



**THE
DUKE
DIVINITY SCHOOL
REVIEW**

Spring 1970

A New Departure

The present issue of the *Review* represents something of a new departure, at least in recent history. It arose out of a discussion in the Review Committee, in which it was suggested that our readers might be interested in becoming acquainted with some of the new directions being pursued in The Divinity School. Recently, Professor Harmon L. Smith has been investigating certain ethical issues arising from the practice and procedures of modern medicine. In fact, he has conducted courses on this subject and now has a book scheduled for publication in the fall of this year. So, this area of research presented itself as a natural possibility.

The proximity of the Duke Medical center has given Harmon Smith and a number of students opportunity to pursue these matters quite extensively and in an informed way. The articles in this issue represent the tentative results and proposals issuing from some of their investigations. They were submitted at the invitation of the Committee and under the direction of Professor Smith. All of the authors are students in Duke Divinity School. Hopefully, we shall again in the future be able to exhibit in this journal representative examples of the relatively new kinds of work going on here.

D. M. S.

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in a Christian Perspective

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Preface

No one who reads newspapers, listens to radio, or watches television (or pays taxes!) has to be convinced of the enormous accomplishments of modern science and technology. Indeed, most of us benefit from these achievements in ways that make them seem more or less indispensable. If you yourself do not see Cinerama movies, or dress more comfortably, or eat healthier foods, or drive the latest thing in automotive design, or know what it is to recover from an illness that only a few years ago would almost certainly have caused your death, odds are that you know someone for whom these things do apply and that you could compose another list (comparable to this one) from your own experience.

That modern science and technology provide a potential (and, in some ways, already actualized) boon to our common human existence appears self-evident. That this remarkable and relatively new power will in fact be put to uses that are genuinely directed toward humane goods remains, however, to be ascertained. Saying this, I do not mean to imply either a prejudice against or a naive approval for whatever is done or might be done to advance or retard our science and technology. On the contrary, I would rather we try to assess what words like "advance" and "retard" mean in this context. Or, to put it differently, I believe with Reinhold Niebuhr that our capacity for doing evil is proportional to our capacity for doing good; and this suggests to me that we need therefore to be alert to both the promise and the threat of our science and technology if we are responsibly to exercise control over them for good rather than evil ends. It may be finally an article of faith—at least there is not space here to develop the argument—but I think that we function as men in the measure to which we control our technics and are not controlled by them, and that science and technology function best when they serve human need and purpose rather than vice-versa.

Last fall the chairman of the *Review* committee indicated to me the committee's interest in developing an issue of this journal which would undertake to address some (but only some!) of the moral questions which are emerging from medicine and bio-medical technology. The rationale for such a venture (if I may quote myself!) is that "Physicians and clergymen are increasingly obliged to talk to

each other (and sometimes about each other!) ; and there is no reason currently to suppose that this obligation will not intensify in the years ahead. If we are ever to get beyond the stage of polite euphemism and anecdote and down to the business at hand, each of us will have to become better informed about and acquainted with the other." That, at least in part, is what these papers are about.

Among several alternative approaches and resources considered by us, we elected to publish the following essays which, in their original form, were composed by students enrolled in an advanced course in Christian ethics in the Divinity School. In their present form, however, these papers represent not only the primary research and reflection of original authors but also the additional contributions of class members together with revisions and emendations by an editorial committee.* There is therefore an uncommon kind of corporate authorship and collaborative effort which has produced these articles.

The focus of these essays is on the issues and elements which emerge in decision-making within these several contexts. Because of limited space the papers mainly intend merely to describe *some* of the ways in which these issues and elements raise theologically and morally significant questions, and then to offer *some* modest suggestions for direction in addressing them. There is, as you will see, no external coherence among the essays except a common sphere of interest. Moreover, you may also detect that internally the papers make different emphases and employ different approaches. We think that is as it should be, both as illustrative of the varieties in ethical method as well as affirmative of situational diversity. We submit them with the hope that you will find them informative, suggestive, and perhaps even useful.

Harmon L. Smith

Associate Professor of Moral Theology

*Members of the editorial committee were Gregory R. Dell, Melvin D. Dowdy, Russell E. Martin, L. Powers McLeod, and Richard P. Richards.

