STUDY MATERIALS: Medical Ethics

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Lesson 1: The Foundations (Lectures 1 and 2)

1. Read the *Oath of Hippocrates*. Enumerate its duties and its limitations on the practice of medicine. What are some of the consequences for physicians who would be guided in medical practice by the Oath?

2. The care of Jesus for the vulnerable is the model for the Catholic physician. Read chapters 8 and 9 of Matthew's Gospel. How do these Gospel passages guide physicians who would model their medical practice on the ministry of Jesus?

3. The *Prayer of Maimonides* is often considered to contain a moral code for the practice of medicine. It can be found easily with a search online. List some of the important elements in the prayer. What are some of the consequences for physicians who would be guided in medical practice by the Prayer?

4. Read Part One, "The Social Responsibility of Catholic Health Care Services," of the *Ethical and Religious Directives for Catholic Health Care Services* [original external link is no longer active]. List the principles enunciated there and indicate how these principles animate directives 1 through 9.

5. Read Part Two, "The Pastoral and Spiritual Responsibility of Catholic Health Care," of the *Ethical and Religious Directives for Catholic Health Care Services*. List the most significant ideas contained in directives 10 through 22.

6. Read Part Three, "The Professional-Patient Relationship" of the *Ethical and Religious Directives for Catholic Health Care Services*. Reflect on the dignity of the human person as a free creation by God in the image of God. What are the consequences for the practice of medicine? What are the consequences for the patient in the practice of medicine?

7. The natural law tradition as explicated by Saint Thomas Aquinas is foundational for medical ethics in the Catholic tradition. Describe and evaluate the Natural Law theory of Thomas Aquinas. Include in the description (a) the historical antecedents of Natural Law, (b) the remote and proximate foundation of Natural Law, (c) the specification of the first principle and precept of Natural Law, (d) the formulation of the specific principles of Natural Law, and (e) the limitations as the movement to made from general principles to contingent action, and (f) the response of the Natural Law position to any issue in medical ethics.

8. The integral goodness of an act requires that it be good in object, in intention, and in circumstances (*bonum ex integra causa et malum ex quocumque defectu*). Thomas Aquinas examines this principle in Question 18 in the *Summa*

*Theologiae I-II (*NewAdvent.org*)*. Summarize what he says in Question 18, article 4 and give an example of an integrally good act and give examples of each of the possible kinds of defect that renders an act evil.

9. The Principle of Sanctity of Human Life has been subjected to a variety of interpretations in the contemporary culture. List several interpretations and then using an example from the practice of medicine show how the different interpretations bring about different results. Which interpretation would you defend as correct?

10. Explain the principle of Double Effect and give an example of its application in contemporary medicine.

11. Explain the Principle of Totality. Include in the explanation the difference between the application of the principle to a physical entity and to a moral entity. Give an example of the application of the Principle of Totality in contemporary medical practice.

Lesson 2: Abortion (Lectures 3 and 4)

1. In the assessment of the morality of an act, the object, intention, and circumstances must be considered. What is the object of abortion and why is it important to know what the object of a proposed act is?

2. Abortion as an elective medical procedure was unknown until modern medical practice. Nonetheless, from time to time, there were indications of concern for developing life in the womb. Indicate some of those significant acknowledgments.

3. The soul was posited as the active principle of human life at least from the time of the ancient Greeks. What part does soul theory play in the abortion debate?

4. Read "Abortion," which describes the early development of human life from fertilization until birth. Chronicle the significant development stages in the life of a new human being from syngamy until birth.

5. Define the ontogenetic zero point of development and the ontogenetic zero point of behavior. What is the significance of each in the development of human life?

6. Explain the following terms:

a. Being in act

b. Active and passive potentiality

c. Constitution and tendency of active potentiality

d. Natural and specific active potentialities

e. Remote and proximate potentialities

7. Give a summary minimal description of human life as it is present in the zygote, the fertilized ovum.

8. The notion of autonomy is a powerful notion in the contemporary culture. Present and assess its application in the culture and in the issue of abortion.

9. Develop and evaluate the notion of pregnancy as an example of lives embedded in relationship.

10. What is the notion of a person as a juristic concept?

11. Evaluate the claim the since only forty percent of human zygotes survive to become fully developed rational beings the zygote should not receive full protection of the law.

12. Explain and evaluate the theories of ensoulment as they apply in the abortion debate.

Lesson 3: Research Ethics (Lecture 5)

1. Research as a function of the drive to know and medicine as an aspect of the desire to heal are opportunities for human beings to exercise creative stewardship. Assess the opportunities and limitations found in each.

2. The Tuskegee Syphilis Study had both a scientific purpose and a social purpose. Identify those purposes. Assess the study and the longevity of the study. In your assessment pay careful attention to: (a) cultural bias, (b) the availability of penicillin, (c) the provisions and acceptance of the Nuremberg Code, and (4) the research imperative.

3. Medicine as practiced under the cloud of the Nazi dictatorship provides an example of the power and perversion of the research imperative and the

medical imperative exercised in the presence of a particular ideology. Assess that practice and in your assessment pay careful attention to: (a) cultural bias, (b) the research imperative, and (3) the medical imperative.

4. Read the *Nuremberg Code*. List its most important precepts. List the important elements in the informed consent provision.

5. In what ways is the *Declaration of Helsinki* [external link] an advance on the *Nuremberg Code*?

6. The Code of Federal Regulations guides research on human subjects in the United States. Read the guidelines found in §46.404, §46.405, §46.406, and §46.407 and list the significant regulations for research projects involving children.

7. Assess participation in research from the perspective of the Catholic tradition in medical ethics. Be attentive to the role of the researcher as well as the role of the subject.

Lesson 4: The New Eugenics: Genetic Testing, Screening, and Therapy (Lecture 6)

1. The desire to improve the quality of the human race and the quality of individual members is as old as the history of mankind. Cite some significant historical and personal instances of the press of this desire.

2. The goal of genetic engineering is to contribute to the improvement of human life. This goal becomes suspicious when it becomes the tool of the state as part of a eugenics program. In the late nineteenth century and in the early twentieth century, the United States was a leader in a eugenics program that was advanced by way of non-voluntary sterilization. Indicate some of the significant moments in the history.

3. Read the excerpt by Oliver Wendell Holmes from the Buck v. Bell decision of the United States Supreme Court.

   http://supreme.justia.com/cases/federal/us/274/200/case.html#207

4. This statement represents an apt summary of the prevailing position of a powerful elite in the United States in the early twentieth century. What are the values contained in that excerpt?

5. Eugenics efforts in the United States exercised considerable influence on other nations. Cite and describe an example of that influence.

6. Because of its past history with non-voluntary sterilization, the United States now has in place a formidable set of protections surrounding the important right to procreate. These protections are to be found in court decisions as well as in the department of human service guidelines. Read the court-developed guidelines for the protection of the mentally incompetent in sterilization decisions. What are the provisions of these guidelines?

7. Advances in technology offer amazing opportunities in genetic engineering. Describe the four types of genetic engineering. What are the medical and ethical implications of each?

8. Advances in technology offer the opportunity for prenatal genetic testing. What are the types of genetic testing now in use? What are the medical and ethical implications of each?

9. The genetic testing of children is a particularly difficult decision. What are its problems and what guidelines are in place to protect the child?

Lesson 5: Cloning and Embryonic Stem Cell Use (Lectures 7 and 8)

1. What are the three most significant recommendations found in the *Scientific and Medical Aspects of Human Cloning*, the report of the National Academy of the Science on cloning?

2. What are the most significant recommendations found in *Human Cloning and Human Dignity*, the report of the President's Council on Bioethics on cloning?

3. In order to better understand and sort out the ethical issues of cloning-to-produce-children and cloning-for-biomedical-research describe both in the ethical language of object, circumstances, and intention.

4. Describe the scientific process of somatic cell nuclear transfer (SCNT) that is the current method of cloning.

5. What are the most significant ethical elements in the issue of cloning to produce children?

6. Examine the excerpt from the statement of Professor Lawrence Tribe. What values are embedded in that statement?

7. The experiment of cloning-to-produce-children must be carried out in accordance with the norms governing experimentation on human subjects. What provisions of those codes apply here?

8. What are the potential harms and injustices to prospective offspring who might be cloned? What are the potential benefits?

9. What are the potential harms and injustices to women who might take part in the cloning process? What are the potential benefits?

10. What are some of the potential harms and injustices to families and society as a consequence of the acceptance of cloning? What are the potential benefits.

11. If cloning-for-the production-of-children is violative of your religious principles, why is this so?

12. One of the purposes of cloning-for-biomedical-research is the removal of stem cells from the inner cell mass of the embryo. The removal of the inner cell mass causes the destruction of the embryo. The ontological status of the embryo is, then, a critical issue in assessing the morality of the process. List and evaluate the three positions found in contemporary bioethical literature on the status of the embryo.

13. What are some of the sources of stem cells and why are stem cells so valuable?

Lesson 6: Assisted Reproductive Finality (Lecture 9)

1. What are the significant pressures that have influenced medical science to develop assisted reproductive technologies?

2. What are the different types of assisted reproductive technologies (ART) currently available?

3. Define the following:

    a. Ovarian hyperstimulation

    b. Homologous insemination

    c. Heterologous insemination

   d. *In vivo* fertilization
   e. *In vitro* fertilization
   f. Gamete intrafollopian transfer (GIFT)
   g. Zygote intrafallopian transfer (ZIFT)
   h. Intracytoplasmic sperm injection (ICSI)
   i. Embryo micromanipulation
   j. Assisted hatching
   k. Traditional surrogacy
   l. Gestational surrogacy

4. What are the essential elements of the Catholic tradition regarding marriage that serve to guide the accomplishment of the reproductive finality?
5. Within the Catholic tradition what is the sign that signifies the meaning of marriage. What is the sign that signifies and contains the reality of marriage? What is to be understood from these signs?
6. What are the essential elements in the Catholic teaching on marriage from *Casti connubii* of Pope Pius XI to *Familiaris consortio* of Pope John Paul II?
7. Read Directives 38-42 in Part Four, "Issues in Care for the Beginning of Life" of the *Ethical and Religious Directives for Catholic Health Care Services* [original external link is no longer active]. What guidelines are set down there for married couples in accomplishing the reproductive finality of marriage?
8. What are the significant potential harms for offspring, for women, for the family, and for society in the use of ART processes?
9. What social justice issues are pressing in the development and use of ART technologies?

Lesson 7: Maternal / Fetal Relations (Lecture 10)

1. Feminism has a set of significant values that have brought about many advances for women and for society. What are they?

2. What are the features that distinguish equity feminism from equality feminism?

3. The United States Supreme Court decisions *Roe v. Wade* and *Doe v. Bolton* have had a significant influence on defining the maternal fetal relationship. Describe and evaluate those provisions.

4. Describe pregnancy as a relationship between two developing human beings.

5. Examine and evaluate the justification for abortion from the perspective of a gender equity feminist. Describe and evaluate the justification for abortion from the perspective of a gender equality feminist.

6. Read the Introduction and Directives 48-54 in Part Four, "Issues in Care for the Beginning of Life", of the *Ethical and Religious Directives for Catholic Health Care Services* [original external link is no longer active]. What guidelines are set down there to assist pregnant women and their children?

