent majority support for legalized abortion, the law's approach to personhood appears to reflect the popular will. In a republic, where lawmakers are chosen directly or indirectly by the people, this is as it must and should be. Ultimately, the decision of these issues lies not within the law but within the people. ☸

NOTES

1. See Sigerist 1945:69–70; Amundsen and Ferngren 1986:49–50; Amundsen 1971:566–69; and Amundsen 1978, vol. 3:933–34.
2. *Roe v. Wade*, 410 U.S. 133, 157, 158, 162 (1973).
3. *Roe*, 410 U.S. at 159, 160, 163.
4. *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 435–36 (1983).
5. *Akron*, 462 U.S. at 454, 456–58 (O'Connor, J., dissenting). This "backward" movement of the point of viability was demonstrated last year when the Supreme Court upheld a Missouri antiabortion statute requiring tests for fetal viability after 20 weeks, which is four weeks before the second trimester. The ruling expressly does not overturn *Roe*, however. *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3054–58 (1989).
6. *Summerfield v. Superior Court, Maricopa Cty*, 144 Ariz. 467, 698 P.2d 712, 722 (1985).
7. *Douglas v. Hartford*, 542 F. Supp. 1267, 1270 (D. Conn. 1982).
8. *Jefferson v. Griffin Spalding County Hospital Authority*, 247 Ga. 86, 274 S.E.2d 457, 459 (1981). Twenty-one such cases are reported in Kolder et al. 1987:1192–93.
9. *Gloria C. v. William C.*, 124 Misc. 2d 313, 478 N.Y.S.2d 991, 997 (Fam. Ct., Richmond Cty, 1984).
10. *In re Application of Jamaica Hospital*, 128 Misc. 2d 1106, 491 N.Y.S.2d 898, 900 (Sup. Ct., Queens Cty, 1985).
11. For example, N.Y. Penal Law sec. 125.00 (covers fetuses more than 24 weeks old); and Cal. Penal Code sec. 187 ("Murder is the unlawful killing of a human being, or a fetus, with malice aforethought").
12. *Del Zio v. Presbyterian Hospital*, 75 Civ. 3588 (U.S. Dist. Ct., S.D.N.Y. 14 November 1978).
13. Ill. Rev. Stat. ch. 38, secs. 81-22(8) and 81-26(7).
14. *Smith v. Hartigan*, 556 F. Supp. 157, 163 (N.D. Ill. 1983).
15. 45 C.F.R. secs. 46.201–.210 (1987). For a discussion of the implications of these restrictions on the legal status of the fetus, see Carmen 1985:52–54.
16. Ethics Advisory Board, U.S. Dept. of Health, Education and Welfare, *HEW Support of Research Involving In Vitro Fertilization and Embryo Transfer: Report and Conclusions* 107 (1979); Mary Warnock, *A Question of Life: The Warnock Report on Human Fertilisation and Embryology*, par. 11-22, at 66 (1984); Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* 216 (1985); and Victoria Commission to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by IVF*, par. 3.19, at 42 (1984). The distinguished zoologist and biomedical ethicist Clifford Grobstein (1988) describes human preembryonic, embryonic, and fetal development and discusses the ethical implications of this development.
17. Memorandum from Assistant Secretary of Health to Director, National Institutes of Health (22 March 1988); and Joseph Palica, "Fetal Tissue Transplants Remain off Limits," *Science* 246 (1989): 752.

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18. Note, "The Parpalaix Case and Post-mortem Insemination," *Australian Law Journal* 58 (1984): 627–28.
19. Victoria Commission (see n. 16 above), par. 2.9, at 28; George P. Smith II, "Australia's Frozen 'Orphan' Embryos: A Medical, Legal and Ethical Dilemma," *Journal of Family Law* 24 (1985): 37; and *Davis v. Davis*, No. E-14496 (Cir. Ct., Blount Cty, Tenn. Sept. 21, 1989) (The court used the term *embryos* for these four- and eight-cell entities).
20. See *Commonwealth v. Golden*, 373 Mass. 249, 366 N.E.2d 744 (1977).
21. For example, Va. Code secs. 54-325.8.2–.11.
22. *Bouvia v. Superior Court (Glenchur)*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297, 304, 306, 305 (1986).
23. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1228–29 (1985).
24. *In re Peter*, 108 N.J. 395, 529 A.2d 419, 422 (1987); and *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626, 628 (1986).
25. *Peter*, 529 A.2d at 424, 427. The Missouri Supreme Court recently rejected this quality-of-life approach in a decision refusing to authorize the termination of life-sustaining treatment for a persistently vegetative patient with a long life expectancy. The court sharply contrasted this situation with that of a terminally ill patient by noting that the state's interest in preserving life wanes "when the issue is not 'whether, but when, for how long, and at what cost to the individual that life may be briefly extended.'" The court's ruling, however, turned on its finding that there was insufficient evidence of the patient's wishes to support making a substituted judgment on her behalf. The ruling has been appealed to the U.S. Supreme Court. *Cruzan v. Harmon*, 760 S.W.2d 408, 419, 426 (Mo. 1988), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).
26. *Peter*, 529 A.2d at 431 (O'Hern, J., dissenting).
27. *Brophy*, 497 N.E.2d at 635, 636.
28. *Brophy*, 497 N.E.2d at 640 (Nolan, J., dissenting). See also *Brophy*, 497 N.E.2d at 623 (Lynch, J., dissenting) and at 646 (O'Connor, J., dissenting).

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On a Child Who Lived One Minute

Into a world where children shriek like suns
sundered from other suns on their arrival,
she stared, and saw the waiting shape of evil,
but could not take its meaning in at once,
so fresh her understanding, and so fragile.

Her first breath drew a fragrance from the air
and put it back. However hard her agile
heart danced, however full the surgeon's satchel
of healing stuff, a blackness tiptoed in her
and snuffed the only candle of her castle.

Oh, let us do away with elegaic
drivel! Who can restore a thing so brittle,
so new in any jingle? Still I marvel
that, making light of mountainloads of logic,
so much could stay a moment in so little.

—X. J. Kennedy

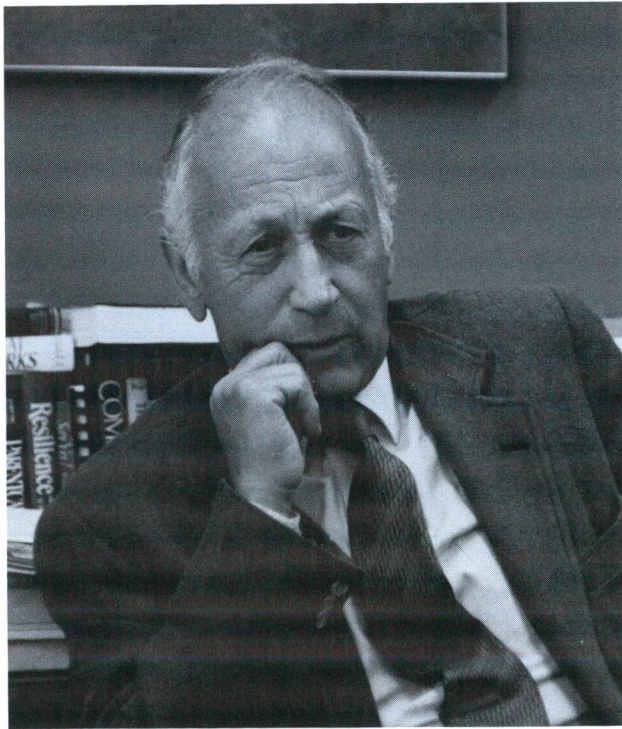
From *Cross Ties*, ©1985 by X. J. Kennedy. Reprinted by permission of the University of Georgia Press.



Breath. Acrylic on cotton duck canvas by Kenneth Noland, 1959.

Courtesy of the St. Louis Art Museum, gift of Mr. and Mrs. Joseph Pulitzer, Jr.

**"The great tragedy of life
is not death but
what dies within us
while we live.
This is another way
of saying that
human potentiality
is the greatest untapped
force on earth."**



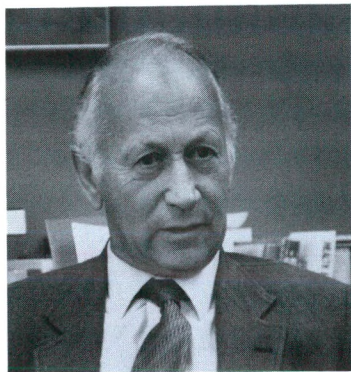
Tapping Human Potential

An Interview with Norman Cousins

Even if his experiences with ankylosing spondylitis and a massive coronary had not resulted in his two best-known books (*Anatomy of an Illness as Perceived by the Patient* and *The Healing Heart: Antidotes to Healing and Helplessness*), Norman Cousins still would have many claims to fame. Longtime editor of *Saturday Review*, diplomat on behalf of three presidents, recipient of nearly 50 honorary doctorates, and author or editor of more than 30 books, Cousins has been a significant shaper of American ideas during the past half century.

More recently, as professor of medical humanities at the University of California, Los Angeles, and as advocate of the body's innate healing capacities, Cousins has helped to focus public attention on the role of emotions and will in human health. In an interview with *Second Opinion* on September 20, 1989, Cousins spoke about his experience, his approach, his responses to his critics, and the relationship between his recent interest in health and his long-term commitments to world peace.

"If a patient leaves the physician's office in a state of emotional devastation, then the environment for effective treatment has been impaired."



Second Opinion: You have become one of America's most famous patients over the last two decades. Can you tell us what you learned from your two most serious illnesses?

Dr. Cousins: The most important thing I've learned is not to think of myself as a patient. I've learned a lot in the last ten years, especially since coming to the School of Medicine at UCLA where I've had a chance to interact with doctors, medical students, professors, hospitals, but most of all patients.

Second Opinion: Let's start with patients then. What have you learned about them?

Dr. Cousins: Since I've been here I have probably met with 1,200 or 1,300 patients, generally at the request of their doctors. Most of them have been seriously ill and in need of a morale boost. So I've had the job, I suppose, of being a cheerleader.

First, I've learned that what a patient takes away from the encounter

with a physician can have a bearing on the outcome of the disease. If a patient leaves the physician's office in a state of emotional devastation, then the environment for effective treatment has been impaired. You can perceive a dilemma: a patient must not be fooled, but on the other hand, a patient in a state of utter despair and depression may have very little inclination for going on with treatment. Furthermore, the physiological changes that result from emotional devastation actually tend to compromise treatment. Now we have here not only a dilemma but a conflict of interests between patient and physician. The patient has the right to know, and the physician has the obligation to inform.

Second Opinion: In *Healing Heart* you tell a wonderful story about talking with a person who has just had a heart attack on the golf course. In your conversation with him before he is rushed to the hospital, you did something you called "rounding out the corners of truth." What con-

cerns motivated you as you spoke to this critically ill individual?

Cousins: The doctor who fears being subjected to a malpractice suit if he doesn't tell the worst, and who tells the worst, may actually help to bring on the worst. Certain techniques of communication can be effective without also being punitive, and I've seen both kinds. A serious diagnosis can be communicated as a challenge rather than as a verdict. The physician who volunteers a terminal date, for example, or allows himself to be pressured into offering a terminal date may actually be putting a hex on the patient. Let me give you an example of both bad and artistic forms of communication. Bad communication: "Completed the diagnosis and completed the examination, and I'm making an unequivocal diagnosis of cancer that's terminal; I give you four to six months." Bad! Good communication: "I've completed the examination. We've got something serious to talk about. One of the first things I'm going to do is bring someone

into this hospital room tomorrow who has had exactly what you have had and has come through it." Every week I read in the medical journals of remissions. The reason they're reported in the medical journals is that the doctors didn't expect them despite all their knowledge. It's important to understand why these remissions occur, and I've got my hunch about that. The doctor might say, "Medical science knows far more than it did only a dozen years ago about the treatment of serious cases. And we now know more about the healing resources of the individual, about the human immune system, than we ever did before—it's a beautiful system. When I give you the best I've got and you provide the best you have, we've got something that's important." Then a physician would talk about the importance of the patient's blazing determination, life-style, coping techniques, and efforts to stay free of depression and despair.

Instead of providing a death sentence, medical communication can thus create a challenge. For exam-

ple, the son of a physician on our faculty here went into surgery for a brain tumor. The doctors couldn't get at it and told the father that this boy had four days—it's now four and a half years. The father worked with the son's spirit as much as he did with his body, and that spirit can do a great deal in mobilizing the body's forces. I don't think most people understand how beautifully constructed the human body is, how wonderfully robust.

Second Opinion: So you resist the patient label because it underestimates and undermines the body's healing resources?

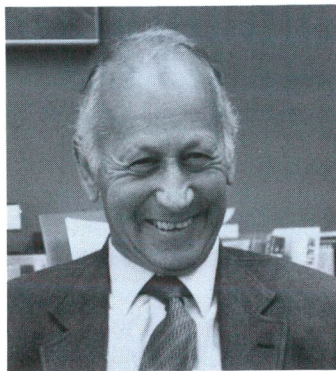
Dr. Cousins: Yes. The forces inside us that link the brain, the endocrine system, and the immune system are designed to do very difficult jobs. Cytotoxic T-cells hook on to individual cancer cells and deposit the body's own very discrete chemotherapy. It kills all the cancer cells one by one but hurts nothing else.