Human Experimentation

DONALD DIAL, RUSSELL MARTIN, AND DAVID PACHOLKE

I

In July, 1963, twenty-two very seriously ill patients at the Jewish Chronic Disease Hospital in Brooklyn, New York, were injected with live cancer cells without their informed consent. The patients had previously been asked only for their verbal permission to be used in tests to determine their resistance or immunity to disease. They were told that a lump would form, but only for a few weeks. They were not told in plain language, however, that this procedure was *not* part of their normal treatment. Neither were they informed that the cells to be used were cancer cells. This case became widely publicized when three physicians, who had resigned in protest of the manner in which the experiment was being conducted took their grievance to a New York lawyer who was also a member of the hospital's Board of Directors. After being refused permission by the hospital to examine the records of the experiment, the lawyer appealed to the Brooklyn Supreme Court for formal permission to see the information. The story was quickly picked up by the news media.¹

In subsequent hearings before the Board of Regents of the University of the State of New York, two primary arguments were presented on behalf of the two reputable doctors who had directed the experiment. It was argued that there were no clear standards to guide the researchers in such experiments and that the methods employed were not significantly different from those used by other professional researchers. Several notable medical researchers testified on behalf of the defendants. The accused doctors were found guilty of fraud and deceit and unprofessional conduct in the practice of medicine. The real importance of the case, however, came in the realization by physicians and concerned laymen alike that there were no adequate guidelines for medical experimentation on human sub-

1. E. Langer, "Human Experimentation: Cancer Studies at Sloan-Kettering Stir Public Debate on Medical Ethics," *Science* (1964), 143:551-3; E. Langer, "Human Experimentation: New York Verdict Affirms Patient's Rights," *Science* (1966), 151:663-6. A good legal review of the case is contained in Robert D. Mulford, "Experimentation on Human Beings," *Stanford Law Review* (1967), 20:99-117.

jects when the experiment was not for the direct benefit of the patient. Indeed, this case called to the attention of all concerned persons that the issue of non-therapeutic human experimentation had not been adequately explored as regards either its ethical or its legal implications.²

Although the above case is perhaps the most dramatized instance of non-therapeutic human experimentation in the past decade, it is far from being the most questionable. Dr. Henry K. Beecher has listed twenty-one other examples in which medical investigators ventured to "risk the health and life of . . . patients" in experiments without any direct benefit to them.³ Dr. M. H. Pappworth, in his book *Human Guinea Pigs: Experimentation on Man*,⁴ has given extensive case material to indicate the ethical problems present in non-therapeutic human experimentation. These problems are not new, but they have come to the attention of many people lately because of the frequency with which they have occurred in recent years.

The rapid growth and advancement in medical techniques and skills since World War II have kept medicine constantly on the frontier of new discoveries in the diagnosis and treatment of diseases which, before that time, had been beyond its reach. This rapid advance has provided numerous situations in which human trials are necessary. Many new discoveries simply cannot be tested adequately on animals due to basic physiological differences between human beings and other species. Thus, medical research has been increasingly obliged to employ human experimentation as a means of testing and confirmation.

Human experimentation is itself a very broad category; for, technically, every medical procedure is an experiment to the uniqueness of each individual and the subsequent uncertainty factor. However, human experimentation is generally separated into two areas: therapeutic and non-therapeutic. The therapeutic experiment is characterized by having as its purpose the welfare of a particular patient. The *doctor-patient relationship* is typically based on the as-

2. Two excellent contributions bring together much of the literature from various disciplines: I. Ladimer and R. Newman (eds.), *Clinical Investigation in Medicine: Legal, Ethical and Moral Aspects* (1963), and "Ethical Aspects of Experimentation with Human Subjects," *Daedalus* (1969), 98.