7. The Principle of Double Effect is used to sort out complex moral issues some of which arise in pregnancy. Among those issues are the rare but real risk to the life of the mother and the occasional need of a pregnant woman to receive medical treatment necessary for the continuation of her life and health. How is the Principle of Double Effect to be applied in these instances?

8. Abortion is sometimes suggested as a remedy for fetal deformity. Evaluate this remedy. In your evaluation consider the distinction between a condition of disability and a condition incompatible with life.

9. Abortion is sometimes suggested as a remedy for a pregnancy that resulted from rape or incest. Evaluate this proposed solution and its application to human beings who might become disabled at some time in the course of their life.

10. Examine and evaluate the issues for pregnant women and companies who would employ them in the contemporary cultural milieu.

Lesson 8: Issues at the End of Life (Lecture 11)

1. Describe the transitions in death and dying in the modern era and the shifting human assessment of the gains and losses found in the transitions.

2. In the search for a new construct to enable human beings to deal with dying and death, the Patient Self-Determination Act became law. What are its advantages and disadvantages?

3. Physician Assisted Suicide has been suggested as an appropriate remedy to the restraining of death. Develop and evaluate the set of arguments that have been brought forth in its defense. Be certain to include the following:

    a. Legal arguments

    b. Philosophical arguments

    c. Medical arguments

    d. Practical arguments

    e. Economic arguments

4. Against the right to assistance in suicide by medical personnel as a liberty right, there are asserted rights and obligations of the state. What are the *Parens patriae* obligations of the state?

5. Read the Introduction and Directives 55-66 in Part Five, "Issues in Care for the Dying," of the *Ethical and Religious Directives for Catholic Health Care Services* [original external link is no longer active]. What guidelines are set down there to assist health care practitioners in the care of the dying?

6. How should a Christian prepare for death? What obligations do Christians owe the dying?

Lesson 9: The Distribution of Health Care (Lecture 12)

1. Read Luke 14:13. What does the text have to say about health care in the Catholic tradition?

2. What are some of the most important challenges to the delivery of health care? Include in your discussion economic, legal, political, medical, and ethical challenges.

3. In discussions of the delivery of health care, the question as to whether health care ought to be regarded as a right or as a commodity if often raised. Assess

the proffered disjunction and offer an appropriate approach to the distribution of health care.

4. If health care is a scarce or limited resource, how, given human nature, can we best deal with its limitations?

5. Return to the distinction between ordinary care and extraordinary care found in Directives 56 and 57 in Part Five, "Issues in Care for the Dying," of the *Ethical and Religious Directives for Catholic Health Care Services* [original external link is no longer active]. How does this distinction serve to guide the use of medical interventions?

6. Medical resources have as their primary application (a) to cure illness, (b) to assuage suffering, and (c) to compensate for disability. Assess the restrictions that ought to apply to both individuals and to the medical profession in the use of the limited resources of medicine.

7. How ought individuals and the medical profession respond to the use of the art of medicine to serve the desire for human enhancement?

8. What considerations are significant in order to put into place appropriate structures to serve the health care needs of citizens?

9. Read *Catholic Health Care Institutions: Dinosaurs Awaiting Extinction or Safe Refuge in a Culture of Death*. What significant points are made as to how Catholic health care can provide witness to the values it holds in the contemporary world?

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Additional Reading: Excerpts from the Summa Theologica

Text available at NewAdvent.org

Question 90: The Essence of Law

Question 91: The Various Kinds of Law

Question 92: The Effects of Law

Question 93: The Eternal Law

Question 94: The Natural Law

Question 95: Human Law

Question 96: The Power of Human Law

Question 97: Change in Laws

Additional Reading: Oath of Hippocrates, ca. 400 B.C.

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INTRODUCTORY NOTE

HIPPOCRATES, the celebrated Greek physician, was a contemporary of the historian Herodotus. He was born in the island of Cos between 470 and 460 B.C., and belonged to the family that claimed descent from the mythical Æsculapius, son of Apollo. There was already a long medical tradition in Greece before his day, and this he is supposed to have inherited chiefly through his predecessor Herodicus; and he enlarged his education by extensive travel. He is said, though the evidence is unsatisfactory, to have taken part in the efforts to check the great plague which devastated Athens at the beginning of the Peloponnesian war. He died at Larissa between 380 and 360 B.C.

The works attributed to Hippocrates are the earliest extant Greek medical writings, but very many of them are certainly not his. Some five or six, however, are generally granted to be genuine, and among these is the famous "Oath." This interesting document shows that in his time physicians were already organized into a corporation, or guild, with regulations for the training of disciples, and with an esprit de corps and a professional ideal which, with slight exceptions, can hardly yet be regarded as out of date.

One saying occurring in the words of Hippocrates has achieved universal currency, though few who quote it today are aware that it originally referred to the art of the physician. It is the first of his "Aphorisms": "Life is short, and the Art long; the occasion fleeting; experience fallacious, and judgment difficult. The physician must not only be

prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate."

THE OATH OF HIPPOCRATES

I SWEAR by Apollo the physician and Æsculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment,

I will keep this Oath and this stipulation — to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction,

I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others.

I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.

I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art.

I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad,

I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.

Additional Reading: "Englehardt" (excerpt)

Tris Engelhardt and the Queen of Hearts: Sentence First, Verdict Afterwards

Margaret Monahan Hogan

The bioethics of H. Tristram Engelhardt, Jr. presents a challenge. On the one hand, his grasp of this moment in the history of philosophy, the post-modem period, and its impact on the intersection of morality, medical practice, and public policy is incredibly precise. On the other hand, his direction for the remedy -- a philosophical position anchored in the choices of mutually consenting, rationally developed adults -- and, as a consequence, some of his particular conclusions are seriously flawed. In both his direction for the remedy and in the particular conclusions his work resembles the rule of the irascible Queen of Hearts in the Wonderland Kingdom encountered by Alice in her journey through the looking glass. In his general position, Engelhardt constructs a community in which only fully developed, self-conscious human beings count as persons, while in her domain the Queen permits only red roses. Engelhardt allows the conferral of personhood on lesser humans by fully developed, self-conscious human beings and the Queen allows the non-red roses to be painted red. In his conclusions, Engelhardt, like the Queen, wants to deliver the sentence -- death -- before he allows for the sufficient examination of the evidence and the determination of the verdict.

In his response to the contemporary moment, Engelhardt takes up the task of fashioning an ethic for biomedical problems that can speak with rational authority across a plurality of moral viewpoints present in this historical period which, in his view, is post-Christian, post-scientific, and post-humanist. In the absence of faith and the failure of reason to discover a content-full moral framework, Engelhardt articulates his theory, "The Will to Morality" which, he claims, provides "a moral framework that can be shared by moral strangers in an age of both moral fragmentation and apathy."1 The central notions that constitute the matrix of "The Will to Morality" are the following:

(1) a content-full secular morality cannot be discovered;

(2) we are moral strangers;

(3) peaceful negotiation is the only possible way to secure a general moral framework;

(4) only human beings who are autonomous, i.e., fully developed, rational, and self-conscious are persons:

(a) personhood is a matter of accomplishment;

(b) only persons are bearers of rights in the strict sense; and

(c) human non-persons are vulnerable.

While Engelhardt is partially correct in regard to (1), (2), and (3), his philosophy of person (4) is inaccurately framed and inadequately developed. This paper will briefly respond to the incompleteness of (1) and (2) and, then, will develop a more complete response to (4), the inadequate philosophy of person. From within the context of these responses, a more structured matrix will be fashioned to facilitate and to direct (3), the

negotiation of the possible peaceful community. The response suggests that human beings live their lives in various relationships and in varying degrees of dependency. And it further suggests that if there is to be peace, the vulnerable are in need of protection. In summary, Engelhardt has an inadequate epistemology which results in an incomplete metaphysics which yields an improper ethics.

Engelhardt moves too quickly from his assessment that a content-full secular morality cannot be discovered to the conclusion that there is not some content available to be discovered. Two notions need to be developed here. One has to do with the activity of reason; the other has to do with the objects of reason. Between an understanding of the role of reason as limited to discovering "the already out there now reality" and an understanding of the role of reason as empowered to construct reality there is a middle position. The middle position holds that sometimes reason discovers and sometimes reason creates. Reason is directed, and sometimes constrained, in constructing by that which reason discovers, that is, reason is fettered to truth. Reason is guided in discovering and creating by its own method -- the ongoing, recurrent, related, cumulative, corrective set of operations employed in every cognitional enterprise yielding results that are cumulative and progressive.2 This method moves from experience, to inquiry, to understanding, to judgment. It moves from the *quid sit* question that initiates inquiry to the *an sit* question which demands verification and does not rest until that verification is accomplished.3 It is this method which guides human inquiry within a horizon that has expanded beyond the classical worldview of the past to the contemporary cultural moment with its historicist context. This method does not guarantee the possession of truth but lays out a path toward truth not as certain knowledge of the necessary, the essential, the universal, but as the probable affirmation of the particular and concrete.

In regard to possible concrete objects of reason, there are, between the emptiness of abstract heuristic guidelines such as "do good; avoid evil" or "be a peaceable member of a willed moral community" and the richness of content laden particular moral traditions such as that which can be found in the narrative schools of thought, specific markers to be discovered which place limits on and give direction to moral theory. Engelhardt has developed one -- the will of the autonomous rights-bearing isolated individual. There is at least one other. This marker lies in our nature as related beings. It is the source of the principle of beneficence and the activity of intersubjectivity. Furthermore, it lies latent in Engelhardt's treatment of mutual respect, of beneficence, and of intersubjectivity. This being-in-relation counters Engelhardt's categorical claim that we are moral strangers and attenuates his elitist philosophy of person. While we are moral strangers in one sense -- in the sense that we are holders of different moral traditions whose possible points of convergence we have chosen to ignore -- there is another sense in which we, as related beings, are not moral strangers. We exist in real relationships to one another. And from these specific relationships to each other, concrete duties to each other arise and are defined. In addition, the human beings who anchor these relations possess individual identity, that is, their lives do not receive definition only in terms of the relations. They have significance in themselves quite apart from the relationships. An adequate moral theory attends both the beings who

constitute the relationships and the link which defines the relationships. Engelhardt misses the linkage entirely and errs in his segregation of some human beings who anchor specific relations into classes of person and non-person.

Human relations vary. Some are quite close -- even intimate. Some are distant -- so distant that it takes a concerted effort to experience them. Some are problematic; some are so effortless as to appear natural. Some of these relationships are physical; some are moral. Some are freely chosen; others occur without choice. Some are symmetrical; others are asymmetrical. Some of the more obvious relationships are those of husband and wife, mother and fetus, parent(s) and family, family and community, physician and patient, attorney and client, experimenter and subject, teacher and student, the community of scholars . . . membership in the world community. These relationships suggest definition and give content to our responsibilities and duties. These relationships limit and structure the activity of "the willing" in peaceful negotiation. It is our existence as related beings that is the source of our traditions of community and hospitality, of mutual respect, and of liberty as ordered. These relationships constitute the links in the web of sociality. Insufficient attention to these links provides only a partial sense of reality. And we are guilty of insufficient attention to these links.

An examination of human lives as embedded in relationships suggests the following: (a) autonomy is always a limited accomplishment achieved over time after a long period of dependency and often followed by another period of dependency; (b) living the rich human life often places human beings in asymmetrical relationships of varying degrees of dependency throughout life; (c) autonomy is constrained by the relationships which define one's life; and (d) relationships to others sometimes require the acceptance of disadvantages for the sake of the other.