Second Opinion: During the last decade you have been on a fascinating odyssey of uncovering what the human body can do. Can you summarize your discoveries?

Dr. Cousins: Certainly. We're dealing with a totality. The body is an expert in interaction where all the body systems are involved—in the process that Walter Cannon called *homeostasis*. Therefore it may be useful for us to try to penetrate this totality and understand how the body rises to meet its challenges. Why should there be remissions despite the predictions of the experts? Here we deal with the power of abstractions and intangibles: human spirit, faith, love, hope, purpose, determination, festivity, the will to live. Above everything else the will to live because that represents the summoning of all those forces.

We have these powers, but we tend to live far within them precisely because we have been educated for weakness not strength; we have been educated for panic and timidity. We get a pain, and we

"Why should there be remissions despite the predictions of experts? Here we deal with the power of abstractions and intangibles: human spirit, faith, love, hope, purpose, determination, festivity, the will to live."



equate it with disease. We need to be prudent without being panicky. We have become a self-medicating society using aspirin, Tylenol, Advil, all the others—we almost feel subversive or un-American unless we douse ourselves with these things. So we've become a nation of sissies and hypochondriacs, and doctors' offices are clogged with people who have no business being there. I think it's important for people to know that 85 percent of all illnesses are self-limiting.

Second Opinion: By that you mean . . .

Dr. Cousins: That if they do nothing the body will take care of its needs. Franz Ingelfinger, in his last piece in the *New England Journal of Medicine*, made that his theme. We're not going to get through this life without challenges. At the same time, we're superbly equipped to deal with those challenges. Meeting a challenge doesn't have to be a morose affair; it can be rather interesting and even fun, I've discovered.

It's pretty heady stuff when you fear you've got something inside you the experts haven't properly evaluated; this is rather potent medication.

Second Opinion: Just how is your message being received by the experts?

Dr. Cousins: I've been deeply gratified with the predominant response, beginning with my colleagues here at UCLA. Former dean Sherman Mellinkoff first invited me to join the faculty. Dr. Kenneth Shine was my cardiologist at the time of the heart attack and then became dean of the medical school. They know I'm not suggesting that people do away with medical science and just do some psychological and spiritual whistling in the dark. They understand that I'm interested in getting the best out of medical science but also the best out of the human mind and human body. I'm interested in creating an environment in which doctors can do their best, in which people are liberated from feelings of panic and helplessness.

They understand that, but not all doctors do. Some doctors think that I'm passing a Ouija board over the field of medical science or telling cancer patients that they can laugh their way out of serious illness. They haven't read what I've written very carefully: I don't talk about laughter except as part of a vast array of forces. Laughter is only one of the positive emotions, but it has the valuable tendency to aid respiration by bringing additional oxygen into the body and also by helping to set a stage in which the individual can react responsibly to challenge.

Second Opinion: Tell us, as precisely as you can, your central claim about healing.

Dr. Cousins: First, there is such a thing as a healing system. Unfortunately, the healing system is not part of a great deal of medical education. In medical textbooks, for example, you're not going to find very much in the index under *healing system*. You'll find listings for all the other systems but none for the healing

system. And that unfortunately is an accurate indicator that the healing system is not sufficiently appreciated or understood. Yet if Franz Ingelfinger is right in believing 85 percent of all illnesses to be self-limiting, something must be happening, and that something should have a name. I'm pretty sure that *healing system* is about the best that we can come up with, but why isn't it taught as such?

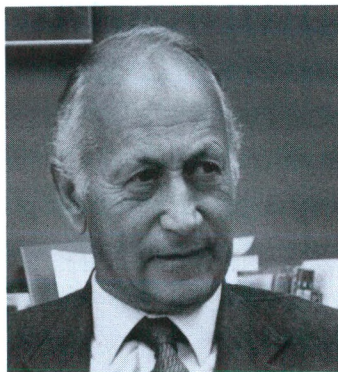
Second Opinion: What's your answer to that question?

Dr. Cousins: The answer is that medical education is evolving and that it *will* be taught as such. Few branches of science have seen as much change as has medicine. Within 15 or 20 years after a student graduates from medical school, he or she discovers that a great deal of knowledge has been and will continue to be superseded. But one item of medical knowledge never changes: the physician needs to tap the patient's powers, recognizing them as a primary force to be

worked with. The physician also needs to recognize that individuals differ in their ability to meet challenges; therefore the doctor has to tailor her approach to that patient just as meticulously as she does in writing a prescription. Not all medication serves the needs of patients equally well even when they have the same illness, so the doctor willy-nilly is forced into the role of understanding human beings.

Here we come to another problem in medical education: the need to cover all the new knowledge about working parts of the body puts a great deal of pressure on those who divide up the curriculum. So the time and space allowed for dealing with philosophical abstractions tend to shrink even as the need increases. These philosophical abstractions actually govern the climate of treatment. In addition to being a good communicator, therefore, the physician has to be a psychologist, a philosopher—has to know at least as much about patients as about disease or at least as much about the environment in

"We have been educated for weakness, not strength; we have been educated for panic and timidity. We get a pain, and we equate it with disease."



which that disease took hold as about the nature of the microorganism involved. We spend so much time getting to know bugs that we've lost sight of people.

Second Opinion: You are simply reaffirming the old maxim, know your patient.

Dr. Cousins: That's right. And also *primum non nocere*, "first, to do no harm." The opportunity for doctors to do harm today is far greater than it was when Hippocrates fashioned that particular maxim. I've seen estimates of the number of hospital beds being filled with patients for iatrogenic reasons ranging from 10 to 30 percent. More than a few of the patients I've been asked to see were suffering not just from individual medications but from medications in combinations. The pressure on doctors to prescribe is fiendish. Patients feel that this is the test of a good doctor—whether they write a prescription. When doctors themselves come to believe that the only way or the best way they can treat

patients is through medications, they are putting themselves in a very precarious position. Medications are powerful even when you can identify the right one for a particular case.

Disease comes and goes because the body creates its own medications. The human body is a magnificent hypothecary, and the human brain has thousands of secretions that it works with in meeting disease. Yet the young doctor is told, "the patient expects you to prescribe, so you've got to prescribe. But be sure that what you prescribe—if it doesn't help the patient—at least doesn't hurt him." That becomes increasingly difficult for the doctor today because the medications tend to be more and more sophisticated, more and more powerful; they are designed to create dramatic effects and bury the symptoms. The doctor is put in the business of being a pain killer.

Second Opinion: How do you certify to other people the effectiveness of the body's healing system?

Dr. Cousins: I think doctors would be irresponsible if they concluded from the stories I've been telling that they should change their style or approach. It becomes necessary therefore to provide scientific evidence that what I've been saying illustrates certain basic scientific principles. An emerging new branch of medicine called psychoneuroimmunology deals with the interaction of the brain on the endocrine system and the immune system. Research is now going forward in at least three dozen medical centers throughout the world on these interactions. We have a program here at UCLA in psychoneuroimmunology. So it can no longer be contended that we're operating in the absence of evidence. The evidence shows that moods have a bearing on the efficacy of treatment. In terms of changes in the immune system and other physiological changes where we can make measurements, the evidence shows that unless the physician deals with the psyche of a patient, treatment will be incomplete. The scientific ev-

idence now identifies the pathways and the interactions, so the principal problem today is no longer the development of scientific evidence. The big problem is getting doctors to look at the evidence.

Second Opinion: Where would you direct a very busy physician who wanted an authoritative overview of this new knowledge?

Dr. Cousins: Well, the literature is very substantial. Two books provide rather good introductions to the field: *Foundations of Psychoneuroimmunology*, edited by Steven Locke and others, and *Psychoneuroimmunology*, edited by Robert Ader. More specialized papers have been written by other American scholars, and work in the field continues in the Soviet Union, Yugoslavia, Italy, France, and Switzerland.

Second Opinion: One of the undervalued human resources that you identify as essential for dealing with illness is faith. What do you mean by faith?

Dr. Cousins: It's faith with a lower-case *f*. I don't think it's necessary for someone to pay dues, to wear certain garments, in order to experience faith or its benefits. Faith has something to do with the uniqueness of human beings, the recognition of the supreme gift that human life represents. After all, in a world that contains three billion species, we are members of the species that has sentience, can look back, can look ahead, has conscience, is capable not only of joy but of identification and commitment. These are extraordinary gifts, and they require that we respect not just the wonder of human life but also its fragility and its possibilities.

It is at this point, of course, that we enter a zone of wonderment and mystery. Different people have different ways of observing or celebrating that particular fact, and these are to be respected so long as no one attempts to impose ideas concerning the nature of those mysteries on others. Just as we celebrate the fact of uniqueness we surely can recognize the things outside ourselves to

which we are connected. We can summon those forces. I don't think that we're justified in overworking the deity. When you think of five billion human beings making their claims and asking God to mop up after their mistakes it doesn't leave time to do much else. I don't think the deity exists just so that we can ask favors of him. But I do think that there is an indwelling God, and it's our job to do whatever we can to make God comfortable living inside us.

Second Opinion: What is faith's contribution to the process of human healing?

Dr. Cousins: It's a very natural one. It represents a resource that needs to be developed and not just called into being on an emergency basis. "Oh God, help my McDonald's stock go up two points." Or, "Why me?" in the case where something goes wrong. These attitudes conceive of the deity as someone who does the job that only we can do. Deities give us the power to do things and the

ability to make responsible, humane judgments. But to expect the deity to exercise our judgments for us is a misconception.

I don't think that faith becomes relevant only when someone becomes ill—although it's natural under those circumstances to want to reach out. But even in extreme illness I don't think God can be faulted for wanting us to do our best for ourselves too. The healing forces within us are God-given. Faith comes into play when we recognize them as such and don't assume that God is obligated to do anything just because something has happened to us.

Second Opinion: What name would you give your form of faith?

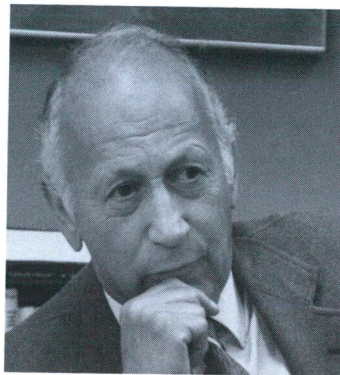
Dr. Cousins: You might call it consequentialism, which is to say that everything we do or think has consequences. The more differentiated we become as human beings, the more we develop our potentialities and discover the possibilities of being human, the greater the sense

of responsibility that goes with it. Nothing is without a cause, and all things have their effects. Our job is to try to anticipate the effects of causes, the effects of our actions. If I had to think of something that was supremely God-given about us, it would be the ability to understand and anticipate the effects of what we do.

Second Opinion: Not everyone can arrive at an emergency room following a severe heart attack and be able to sit up and make decisions about medications and all the other things you did when you took control of your most recent health crisis. Not everyone is a Norman Cousins, either by temperament or in social standing. How transferable is the active, responsible form of partnership between the patient and the physician that you advocate?

Dr. Cousins: Actually I've encountered far more dramatic cases than my own, and I've learned a lot from the patients I've spoken with. But all of us have been intimidated by

"I'm not suggesting that people do away with medical science and just do some psychological and spiritual whistling in the dark. I'm interested in getting the best out of medical science but also the best out of the human mind and body."



illness. We've had our attention fixed on problems and not on possibilities, and we tend to become paralyzed by that fear. When I was taken to the hospital, I didn't want to scare people along the way. Because paramedics lead somber lives, I thought it might be fun to get a rise out of them. So we told jokes on the way, which put them at ease, and they didn't have to scramble to get to the hospital. When I was wheeled into the emergency room, I saw all those anxious faces—Dean Mellinkoff and a whole battery of specialists waiting for me. I said, "Fellas, I just want you to see the damndest healing machine that's ever been wheeled into this hospital." That put them at ease.

Second Opinion: What would happen if all of us entered the emergency room in that manner? Could doctors do their job?

Dr. Cousins: Yes, and they could do them far more effectively because they would be dealing with patients in which the intensifying factor had

been reduced, the intensifying factor being panic. In short, they would have a much more responsive field for medical treatment than when they're dealing with the effects of panic and fear. Instead they could focus on the underlying illness. You can't really deal with a heart patient to deconstrict blood vessels when panic continues to constrict them. It's important for people with heart conditions to know that the heart can be reconditioned.

Second Opinion: Your claim is that the heart can be reconditioned even to the point of regenerating new arteries?