3. Henry K. Beecher, "Ethics and Clinical Research," *New England Journal of Medicine* (1966), 274:1354-60.

4. M. H. Pappworth, *Human Guinea Pigs: Experimentation on Man* (London: Routledge & Kegan Paul, 1967).

sumption that the doctor will act only in a manner that is intended to benefit the individual patient. In the non-therapeutic experiment, the primary objective is the discovery of knowledge. The *investigator-subject relationship* does not assume that the patient's benefit is the primary goal. The question of whether new knowledge obtained by the experiment might benefit the subject is of secondary importance. It is therefore the primary intention of the physician-investigator that tends to determine the nature of the experiment.⁵

Within the category of non-therapeutic experimentation are various sub-categories which are generally determined by what is being tested. One such division is between experiments designed to test new drugs and experiments designed to test new non-drug procedures. The experiment involving the injection of live cancer cells offers an example of non-drug, non-therapeutic human experimentation. Another important area of consideration concerns the subject involved in the experiment. Any subculture of society might be potential subjects: children, prisoners, the mentally-ill, hospital patients, healthy persons, etc. This paper will deal only with the ethical issues raised in non-drug, non-therapeutic human experimentation on mentally competent, non-imprisoned adults who are being treated in or by a hospital.

II

The ethical questions involved in non-therapeutic human experimentation can ultimately be traced to the problem of individual rights versus social responsibility.⁶ In principle, it may be argued that human beings should not be used as guinea pigs because this action contradicts an individual's rights. By appealing to other principles, however, it may be argued that it is the individual's responsibility to become an experimental subject for the good of the society. In any society certain individual freedoms have to be forfeited to the society in order that the society and the individual might exist and grow. Thus, the question concerns the degree to which an individual is to be called upon to forfeit his rights for the good of the social

5. Hermann L. Blumgart, "The Medical Framework for Viewing the Problem of Human Experimentation," *Daedalus*, op. cit., pp. 248-74.

6. For two excellent treatments of the philosophical problems see Otto E. Guttentag, "Ethical Problems in Human Experimentation," *Ethical Issues in Medicine*, ed. E. Fuller Torrey (1968), pp. 195-226; and Hans Jonas, "Philosophical Reflection on Experimenting with Human Subjects," *Daedalus*, op. cit., pp. 219-47.

order. At what point does society have the right to take from its members their individual liberties?

The actual balance between individual rights and social responsibility is never static but always responding to the circumstances which affect the society. For example, when a society is threatened by war, it requires its members to forfeit some of their individual rights for the defense of the society. Careful analysis would also show that certain basic attitudes about the individual are the basis upon which the society is built. These attitudes, moreover, are reflected in the laws of the society.

In the laws of a democratic society, high value is placed on the individual and his personal physical integrity. The value of the individual is primary except in issues which threaten the society's existence—as in the case of war. The rights and freedoms of the individual are the very basis upon which a democratic society is founded. Any threat to the primacy of the individual under normal conditions represents a threat to the whole social order. This principle applies to all persons in the society, regardless of their objective merit or station or status of life, or nearness to death. The governing standard is the equal worth of each person as a human being.

Normally in such a society, where the individual is primary, no individual or group of individuals is singled out as a special sacrifice for the good of the society. In fact, "we like to think that nobody is entirely and one-sidedly the victim in any of the renunciations exacted under normal circumstances, by society 'in the general interest,' that is, for the benefit of others."⁷ This type of social order is primarily concerned with men's overt public acts and not with the individual's private life. The primacy of the individual is the foundation of a democratic social order.

Totalitarian or communistic systems, on the other hand, are based on the principle of the primacy of the society. The freedoms of the individuals are always of secondary consideration under the primacy of the state. In such a society the individual is unquestionably used for the benefit of the social order.

Justification for non-therapeutic human experimentation falls somewhere between the totalitarian value of community and the democratic value of the individual.⁸ In human experimentation there is (for the most part) no extreme issue of social survival at stake; the

7. Jonas, *op. cit.*, p. 225.

8. *Ibid.*, p. 226.

issue is rather societal benefit. The individual who is asked to be a subject is really being asked to forfeit some of his individual rights to the society in order that the society might benefit. Some forfeitures might be one or more of the following:

1. invasion of privacy;
2. donation or sacrifice of personal resources such as time, attention, dignity and physical, mental or emotional energy;
3. surrender of autonomy as in studies entailing restriction of movement or action;
4. exposure to procedures entailing mental or physical pain or discomfort, but no risk of injury or lasting harm;
5. exposure to procedures that may entail risk of physical or emotional injury.⁹

What is being requested goes beyond what is normally asked of a person for the betterment of society in a democratic system. In light of these considerations, two questions need to be raised. What right does the society in general, and the medical profession in particular, have to ask persons to participate in non-therapeutic human experimentation? What reasons justify a person in risking his health and well-being in a non-therapeutic experiment?