This understanding of human life as woven in relationships gives direction, even substance, to the negotiation of the guidelines for the peaceable community. In the absence of a common moral authority, in the absence of the discovery of a final, rational, canonical perspective, and in the presence of individuals whose limited autonomy is temporary and defined by specific relationships, we, who live together, must both create and discover solutions to the moral problems we encounter. Whether or not we choose to solve our moral problems is dependent on our choice -- hence the "will to morality" is crucial. However, the deliberation that guides the will must be informed by the reality discovered. The goals of peace and the emergence of the community require great protection for those who are dependent. Those who have achieved relative autonomy or those who exercise specific autonomy are required to protect those in conditions of dependency. Here the values of care, nurture, and relation, espoused by some feminists have a powerful role to play. This same observation has also been made by communitarians such as Mary Ann Glendon who wrote in *Rights Talk*:

As mothers and teachers [women] have nourished a sense of connectedness between individuals, and an awareness of the linkage among present, past, and future

generations. Hence the important role accorded by many feminists to the values of care, relationship, nurture, and contextuality, along with the insistence on the rights that the women's movement in general have embraced. Women are still predominately among the country's caretakers and educators and many are carrying insights gained from these experiences into public life in ways that are potentially transformative. Their vocabularies of caretaking are important sources of correctives to the disdain for dependency and the indifference to social bonds that characterize much of our political speech.4

Knowledge of human relations and the beings who are the terms of the relationship does not depend on belief in a creator God as the source of nature as normative. Furthermore, knowledge of these relationships does not depend on a privileged intuitive power to recognize a nature as morally normative. Knowledge of these relationships and their terms arises from the concerted and ongoing work of experience, inquiry, understanding and judgment, followed by more experience, inquiry, understanding, and judgment. Knowledge of the relations and terms provides a foundation to derive prescriptions from descriptions in the same way that knowledge of the role of a quarterback offers direction to the aspiring athlete or the knowledge of the role of the Snow Queen offers guidelines to the fledgling ballerina or knowledge of the nature of the heart offers direction to the surgeon.

Pregnancy provides an example of human lives embedded in relationship. The relationship is constituted by two human beings variously described as woman and fetus or mother and child. They exist as really related to each other. An adequate morality requires that attention be directed both to the relationship and to the beings who constitute the relationship. Directing attention to the relationship reveals the union to be asymmetrical. Directing attention to the beings in the relationship reveals an isomorphic symmetry, that is, each related being is a human being at a particular point on the human development trajectory.

Examination of the pregnancy relationship reveals several things. There is a physical union -- a union of being. There may be a moral union -- a union of purpose. That there is a physical union there is no doubt. However, this relation is more complex than most physical unions. If it were a kind of relationship that characterizes most physical unions, that is, a relationship of whole to part where the part is not necessary for the continuation of the whole and where it may be the case that the part threatens the life of the whole, there would be very little to discuss. However, since pregnancy is a temporary relationship between two physically whole human beings, one immature and the other more mature, a more complicated set of questions arises.

This temporary physical union is also a moral union -- a union of purpose. Neither of the human beings who constitute the relationship is determined to accomplish the totality of existence within this relationship. Since each of the two entities has meaning outside the relationship, then the discussion of problems within the relationship cannot be resolved only in the limited examination of the relationship. The woman is a relatively autonomous being. Her life is characterized by a set of ends that extend

beyond the pregnancy. For the duration of the pregnancy the fetus is a radically dependent being. While the growth and development of the fetus is intrinsically directed, the continued existence of the fetus is possible only within the nurturing environment supplied by the woman. The accomplishment of the ends of the fetus which lie outside the pregnancy require the cooperation of the woman. When the union is chosen either explicitly or implicitly, its status and the obligations of the more powerful member are less problematic from an ethical perspective. The more powerful accepts the disadvantages which occur for the sake of the more dependent. When the union occurs without implicit or explicit consent a more problematic relationship is constituted. The obligations that arise from a nonvoluntary relationship are a function of the need fulfilled by the relationship and the status of the beings who constitute the relationship. In attending to that relationship as a physical union the appropriate question may be: what obligations might be claimed to arise where the life of one human being is so radically dependent on the other for such a limited period of time? In attending that relation as a moral union the appropriate question may be: what limitations may be placed on the activities of the more powerful when they find themselves in relationships that are not of their own choosing? Attending those questions might defuse the prevailing rights-claiming and rights-trumping that marks the contemporary abortion debate and might facilitate peaceful negotiation. However, the approach to these questions requires more knowledge of the beings who constitute the relationship. And it is here that Engelhardt' s philosophy of person enters into the discussion.

When Engelhardt turns his attention to the beings who form the bases of the relationship, he applies his philosophy of person to them. In that philosophy, he segregates human beings by degrees of autonomy into categories of personal human life and non-personal human life. His core claim is that only human beings who are fully developed, rational, and self-conscious are persons. The elements that shape his view are (a) personhood is a matter of accomplishment; (b) only persons are bearers of rights in the strict sense; (c) human non-persons may have rights conferred upon them by human persons; and (d) human nonpersons are vulnerable. When applied to the beings involved in the pregnancy relationship this means that the woman is a person and the fetus is a nonperson. The woman may be a bearer of rights and the fetus has rights only if the woman so chooses.

This philosophy of person with its division of human beings into two classes -- "[p]ersons, not humans, are special"5 -- and with its claim of significant moral difference -- "[a]dult competent humans have much higher intrinsic standing than human fetuses or adult frogs"6 -- receives a multifaceted defense. The defense is tied to the principle of autonomy and it derives from Engelhardt's assessment of the fetus in terms of potentiality and probability. An exposition of Engelhardt's defense will be followed by a response to its inadequacies.

To be a person, Engelhardt claims, one must be autonomous. Only autonomous beings are capable of mutual respect. The constitution of a moral community requires personal beings. The required characteristics for the status of person are "self-conscious,

rational, free to choose, and in possession of a sense of moral concern."7 Those who do not have these characteristics are non-persons. Engelhardt says: "[f]etuses, infants, the profoundly mentally retarded and the hopelessly comatose provide examples of human non-persons. Such entities are members of the human species. They do not in and of themselves have standing in the moral community."8 And, even more forcefully, he says:

[I]t is nonsensical to speak of respecting the autonomy of fetuses, infants, or profoundly retarded adults, who have never been rational. There is no autonomy to affront. Treating such entities without regard for that which they do not possess, and never have possessed, despoils them of nothing. They fall outside the inner sanctum of morality.9

In developing his position, Engelhardt chooses the language of potentiality and probability to frame his dismissal of the fetus from the category of personhood. He presents an undifferentiated understanding of potentiality with a distinction between abstract and concrete potentiality, between material continuity and substantial discontinuity, and a deficient discussion of probability.

Engelhardt presents potentiality as a rather simple affair. If one is potentially something, then one is not yet that something. It is an all or nothing affair. He says: "[i]f fetuses are potential persons, it follows clearly that fetuses are not persons . . . If fetuses are potential persons they do not have the rights of persons."10 By way of analogy he argues that "if X is a potential president, it follows from that fact alone that X does not have the rights and prerogatives of actual presidents."11

In describing the fetus as possessing abstract potentiality, he contrasts the potentiality of the fetus with the concrete potentiality of the sleeping person. In this limited discussion of concrete potentiality versus abstract potentiality, framed in terms of states of consciousness, he says:

[T]he potentiality of the sleeping person is concrete and real in the sense of being based upon the past development of a full blown person. Unlike the fetus, the sleeping person has secured the capability of being fully human and has exercised it in the world. Far from a promissory note, the potentiality of the sleeping person to awaken is presented in concrete actuality in the physical substratum of that person, in his intact and functioning cortex. In this case the concept of person and personal presence depends heavily upon an intact normally developed brain; it presupposes some doctrine of the concomitance of mental personal life with an appropriate physical substratum. Further it requires recognizing the singular role of this intact substratum in weaving together the otherwise discontinuous life of the mind. . . . The discontinuity of sleep...is bridged and woven together in mental life.12

Further, he maintains that the human person emerges from the human animal in a process best described in terms of material continuity and substantial discontinuity. This discontinuity, Engelhardt claims, is based on the development of new properties. He says: "it is easier to construe the situation as a development from biological properties

to personal properties with a consequent and substantial change in the significance of the bearer of properties."13

Finally, in his application of the notion of probability to preborn beings, he claims that because research reveals that forty to fifty percent of human zygotes do not survive to become fully developed self-conscious rational human beings, it is more appropriate to consider the human zygote a 0.4 probable person.14

When one becomes a fully developed self-conscious being one gains significance and becomes a bearer of rights which may not be transgressed. Before one accomplishes such significance, one is not a person in the strict sense. However, rights for non-personal humans may be socially derived, that is, rights may be bestowed on human animals by the activity of already existing human persons on the basis of a utilitarian or consequentialist calculus. In setting value to non-personal human life, Engelhardt says:

The value of animal life which is not the life of a person, must be determined by other persons. . . The value of an animal's quality of life is thus set by persons in two senses. First, if the animal has no developed conscious life, persons may find no intrinsic value in such life and the predominant value may be the value that the life has as an object for persons. Second, even if the animal has an inward life that in a prereflective sense has a value for that organism, persons must still compare the value with other competing values.15

Until the personal properties emerge or once the personal properties are lost, one is vulnerable. When this philosophy of person is applied to the beings involved in the pregnancy relationship the woman is a person and the fetus is a non-person. The woman is a bearer of rights and the fetus has rights only if the woman so chooses. Thus, in Engelhardt's peaceable community, the white roses have to be painted red.

Engelhardt's demarcation of biological human life from personal human life as determined by the relative accomplishment of autonomy and other characteristics of personhood is artificial, arbitrary and, even more, it is elitist. Its central error lies in his construal of the notion of potentiality. Potentiality does not simply describe a "have" or "have not" state of affairs. Potentiality is a rich notion with an ancient pedigree. Its legacy continues to the present.

The fetus is a human being in act. Within that being resides the potentiality -- active natural remote potentiality -- to become a more fully developed human being who may achieve a degree of autonomy or may accomplish whatever characteristics are used to define personhood. A nuanced explication of potentiality requires attendance to the distinctions of potentialities as active/passive, as natural/specific potentiality, and as remote/proximate. In active potency the being goes from not acting to acting and is also the agent of the action; for example, the human being may develop or go, by its own agency, from being not conscious to being conscious. In passive potency, a human being has the capacity to receive a modification but the agency of the modification is an external agent. The present reality of the fetus in relation to the adult human being is not that of passive potentiality which requires extrinsic agency for actualization. In the

act that is the fetus there resides the active natural potentiality to become a more fully developed human being. Engelhardt's example of the potential presidential candidate who becomes president and enjoys presidential privileges is an example of a passive potentiality, that is, the extrinsic agency of the voters is required.

There are two distinct factors that make up the notion of active potentiality. One is constitution or nature and the other is tendency.16 The fetus is, by its constitution, determined as a human being and is, by tendency, determined to become -- in a fashion prefixed by its constitution -- rather than not. Since the tendency of the fetus in regard to fuller human development proceeds in a completely determined manner and since it cannot become something other than what the constitution determines it to be and since it cannot of itself not become, it may be said that the potentiality of the fetus for more fully developed human life is an active potency.