Dr. Cousins: Absolutely. In my case and in a number of other cases I've been close to, they've discovered that even though the arteries are still blocked with plaque, which is difficult to eliminate, the heart made its own bypass. It opened up new blood vessels, and that meant the heart was getting all the oxygen it needed. This is not to say that I have no problem. I still have an arterial

problem, but I've gotten the best out of what is possible. It's now almost nine years beyond the point some felt I would not reach because of the severity of my heart attack, but I play tennis and have a full schedule, which seems to indicate that the heart can be reconditioned. It's important for people to know that. People who have had heart attacks feel that they'll never be the same and that they've got to go through life with mincing steps. By accepting that concept of themselves, they're going to suffer the consequences. You may not get through life without a serious illness, but we've got resources for meeting serious illness that we don't really appreciate.

Second Opinion: Have you found any examples of the body's ability to heal itself so difficult to comprehend that you didn't write about them?

Dr. Cousins: One young woman had a breast lump that had been biopsied and found malignant, and

she resisted the surgery that was mandated. I was asked to talk to her to see whether I could turn her around. This was not a casual tumor. It was the size of a small lemon and like molten metal—as hard as the metal on my desk. It had sharp points on it. So I could understand the apprehension of the physicians and the need for the surgery. But I also perceived that she felt the doctors were being altogether too casual in telling a woman to have her breast removed and that they were looking at just the medical problem rather than everything that would be involved. It also seemed to me that she didn't realize she had some measure of control over that surgery's outcome. Instead of dreading it and regarding it as invasion, she should have had a feeling of thanksgiving that she lived at a time when science could enter a body and pluck out the offender, freeing her and her husband for a good life together.

Because she didn't feel that she had any powers to program herself for a good result in surgery, I

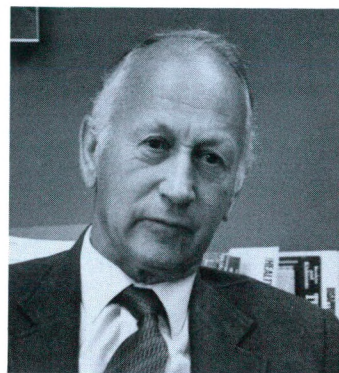
showed her that she could have some measure of control over her nervous system. I put her through a hand-warming drill which demonstrated that she could actually move blood to her hands—she was able to increase the surface temperature of her skin by 14 degrees. Then we could talk about programming her for a good result, and she could hardly wait to get to the surgery. However, they called on the day of the surgery to say it was canceled: there was no sign of the tumor. That was difficult for me to believe because this was a molten mass. Even if it had been soaked in formaldehyde I didn't see how it could be dissolved. But there was no sign of it at all on the X-rays. Something had happened: she had been taking her medication, and her cytotoxic T-cells were free to go to work. They went to work with a vengeance. Now I don't talk about this generally because it's a single case. It smacks too much of miracle claiming, laying on of hands, and so forth, but it was real. And it has given me a great deal of cause for thought.

What was this wonderful thing that happened inside her? It was a combination, I believe, of many things. It was not just faith alone. It was her body responding to the totality of all those forces—responding to a challenge.

Second Opinion: How did the other medical people around this incident respond? How did they explain it to themselves?

Dr. Cousins: I've never been able to find out. But another case is instructive. A man came to this office to demonstrate his ability to sustain pain. In front of 16 doctors he produced a board from under a dirty burlap bag. It was two feet by three feet and contained 40 or 50 irregularly spaced nails. The man lay on this bed for about five minutes with no sign of pain or discomfort. When he sat up his back was peppered with red puncture sites. But there was no bleeding except for one wound which he stopped when we called his attention to it. He was able to turn off bleeding and also control

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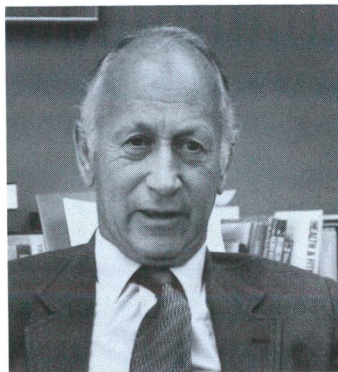


infection—I kept calling for days afterward to check. Those nails were not sterile. I wonder what went on in the minds of the doctors. After all, he was a violation of everything we'd been taught. How did these doctors go back to their classrooms? Perhaps they put it out of their minds. But this man was able apparently to provoke the human healing system and put it to work.

Second Opinion: Is religion an obstacle or a resource in that process? Can religion as it manifests itself today offer anything?

Dr. Cousins: There are different religions, of course. And even the same religion has a rather wide spectrum of approaches to healing. For me, the highest function of religion is not to tell people how to get favors from the deity but to give them a sense of the preciousness and fragility of human life. It's unfortunate that some people go to places of worship either out of fear or out of a need for favors. I've always been troubled by the term *God-*

"The pressure on doctors to prescribe is fiendish. Patients feel that this is the test of a good doctor—whether they write a prescription."



fearing because some people take that literally and have that relationship to the deity. I don't think it's necessary to figure that there's someone up there with a whip or that we're going to be consigned to a pretty hot kitchen if we don't do this or that—that's part of the fear syndrome. I think God would be pleased if we had enough understanding of the rarity of human life and the majesty it represents that we were properly respectful of life. I don't think God wants to be feared or even exalted; praise, and occasional thanks of course, would be useful.

Second Opinion: If you had an opportunity to write a postscript to *The Healing Heart* addressed specifically to religious communities, what would you put in it?

Dr. Cousins: Well, I've done that. I just finished writing a novel that tries to deal with some of these questions. It's unfortunate that religious belief depends to such a large extent upon antiquity—something had to

happen a long time ago in order to be believed. If the same events occurred today that gave rise to religion in the past, they would be rejected because we don't expect such events in a contemporary setting. Articles of faith, however, should be independent of chronology; it's not *when* something happens but *what* happens that should serve as the basis for belief.

Second Opinion: You've had 45 years to think about the issues you raised in one of your earlier books, *Modern Man Is Obsolete*. How has your diagnosis of our situation changed from what you wrote in the wake of Hiroshima?

Dr. Cousins: Well, the book has proven to be on target, unfortunately. It tried to identify the problems connected with absence of control, with the spread of nuclear weapons, with failure to create an adequate world organization, and with revolutionary science and primitivism and the way we approach our collective problems.

And those problems are still with us. On the other hand, in the absence of institutional approaches to deal with those problems, I would never have thought the world could continue for 45 years without a breakdown. So I take a great deal of comfort in the fact that I may be wrong about these things. That has given rise to my belief that no one really knows enough to be a pessimist.

Second Opinion: In *Modern Man Is Obsolete* you made the compelling case that human beings need to change, given those new troubling realities. What qualities should we really be striving now to instill in or call forth from humans?

Dr. Cousins: First, we need to identify our problems and not underestimate their severity. Second, and equally important, we should not underestimate our ability to deal with them. Recognition of a problem tends frequently to produce paralysis and panic, and then we can't possibly meet that problem.

Time is not infinite here. We've been making some gains, but meanwhile all the problems have intensified at a faster rate than expected—the deterioration of the environment, pollution of the seas, holes in the ozone layer.

Second Opinion: You've asked people like Robert Hutchinson, Jawaharlal Nehru, John F. Kennedy, Albert Schweitzer, Pope John XXIII, Nikita Khrushchev what they really learned in life. How would you answer that question?

Dr. Cousins: The great tragedy of life is not death but what dies inside us while we live. This is another way of saying that human potentiality is the greatest untapped force on earth. I can think of no higher calling, whether for a writer, a doctor, or a diplomat, than to try to create the conditions out of which that human potentiality can be developed. It's certainly a very exciting prospect even to contemplate the kind of world we can make once we allow the possibilities of develop-

ment to assert themselves. We're still an unfinished species.

I suspect that the next development in human beings will be a detribalism. We need to apply individual collective wisdom to that end and create collective institutions. World anarchy is a specific threat to everything I've been talking about, so we have to grow up as a species and liberate ourselves from the anarchy that is self-imposed. The nation is a very imperfect form of human organization, and we need a philosophy today to correct that. Philosophy, I think, precedes institutions, precedes the organization. So the next great development in human beings would be the sense of membership in a species with common problems.

Second Opinion: Do you see specific signs of promising creativity in this area?

Dr. Cousins: You want me to stop whistling in the dark, I take it. The fact that we're able to generate concern about these problems is the be-

ginning of wisdom and meaning. At last people are beginning to recognize that we are part of the universe and not just part of the nation. They're beginning to think about the threat to human life represented by contamination of the atmosphere and seas. There's not enough realization yet about disparities—for example, the expenditure of about \$80,000 on defense for every American at a time when millions are homeless and many more are hungry or poorly educated. We are still out of sync in that respect, but awareness is growing.

Second Opinion: In *Modern Man Is Obsolete* and several other places you talk about Christianity as the greatest idea ever to be taken up by the human mind. What do you mean by that?

Dr. Cousins: I suppose I was really thinking of the Sermon on the Mount—how in a single paragraph you could embody philosophy, politics, systematic thought, which is what we mean by science. A great

idea, but as I tried to suggest in my new novel, it would be interesting to see whether it can be adopted.

Second Opinion: That's the other side of it. You also say that Christianity has not truly involved itself in the human situation, that it's strangely adjacent to the crisis of humanity. How should Christianity be involved in the human situation?

Dr. Cousins: This leads to the most interesting question of all perhaps: what would Jesus say about the specific problems that now confront the human race? Can anyone imagine Jesus patting a big atomic bomb and saying that it is necessary for security? Can anyone imagine Jesus saying that we ought to cut back on those things that sustain life? Or advancing the notion that they can only be protected by force? Can anyone imagine Jesus looking with favor on the separatism of the religions? Or on the notion that God views some people with greater favor than he does others? In all these respects, I think, not only

Christianity but religion in general becomes more a way of justifying ourselves, obtaining favors, than a way of developing a spiritual approach to life or a way of sustaining life on this planet. I guess that's what I mean by saying it's adjacent.

Then, too, I listen to attempts to interpret the word of God, and I'm not sure that Jesus would appreciate the sideshow aspects of those particular activities—talking about spirituality without the substance of spirituality is almost an obscenity in itself. The notion that we demonstrate our religiosity with financial support primarily or have that interpreted for us (send in your dollars if you want to be saved) is a form of infantilism and not true spirituality. So we've got a long way to go.

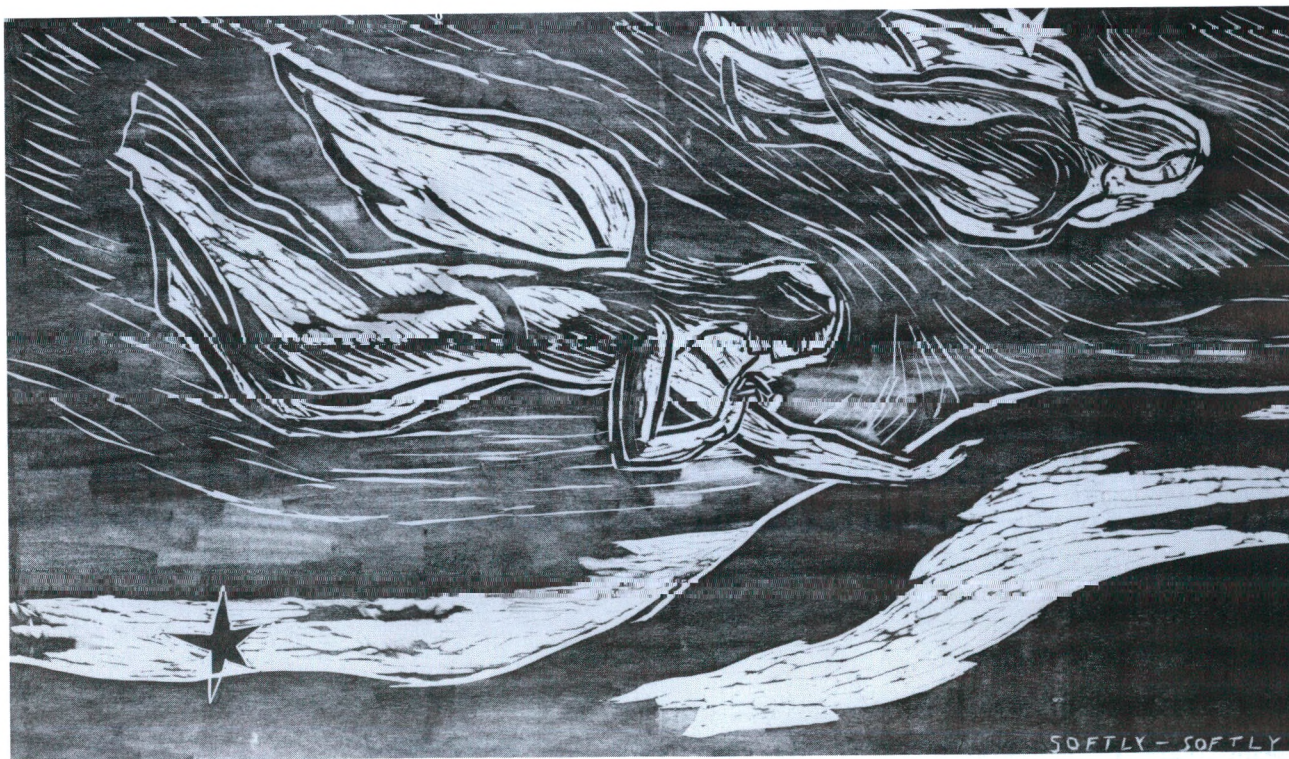
Second Opinion: At one point you wrote about the need for a final graduation ceremony in a human being's life where friends are gathered, memories shared, and a group of last rites observed. If you were at your own final graduation ceremony, what would your friends and

**"A serious diagnosis
can be communicated
as a challenge rather
than as a verdict."**



you agree has been the main thread linking all the things that Norman Cousins has been about—diplomacy, editing, studying healing, being an advocate for peace?