Active potentialities are designated either natural or specific. In the accomplishment of an active specific potency, the agent has a degree of freedom in the actualization of the potency. The agent may specify the manner in which to actualize the potency. Active natural potencies are accomplished in a completely determined manner. The agent is not free to choose whether or not to actualize the potency. In addition the agent is not free to specify the manner in which to actualize the potency. Factors external to the agent, such as the destruction of the normal environment or dismemberment, can inhibit the actualization but the agent cannot inhibit the actualization.

A further distinction is made between those potentialities which may be designated remote and those which may be designated proximate. This distinction is a function of time and development. The presence of the proximate potentiality allows the possibility of immediate realization. The presence of the remote potentiality allows the possibility of future activity and future realization. However, the remote precedes the proximate and is the necessary condition for the existence of the proximate in terms of both constitution and tendency. The proximate is the further developmental specification of the remote. In regard to specific functions characteristic of more developed stages of human life there exist in the fetus the remote potentialities which specify the proximate potentialities necessary for action. In the chromosomal material, there is all that is necessary -- in a relatively unachieved state of affairs -- for the becoming of the neocortex which serves as the proximate potency for higher mental processes.

These distinctions suggest the inadequacy of Engelhardt's position. Engelhardt's distinction between the concrete potentiality of the sleeping person for human activities and the abstract potentiality of the conceptus for human activities is a strange distinction. On one hand, it seems to embody the distinction used in medical practice in problems which arise in the allocation of scarce resources when the decision is to be made between the patient that the physician knows and has treated and the similarly situated patient whom the physician does not know and has not treated. The former is perceived as concrete, while the latter patient is perceived by the physician as abstract. On the other hand, the concrete/abstract distinction seems rooted in the person/ personal consciousness distinction, that is, one is a person so long as one is conscious

of oneself. From the perspective of the first distinction, the reality of each patient is the same; the difference lies in the relation of the physician to each of the patients. From the perspective of the second distinction, Engelhardt appears to be reducing the person to personal consciousness. He mistakes an attribute for the whole. He makes consciousness the determinant of the person, rather than viewing human beings as persons who have the capacity to be conscious. That is, human persons are beings who are (1) sometimes conscious, that is, accompanied by the awareness of the self as a subject, (2) sometimes conscious with the awareness of the self as an object, and (3) sometimes (a) in act -- as the fetus or as the sleeping person or as the person under anaesthesia -- or (b) in action -- so immersed in a problem or an activity or an encounter -- that awareness or consciousness of self is lost. These different states are states of one being who continues throughout the states. This condition has been described as:

The conscious life of the person is not the whole person; it is that in which the being of the person is actualized and this implies that a person is more than consciousness and that his or her body is to be distinguished from consciousness.17

From both perspectives, Engelhardt's analysis suffers from an inadequate notion of potentiality and from a lack of appreciation of the reality of the fetus. The fetus, or even earlier, the embryo or zygote, does exist and in its act resides the potentialities that may be actualized in the life of the individual. The potentialities are not in action but are present nonetheless. They may be abstract on the side of the observer but they are real and therefore concrete on the side of the fetus. In order for the activities of the higher central nervous system to be possible in the adult human being the cerebral cortex must be present (proximate potentiality). In order for the cerebral cortex to be present in the adult it must be present (remote potentiality) in the conceptus.

The description of the fetus as "an animal with great promise of becoming more than just an animal"18 suffers from the same inadequacies as the distinction between abstract and concrete potentialities, namely, an inadequate perception of the reality of the fetus and an inadequate notion of potentiality. The possibility of the fetus's becoming a human being, i.e., Engelhardt's fully developed self-conscious person, is more than just a promise. By virtue of its active natural potency, "which is a guarantee of the future insofar as the agent is concerned,"19 the fetus will develop itself (tendency) into an adult human (constitution).

Engelhardt' s questioning of the appropriateness of identifying the "what or the who that the fetus is" with the "adult 'who' which develops out of the fetus" is framed in terms of material continuity and substantial discontinuity. If there is discontinuity it seems appropriate to inquire as to the source of the properties of personal life and the subsequent change in the significance of the bearer of the properties. If discontinuity is maintained, the source cannot be the fetus. Engelhardt does not designate a somewhere or a someone else. His difficulty seems once again to stem from his impoverished notion of potentiality. For example, he maintains, "The genetic basis for the development of the physiological substratum of consciousness is not yet that

substratum."20 The genetic basis for the physiological substratum of consciousness may not yet be that substratum, but it is not nothing. It is not a simple case of have or have not. It, the genetic basis, is that from which will develop the physiological substratum of consciousness. In the genotype there is the remote potentiality -- an active natural potency -- that is the necessary condition for the emergence of the proximate potentiality -- the physiological substratum -- of consciousness. Personal properties are present in the reality of the conceptus, a being who is in the process of building a body of a particular kind, but whose organs are not yet in operation. This reality has been described in this fashion, "it would be proper to say that it is an actual human person with a body whose full development is already in dynamic process."21

Finally, in Engelhardt's discussion of probability as it relates to the possibility of the human zygote's being born, he confuses predictions of the future with descriptions of present states of existence. He fails to distinguish between classical laws and statistical laws. Classical laws describe regularities -- a one to one causal relationship . . . "other things being equal."22 An example of a classical law in operation is syngamy -- the union of the human sperm and the human ovum with the restoration of the diploid number of chromosomes along the mitotic spindle which marks the beginning of a new human life. Here there is an anticipation of invariance, the mark of a classical law. Another is the law of gravity -- the anticipation of constant velocity. Statistical laws relate to probabilities, that is, assessments based on relative actual frequencies. The statement that only forty percent of fertilized ova survive to be born may be used to formulate a probability statement, that is a statistical assessment of the likelihood that a fertilized ovum will survive to be born. It says nothing of the nature of the surviving being. What one might conclude from this probability statement is that existence is precarious at this period in one's life. At the other end of the life continuum, it may be the case that only forty percent of those who reach the age of seventy-five live to be eighty. That does not make those who are now seventy-five only 40% persons. It simply means that those who have reached the age of seventy-five are rather vulnerable in a statistical sense.

Engelhardt's distinction between human biological life and human personal life is an artificial distinction without adequate philosophical foundation and cannot serve to segregate human beings into categories of non-vulnerable rights bearers and vulnerable non-rights bearers for the purpose of killing the vulnerable. The status of personhood as a matter of conferring value should include all members of the human community regardless of their degree of development. A more adequate philosophy of person holds that (a) all human beings have value, that is are rights bearers; (b) the human community is constituted by some humans who are dependent and some humans who are relatively autonomous; (c) autonomy, which is preceded and followed by states of dependency, is a matter of relative accomplishment; (d) the accomplishment of the peaceable community requires that dependent vulnerable beings, including the conceived but not yet born, be protected. The application of this philosophy of person to the physical union and the moral union of the nonvoluntary pregnancy would require the recognition that the relationship is constituted by two human beings possessing value. Each human being endures a degree of dependency.

The woman is dependent on the larger community; the fetus is dependent on the woman. Care of both seems the appropriate response of the peaceable community.

And so, finally, sufficient attention to evidence changes the verdict and stays the death sentence for dependent vulnerable human beings.

Notes

{1} H. Tristram Engelhardt, Jr., *Bioethics and Secular Humanism* (Philadelphia: Trinity Press International, 1991), xi.

{2} Frederick E. Crowe and Robert M. Doran, ed., Bernard Lonergan, S. J., *Insight: A Study of Human Understanding* (Toronto: University of Toronto Press, 1992).

{3} Lonergan, Insight: A Study of Human Understanding.

{4} Mary Ann Glendon, *Rights Talk* (New York: Free Press, 1991), 174.

{5} H. Tristram Engelhardt, Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 1986), 104.

{6} Engelhardt, *Foundations*, 104.

{7} Engelhardt, *Foundations*, 105.

{8} Engelhardt, *Foundations*, 107.

{9} Engelhardt, *Foundations*, 108.

{10} Engelhardt, *Foundations*, 111.

{11} Engelhardt, *Foundations*, 111.

{12} H. Tristram Engelhardt, Jr., "The Ontology of Abortion," *Ethics* 84, 3 (1974): 217-34.

{13} Engelhardt, "The Ontology of Abortion," 225.

{14} Engelhardt, *Foundations*, 111.

{15} Engelhardt, *Foundations*, 111.

{16} Gerard Smith and Lottie Kendzierski, *The Philosophy of Being* (New York: The Macmillan Company, 1961), 105.

{17} John F. Crosby, "The Personhood of the Human Embryo," *The Journal of Medicine and Philosophy* 18 (1993): 407.

{18} Engelhardt, "The Ontology of Abortion," 225.

{19} Francis Wade, "Potentiality in the Abortion Discussion," *Review of Metaphysics* 29 (1975): 245.

{20} Engelhardt, "The Ontology of Abortion," 226.

{21} Joseph T. Mangan, "The Wonder of Myself: Ethical -- Theological Aspects of Direct Abortion," *Theological Studies* 31 (1970): 130.

{22} Lonergan, Insight: A Study of Human Understanding, 88.

Additional Reading: Abortion

by Margaret Hogan, Ph.D.

When a Catholic woman philosopher enters into the discussion of abortion, she enters with a variety of tools and experiences that provide the perspective for her examination. She enters with the tools of her disciplines -- philosophy and science. She, because she is Catholic, has been formed by the stories of the scriptures -- the Annunciation, the Visitation of two women each with a problem pregnancy, the Nativity -- and she is formed by the scriptural theme of "love for the least of these." When, in addition, she is a mother, she enters the discussion of abortion with the memory of her experience and awareness of nascent human life developing within her body. These are important experiences, which enrich her perspective and which she ought not cast aside.

The question of abortion continues in the contemporary culture to be an emotion-filled and value-laden issue. The public debate appears to be centered on the subjective pole of the act -- the reasons why and the justification for abortion. This focus has been so powerful that the objective pole of the act, that is, the reality of what is done when an abortion is procured or performed has been largely obscured. As a consequence, the public debate has been seriously skewed. The philosophical debate centers on the ontological status of the conceived but not yet born human being -- the *conceptus*. What I would like to do in these next two lectures is: (1) offer some observations; (2) present some historically interesting information; (3) delineate the outline of the contemporary debate; (4) formulate an ordered position; and (5) from within that position respond to the opposing positions. (The adequacy of the justification for abortion will be addressed in the lecture on maternal-fetal relations.)

First the observations. The first observation is that there is a certain simplicity about the issue of abortion. If abortion takes the life of a human being, then abortion is a species of the moral problem of killing human beings -- a kind of homicide. And the ethical injunctions that apply to other kinds of killing of human beings apply similarly to

abortion. If, on the other hand, abortion is an act that destroys a life that is not a human life, then abortion is not the same as other acts of killing human beings and the ethical injunctions regarding abortion are to be attenuated according to that circumstance. So a central issue here is what is the object of abortion, that is, what is it that is destroyed when an abortion is procured. The second observation is that the conclusions that are reached in regard to abortion have implications for other significant issues in medical ethics among them cloning, the use of stem cells, genetic testing and screening, and assisted reproduction.

A bit of history: Abortion as a means of birth control is as old as the human race. There are other practices, such as stealing, murder, and rape, are also as old as the human race. And society rightly condemns these actions. The longevity of the practice of abortion is no more testimony to its moral acceptability than the fact that presence of the practices of stealing, murder, and rape would require their acceptance by society.

Now throughout much of history there has been little regard for the nascent human life, mainly because it remained hidden. Nonetheless, there are some early instances of the condemnation of abortion. The Oath of Hippocrates (c. 5th century B.C.) which called the guild of ancient physicians to practice their art within a set of specific ethical constraints contains the pledge, "I will not give a woman a pessary to cause abortion." While the meaning and the extent of application of that swearing has been subjected to interpretation in the contemporary world, nonetheless its appearance in antiquity suggests at least that those most closely associated with the practice of medicine condemned the practice of abortion.

On the other hand some philosophers including Plato, in pursuit of his ideal *Politeia*, encouraged or permitted abortion for pregnancy out of season and infanticide for unwanted and imperfect children. Plato admonished the citizens of the Republic that it was, "preferable not even to bring to light anything whatever thus conceived, but if they were unable to prevent birth to dispose of it on the understanding that we cannot rear such an offspring" (5.461c). Recall that for Plato the more important good is the good of the *polis*. The individual is subsumed in that larger good. In a more limited sense, Aristotle, in the *Politics*, permitted abortion provided that it be done before life begins. Aristotle wrote, "when couples have children in excess, let abortion be procured before life and sense have begun; what may or may not be lawfully done in these cases depends on the question of life and sensation" (1335b 20-25). Note Aristotle's careful caveat "before life and sensation."

While the Scriptures of the Old Testament record nothing about abortion in the modern medical sense as an elective medical intervention, they do testify to a profound regard for the human being developing in the womb of the woman. The prophet Jeremiah records God's love for the unborn in these words, "Before I formed you in the womb, I knew you, and before you were born, I consecrated you" (Jeremiah 1:15). The Psalmist acknowledges the careful creation and intimate love of God for God's creature in these words, "You formed my inmost being; you knit me in my mother's womb. My very self

you knew; my bones were not hidden from you, when I was being made in secret, fashioned as in the depths of the earth" (Psalm 139:13-15).

And there is in Exodus 21:22 a passage that refers to the accidental injury to a pregnant woman and the possible occurrence of miscarriage as a consequence of the injury. In the Hebrew translation it is said that if the woman is injured, the person who caused the injury suffers a punishment commensurate to the injury, that is life for life, eye for eye, etc. If the woman is uninjured but the child is lost, a penalty is to be set by the husband of the woman. However, the Greek translation of the same passage prescribes the penalty of life for life for the death of the child if the child is formed. (Noonan, 6).

In the early Christian tradition, abortion is condemned as early as the *Didache* (c. 1st century A.D.). The *Didache* or *Teaching of the Twelve Apostles* is an ancient statement of Christian principles. Among its proscriptions are: "You shall not slay a child by abortion. You shall not kill what is generated."

For some of the early philosophers and some of the early theologians the questions of the determination of the humanity of an entity was answered in terms of the kind of soul -- the *psyche* that was the source of its activities -- that is, the soul as the principle of its life. Ensoulment was not a narrow theological question. It was an account of the internal source of the variety of activities manifested in the life of the entity. The move was from activities to the intrinsic principle of those activities. Nutritive activities, such as living, growing, and developing, offered evidence of the presence of a vegetative soul. The activity of motion suggested the presence of a sentient soul which higher-level soul subsumed the lower level activities, that is the nutritive. Rational activities indicated the presence of the rational soul, a soul that has the capacity to think, to understand, to reason, to choose, to decide. The rational soul as a higher-level soul subsumed the vegetative and sentient activities. (I shall return to this question in the next lecture.)

In the contemporary world, the abortion debate is embedded in a matrix which is defined by limits which range from the most subjective claims to the barest objective claims. Among these elements on the subjective side or the "why" side are the following. There is the claim of a right of women to abortion as the necessity of absolute control over reproductive processes in order that women be free to develop their potential. This right has been given legal sanction by courts and legislatures in many countries. In the United States, for example, the 1973 decisions by the Supreme Court found abortion to be a fundamental right inherent in the right to privacy and protected by constitutional guarantee (in the penumbra of the Constitution in Amendments 1, 4, 9, and 14). Some social planners have offered abortion as an aid to families in circumstances of social and/or economic distress and others have offered abortion as a humane solution to the problems of deformed, battered, and retarded children. On a global level, abortion has been suggested as a significant contribution to the solution of population problems. In addition, the contemporary culture is rife with a particular kind of liberalism which canonizes autonomy and makes personal choice the

essential criterion for the determination of the rightness of an action. Choice has become the trump card in the culture; human beings are considered autonomous rights-bearing individuals whose obligations are those chosen. On the objective side or the "what" side lie the questions of the beginning of human life, the nature of the *conceptus* -- the conceived but not yet born human being, and the question of personhood or the value of a human life.

Because the objective question must be answered first in order to be able to weigh the adequacy of the subjective determinants, it is appropriate to start there. The empirical sciences, especially embryology and fetology, are the sources of the empirical facts describing the developmental stages of human life. The pertinent information from these sciences is that regarding neither the cosmological origin of life nor even the phylogenic origin of human life. It is information regarding the ontogenetic beginning and unfolding of an individual human life from beginning to end.

In those sciences, the occurrence that marks the beginning of the process that is the life and development of an individual human being is marked at syngamy. Syngamy is the end point in the process of fertilization -- a process which begins when the ovum, containing in its pronucleus the species kind and half the species number of chromosomes, is penetrated by the sperm, which contains in its pronucleus a similar complement. The chromosomes borne by each pronucleus conjugate along the mitotic spindle supplied by the sperm and with their pairing the full species number of chromosomes is reestablished. With the completion of this pairing, a new level of metabolic activity begins in the single cell zygote. This new level of activity is not limited to the nuclear activity, for example, the gravitation of the cytoplasm -- a maternal contribution -- establishes a polarity most likely in a direction following the penetration by the sperm.

The activity of the new being is directed to its survival. It generates barriers to its being penetrated by additional sperm; it generates barriers which prevent its implantation in an inappropriate environment; and when it arrives in a suitable environment, it generates those structures to nurture and support its continued existence and growth. The occurrence of syngamy marks a locus of simultaneous convergence and divergence. The convergence is the coming together of the genetic donation of both parents and that of their ancestors. Here the continuity of life is maintained. The divergence is not simply the discontinuity between parent and offspring because of genetic uniqueness but also discontinuity because of inner unity and separateness from others of the *de novo* being. Once the zygote is constituted in the fusion of the chromosomal material there is a new individual. Hence, syngamy has been designated the ontogenetic zero point of development.

The ontogenetic zero point of development for an individual human being is defined as that point on the continuum of development that marks the beginning of the development of a new individual. Prior to this point, the individual and also the particular continuum used to delineate its existence did not exist. From this point forward the individual exists, develops, and expresses or actualizes the potentialities

that are its genetic endowment until some point in time when because of exogenous or endogenous factors the individual ceases to exist.

The ontogenetic zero point of behavior requires significant neural and muscular development. With the commencement of neuromuscular activity, behavior follows. This beginning of behavior is dependent upon prior structural growth which is genetically determined. The structural growth is such that it may be said to anticipate and determine the subsequent behavioral expression. Behavior matures in a direction following organ maturation and behavior functions to reinforce and to refine organic capacities (Carmichael's Law of Anticipatory Function). Development is continuous and is organized in a specific and forward direction. While various stages of development are named for reference and for convenience, the delimitation of stages is "purely arbitrary," that is, one stage merges into another without any real point of demarcation.

The following is a summary of the biological process. Morphological growth and subsequent behavioral development are products of genetic encoding at work in an environment that is normal for the species of organism. Self-generating developmental stages succeed one another in a genetically determined manner. The phenotype (apparitional characteristics) of the individual which was identical to the genotype (assemblage of genes) at syngamy now emerges as the expression of the particularities of the genetic constitution in the process of a continuously changing environment. From syngamy until death the genetic code continues to influence and to determine growth and behavior, provided the presence of a suitable environment and the achievement of the proper stage of development. The present reality of the human being from its ontogenetic zero point of development onward, that is, from zygote, to preimplantation embryo, to embryo, fetus, neonate, child, adolescent, adult is an upper directed dynamism toward ever fuller realization of being until the onset of decline, senescence, and death. Each lower stage lays down the conditions for the emergence of the next higher stage and each lower stage is the necessary condition for the possibility of the becoming of the next higher stage. The self-actualization of the human being is not limited to its biological determinations. The life of the individual is a process that presses towards actualization of psychological and intellectual potentialities that are inherent in the constitution of the individual human being. Abraham Maslow described this process of self-actualization in the following,

Man is ultimately not moulded or shaped into humanness or taught to be human. The role of the environment is ultimately to permit him or to help him actualize his own potentialities, not its potentialities. The environment does not give him his potentialities, he has them in inchoate or embryonic form, just exactly as he has embryonic arms and legs. And creativeness, spontaneity, selfhood, authenticity, caring for others, being able to love, yearning for truth are embryonic potentialities belonging to his species membership just as much as are his arms and legs and brain and eyes (Maslow, 130).

Maslow is making at least two important points here. One of these is that what a human being is -- as constituted in his nature -- determines what a human being may become. The second is that neither culture nor history nor socialization creates human beings.

Environmental factors -- including psychological and biological -- may inhibit or encourage the actualization of psychological potentialities. For Maslow what a human being is and what a human being could be exist simultaneously. He says, "Potentialities not only will be or could be; they also are" (ibid.). The existential reality of the being at its earliest stages of development is that of a being in whom the perfections, whether body or behavior or psychological, exist as an unachieved state of affairs. The existential reality of the adult human being is that of a being in whom some of these perfections exist in a relatively more or less achieved state of affairs. The possibility of self-actualization requires the continuous existence of a being with the capacity for these perfections and the existence of that human being in its normal environment.

Since much of the philosophical discussion about the ontological status of the *conceptus* has centered on the notion of its potentiality, that issue will be addressed next. The rich philosophical notions of act and potency carry distinctions adequate for describing the developing life of a human being. The description of the present reality at any developmental stage in the life of an individual human being must convey the fact neither of nothing nor of completed being. The *conceptus* exists as a present reality -- in act -- with potentialities directed toward a particular perfection -- the goal established by the genotype. The *conceptus* is a human being in act. Within that being resides the active natural potentiality to become a more fully developed human being. Explication of this complex potentiality requires attendance to the notions of potentiality that are active/passive, natural/specific, and remote/proximate. In active potency, the being goes from not acting to acting and is also the agent of the action. For example, the human being may develop or move, by its intrinsic agency from being not conscious to being conscious. In passive potency, a human being has the capacity to receive a modification but the agency of the modification is an external agent. For example, a potential president may actually become president by the agency of the voters. The president received the office (a passive reception) from an extrinsic agency. The present reality of the *conceptus* in relation to the adult human being is not that of passive potentiality which requires extrinsic agency for actualization. In the act that is the *conceptus* there resides the active potentiality to become a more fully developed human being.