Dr. Cousins: Trying to get the best out of whatever is possible—the best out of yourself, the best out of your friends, the best out of specific problems and situations, whether on an individual or collective level. I would hope that the enjoyment of living would fit somewhere in the picture and that they wouldn't be too solemn. I'd hope to pick up a good story or two. ☸



Softly-Softly. Woodcut by Franklin C. Watkins, 1951.

Courtesy of the Philadelphia Museum of Art, Print Club Permanent Collection.

Moral Principles Shaping Public Policy on Euthanasia

Richard M. Gula

IN THE SPRING OF 1989, Americans Against Suffering, the political arm of the Hemlock Society, gathered 175,000 signatures on its petition for the Humane and Dignified Death Act, which sought to legalize euthanasia in California. Although the effort failed, similar referenda are planned for other states in the near future. The demand for a policy permitting euthanasia has been spurred on by technology's capacity to keep the human body biologically alive so that death is no longer a matter of fate but a matter of choice. The fear of being condemned to live tied to tubes and dependent on machines and medicines has deepened the commitment of many to defend the right to choose how and when one dies.

For purposes of public policy, *euthanasia* means in-

tentionally taking the life of a terminal patient who requests it in order to end a painful dying. This definition includes active, voluntary euthanasia. It does not include so-called passive euthanasia—withdrawing or withholding treatment that the patient does not want because the relief afforded by it would not outweigh the burdens resulting from it. The ongoing public discussion of euthanasia would be better served if the notion of passive euthanasia were eliminated altogether: it too easily confuses the unacceptable practice of euthanasia with the well-established and acceptable practice of withholding or withdrawing useless treatment, and it gives a polemical advantage to euthanasia advocates by making it seem as though we already practice euthanasia in some form.

The fear of being condemned to live tied to tubes, dependent on machines and medicines, has deepened the commitment of many to defend the right to choose how and when one dies.

The main focus of the euthanasia discussion thus far has been dominated by the paradigm of individual case ethics. The great temptation now is to inflate into a policy the positions drawn from an individual case. Hard cases, however, make bad laws, and such a move fails to respect the paradigmatic shift that occurs when we move from individual case ethics to biomedical policies. Euthanasia is not primarily a private issue but a societal one. And the further we move from the individual level, the more complex becomes the analysis. Robert Blank (1988:3–24) has shown that analysis at the level of a biomedical policy must consider demographic factors, social values, medical structures, and biomedical technology, along with the influence of public expectations, mass media, special interest groups, and the legal system itself, to discover the impact of an action or policy on the well-being of a person, a group, and society as a whole. A policy on euthanasia ought to be related to individual case analysis because it is concerned with what helps or hinders individual well-being. But the policy will differ from individual cases because it is concerned with the impact that individual acts of euthanasia have on community welfare. Therefore, the principles that contribute to an ethically justifiable policy must include—but go beyond—those pertaining to individual cases.

Three principles have figured prominently in individual case analyses of euthanasia: the sanctity of life, the prohibition against killing, and autonomy. A fourth principle, the common good, establishes the ethical

framework for societal ethics. An understanding of the role of these four principles will aid our public discussion of euthanasia, but the perspective of virtue is required if we are to go beyond the limitations of principles.

Sanctity of Life

The paramount ethical principle in any discussion of euthanasia is the sanctity of life, which is supported on religious and nonreligious grounds. In religion it is grounded in the conviction that the value of human life comes from God, who creates and sustains us by love. In this form, sanctity of life affirms that we are persons of worth beyond any mere usefulness granted us by others. On nonreligious grounds, sanctity of life is supported by the sense of awe one feels before the experience of being alive and by society's abhorrence of killing except in the most extraordinary of circumstances (as in self-defense). In this form, being alive is presumed preferable to being dead, and the burden of proof is placed on anyone who would directly attack, threaten, or diminish life.

Grounding the principle of sanctity of life is not difficult. Applying it is. Its proper use in ethical analysis and subsequent public policy lies between two extremes. The vitalist extreme asserts an absolute value in maintaining biological life regardless of other considerations like loss of independence, loss of dignity, endurance of pain, or financial strain on family. Vitalism leads

to the abuse of overtreatment; no cost is too great and no chance too remote to save life. The utilitarian extreme, on the other hand, values life for its social usefulness; only the strongest and fittest are to have access to treatment. This extreme leads to the abuse of undertreatment, especially for the disabled, for it focuses on the lack of those qualities that would enable the person to realize full human potential and to benefit others.

Between these two extremes the principle of sanctity of life can influence public policy on euthanasia. It entails the limited dominion or right of human persons over life and death; that is, individuals and the community are only stewards of life. Sanctity of life declares that human life is inviolable and must be valued and respected in all its forms. Two obligations are enshrined in this principle: the positive obligation to nurture and support life and the negative obligation not to harm or destroy life. The principle therefore creates a presumption in favor of sustaining life and so places the burden of proof on those who would take life or fail to forestall death. This principle also directs us to foster life-affirming attitudes, to scrutinize any discussion to terminate life or forgo life-sustaining treatment, and to formulate derivative principles to enhance and protect life, such as the ones considered below.

The Prohibition against Killing

The prohibition against killing is qualified by the distinction between killing and allowing to die, a distinction at the heart of the euthanasia discussion. The stance one takes on whether killing and allowing to die are morally different greatly affects the stance one takes on euthanasia. The Hemlock Society, along with moral philosopher James Rachels, regards killing and allowing to die as morally equivalent. For Rachels the distinction simply designates a descriptive difference in actions to terminate life (1986:106–28). Once we decide not to prolong one's dying, whether we actively intervene to cause death or passively allow the person to die makes no moral difference. Although factors like the patient's preference may intervene to make one means morally different from the other, neither means in itself is morally better than the other. According to Rachels, because there is no moral difference between killing and allowing to die, our present acceptance of allowing to die ought to be extended to active killing, when such killing would be more merciful.

A second stance holds that the distinction does have moral significance, but that it dissolves at a certain point in the process of dying, or at least it is not so determinative as to render killing in some instances immoral on balance. The late Paul Ramsey, one of America's great Protestant ethicists, opposed euthanasia on the grounds that it is incompatible with the demand of covenantal fidelity and its imperative never to abandon care. His

Our heavy dependence on technology to fix our health problems leads us to look always for the easiest solution.

ethics of "only caring for the dying" accepts the moral difference between killing and allowing to die, but he also recognizes that some patients, such as those in irreversible coma or intractable pain, may move beyond the reach of being given care and comfort. At that point the distinction between killing and allowing to die vanishes, and Ramsey would allow an exception to the general rule against euthanasia. Ramsey does not fear a weakening of the general rule prohibiting euthanasia as long as the exceptions to it are limited to those patients who truly are beyond the reach of human care and comfort (1970:153; 1978:146–48).

Moral theologian Charles E. Curran also accepts the moral distinction between killing and allowing to die and the general rule prohibiting euthanasia, though he too gives a qualified acceptance of each in limited circumstances. For him, exercising responsible stewardship over life does not exclude weighing the value of life against other values (such as cost, physical and mental suffering, or freedom). He finds such weighing of values to be part of the Catholic tradition's acceptance of the distinction between proportionate and disproportionate means of treatment. By allowing a patient to forgo disproportionate means, the tradition admits to the human capacity to exercise some dominion over the dying process. This is the context for his qualified stance on euthanasia; once the dying process overtakes the person, life has reached its limit and the moral difference between killing and allowing to die dissolves. Because of the difficulty in determining just

when the dying process begins, Curran recognizes the possible abuse that can arise from his criterion and the difficulty of determining appropriate laws in this matter (1973:161; 1975:145–46, 158–61).

Moral philosopher Robert Veatch lists several arguments for morally distinguishing killing from allowing to die: (1) they are psychologically different; (2) active killing conflicts with the role of the physician; (3) they differ in intention; (4) they differ in their long-range social consequences (the possibility of killing creates the suspicion that caregivers sometimes engage in killing at a time when people most need comfort, or that those not terminal [handicapped, poor, uneducated] might become candidates for euthanasia); (5) killing is deontologically wrong. Veatch admits that some of these arguments are more persuasive than others. In the end, the case for holding to a moral difference between killing and allowing to die rests upon all these arguments taken together, not on any one alone. However, Veatch does not believe that any of these arguments leads to the conclusion that killing is always wrong on balance. Even though killing is presumptively wrong, in rare cases it may be justified to improve the situation of the least well off, as in the case of the dying person in intractable pain (1989:61–74).

Medical ethicist James Childress also believes the distinction between killing and allowing to die is worth retaining, but he argues that some acts of killing may be an expression of love, mercy, kindness, and care, as

when pain cannot be controlled and the one in pain expresses a wish to be relieved of such misery (1985:227).

A third stance is represented by philosopher Daniel Callahan, director of the Hastings Center (1988:399–401; 1989:5–6). Callahan holds that the distinction always has "moral bite" and that one should always refrain from intervening to hasten death, though one may withhold or withdraw therapies that only prolong the person's dying. To defend the distinction, he appeals to three different perspectives on nature and human action: the metaphysical, the moral, and the medical.

The *metaphysical* perspective is based on a real difference between the self, which cannot have unlimited control over everything, and the external world, which has its own causal dynamism. Modern medicine, for example, can intervene to forestall death for a time but not indefinitely. The limitations of the body are ultimately beyond final human control. To deny the distinction between killing and allowing to die concedes more power to human intervention than we actually have.

The *moral* perspective draws a line between physical causality (the disease causes death) and moral culpability (a lethal injection causes death). In some instances, however, the lines cross when we are just as culpable in killing someone as we are in allowing someone to die whom we have an obligation to save. The death of the infant born with Down's syndrome and duodenal atresia who was refused surgery and allowed to die is a case

in point: the mere fact that death results from an action or an omission is not sufficient to determine whether that decision is morally acceptable. But the fact that the lines can cross in some instances does not show that killing and allowing to die are always one and the same. For example, the distinction has moral bite in those instances where, with good moral reason, artificial life-support systems like respirators and feeding tubes are removed from patients whose illness prevents them from carrying out ordinary biological functions on their own. In these instances the irreversible incapacitating disease is the cause of death.

The *medical* perspective underscores the social purpose of the distinction. It protects the role of physicians as the ones who use their knowledge of the body and disease to cure or comfort patients rather than to kill them. The physician's power over life should be limited to curing and comforting, and extending that power to killing would violate what it means to be a physician.

These perspectives on the distinction between killing and allowing to die are momentous for the euthanasia debate. If we cannot morally distinguish between killing and allowing to die, every decision to withhold or withdraw futile treatment can be construed as aiming at death and being causally responsible for the death of the patient. If that is so, then we have greased the slide toward a general policy of euthanasia. However, even if we admit that the distinction does not hold under all circumstances (as Ramsey, Curran, Veatch, and Childress allow), we still do not have to concede to

Medicine's need to cure all, or to relieve all suffering, only increases the demand for euthanasia.

justifying euthanasia as a social policy. Medical ethicists Tom Beauchamp and James Childress (1983:119–20), along with the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983:72), have argued that it may be necessary to have a policy restricting the taking of life in extreme circumstances—even when the action does not appear to be wrong—to avoid the undesirable consequences of the unjustified taking of life in less extreme circumstances.

Autonomy

Strong support for euthanasia comes from the argument based on the principle of autonomy, or the right to self-determination. According to this principle each person has value and is worthy of respect, is the bearer of basic rights and freedoms, and is the final determiner of his or her destiny. The prevailing interpretation of autonomy reflects ethical liberalism, which maintains that the individual and personal self-interest prevail over society and the common good. Autonomy is primarily directed toward cultivating individual self-realization apart from any concern of how personal desires and striving contribute to society. Respect for persons as autonomous agents entails allowing them to choose a plan for life and to follow it in their own way, so long as they do not attempt to deprive or impede others from doing likewise. According to this interpretation, to interfere with a person acting on his or her considered

judgments, when such an action does not harm anyone else or constrain another's freedom, would be disrespectful of the dignity of being a person.