There are two distinct factors that make up the notion of active potentiality. One is constitution or nature and the other is tendency. Constitution is the underlying manifold which determines the direction of the tendency. It is that which tendency by its dispositive thrust urges to completion. Tendency is the drive to action.
The *conceptus* is, by its constitution, determined as a human being and is, by tendency, determined to become -- in a fashion prefixed by its constitution -- rather than not. Since the tendency of the *conceptus* in regard to fuller human development proceeds in a completely determined manner and since it cannot become something other than what the constitution determines it to be and since it cannot of itself not become, it may be said that the potentiality of the fetus for more fully developed human life is an active potency.

Active potentialities are designated either natural or specific. In the accomplishment of an active specific potency, such as the choice of a specific food to satisfy hunger, the agent has a degree of freedom in the actualization of the potency. The agent may specify the manner in which to actualize the potency. Active natural potencies, such as the formation of the cerebral cortex, are accomplished in a completely determined manner. The agent is not free to choose whether or not to actualize the potency. Tendency determines that the potentiality will be actualized. In addition the agent is not free to specify the manner in which to actualize the potency. For the actualization of an active natural potency nothing is needed on the side of the agent beyond its constitution and the tendency to realize the constitution. Factors external to the agent may bring about its destruction and hence inhibit the actualization but the agent itself cannot inhibit the actualization.

A further distinction is made between those potentialities which may be designated remote and those which may be designated proximate. This distinction is a function of time and development. The presence of the proximate potentiality allows the possibility of immediate realization. The presence of the remote potentiality allows the possibility of future activity and future realization. However, the remote precedes the proximate and is the necessary condition for the existence of the proximate in terms of both constitution and tendency. The proximate is the further developmental specification of the remote. In regard to specific functions characteristic of more developed stages there exist in the *conceptus*the remote potentialities which specify the proximate potentialities which proximate potentialities are necessary for action. For example, in the chromosomal material, in a relatively unachieved state of affairs, there is all that is necessary for the becoming of the neocortex which serves as the proximate potency for the higher thought processes.

In summary then, the existential reality of the *conceptus* is that of a human being in act. It expresses that being as a unified whole, unified in itself and distinguished from others. It is living as indicated by its growth and its ability to utilize materials from its environment to sustain its existence. Its individuality and uniqueness derive from its genetic constitution. It is human and in it reside not only the biological potentialities but all the potentialities that are distinctive of human existence. "The complexity of the whole human body is contained in some real way in its first cell" (Granfeld, 28). From the facts of biological and psychological development and from the translation of these facts into metaphysical terms a minimal notion of the life of the human being emerges. A human being is an open, unfinished being who begins its existence at syngamy -- the ontogenetic zero point of development -- and who becomes what it is by developing its potentialities. The becoming which is described in various stages is a time-conditioned unfolding of the possibilities given at fertilization. The existential reality at each stage of development is different only in degree of actualization. What exists in the more fully developed human being in a relatively achieved state exists in the zygote in a relatively unachieved state. If there is to be intellectual development, there must be prior psychic development. If there is to be psychic development, there must be prior organic development. Each prior stage is the necessary condition for the emergence of each successive stage, and each prior stage anticipates in its development the

specifications of the next higher stage. It is the same human being who begins in existence, who develops, matures, declines, and dies. The adult human being cannot be more than the reality contained in the zygote. The existential reality of the adult is that of a being who is in action the fulfillment of the existential reality of the zygote in whose act the sum of the potentialities of the being reside. The zygote is the living human being at a particular stage of its development. It is what the human being should be at that age. The embryo is the living human being at a particular stage of its development. It is what the human being should be at that age. And so on . . . It is the same individual who develops organically, psychically, and intellectually.

If this is so, then abortion destroys a developing human being. Hence, abortion is as act of homicide.

Additional Reading: The Nuremberg Code

[from Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10. Nuremberg, October 1946–April 1949. Washington, D.C.: U.S. G.P.O, 1949–1953.]

Permissible Medical Experiments

The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and

the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probably cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

Of the ten principles which have been enumerated our judicial concern, of course, is with those requirements which are purely legal in nature — or which at least are so clearly related to matters legal that they assist us in determining criminal culpability and punishment. To go beyond that point would lead us into a field that would be beyond our sphere of competence. However, the point need not be labored. We find from the

evidence that in the medical experiments which have been proved, these ten principles were much more frequently honored in their breach than in their observance. Many of the concentration camp inmates who were the victims of these atrocities were citizens of countries other than the German Reich. They were non-German nationals, including Jews and "asocial persons", both prisoners of war and civilians, who had been imprisoned and forced to submit to these tortures and barbarities without so much as a semblance of trial. In every single instance appearing in the record, subjects were used who did not consent to the experiments; indeed, as to some of the experiments, it is not even contended by the defendants that the subjects occupied the status of volunteers. In no case was the experimental subject at liberty of his own free choice to withdraw from any experiment. In many cases experiments were performed by unqualified persons; were conducted at random for no adequate scientific reason, and under revolting physical conditions. All of the experiments were conducted with unnecessary suffering and injury and but very little, if any, precautions were taken to protect or safeguard the human subjects from the possibilities of injury, disability, or death. In every one of the experiments the subjects experienced extreme pain or torture, and in most of them they suffered permanent injury, mutilation, or death, either as a direct result of the experiments or because of lack of adequate follow-up care.

Obviously all of these experiments involving brutalities, tortures, disabling injury, and death were performed in complete disregard of international conventions, the laws and customs of war, the general principles of criminal law as derived from the criminal laws of all civilized nations, and Control Council Law No. 10. Manifestly human experiments under such conditions are contrary to "the principles of the law of nations as they result from the usages established among civilized peoples, from the laws of humanity, and from the dictates of public conscience."

Whether any of the defendants in the dock are guilty of these atrocities is, of course, another question.

Under the Anglo-Saxon system of jurisprudence every defendant in a criminal case is presumed to be innocent of an offense charged until the prosecution, by competent, credible proof, has shown his guilt to the exclusion of every reasonable doubt. And this presumption abides with the defendant through each stage of his trial until such degree of proof has been adduced. A "reasonable doubt" as the name implies is one conformable to reason — a doubt which a reasonable man would entertain. Stated differently, it is that state of a case which, after a full and complete comparison and consideration of all the evidence, would leave an unbiased, unprejudiced, reflective person, charged with the responsibility for decision, in the state of mind that he could not say that he felt an abiding conviction amounting to a moral certainty of the truth of the charge.

If any of the defendants are to be found guilty under counts two or three of the indictment it must be because the evidence has shown beyond a reasonable doubt that such defendant, without regard to nationality or the capacity in which he acted, participated as a principal in, accessory to, ordered, abetted, took a consenting part in,

or was connected with plans or enterprises involving the commission of at least some of the medical experiments and other atrocities which are the subject matter of these counts. Under no other circumstances may he be convicted.

Before examining the evidence to which we must look in order to determine individual culpability, a brief statement concerning some of the official agencies of the German Government and Nazi Party which will be referred to in this judgment seems desirable.

Additional Reading: Code of Federal Regulations

CODE OF FEDERAL REGULATIONS TITLE 45 PUBLIC WELFARE DEPARTMENT OF HEALTH AND HUMAN SERVICES PART 46--PROTECTION OF HUMAN SUBJECTS (45 CFR 46)

Revised June 18, 1991 (Effective August 19, 1991)

Edition October 1, 1994

Subpart D -- Additional Protections for Children Involved as Subjects in Research

[SOURCE: 48 FR 9818, March 8, 1983, unless otherwise noted.]

§ 46.401 To what do these regulations apply?

1. This subpart applies to all research involving children as subjects, conducted or supported by the Department of Health and Human Services.
    1. This includes research conducted by Department employees, except that each head of an Operating Division of the Department may adopt such nonsubstantive, procedural modifications as may be appropriate from an administrative standpoint.
    2. It also includes research conducted or supported by the Department of Health and Human Services outside the United States, but in appropriate circumstances, the Secretary may, under paragraph (e) of §46.101 of Subpart A, waive the applicability of some or all of the requirements of these regulations for research of this type.
2. Exemptions at §46.101(b)(1) and (b)(3) through (b)(6) are applicable to this subpart. The exemption at §46.101(b)(2) regarding educational tests is also

applicable to this subpart. However, the exemption at §46.101(b)(2) for research involving survey or interview procedures or observations of public behavior does not apply to research covered by this subpart, except for research involving observation of public behavior, when the investigator(s) do not participate in the activities being observed.

3. The exceptions, additions, and provisions for waiver, as they appear in paragraphs (c) through (i) of §46.101 of Subpart A, are applicable to this subpart.

[48 FR 9818, March 8, 1983; 56 FR 28032, June 18, 1991; 56 FR 29757, June 28, 1991]

§ 46.402 Definitions.

The definitions in §46.102 of Subpart A shall be applicable to this subpart as well. In addition, as used in this subpart:

1. *Children* are persons, who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted.

2. *Assent* means a child′s affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent.

3. *Permission* means the agreement of parent(s) or guardian to the participation of their child or ward in research.

4. *Parent* means a child's biological or adoptive parent.

5. *Guardian* means an individual, who is authorized under applicable State or local law, to consent on behalf of a child to general medical care.

§ 46.403 IRB duties.

In addition to other responsibilities assigned to IRBs under this part, each IRB shall review research covered by this subpart, and approve only research which satisfies the conditions of all applicable sections of this subpart.

§ 46.404 Research not involving greater than minimal risk.

HHS will conduct or fund research, in which the IRB finds that no greater than minimal risk to children is presented, only if the IRB finds that adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth in §46.408.

§ 46.405 Research involving greater than minimal risk, but presenting the prospect of direct benefit to the individual subjects.

HHS will conduct or fund research, in which the IRB finds that more than minimal risk to children is presented by an intervention or procedure that holds out the prospect of direct benefit for the individual subject, or by a monitoring procedure that is likely to contribute to the subject's well-being, only if the IRB finds that:

1. The risk is justified by the anticipated benefit to the subjects;
2. The relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches; and
3. Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth in §46.408.

§ 46.406 Research involving greater than minimal risk and no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition.

HHS will conduct or fund research, in which the IRB finds that more than minimal risk to children is presented by an intervention or procedure that does not hold out the prospect of direct benefit for the individual subject, or by a monitoring procedure which is not likely to contribute to the well-being of the subject, only if the IRB finds that:

1. The risk represents a minor increase over minimal risk;
2. The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social or educational situations;
3. The intervention or procedure is likely to yield generalizable knowledge about the subjects' disorder or condition, which is of vital importance for the understanding or amelioration of the subjects' disorder or condition; and
4. Adequate provisions are made for soliciting assent of the children and permission of their parents or guardians, as set forth in §46.408.

§ 46.407 Research not otherwise approvable, which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children.

HHS will conduct or fund research that the IRB does not believe meets the requirements of §46.404, §46.405, or §46.406, only if:

1. The IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children, and

2. The Secretary, after consultation with a panel of experts in pertinent disciplines (for example: science, medicine, education, ethics, law), and following opportunity for public review and comment, has determined either:

    1. That the research in fact satisfies the conditions of §46.404, §46.405, or §46.406, as applicable, or

    2. The following: (i) the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children; (ii) the research will be conducted in accordance with sound ethical principles; (iii) adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians, as set forth in §46.408.

Additional Reading: Protection of the Mentally Incompetent

Court Developed Guidelines for Protection of the Mentally Incompetent in Sterilization Decisions

(from Non-Voluntary Sterilization in the Interest of the Patient by Margaret Monahan Hogan)

As a consequence of the abuse of sterilization, stringent laws are in place in the United States to protect vulnerable populations from its inappropriate use. Among those vulnerable populations are mentally retarded persons. Many of the present state laws cast the state as the protector, *Parens Patriae*, of the individual against all other interests. These laws were fashioned in order to protect the right of a person to make reproductive decisions and to protect the best interests of the incompetent in regard to reproductive decision-making. The state laws have substantive as well as procedural demands. The substantive criteria adopted by the various states to guide decision-

making yield four kinds of legal rules.{1} These criteria have resulted in standards that range from outright prohibition to discretionary best interest standard and that have been characterized as mandatory, discretionary best interest, substituted judgment, and strict prohibition. The description of the criteria is as follows: Under the mandatory criteria type of rule a court can authorize sterilization only if several specific findings are clearly made. This rule places a significant burden on the petitioner, limits judicial discretion, and makes it difficult to establish the desirability of sterilization. The "discretionary best interest standard" is a more flexible rule; instead of requiring specific findings, it directs judges to consider and weigh designated criteria in determining whether sterilization is in the competent person's best interest. A few states have adopted the "substituted judgment" approach first proposed by the New Jersey Supreme Court in *In re Grady. Grady* directs the court to consider the *Hayes* criteria and any other relevant factors in order to make the decision that the disabled person would make for herself if she were competent. Finally, a few jurisdictions simply prohibit the sterilization of anyone found by the court to be incompetent to give informed consent to the medical procedure.{2}

These procedural and substantive standards that have been established by many state courts include the following:

1. Those advocating sterilization bear the heavy burden of proving by clear and convincing evidence that sterilization is in the best interests of the incompetent.

2. The incompetent must be afforded a full judicial hearing at which medical testimony is presented and the incompetent, through a guardian appointed for the litigation, is allowed to present proof and cross-examine witnesses.

3. The judge must be assured that a comprehensive medical, psychological, and social evaluation is made of the incompetent.

4. The judge must determine that the individual is legally incompetent to make the decision whether to be sterilized, and that this incapacity is in all likelihood permanent.

5. The incompetent must be capable of reproduction, and unable to care for offspring.

6. Sterilization must be the only practicable means of contraception.

7. The proposed operation must be the least restrictive alternative available.

8. To the extent possible, the judge must hear testimony from the incompetent concerning his or her understanding or desire, if any, for the proposed operation and its consequences.

9. The judge must examine the motivation for the request for sterilization.{3}

While these laws and the court procedures protect against the abuse of sterilization, they pose formidable barriers in those instances where sterilization might serve the best interest of an individual. The laws are correct in their presumption that sterilization is a *prima facie* wrong, that is, it is a mutilating procedure and it limits procreation rights. However, the requirements to overcome the presumption are excessively burdensome for the individual, the family, and the state. Most states, in pressing these requirements, cast the family, who have heretofore exercised a caring relationship for incapacitated person, into an adversarial role. It is within this atmosphere that the moral question, the non-voluntary sterilization of the mentally incompetent, not for eugenic reasons, but in the best interest of the mentally incompetent, arises.

Other influences complicate the resolution of this question. The contemporary cultural matrix is one that was given shape by Civil Rights movement of the Sixties. The influence of that powerful Civil Rights movement extended from the originating issue of racism to touch so many other issues including the lives of the mentally impaired. Among the civil rights sought for the mentally impaired were the right to the least restrictive environment, the reaffirmation of the right to bodily integrity, and the right to procreate. It is within this atmosphere that the Courts and the families of the mentally retarded wrestle with the question of non-voluntary sterilization for the good of the patient. The specific question is: How, in a less than perfect world which embraces the ideal of least restrictive environment and the maximization of autonomy for all including the mentally impaired, how is it possible to protect the vulnerable members of the human community from harm?

{1} Elizabeth Scott, "Current Sterilization Law: A Paternalism Model," DUKE LAW REVIEW VOL. 806, 1986, pp. 806-825.

{2} Ibid.

{3} Judith Areen, "Limiting Procreation," MEDICAL ETHICS, edited by Robert M. Veatch, 1997, p. 116-117.

Additional Reading: Catholic Health Care Dinosaurs

Catholic Health Care Institutions: Dinosaurs Awaiting Extinction or Safe Refuge in a Culture of Death

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2001, Vol. 7, No. 1, 163-172 # Swets & Zeitlinger

Health care institutions in the United States are beset by many challenges, some of which are economic, some of which are political, and some of which are ethical. Among the economic pressures are insufficient levels of reimbursement from government or other third party providers, the reluctance of patients who now perceive themselves as "fully covered" to pay out of pocket for health care, the ever-increasing cost of the delivery of high-tech medicine and demand for ever-higher, occasionally obscene, levels of compensation by physicians, especially physician employees. Among the political, political as broadly construed, are the competing claims of the efficiency, efficacy, and appropriateness of the federal government as sole provider of health care as opposed to the similar claims of the free market to provide health care through for-profit managed care systems. Among the ethical are such problems as the appropriate use and just distribution of medical technological advances, what counts as disease to be ameliorated by medicine, the withdrawing and withholding of treatment that is no longer beneficial, the continuation of treatment that is beneficial, the rationing -- precipitated by infinite need in the presence of finite resources -- of potentially beneficial services.

Catholic health care institutions are beset by those same concerns and may, over time, be overwhelmed by those economic, political, and moral forces. However, if Catholic health care institutions should survive, they face an additional set of challenges that derive from their special mission and identity. Now, in the not too distant past, mission and identity were something that Catholic hospitals, as they were called way back then, just had. Catholic hospitals existed as a sign and reality of the presence of a living and rich tradition. While the hospitals operated within the American landscape, they were, and were perceived, as rather different, perhaps even alien, from the surrounding culture and its values. That rich and living tradition viewed human life as a journey through this "vale of tears" that reached its final terminus through the door of death to arrive at joyful union with God in the beatific vision. Suffering and death were considered the lot of every human born of woman, yet life and sickness were patiently endured in faith and in hope. The source of that faith and hope was centered in a robust grasp that our incarnate God took upon Himself our human nature, lived, suffered, and died in expiation for our sins, rose from the dead and returned to a loving Father Who now awaits us. This tradition shaped our expectations and our institutions, especially our hospitals. We acknowledged, not just as an abstract concept, but as lived reality, that we are finite creatures destined in our corporeal nature to die and invited in our spiritual nature to salvation to be had in the embrace of the cross. Catholic hospitals accepted the vocation of ministry to a people thus constituted and committed. There were certain things peculiar to Catholic hospitals -- women in white religious garb, black-suited, Roman-collared priests flowing in and out all morning, physicians and nurses Catholic in practice and profession, crucifixes, holy images, and continuous prayer. And there were certain things forbidden in Catholic hospitals -- abortion, contraception, sterilization, mercy killing, and meat on Fridays.

Some of these signs and realities are now close to extinction and with the loss of some of the visible markers, the visibility of the mission -- and perhaps even the viability itself -- of Catholic health care has diminished. The redirection of a significant number of Catholic women in the post-Vatican II Church away from nursing in the hospitals and teaching in the schools founded and sustained by the remarkable service of religious orders of women to "more meaningful" ministries has had a significant impact on the spirit and the structure of those institutions. (The departure of lay Catholic women from the roles of wife and mother for "more meaningful" jobs in the market is similarly not insignificant.) Furthermore, the assimilation of Catholics into mainstream American culture, both by adoption by Catholics of the values of the culture -- faith as quarantined in privacy, freedom and choice as absolute and as right making, individual autonomy, and personal sovereignty -- and by the shedding by Catholics of the truths of the tradition -- that the object of belief is truth, that the only true freedom is effective freedom, that choice must be right choice, that our lives are lived in real dependence on one another and in radical dependence on God -- may have diminished the perceived necessity for the continuation of a distinctive set of health care institutions. Perhaps Catholics have been co-opted by the comfort and lure of the culture. Perhaps the economic, social, and political successes experienced by so many American Catholics have eclipsed the dedication to religious understanding and commitment.

In response to the exigencies of the contemporary moment, Catholic health care institutions and the Catholic Health Association have mounted several initiatives. The response to the economic pressures propelled the nisus toward mergers and operational effective alliances, appeals for better levels of reimbursement, and advocacy directed to governmental agencies on behalf of the poor. The response to mission and identity issues precipitated an introspective moment occasioning the press to examine their mission, to articulate identity through explicit mission statements, and to activate processes to internalize the meaning of those mission statements. Neither the economic initiatives nor the identity and mission initiatives are unproblematic. And neither will be successful without unified and sustained effort.

The Catholic Health Association in its strategic plan, begun in 1999 and projected through the year 2002, claimed a specific role for itself and identified four strategic directions for the organization and its member institutions. The new role to, "unite members to advance selected strategic ministry issues that are best addressed together rather than as individual organizations," affirms the reality of the need of a sufficiently large group to make an impact and the need of the reality to have intermediary organizations transposed between the individual *qua* individual possessed of very limited resources and the mega-powers of contemporary society. The four strategic directions are (1) Catholic identity, (2) health policies and initiatives, (3) church relations, and (4) ministry innovations. While all four are important, the first is essential, inasmuch as it forms the matrix which nourishes and directs the others. The first is rich and multifaceted. It cannot be contained in a simple mnemonic and it cannot be contained in a set of vague and general statements without ongoing proclamation, explication, and reflection. Hence the identity issue will be the central focus of the remarks that follow. The others will be addressed only within identity development.

Catholic health care institutions as Catholic accept as the core of their identity and directive of their practices the life of Christ and the creative providential action of a loving God. Acceptance of these core notions requires their proclamation and articulation as well as actualization in practice. Their proclamation provides a bold statement of love and commitment in a world groaning in a culture of killing and abandonment. Their proclamation recalls some central truths of our existence including the truth that we are God's creatures fashioned in a particular nature with minds and bodies to know, to love, and to serve God. Failure to make that proclamation is a kind of denial; it is to say, "I swear I do not know that man" (Matthew 26: 72). Failure to make the proclamation risks the possibility of forgetfulness that diminishes internal institutional purpose and the loss of the external role that acts, to use the words of Fr. Kevin O'Rourke, O.P., who has been a towering figure in Catholic health care ethics in the USA, as "leaven . . . by offering health care in accord with the example and teaching of Christ" (2001, p. 2) and acts to penetrate "secular society with the healing spirit of Christ" (p. 4).

The healing ministry of Christ is part of the identity of Catholic health care institutions and they rightly cite that activity of Jesus "to heal as Jesus healed." Examples abound in the scriptures, including the healing of the leper, the servant of the centurion, and the mother-in-law of Peter, the restoration of sight and speech and mobility. Yet, Jesus as healer of physical illness is just one dimension of His healing ministry. His radical healing ministry extended beyond the healing of bodily infirmity. He healed those who suffered from sin as well as those who suffer from physical infirmity. He drove out demons and forgave sinners and condemned hypocrisy. A health care institution worthy of the name Catholic would, through the continuous presence of clergy, as well as a full complement of medical practitioners, keep alive the multi-dimensional healing that our fallen human nature requires.