In health care, autonomy asserts that competent individuals have the right to make the ultimate decision about what will or will not be done to their bodies. Advocates of euthanasia maintain that this entails not only the freedom to refuse treatment so that death might come but also the freedom to choose death along with the means to achieve it, including eliciting the assistance of another if necessary and desired (Humphry 1986:172–75; Kushe 1988:17–19). Our cultural and moral climate, which seeks to maximize self-interest largely free of external constraints, is fertile ground for the support of euthanasia as the logical extension of the right to self-determination.

We can appreciate the significant place given to autonomy in efforts to endorse euthanasia as a moral practice and legal policy when we look at the larger context. The President's Commission observed in 1983 that nearly 80 percent of deaths in the United States occur in hospitals or nursing homes (1983:17–18). In such institutions, machines, which represent great developments in medical technology to prolong life, often come between caregivers and patients so that patients no longer feel themselves to be independent persons. Rather, patients become extensions of the machines. In such a setting, patients can easily lose their sense of personal identity, dignity, independence, and control over the direction of their lives. Euthanasia is thought

the best guarantee for avoiding such an indignity or escaping it once it occurs. Daniel Callahan (1989:4) correlates the increasing support for legalizing euthanasia with the increasing fear many people have of being trapped in unacceptable conditions of dependency and disability brought about by medicine's power to prolong dying.

Callahan criticizes the argument for euthanasia based on autonomy (1988:399; 1989:4–6). He argues that the very right to self-determination on which euthanasia depends is actually contradicted when we give to another the freedom to end our life. He also argues that euthanasia cannot be properly classified as an autonomous act of managing one's private affairs. Because euthanasia involves at least one other person, it must be regarded as a form of public action and must be assessed with its social dimensions and implications. We surround killing with public scrutiny and strict limits in order to protect the welfare of others (as in the cases of capital punishment and just war) and to protect ourselves (as in self-defense). These mechanisms of public scrutiny underscore the strong public interest that is at stake in the taking of life. At present, we regard killing for personal benefit—even if it be for compassion or the relief of suffering—as too great a power to be part of a contractual relationship. We would have to be convinced that sanctioning euthanasia would actually benefit society as a whole more than prohibiting it would.

The Common Good

At present, the right to self-determination is the most popular basis for justifying euthanasia in an individual case. But before we make a policy that sanctions euthanasia as a practice, we need to show that it can be justified in more than *some* individual cases. We must be able to show that such a policy will enhance and protect the life of individuals, groups, and society as a whole. Because we are social by nature, the communal aspect of life must be nurtured; community life must support the dignity of each person. Therefore, a policy on euthanasia must include an assessment of communal values and commitments.

The principle of the common good establishes an ethical framework for such an assessment. The common good points to those actions and policies that would contribute to the well-being of the person and the community, and it implies that when assessing private goals, we ought to think of how these contribute toward making society the context in which human life can flourish. In short, this principle holds in perpetual tension the relation between satisfying personal goods and contributing to the good of society.

This principle receives little attention, however, in discussions on euthanasia. First, euthanasia is discussed primarily as a private issue, not a social one. Second, the principle of the common good is countercultural; that is, ethical liberalism in our culture resolves conflicts between individual rights and the common

The physician's power over life should be limited to curing and comforting, and extending that power to killing would violate what it means to be a physician.

good in favor of individual rights. It so separates private and public morality that we have no way of talking about communal life, shared values, and the common good. The highly acclaimed sociological analysis of American culture by Robert Bellah and his associates, *Habits of the Heart* (1985), reveals that our tradition of individualism has robbed us of a language of values reaching beyond the self, even though we retain some sense of the importance of those values. Without a framework for shared ethical language and action to deal with the realities of relating to one another, our society cannot build satisfactory communities for its members. By favoring self-realization, we seek to resolve ethical issues and to shape public policy in the direction of maximizing individual liberty rather than to think about personal desires as part of the common good.

Awareness of this cultural context is important, because our culture has a great influence in shaping moral values (Shindler 1989:153–76). Even though our culture provides values (like autonomy and death with dignity) that give direction to our lives, we need not accept those values uncritically. We have to ask whether subscribing to these values as understood in our culture and to the practices that embody them actually contributes to human flourishing. Such is the task of societal ethics shaped by a commitment to the common good.

The principle of the common good envisions society not as a loose association of individuals bound together by self-interest but as an interdependent community

whose members are joined in the pursuit of values and goals. Living together requires that we look beyond the protection and satisfaction of individual rights and seek to contribute to the good of the whole. This principle does not support sharp distinctions between private and public spheres: we are interdependent persons, and what we do with our personal lives bears on the well-being of the whole society. We flourish as individuals insofar as society as a whole flourishes.

Invoking the principle of the common good in discussions of euthanasia involves a critical look not only at our culture in general but also at the culture of our health care delivery system. At this level of analysis John Glaser, director of theology and ethics for St. Joseph's Health System in Orange, California, raises some important questions (1988). For example, into what kind of society would we introduce euthanasia? What are the moving forces in our present network of providing health care? Glaser contends that we do not have a well-balanced system of health care delivery in this country. Our social values emphasize individual autonomy and personal rights, but we have stratified our population into sectors by age, race, gender, wealth, and mental condition. These divisions influence our attitudes and affect the distribution of health care. Moreover, our heavy dependence on technology to fix our health problems leads us to look always for the easiest solution. We use the benefits of technology to avoid making the more difficult changes in life-style.

How would the powerful mechanism of euthanasia

operate in this context? Would it alter our consciousness of the obligation to care for the sick and dying? How would it affect our well-established right to refuse treatment? Would it alter our efforts to find better ways to deal with pain? Would it make the sickroom a safer place to be? Would it force the court to be more or less involved in the lives of the sick and dying? What forces in society would the policy reinforce, challenge, or resist? Would the legalizing of euthanasia be the best way to respect and protect the life and dignity of individuals and of society as a whole, especially the lives of the most vulnerable? The principle of the common good challenges us to answer these critical questions before we decide to legalize euthanasia.

Virtue

Arguing from principles without appealing to virtue is of limited value. The strength of appealing to principles is that they light up shared values that should be respected in the discussion of euthanasia. Their weakness is that they circumscribe moral reality and moral responsibility too narrowly. On the way to shaping public policy, we need to ask questions that reach beyond principles. For example, does giving the physician ultimate power over the patient's life in the way euthanasia does create the right relationship between the physician and patient? Is it the relationship a good community would endorse? The imperative of the common good is mediated by virtue—the kind of persons and commu-

nity we are and want to become so as to support life in difficult circumstances.

Medical ethicist Albert Jonsen argues that the physician's relationship to a patient is based not only on scientific knowledge and clinical skills but also on certain virtues like "respect and compassion, caution and courage" (1988:196). Killing requires no special skills that would make it part of the business of being a physician (though it may require courage). To the objection that the virtue of compassion and the task of relieving pain are compatible with euthanasia, Jonsen responds that compassion is a virtue when it expresses itself as a mean between the extremes of pitilessness and softheartedness. Compassion manages a patient's pain skillfully and attentively within the limits defined by the physician's purpose and role (1988:197).

Similarly, Drs. Gaylin, Kass, Pellegrino, and Siegler argue that if physicians are licensed to use their medical power to kill, they will be engaging in an activity that has nothing to do with being a physician. As a result, they become unworthy of trust and respect as healers and protectors of life (1988:2139–40).

Stanley Hauerwas, a theologian noted for his emphasis on the importance of being a virtuous community, bases his argument against euthanasia on our being partners in a covenantal community. Those practicing medicine embody the virtue of fidelity in their commitment to be partners in a caring community and to be present to those they cannot cure. The demand for euthanasia is a reminder that the human family is fail-

Because euthanasia involves at least one other person, it must be regarded as a form of public action.

ing to embody the trust that sustains life and to live out the commitment to be companions to one another, especially the ones unable to contribute to the community. For Hauerwas, one reason for prohibiting euthanasia is to show the one who is dying "the continuing trustworthiness of his or her existence" (1977:115). The refusal to participate in euthanasia, then, is a reminder and an encouragement to remain an interdependent community of trust and care.

Medicine's need to cure all, or to relieve all suffering, only increases the demand for euthanasia. For Hauerwas, legalizing euthanasia can too easily become a way of ridding ourselves of those who bother us because we cannot live with their suffering. Or it may legitimate the view of a life free of suffering as the only life worth living. Hauerwas does not advocate suffering for its own sake, but he believes we must learn to accept that some human situations have unavoidably tragic elements and that humans must bear the inevitability of suffering as part of our creaturely existence (1986:167). An important element in bearing suffering that cannot be alleviated is communal support. This entails providing the structures and developing the skills to make ourselves present to those who suffer,

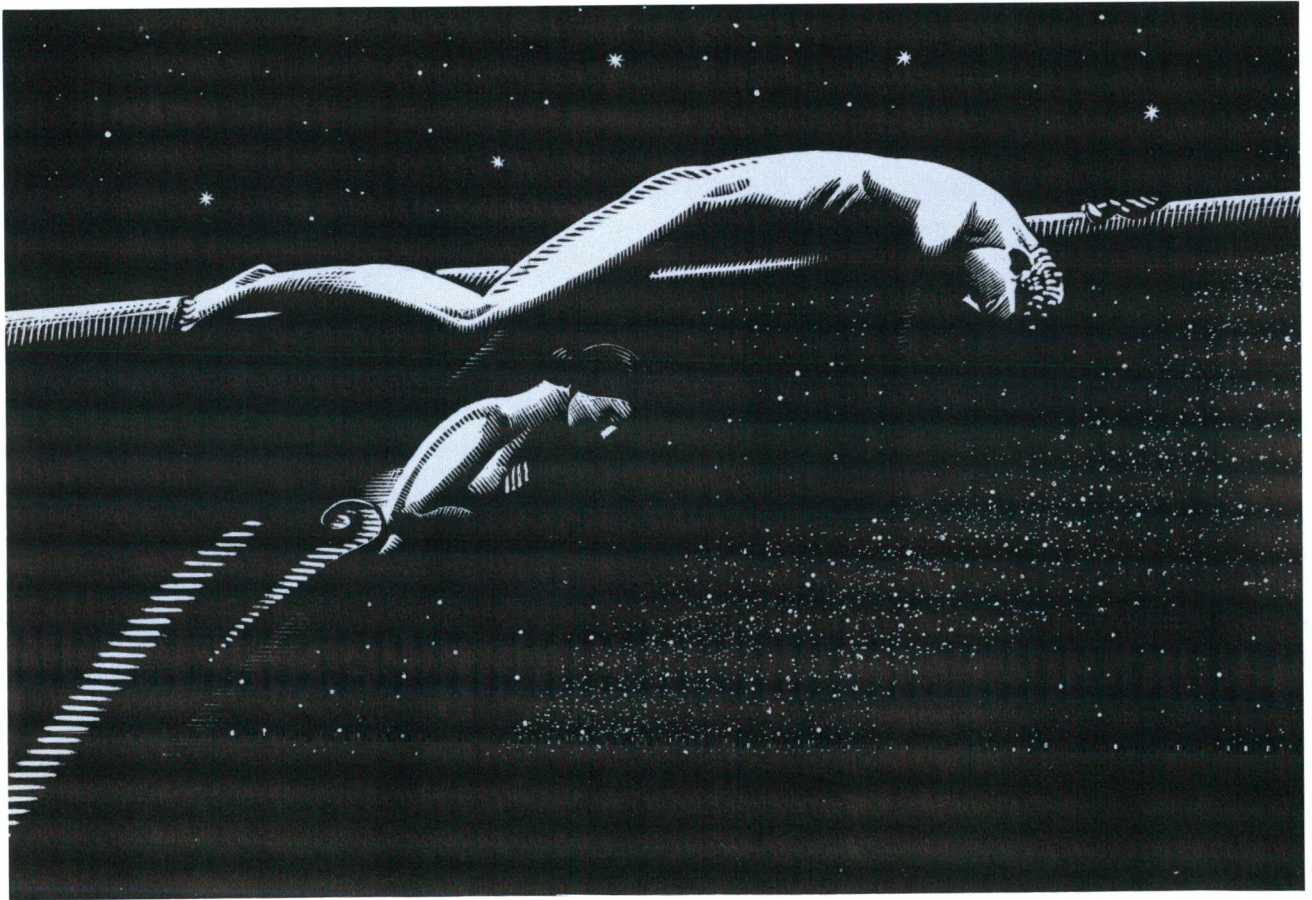
letting them know that they are still our partners in a covenantal community.