However, healing of physical illness is not always possible. Furthermore the exclusive focus on healing is too narrow and too exclusive a center. It is to buy into the Promethean myth of modern medicine that offers the promise of human salvation in more and better medicine. Jesus healed but he also suffered and died. Here Catholic health care institutions have special obligations because of the Jesus revealed in Scripture. Catholic health care institutions must be places of caring for the dying that is inevitable. And here they must offer visible witness to the truth of the finitude and promise of human existence. In His suffering and dying, Jesus, from the depths of His humanity, called out for consolation. In Gethsemane, He asked to be rescued, "My Father . . . take this cup of suffering from me." He revealed to His friends His grief and anguish. He said, "The sorrow in my heart is so great that it almost crushes me." He asked them to stay with Him and He is sorely disappointed by their failure to remain with Him. He experienced abandonment and, close to the end, He cried out to His heavenly Father, "Eli, Eli, lema sabachthani." And, at last, He placed Himself into His Father's care. Catholic health care institutions have to be places and have to provide services and spaces within which human beings who are experiencing crushing sorrow, anguish, and abandonment will find in attendance caring people to touch, and wash, and anoint their bodies, attentive people who do not turn away from them, loving

people whose simple presence sustains them, and faithful people who do not abandon them in their dying.

In healing the sick and caring for the dying, Catholic health care institutions must provide living witness, simultaneously, to respect for the sanctity of human life and acknowledgement of the transcendent end of human life. The direct destruction of innocent nascent human life hidden under such euphemisms as "pregnancy termination," "selective fetal reduction," or "beneficent killing" must remain proscribed. With this forbidding comes the obligation to offer succor to women in a manner which respects the dignity, the intelligence, and the moral strength of women, even as they may be experiencing a temporal and particular vulnerability. Rather than leave her in privacy, she needs to know and to be welcomed into a community of care. When a woman is pregnant, she knows she is with child. If, within the contemporary horizon this truth is being hidden from her, Catholic health care institutions ought to speak this truth publicly and often in order to contribute to the recognition of women as moral agents to whom the truth is owed. The brute fact of more than a million abortions a year in the USA suggests the societal fabrication of a kind of amnesia in regard to the reality and life of the conceived but unborn human being.

There may be no direct killing and no prolongation of dying in Catholic health care institutions. The exact and powerful conceptual tools, such as the distinction of extraordinary care from ordinary care, developed in the Catholic philosophical and theological tradition, must be applied with resolute firmness. We need to affirm the goodness of the gift of life and the goodness of its end. It is, perhaps, in our dying that we experience, finally, our nature as created beings. Fr. Richard McCormick, S.J. sketched out a careful path for us here. In his words and in his living to the very end, he reminded us frequently that dependency, whether from age or illness, is a call to cling to the power of God. He, when speaking of physician assisted suicide as an act of isolation and abandonment, said, "rejection of our dependence means ultimately rejection of our interdependence and eventually of our very mortality" (1991, p. 1133). And when he addressed the issue of the cessation of no longer beneficial nutrition and hydration, he reminded us that we as a people who say we believe in life after death ought to act as if we actually believe that (1992, p. 214). He warned us, too, that failure to attend to these distinctions and failure to use the intellectual tools and concepts of the tradition might force people who desire to hold to the tradition to flee it. He recalled in the pages of this journal the words of Dr. André Hellegers, who in 1979, just before his own death, warned us about the inevitable consequences of the displacement of the traditional caring task by the curing goal. Hellegers said, "as the caring branches of medicine were gradually pushed aside by the curing ones, there seemed to be less use for the Christian virtues. I think that shortly the need of those old Christian virtues will return and once again be at a premium. Our patients will need a helping hand and not a helping knife . . . We must either recapture the Christian virtues of care or we shall be screaming to be induced into death to reach the discomfort free society" (quoted in McCormick, 1995, p. 101). The time is at hand.

On these two issues of abortion and mercy killing, Catholic health care institutions ought to continue their powerful witness and absolute prohibition. They will find many allies, if they are willing to disturb the false peace fashioned by the euphemism of "compassionate killing." They and their allies may be the agents in the reversal of the culture of death by faithful, prayerful, patient building brick by brick, truth by truth, witness by witness of communities who strive to love each other as God loves us.

Life issues, and having excellent health care is a life issue, need to be carefully distinguished from reproductive issues. The asserted necessary connection between contraception and abortion, as the direct destruction of the conceived but unborn human being, seems a tenuous claim. While a contraceptive mentality, a mentality that sets the mind and heart against the good of procreation, may be factually linked to the procurement of abortion, there is no such necessary link between contraception itself and abortion. The inability to make this distinction, on occasion, has impeded the completion of mergers of health care institutions whose co-operative might have provided more effective and more efficient health care to communities and has, on many occasions, impeded the work of the work of the pro-life movement to advance their case as a civil rights movement. The untangling of this Gordian knot needs careful attention by Catholic scholars, academicians and medical practitioners, lay and ordained, and men and women. Its resolution will be found only in the careful articulation of the nature of marriage and careful specification and delineation of the goods to be accomplished within marriage. It will require openness to the question of the appropriate moral referent in marriage so that the goods of marriage may be properly ordered. Failure to continue to unwrap the realities contained in the mystery of marriage is to reject, out of fear, two gifts -- the gift of marriage and the gift of intellect. The Catholic identity of health care institutions is tied to the authority of the Church -- its teachers and its doctrines. The hierarchy has an authority, bequeathed to it by Christ, to guide the faithful. And Catholic health care institutions have strong responsibilities to operate within the ambit of that authority. Nonetheless, as health care institutions, Catholic health care institutions are subject to other authorities, the most significant of which is the authority found in the art and practice of medicine. Authority exercised rightly recognizes the power of the dialectical tension between theory and practice in the pursuit of the truth. Authority is not exercised for its own sake or for the sake of power but for the sake of truth (McCormick, 1996). Both domains of authority, medicine and Church, are capable of incredible hubris and authoritarianism. Nonetheless, there are remarkable examples of the cooperation of the authority of the Church and the authority of medicine in the service of the good of God's people in health care. One of the most recent products of that cooperation is the 1995 Ethical and Religious Directives for Catholic Health Care Services. One particular example within the directives is evident in Directive 58 which asserts a presumption in favor of providing food and water to patients so long as the food and water provide a benefit for that patient. Directive 58 was accomplished by the careful testimony of physicians, theologians, and philosophers. The physicians offered their medical judgment that there are some conditions of illness and decline in which food and water no longer benefit the person. Philosophers and theologians offered their expertise in the careful application of the distinction between ordinary and extraordinary means of preserving human life of

the person, in their affirmation of life as a fundamental, not an absolute, value, and in the distinguishing of physical continuation from human existence.

There are, within the contemporary horizon, two points of contention simmering just below the surface in Catholic hospitals. These two issues require careful attention on the part of the authorities of medicine and church. One is found in the distinction between withdrawing and withholding of treatment; the other is the question of the care appropriate to certain children such as those who are anencephalic and those with Potter's syndrome. In regard to the distinction between withdrawing and withholding of treatment, theologians and philosophers are now, for the most part, quite content to say that the ethical assessment of withdrawing and withholding treatment is entirely dependent on benefit to the patient. If there is no benefit, withdrawing and withholding treatment are morally equivalent. Many physicians, on the other hand, persist in maintaining that withdrawing feels different from withholding. In their professional experience these actions are not the same. Philosophers and theologians need to listen attentively to this testimony by physicians. There needs to be a reopening of the conversation.

The appropriate care of children who are anencephalic and children with Potter's syndrome has become a more sensitive and pressing issues with the advance of technologies surrounding pregnancy and prenatal care. Once the diagnosis of anencephaly or Potter's syndrome has been confirmed, how do we care for the human beings, mother and child, in this sad and temporarily devastating situation? Catholic health care institutions have responded in various ways to this tragedy. The two most common are to forbid intervention or to proceed with early induction. The former response directs attention solely to the child and the sanctity of the child's life. If the woman and her family persist, she and they must seek help elsewhere. In regard to the latter option, some Catholic health care institutions, paying very close attention to Directives 45 and 49 in the Ethical and Religious Directives for Catholic Health Care Services, allow the early induction, after twenty weeks, of delivery of the child and the provision of comfort care for the child until death occurs.

Neither interpretation is without problems. The first seems to dismiss the woman and her concerns and the concerns of her family. Some women report feeling abandoned by another institution in a church within which they already feel marginalized. The child that they so desperately loved will not be, and they wish to bring closure to the tragedy by an early induction. Some women, on the other hand, find comfort in carrying the child to term. They experience consolation in the fact that they cared for their child in the only way still possible for them, that is, the patient accompanying of the child in this brief life until the child dies. Here there needs to be a sustained conversation. And in that conversation the voices of women must be heard. Rather than being dismissed as having vested interests, they must be accorded respect as the voice of experience. The recording of the conversation itself is important. We shall have listened and we may learn.

The second, induction and delivery at twenty weeks, is problematic, even while it intends to stay within the letter of the law. There is a very real sense in which the child with anencephaly or the child with Potter's syndrome is never viable. These children have conditions incompatible with human life; they are not disabled as is the child with Down's syndrome. So an early induction with all equipment on hand for resuscitation may have the appearance of a sham.

The identity of Catholic health care institutions requires these institutions to pursue justice. Nevertheless, a too-narrow conception of justice, a too facile acceptance of justice as only a scheme involving the redistribution of resources, here tax revenues, controlled by governmental agencies, places in jeopardy both the existence and the witness of Catholic health care institutions. In regard to continued existence, it is important to recall the early efforts, although to this point unsuccessful efforts, to require Catholic hospitals to accept abortion as part of a package of total reproductive services or to lose their perinatal centers entirely. {While some tax generated payment, money which comes from individuals -- not the government -- to support basic goods, here health care, needed by other more vulnerable less capable individuals, Catholic health care institutions cannot limit their role in just service to the poor to advocacy only.} A role limited to advocacy casts Catholic health care as just another special interest lobby group. Each Catholic health care institution must find and set aside resources, even if only the Biblical tithe, to provide direct services to vulnerable people. This will call for sacrifice by the institutions, by physicians, by other health care providers, and by patients. The call to sacrifice should not appear strange to a people who call themselves Christian. If a largely immigrant population, led by and inspired by lively and committed religious leaders and committed physicians and other professionals, could build and sustain a vast network of Catholic health care institutions, what could possibly excuse an affluent and free Catholic population from its obligation in justice, not charity, to respond generously to the call and example of its model to serve the poor. Perhaps we have lost the biblical sense of justice found in the realization of our reality in shared creaturehood directed to live in right relationships that we may have that salvation offered in Jesus.

If Catholic health care is to flourish in the USA, if it is to serve as leaven, witnessing the life and love of an incarnate God, then it must be prepared to act as light and salt too. Its mission must be clear and it must be open to appropriate development as both medical science advances and Catholic teaching advances. Catholic health care must reflect on its identity and teach its mission. It must be visible reproof to a kind of contemporary medicine which prescribes killing to cure illness and disability. The continuation of the mission, as leaven and light and salt, of Catholic health care requires the continuous sacrificial commitment of converted individual Catholics, lay and religious, to accept that mission. The conversion of individuals (Were there not once only twelve?) can make possible the conversion of institutions, which in turn can sustain the energy of committed individuals and can draw other individuals into the shared mission. If Catholic health care institutions should choose not to affirm their identity and live their mission, then their fate should be that of the dinosaurs. The choice is now: either a robust Christo-centric identity and mission or extinction.

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