Conclusion

At least these four principles and the perspective of virtue will shape an ethical framework for assessing a public policy on euthanasia. Sanctity of life, dimensions of the prohibition against killing, and autonomy have widely been used to judge whether euthanasia can be justified in an individual case. But individual cases cannot be converted without remainder into a public policy. Appealing to the common good helps us resist the temptation to do so. The common good calls for the complex analysis of societal ethics before we can determine a proper public policy. We must consider how the burdens to one individual compare to the burdens and benefits to the medical profession and to society as a whole. Ultimately, however, the arguments turn not on principles but on virtue. A social order governed by the common good and individual freedoms calls for significant social change and a renewal of professional and public virtue. ☸

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Over the Ultimate. *Wood engraving by Rockwell Kent, 1926.*

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The Exclusion of Theology from Public Policy: The Case of Euthanasia

Brendan P. Minogue

UNLIKE ORDINARY OPINIONS, "received views" are trustworthy. They are taken as given. Furthermore, when a common set of opinions on a subject comes to control the assumptions that guide further inquiry on that subject, those opinions can be deemed "the received view" on the matter (Suppe 1974:6–106). To be so designated indicates not only that this cluster of opinions has won out in the intellectual marketplace but also that it must face intellectual standards different from those that ordinary "mere opinions" must meet. Received views are presumed to have been tested over and over by exacting empirical or dialectical tests, and thus they are not viewed as critically as the garden variety of opinions.

Such a view exists with respect to the role of theology in ethical decision making in our pluralistic society. My

aims are (1) to spell out the details of this view and to show how it operates when a novel moral dilemma is encountered; (2) to demonstrate some of the weaknesses of this approach; and (3) to offer an alternative to the received view that accommodates a role for theology in public debate. I draw examples from medical ethics to illustrate the principles of the received view, but with little effort these same conclusions could be drawn from other ethical domains.

Before presenting a detailed account of the received view on the role of theology in public decision making, it is valuable to present some brief background on the philosophical origins of this view. In the West, John Stuart Mill and Immanuel Kant are at its roots. Mill maintained that moral controversy had to avoid appealing to that which was idiosyncratically or privately

Respecting the autonomy of individuals, avoiding harm to others, requiring peaceful conflict resolution, and adhering to contractual obligations are the linchpins of a minimalist ethic.

known. Everyone had to agree about what was "good in itself" if the good was going to be effective in resolving public ethical conflict. Theologians appeal to scripture, tradition, and ultimately to grace as the basis for their knowledge claims. They therefore forsake the universality that is essential for rational ethical dispute. Mill thought happiness a rationally preferable basis for ethics and recommended that we substitute happiness for the religious beliefs that were universal in the medieval world but had become idiosyncratic in pluralistic culture.

Kantians, however, were skeptical. Both the meaning of happiness and the means of achieving happiness seem to vary among women and men. Christians view both issues in one way, and secularists view them in another way. Therefore happiness lacks the universality required for resolution of ethical conflict in a pluralistic society. More important, even if happiness could be universally defined, individual autonomy and equality were more important to ethics than happiness. For Kant, one cannot coerce individuals or unfairly discriminate against them even if it would make them truly happy. To do so would involve treating them as objects or showing disrespect for persons. In short, Kantians believe the duty to respect persons is the fundamental duty of the ethical life.

What is common to both of these theoretical views is the notion that universality is at the core of ethics. Practical men and women have been affected by this theoretical debate because ethical conflict emanates

from practical conflict. The practical citizen has responded not by taking sides in the Mill/Kant debate but by drawing a practical rather than a theoretical distinction between public and private questions. Public decision making tends to require universality or at least substantial majorities, while private decisions may be idiosyncratic.

This distinction between public and private affairs is rough and ready; it needs to be made concrete.

The most recent and clear expression of the received view on the question of theology's role in public ethics appears in H. Tristram Engelhardt's *Foundations of Bioethics* (1986). There are at least five elements in this received view.

1. *Ethics in a pluralistic culture must be divided into two spheres: public and private.* The public sphere is governed largely by formal principles that establish the conditions that make social collaboration possible. These principles are formal in three senses. First, they offer no specific prescriptions about what constitutes the "good life" for individuals. Second, public sphere morality is "procedural" morality in that it spells out not how moral conflicts ought to be resolved but merely the procedures people should follow to reach agreement about their moral conflicts. Finally, while it does not spell out a specific definition of the good life, it makes different definitions of the good life possible by allowing for a high degree of personal autonomy. Thus, respecting the autonomy of individuals, avoiding harm to others, requiring peaceful conflict resolution, and adhering to

contractual obligations are the linchpins of this public morality. These principles constitute a minimalist ethic that can govern this realm. The key however to this *minimalist* ethic is the Kantian notion that others must be treated as ends and not as means and that any refusal to recognize these rules makes one a moral outlaw.

2. *Public ethics within a pluralistic culture must permit a private sphere.* In the private sphere individuals or groups of individuals specifically define the good life. The agnostic, the Jehovah's Witness, and the Catholic can each define what constitutes a good or meaningful life in their own terms and can seek protection for their definitions of the good life as long as they are respectful of the rights of others. In short, theology enters into the social collaboration only within the private realm.

3. *Citizens of a pluralistic republic must not try to transform private convictions concerning the good life into public requirements.* Tolerance is the chief civil or public virtue and extends even to that which virtuous citizens consider immoral in the private sphere. In the received view, the good life is a private construction unfit for public determination.

4. *Private ethics can be highly idiosyncratic.* This is because the content of ethics is specified in the private domain. The public sphere merely contains the form of any possible collaboration in that the public ethic requires noninterference based on the respect for the autonomy of the individuals involved.

5. *Not only do bridges between the public and private spheres threaten pluralism; they are also logically impossible*

to build. This is because there is a rigid distinction between the public form and the private content of ethics.

Any number of issues could be used to illustrate the operation of the received view, but the current debate surrounding active euthanasia is particularly revealing. How does theology function in the debate? How does the received view determine the role of theology even before the substantive discussion begins?

Until recently, active euthanasia was considered a public issue about which public decisions could be made. Because active euthanasia was taken as a *public harm*, the public could take action. It was believed to violate the formal conditions that made social collaboration possible. Supporters of active euthanasia, such as Engelhardt (1989), have used the received view about the role of theology in public ethics to try to transform the matter of euthanasia from a public harm into a question concerning what constitutes the good life. Whether active euthanasia is a public or private matter is *the essential question* in the debate.

How exactly is the question of whether active euthanasia is a public or private matter to be resolved? The strategy of those who support active euthanasia is to try to change the classification of the behaviors at issue. Currently, active euthanasia belongs to the category of public harms, but its status as a public issue is weakening. Those seeking a change in the status quo characterize both support and opposition to euthanasia as theologically grounded. If this assumption became widely accepted, the received view would automati-

To be tolerant within social discourse is not merely to leave people alone. Rather it requires an active willingness critically to engage their convictions.

cally transform a formerly public concern into a private concern. Having a theological ground or justification is the key to transforming a public into a private matter because the received view assumes that having a theological ground is the sufficient condition for treating an issue as private.

The principle of tolerance also plays a vital role, for it is the basis for assuaging the moral outrage that formerly attached to a behavior considered a public offense. For if active euthanasia can be transferred from the public into the private domain, then the feeling of moral outrage that formerly attached to it will necessarily diminish. It is crucial to recognize that tolerance is not simply an ideal. It is an actually existing psychological state that can extinguish other feelings such as moral outrage. It really puts out the fires that sustain public hostility toward active euthanasia. In effect, the received view has the resources to get us to feel neutral or perhaps even feel good about what we formerly felt bad about.

Perhaps the most significant element of the received view is the assertion that ethics is divisible into form and content—for that determines the limits of the role of theology. Formal ethics is public ethics in that it specifies (or at least is supposed to specify) the necessary preconditions for any rational, human collaboration by laying out the principles by which agreement ought to be reached. It does not determine which of an infinite number of possible kinds of agreements or collaborations is morally best (Engelhardt 1986). This

would be to confuse form with content. Furthermore, an underlying assumption of the received view is that the state can concern itself with content only at the peril of sacrificing its formal concern for individual autonomy. The content of the good life must be settled privately. Theology can play a role, but it is a private role. Theologically committed individuals can privately forbid themselves but not others from committing active euthanasia. Can men and women collaborate so as to insure that the end of life will be as pain free as possible? Supporters of active euthanasia argue that the received view requires that both support for and opposition to active euthanasia be treated as ways of defining the good life. To respect these options is required by the Kantian obligation to respect the autonomy of individuals to define for themselves the content of the good life.

The final element of the received view is the belief that attempts to connect the private sphere in which one determines the content of the good life with the form of the public life are threats to cultural pluralism. Thus, theological arguments for or against public issues such as active euthanasia are irrelevant because theology can only function at the private level to determine the content of the good life.

It is important to emphasize that while my characterization of the received view has necessarily focused on only one of its representatives, namely Engelhardt, it is a widely held view. Contemporary philosophers as different as John Rawls in his *Theory of Justice* and Robert Nozick in his *Anarchy, State and Utopia* emphasize the

received view thesis that the public good in itself is not determinate. The fundamental task in philosophy, therefore, is to determine procedures for resolving conflict that do not themselves assume substantive ethical commitments. Ethics is procedural not substantive. The public person should mimic the philosopher and leave substantive ethical commitments to individuals within their private lives.

But while this received view is widely shared, there are a number of significant difficulties associated with it. First, theologies frequently defend positions on what most of us consider public matters. Murder, theft, and burglary are, for example, frequently criticized within theology, and if we were to take the received view seriously, we would then be required to transfer these matters into the private domain. This, of course, is absurd. The mere fact that an action is both supported and criticized theologically is completely irrelevant to whether the action should be treated as a public or private matter. In effect, the received view conflates views that *may* have a theological defense with views that *only* have a theological defense. Moral objections to missing Mass on Sundays can only be defended using religious language while the arguments for and against active euthanasia may be expressed in theological or nontheological language or some mixture of the two.

Second, the received view attempts to treat the public-private distinction as belonging to the category of problems that ought to be handled by the principles of church-state separation. The church is permitted to

speak about private matters, but the separation inhibits theologians from affecting public policy. The aim—to immunize the body politic from the undecidable squabbles that divide theologians—is well intended. The effect—to require individuals to avoid speaking theologically if they wish to affect public policy—is paradoxical since all issues relevant to our public life can be discussed theologically.

Third, the received view assumes that a minimalist ethic exists. Engelhardt claims that a public ethic rich enough to support all of our public values can be built on the back of the Kantian admonition that we ought not to use one another without consent (Engelhardt 1989). But can all of our public values, ranging from how we treat terminally ill cancer patients to medical welfare, be derived from this one principle? This is doubtful since Kant's imperative is open to many interpretations, and if we are going to make hard choices concerning social welfare, we are going to need some ethical principles that go beyond the purely formal realm.

Content must be added to the imperative to avoid using individuals in the sense that we must find a way to distinguish legitimate uses of people from illegitimate uses. For example, if a guardian attempts to have his terminally ill ward euthanized, should we consider this a moral use or an immoral use of another human being? A case can be made for both viewpoints. Kant's rule by itself will not solve the problem precisely because it is so formal that, when taken in isolation from

Until recently, active euthanasia was taken as a public harm, so the public could take action.

a host of other social values, some of which have religious origins, it approximates emptiness. For example, we cannot be faithful to history and separate Western society's commitment to social welfare and opposition to active euthanasia from the Judeo-Christian values concerning charity and the value of individual life. Historically, these values cannot be derived from the Kantian principle alone. In effect, if Kant's rule were effective, it would allow us to distinguish harmful uses from harmless uses, and that is what it cannot do. The substantive public issues that face us as a nation cannot be addressed from this purely formalist stance without significant impact on what many of us consider public matters.

Finally, the received view offers us a radically normative rather than a historical picture of what ethics is and ought to be in a pluralistic society. Has any society ever proceeded in its public deliberations about ethics under the assumption that questions concerning the good life were irrelevant to such discussion? Certainly not! Has any society ever proceeded under the assumption that theological convictions were irrelevant to the public concerns about ethics? Such societies simply do not and never have existed. To treat questions of the good life as purely private is to miss one of the very ends for which the public dimension of society exists, namely to seek the *public's good*.

These problems suggest that the received view needs to be reconstructed and that history is the key to that reconstruction. In the history of social ethics there is no

instance in which the form of ethical conflict is logically separable from the historically particular content of those conflicts. Rather, history provides us with a broad spectrum of models for understanding the relation between public affairs and theology. At opposite ends of this spectrum are the received view—which holds that theology plays no legitimate role in public affairs—and theocracy—which holds that theology plays the only legitimate role in the ethical affairs of the public. A middle ground is possible.

The middle ground can be found by offering a more historically sensitive model for understanding ethical conflict within pluralistic societies. This model is based on the assumption that society is not a structure resting on foundations. Engelhardt's formal principles are foundational in the sense that he recommends them as the basis for decision making, but he never asserts whether these formal principles are *actually* shared by the community and therefore empirically provable, or whether they *ought* to be shared by the community and therefore require a normative rather than an empirical proof. This ambiguity is traceable to his conviction that public ethics must have a foundation because the public is best viewed as society and society is best construed as a *structure which rests on foundations*. A structure without foundations would collapse, and, since ours has not collapsed, it too must be a structure with foundations no matter how hard it is to find them. According to the alternative model, culture is an ongoing conversation: a conversation with a history but without a

foundation (Rorty 1979:chs. 7, 8). For, unlike structures, conversations do not require safe and epistemically secure foundations. They require participants with concrete histories that determine how they interact. Because of this historical dimension, the conversational picture of society opens up new possibilities for understanding the public and private dimensions within society.

Hermeneutics is the study of the general principles of interpretation and explanation, and there are four reasons for speaking of this new picture of public-private distinction as the hermeneutic model. First, this model does not impose a timeless unchanging litmus test to distinguish public from private affairs in the pluralistic society. Second, we cannot in principle decide, prior to the actual presentation of the arguments within the conversation, what are or are not the relevant issues within a public debate concerning ethical matters. Shared theological or political or economic conviction may function within the public debate. Third, it is hermeneutic in the sense that there are no timeless rules for determining what will count as meaningful ethical discourse within this conversation. Ethics on this model is a historical enterprise in the sense that, while ethical principles remain vital within conflict resolution, these principles in themselves must be treated as abstract directives that imply specific social policies only after they have been interpreted within the limits of a specific set of historical conditions. Fourth, it is hermeneutic in the sense that it denies that there are categorical founda-

tions for ethics, be they public or private. Conversations are not buildings. Indeed it is the absence of such foundations that precipitates our skepticism regarding the existence of litmus tests for what is public material. Both the search for the litmus test and the search for foundations are consequences of the larger Enlightenment attempt to escape from the fate of being historical creatures.

According to this model, public ethics emerge from a social conversation among a thoroughly divided citizenry rather than from a community that agrees about formal conditions of social collaboration and merely disagrees on questions concerning content of the good life. The division is real and deep on both levels. The conversation occurs without a fixed language in which the relevant ethical terms have a common formal meaning shared by all the citizens. In short, it gets on quite well without a foundational semantics. This social conversation is carried on in a language in which words like *good* and *right* and *obligatory* are governed by secular (philosophical), economic, and political as well as religious usage and meaning.

Individuals in society cannot be viewed as rooms in a common structure which share a common but deeply hidden formal or empirical foundation. Social conversationalists share a rough and ready language, not a common foundation. Consequently, the participants in this conversation are always obligated to "pick up" the language of their fellow citizens if the social conversation is going to continue, just as the early-twentieth-

The effect of church-state separation is to require individuals to avoid speaking theologically if they wish to affect public policy.

century Newtonians were required to pick up the language of the relativity theorists so that scientific conversation could continue. The willingness to "pick up" the language of those within the conversation is essential to social conversation, for without this willingness public ethical discourse across different ethical paradigms is largely hopeless. To be tolerant within social discourse is not merely to leave people alone, that is, merely to allow them to talk as they wish. Rather it requires an active willingness critically to engage their convictions and a genuine attempt to "cut the deals" necessary to allow the public conversation to continue. Conversation among proponents of secular and religious analyses of moral discourse at first glance seems impossible but only against the background of the foundationalist view of social interaction. When this foundationalist image is scrapped, the historical fact of conversations among vastly different people with vastly different convictions emerges not only as possible but as commonplace.

How then should such a conversation proceed concerning active euthanasia? First, conversational etiquette should take precedence over normative ethics, epistemology, or constitutional law in the public debate over active euthanasia. It is not that these matters are irrelevant, it is just that neither lawyers nor philosophers nor theologians have any priority within public debate. To speak of such priority is to assume foundationalism. Second, participants in the conversation about euthanasia should refrain from the tendency

to characterize it as either a purely public or a purely private matter. Public as well as private considerations must be united in a compromise policy position that preserves the integrity of the participants in the social conflict. What is important to recognize is that this compromise may have theological, political, and economic as well as philosophical components.

To offer a complete picture of what such an a compromise policy is with respect to active euthanasia within our society is clearly beyond the scope of this paper, but one element of it may involve distinguishing individually initiated from guardian-initiated active euthanasia. Our society permits both forms of passive euthanasia. But in a nation such as ours, with our deep suspicions of both the state and our fellow citizens, it may be wisest to construct a very limited form of active euthanasia. This limited form would categorically forbid guardians to have any role in the active euthanasia process except to validate the signature on an active euthanasia will. In effect, it may be that one component of such a compromise would be to forbid guardian-initiated active euthanasia and permit only individually initiated active euthanasia if it is duly authorized within a living will.

It is appropriate to close then with a summary of our model for understanding theology's role in the public sphere. The public-private distinction is not one that is based on formal or empirical foundations. It is not a distinction based on epistemology or normative ethics or constitutional law. If it were, then the philosophers

or theologians or lawyers would have priority within the conversation. Rather, the pluralistic society grants *equity of access* to all participants within the public's ethical conversation. Religious arguments concerning active euthanasia are, therefore, no more irrelevant to public debate on the issue than economic or political arguments, because the alternative model steadfastly refuses to establish any preconversational principles for

engaging in the social debate. Many of us will find theological discourse difficult to understand, but that does not imply that it is impossible to understand or appreciate since understanding and appreciating do not necessarily entail assent. However, this appreciation and understanding, even in the absence of assent, can assist in constructing the compromise so many terminally ill persons need. ☸

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A Protestant View of New Reproductive Technologies

Harmon L. Smith and Paul A. Lewis

IT IS WIDELY AGREED THAT WE IN AMERICA live in a secular and pluralistic culture. There is less agreement, however, on how the particular communities that constitute this society should appropriately act and interact. One consequence of this is that there is no shared conception of appropriate human ends. The resulting tensions among competing communities become acutely felt when laws and policies are formulated regarding matters of common concern. Human sexual conduct is one such area, and the new reproductive technologies therefore inevitably invite controversy, as we have seen in the debates on artificial insemination (AI), in vitro fertilization (IVF), and surrogacy.¹

Two principal alternatives for ordering public life seem open to us. Alasdair MacIntyre (1984) represents the perspective which claims that the rational resolution of moral disputes requires the appropriation of a shared set of values, traditions, and metaphors. Tristram Engelhardt (1986) represents the other view by advocating a classically "liberal" solution in which formal procedures allow persons to pursue their own interests freely so long as they do not interfere with the autonomy of other persons or communities. These two accounts put our basic options in stark relief and help us acknowledge what is at stake, but they do not help in making public policy decisions because both authors expect too much.²

Perhaps John Howard Yoder's (1984:49) insight that no one speaks a metalanguage can suggest an alternative. The implication of his observation for public policy debate is that understanding one another requires deliberate and sustained effort.³

How might Christians speak in such a situation? This question assumes, of course, that Christians can indeed contribute to the formation of a good society by addressing questions of public policy, although such a task may not be the most important on the agenda of Christian mission. According to this construal of Christian theology and public policy, an appropriate task is to suggest the proper ends that technologies should serve. Makers of public policy have the complementary duty of exercising their own moral imagination and professional skill to design policies that serve these ends. A clear implication of this approach, which is dialogical and conversational, deserves to be made explicit: participation in public policy debate requires fluency in many discourses by the parties involved. In addressing these matters here, we draw first from the insights of our particular traditions and do so unashamedly, since everyone's knowledge and discourses are conditioned by perspective, historical conditions, and social location. As H. Richard Niebuhr (1941:5–16) recognized, Christians are no different from others in having to start confessionally.

I. Theological Reflections

Christians claim to order loyalties in accord with the confession that Jesus is Lord. So it makes sense to say that genealogical lineage, biological procreation, children, family, and reproductive technologies are plainly not to be adored or worshipped. These goods, though valued, are not worthy of ultimate allegiance.

What might be said about the family from such a perspective? It is both a biological and a sociological phenomenon: biological in the way that families are brought into being and the young nurtured, and sociological in the various forms that the family has taken (extended, nuclear, serial, single-parent, and so on). For Christians, however, these perspectives do not exhaust the meaning of the family.

The baptismal liturgy can be instructive here: it makes clear that parenting in the Christian community is a vocation for all of us. Although marriage and the nuclear family have ancient origins in concern for the care and well-being of offspring, Christian baptism makes it clear that couples do not own, nor are they solely responsible for, their children.⁴ In baptism, we acknowledge that these children whom we have procre-

ated (literally brought into being on behalf of God) belong to God and to the Church on God's behalf. Baptism tells us that all Christians together are responsible for our children, challenging the autonomous and exclusivist claims of the nuclear family. It further challenges assumptions about who has responsibility for the well-being of children. Thus Christians are emancipated from any "natural necessity" to have babies; they are freed from the compulsion to continue a particular genetic inheritance or to preserve their identity through posterity.

Of course, Christians do not typically live out this emancipation. We have babies just as everyone else does, generally without serious forethought and consideration of what we are doing and why. Still, the baptismal liturgy describes who we as Christians, by God's grace, ought to be. We are this kind of people and not some other because we perceive God to care for us, regard us, love us, bless us, and give himself to us. How God in Christ is to us shows us how we are meant to be for our children, though clearly we often know better than we do.

It is the good news of Jesus' gospel, not the powers of this world--political, social, economic, scientific, technical--that provides the norms of our existence. But the Church has not done so well in converting its communicants to the view that having or not having babies is a witness to our belief in God. So the "new reproductive technologies" are among those powers that may control our lives, imposing on us the "natural necessity" to have children who are our genetic heirs. Consider a case in which a couple discovers that they cannot "have their own children" even though they are desperately trying. Their desire for children can become a "natural moral necessity" which the new reproductive technologies only accelerate and perpetuate.

But surely when Christians speak of parenthood, they are considering relationships neither defined nor exhausted by biological reproduction and genetic succession. We have in mind certain virtues like loving, caring, long-suffering, patience, and responsibility that endure through thick and thin, in sickness and in health, in good times and in times that are immeasurably bleak, bordering on the hopeless. These virtues are not limited to biological parents; adoptive parents know them very well.

To be reminded of these understandings ought to emancipate us from the fear of technology. Of course technology can be misused; Christians call that sin. But we do not fear technology, because it is not worthy of

our ultimate trust. Like fire and the wheel, these new reproductive technologies allow us to exercise our abilities and capacities and to direct them to moral ends. We know that we are likely to misuse new technologies and that our technologies may outrun our immediate resources for comprehending and controlling them. Human finitude and sin remind us that we have no access to privileged modes of discourse that can precisely forecast satisfactory outcomes. We do not claim omniscience. We are too familiar with tragedy to be naively optimistic. We are women and men trying, as best we can, to be faithful to that vision of ourselves and our world which the Gospels portray.

At least since the time of the Enlightenment, our temptation has been to embrace every scientific and technical innovation as the means to our salvation. But discovery and mastery often carry a capacity for evil that is proportionate to their capacity for good--and sometimes even a disproportionate capacity for one or the other. Therefore we seek to direct and restrict, but not outlaw, these innovations for the sake of human goods that are theologically defensible. W. R. Inge, former Dean of St. Paul's in London, once remarked that people who become wedded to the spirit of the times often find themselves widowers in the next generation. The truth of this aphorism need not paralyze us, but it ought to give us pause.

Furthermore, humanity is situated interdependently within a larger whole. Thus life is not so ordered that each of us always gets what he or she wants, and the common good can rightly override one's individual sense of well-being. Now and then we are called upon to sacrifice when our neighbors would be offended or harmed. Christian people find resources for affirming this in the life and teachings of Jesus. Neither do we forget that Christians are called to be sensitive to the needs of all who suffer. Indeed, one of the functions of Christian sacrifice and denial is to make us available and present to those who are desolate and despairing. We can respond to the pain of childless couples who sincerely desire a child of their own and at the same time attend to the needs of those who may lack basic health care.

As Christians, then, we will need to learn how to deny ourselves some forms of high-technology medical treatment if using it means depriving our sisters and brothers of basic care for fundamental needs. We will have to learn how to say "no" to some technologies, because we will have come to some acknowledgments about ourselves and our neighbors, and

about the people we are called to be. We will need to see ourselves as a people who accept the notion that service to "the least of these" is more important than self-gratification or even the life of any one of us. In the case of these new reproductive technologies, we will need to understand better why we should not strive to maintain our own genetic inheritance if that would mean that the weaker and underserved members of the community will go without basic and rudimentary forms of health care.⁵

Now this may be as good an example as any of how it is that Christian ethics can appear unintelligible, or at least unconvincing, to those who do not share our stories and traditions. While Christian ethics is written by Christians for Christians, it is not written for Christians only. Being faithful to the gospel obliges us not only to honor distinctive Christian commitments but also to do that in communion with historically particular and culturally specific realities, as well as with persons who do not share our tradition. Some may in fact share compatible concerns for very different reasons.

II. Considerations in Framing Public Policy

How technologies and practices are described and defined is an important but often overlooked aspect of ethical and policy deliberation. Descriptions betray certain loyalties and commitments because there is no neutral, value-free way of talking about matters of fact. Terminology, vocabulary, grammar, and syntax both reflect value assumptions and influence public acceptance or rejection of a practice.

When we talk about "new reproductive technologies," language invariably seems to connote approval or disapproval. "Surrogate motherhood," for example, sounds like a grammatical misfire. The "surrogate" is "mother" only in the sense that she provides the biological fixtures and furnishings necessary to host and sustain fetal life until birth (or shortly thereafter). This holds even if the surrogate provides the ovum. She functions, in fact, as a "hostess" for the time necessary for gestation and delivery.

Despite claims of selflessness and compassion, which may indeed motivate women to volunteer for surrogacy, what these women actually provide is a surrogate womb since human motherhood is not a matter just of biology but of social role and responsibility. Human parenthood

comprises emotional, financial, physical, and other attentions spread over the lifetime of the child—given in love, nurtured by resolution, and sustained by commitment. In the future, a completely artificial environment may exist for gestating and birthing our species. Still, then as now, we will call "mother" the woman who takes up the vocation of mothering, not the biological ancestor, surrogate womb-provider, or machine. Likewise, it will be the man who takes up the vocation of fathering whom we will call "father," not the sperm donor.

Beyond terminology and grammar, policymakers need to attend to the purposes of medicine. How we understand medicine and its purposes will affect whether the new reproductive technologies are properly considered to lie in the province of medical intervention. It is clear that there is no consensus, either within the medical community or within society as a whole, on medicine's proper purpose.⁶ If we assume that medicine's purpose is the cure of illness and amelioration of suffering in pursuit of health, urgent and important questions remain regarding the new reproductive technologies. Is infertility an illness? Can it be described as a pathological condition? Must it be labeled an illness or a disease in order to qualify for medical intervention?⁷ Does infertility entail suffering? Do couples have an unqualified right to bear or to have children and thus to receive this treatment? How can infertility be ranked alongside other conditions that plainly warrant medical intervention?

As to the last question, we can compare infertility with certain other conditions, which we have nominated diseases, as to frequency, mortality, and morbidity. Infertility strikes one in 12 couples in the United States, but it is not a mortal illness; people do not die from it, nor is it life-threatening. It does not impair other biological and social functions, including parenting, as adoptive parents can attest. Even if we grant that infertility is a condition which medicine should treat by means of available technologies, it does not appear that infertility deserves to be ranked high on the list for medical intervention when compared, say, to heart disease or cancer or other leading health problems in the United States.

Public policy also addresses standard ethical concerns, among which are distributive justice, calculations of possible consequences, and concern for the common good. At some point policymakers must deal with the allocation of finite resources and ask related questions about the new reproductive technologies. For example: should they be available to all

infertile persons regardless of ability to pay? Would mental retardation or other conditions disqualify? Should access be limited only to infertile married couples, or should it be extended to anyone who wants a child, including single men, single women, and homosexual couples?

Is it a proper stewardship of limited resources that we invest so much time, money, and energy in fertility-enhancing projects when neonatal mortality rates are rising in several states, particularly among blacks (where it is already twice as high as for whites);⁸ when thousands of our children become permanently brain-damaged every year because of malnutrition; and when we simultaneously make large investments in abortion and conception control? It is not generally regarded as irony, much less contradiction, that the technologies to promote fertility proceed alongside others that seek to limit and inhibit fertility. For a society such as ours, this is simply business as usual. Although the scale of our investment in these competing technologies may not compel moral conclusions, it is nevertheless sobering to be reminded that while we spend millions of dollars on sterilization, abortion, and population control, we simultaneously spend additional dollars promoting AI, IVF, and surrogacy. This circumstance reflects confusion and competition regarding desirable ends. Can we as a society employ our scarce economic and other resources toward goals that are complementary rather than contradictory, coherent rather than conflicting?

Like most other medical assistance in a fee-for-service system, the new reproductive technologies are available as treatment only for those who can pay for them. But do we in fairness owe this intervention to the poor as well since infertility is not a bane only to the wealthy? It might appear that these technologies should be made available to all infertile persons who wish to use them, since other non-lifesaving therapies are not restricted to certain population groups. On these terms, moreover, it might seem that there is no reason to restrict the technology to infertility. Why should it not be available to persons who simply do not want to have their lives interrupted by conception, pregnancy, and birth, but who wish nonetheless for a child with their genetic inheritance?

That infertility does not claim a high priority when compared with other kinds of medical intervention might settle part of the distributive justice question. But other aspects of this issue will require us as a society to say more clearly where our understandings of words like *medicine*, *par-*

ent, and *family* impinge upon decisions to offer or withhold interventions of this sort. Sooner or later, we must say more clearly whether the claims we make about who we are as a people might require us to forgo some exotic technologies (perhaps AI, IVF, and surrogacy?) when embracing them may involve denying to some of our neighbors the most rudimentary health care.

Many people see the family today as a beleaguered social institution, its stability and structure threatened by increased mobility, competition in the workplace, pressures to accumulate, the market mentality, various competing subcultures, and unreasonable expectations placed on the family unit to provide a sanctuary from the world "out there."⁹ Whether this picture is accurate, if people believe that the family is a key unit of society, it is appropriate to question what impact these technologies might have on it. The answer at this juncture is likely to be uncertain, owing to a paucity of data.¹⁰

It is also too early to be conclusive about the effects of these technologies on the children produced by them. Studies to date indicate no abnormal physical or psychological problems.¹¹ We can, however, compare children born by these means with adopted children who show a sometimes serious and sustained curiosity about the identity of their biological forebears. Knowledge of lineage, at least in our society, is part of one's identity. To the extent that our society continues to reinforce this notion, practices that obscure and confuse lineage (like artificial insemination by donor, IVF, and surrogacy) may contribute to psychological problems for these children.

As for effects on the surrogate, a number of concerns can be voiced, but we will mention only economic exploitation. The \$10,000 fee typically paid to a surrogate amounts to about \$1.50 per hour over the course of pregnancy (Bettenhausen 1987). This seems parsimonious and exploitive considering the sacrifices the surrogate makes and the risks she runs in order to perform this "service."

The new technologies also will have an effect on the act of human procreation. These technologies generate a distance between conception, gestation, birthing, and parenting so that these events are no longer viewed as points along a continuum but as discrete occurrences that can be compartmentalized and separated from each other. We believe that such interventions affect not only tissues and organs but also the persons whose

tissues and organs these are.

Policymakers must always work, of course, within certain political limits, not least of which are certain pragmatic realizations of what can actually be done and who wields power. Perhaps most important, however, is a clear understanding of what statutory law can and cannot do. Law typically intervenes only after a problem arises. It does not so much seek to prohibit actions as respond punitively to the outcomes of those actions, often in such a way as to discourage them. Among the law's repertoire of responses are the imposition of penalties and refusal to enforce contracts. Past experience should make us cautious about trying to legislate behavior that is difficult for law to control. Technology has a way of outstripping the ability of law to govern, since the law relies on clear and unambiguous "do's" and "don'ts."

III. Policy Suggestions

Our response to the challenges and opportunities afforded by these reproductive technologies (AI, IVF, and surrogacy) is one of qualified support. This stance contrasts with at least three other policy options: (1) unqualified support, which would obligate us to clarify legal matters, to allocate research funds to develop the technologies, and to make these technologies available; (2) total opposition, which would entail discouraging them in every way--legally, financially, socially, and scientifically; and (3) postponement of any policy intervention while we wait to see how things develop.

Qualified support does not forbid the use and development of technologies, but it seeks to limit use and slow development. Such a position places the burden of proof for continuation and expanded application of these technologies on their innovators and advocates. Giving qualified support might mean, for example, approving some applications of artificial insemination by husband (AIH) and objecting to all applications of artificial insemination by donor (AID), out of concern for confusion of lineage and identity. One might support IVF in some cases and disapprove of surrogacy because these two technologies do not require each other. We might, in other special cases under strict controls, endorse surrogacy, while maintaining that this should not be a purely private decision, taken by individuals alone apart from the community.

Giving qualified support can be difficult because it requires room for practical reasoning in discerning the particulars of each case. It requires a casuistry that begins with certain assumptions but does not decide cases in advance. The ambiguity will be frustrating for many, especially for those who seek to implement policy, as law rarely can build in such flexibility. Still, such flexibility seems necessary given the ambiguities of the situation, the concerns of policymakers, and our theological convictions.

Our qualified support for these new reproductive technologies begins confessionally but is also based on practical concerns that policymakers must consider. Qualified support is based on a recognition that any attempt to obliterate technology is wrong-headed (as well as impractical) and alienates us from one of our distinctive capacities. Still, human finitude and the possibility of the abuse of technology (of which we can find many historical examples) make giving in to a technological imperative unwise. Further, a Christian commitment to others means that research and treatment of infertility should be seen against the backdrop of other instances of suffering and pain. Finally, Christians cannot give primary or ultimate loyalty to biological lineage and reproduction.

How does this Protestant-informed perspective differ from policy suggestions backed by "secular" rationales? That is difficult to say because, while it is clear that Christians ought to be a distinctive people, it is sometimes difficult to say what role those perspectives not shared by the larger society can and should play in public policy formulations.¹² But the problem may not be as great practically as it seems at a theoretical level. We advocate qualified support, and interestingly, major commission reports from around the world assume a similar posture, even though all differ in some details (Walters 1987). These reports include the United Kingdom's Department of Health and Social Security *Report of the Committee of Inquiry into Human Fertilization and Embryology* (the Warnock report, July 1984) and the U.S. Department of Health, Education and Welfare Ethics Advisory Board's *HEW Support of Research Involving Human In Vitro Fertilization and Embryo Transfer* (4 May 1979). Christian particularity in this case does not seem to lend itself to exclusivity. This should not surprise those familiar with even the recent history of Christianity. Some Christians have already learned (for example, in the protests for civil rights and nuclear disarmament) that they can join with non-Christians in the same moral action.

Such an overlap does not obscure distinctively Christian reasons for supporting some policies over others or for interpreting circumstances in certain ways. Nor does it fail to recognize that others can support the same policies for their own (perhaps different) reasons. In the end, it is enough, indeed it may be all that is possible, for Christians to seek to live faithfully according to their vocation as disciples, letting the answers arise out of concrete, particular cases, rather than in the speculative futility of trying to decide issues in advance. For a people who live by faith and who know they are saved by grace, it ought to be possible to be decisive without supposing they must also be definitive.

Christian traditions provide Christians with memory and identity. They denote the truth about who we are. So our attempts to develop understandings of parenthood, marriage, parent-child bondings, and the impact of the new reproductive technologies on our common life cannot be abstracted from a deep and pervasive sense of the Christian tradition and community. This account offers us the prospect of acknowledging both our religious heritage and our moral agency with integrity, without imperially imposing on society our sense of what is right and true and good. ☸

NOTES

1. Related issues like the disposition of human embryonic materials are also important, though space does not permit us to examine them in this article.
2. MacIntyre does not tell us how to recover shared traditions in light of the present fragmentation. Instead, he ends the book disconsolately waiting for a new St. Benedict (1984:263). Engelhardt fails to acknowledge that his approach is coercive because it forces dissenters either to become outlaws or to subordinate their convictions to "neutral" ideas which may not be compatible with the convictions of participating communities.
3. This paper essays to be part of that effort by displaying a pattern of dialogue which may prove suggestive for other Christians, and indeed all who share what might be called the dilemma of bringing "public" and "private" together.
4. It has long been held by Christians—Roman Catholic and Protestant alike—that marriage is the appropriate context for human procreation. Begetting children and the attendant parental responsibility is a major purpose of marriage. Indeed the tacit logic appears in some ways to suggest that one should remain unmarried unless one embraces the vocation of parenting. That is, of course, a sensible position for a people who believe that it is neither desirable nor possible for all adults to marry and have babies. Celibate, single Christians are simply called to another vocation.
5. Of course a mechanism will be required to assure that denied funds be shifted to provide basic health care. It is neither necessary nor pertinent to our purposes to design such a mechanism here.
6. Its purposes range from curing illness, alleviating suffering, and caring for the ill, to sustaining human physical and mental well-being, restoring what can be restored and corrected within the limits of current skills, and seeking to preserve that health which is a species-specific state of being revealed in activity, bodily excellence, and fitness. See Kass (1985:174–86), Hauerwas (1986:78–79), and Pellegrino and Thomasma (1981:69) for a sense of this variety.
7. The classical warrant for medical intervention was the presence of a definitely diagnosed physiological lesion which was believed to be life-threatening or function-inhibiting. Infertility might qualify on the latter grounds but would stretch the point. A more likely warrant comes from psychosomatic medicine, in which the classical warrant has been enlarged to include psychological and social well-being.
8. For example, in North Carolina, the infant mortality rate rose 4.1 percent in 1988, from 12.1 deaths per 1,000 live births in 1987 to 12.6. In the same period of time, the mortality rate among nonwhite infants rose from 17.6 per thousand to 18.7, while the rate for white infants remained the same (figures cited in *Durham Morning Herald*, 14 September 1989).
9. See, for example, Cox (1973:18–21) and Hauerwas (1981:155–74).

10. Some argue that these practices will serve to strengthen the family. Psychological profiles of couples applying for IVF tend to show, however, that they are well-adapted, cohesive units. They are already, in some sense at least, "strong families" (Hearn et al. 1987).
11. See, for example, Spensley et al. 1986.
12. Among contemporary authors, Stanley Hauerwas (1983) and James Gustafson (1975) can be read as representing opposing positions.

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Examples

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