What is at issue is whether individual rights or social health is more important. Probably no one would argue that health is not a desirable good. If we had the opportunity to choose between health and disease, there is little doubt as to which of these two we would elect. Health is a value. Public attitudes reflecting our society's valuation of health over disease may be attested by the widespread public support of medical research by the federal government.¹⁰ People generally encourage the conquest of disease through medical research. This societal support for health is an indirect support of life.

People associate health with life and illness with death. But life and health for whom? For the society, of course! The health in question is predicated on the whole of society. In reality, however, very rarely is disease of such an epidemic proportion as to threaten the health and, thus, the life of a society. Attributing health to the whole society has the effect of making society's health a higher good

9. Wolf Wolfensberger, "Ethical Issues in Research with Human Subjects," *Science* (1967), 155:49.

10. Medical research funds in the United States have steadily grown from approximately \$45 millions in 1940 to approximately \$2.5 billions in 1968; and current trends indicate that they will continue to grow.

than the individual's health and thereby gives it more social appeal. Thus, in non-therapeutic human experimentation, the conflict is finally between two societal values, namely, health and individual physical integrity. Is an individual's physical integrity to be sacrificed for the benefit of a more healthy society or is the general health of society to be sacrificed to maintain the principle of the individual's physical integrity? Or more specifically does the society in general, and the medical profession in particular, have the right to use a person for non-therapeutic experimentation? Legally these questions are unresolved; there seems to be great uncertainty about non-therapeutic human experimentation in the laws.¹¹

III

Over the last several years the increase in human experimentation in medical research has put pressure on the legal establishment to give guidance to clinical investigators in their research. The development of legal wisdom to deal with the new techniques and discoveries has not kept pace with advancing medical research. This advance is a result of the basic scientific nature of medical research, wherein each breakthrough suggests a possible next step to be taken. Thus, medical research is constantly taking the initiative in new areas while the law must generally await these discoveries in order to respond with appropriate legal considerations. Not only does the law have to wait for medical science to initiate the new situation, but insofar as the law is frequently "no more than the technical and official formulation of the society's moral convictions," the law has difficulty in dealing with questions of a moral nature until the society has come to some conclusions about them.¹² Thus, in a sense, the law is caught between medicine's adventuresome research and society's conservative morality.

The law embraces three major areas: the legislative (statutes), the executive-administrative (regulations and adjudication), and the courts (adjudication). Prior to 1960 there were no specific federal or state statutes purporting to regulate investigators or research organizations in their methods, their areas of research, or their use of

11. For legal treatment of human experimentation, see Paul A. Freund, "Legal Framework for Human Experimentation," *Daedalus*, *op. cit.*, pp. 314-24; and Howard N. Morse, "Legal Implications of Clinical Investigation," *Vanderbilt Law Review* (1967), 20:747-76. See also Mulford, *op. cit.*, pp. 99-117.

12. Samuel E. Stumpf, "Some Moral Dimensions of Medicine," *Annals of Internal Medicine* (1966), 64:462.

human subjects or patients in research.¹³ Today legal experts who have examined this area believe that American courts, if confronted with the necessity to determine legal principles which are applicable, would turn to a small number of appellate court decisions in the United States and Great Britain which involve the common law (by which we mean the law devised and administered by the courts) of medical malpractice.¹⁴ Thus, it may be expected that the law will develop on a case-by-case basis, in traditional common law fashion, i.e., the courts will look to expert witnesses from the research field to guide judicial understanding of the common, accepted practices in clinical investigations.¹⁵

In examining the common law, two principles are applicable to the consideration of non-therapeutic human experimentation: consent and reasonable care. The common law places high value on consent to physical invasions which threaten the health or physical integrity of the individual.¹⁶ But consent presupposes some knowledge of the procedure to which consent is being given. The clinical investigator is therefore under a general duty to communicate to the patient such information as is necessary for his free and informed consent. The question of the kind and amount of information necessary for such a consent is a knotty problem. While in theory it is recognized that there is no relationship between consent and risk, it can generally be said that the courts will require understanding proportional to the risks involved.¹⁷ It should be noted that the consent requirement allows the subject the final veto regarding participation in the experiment, thus affirming the basic democratic principle of individual physical integrity. In principle the consent requirement is the affirmation of the equal worth of every person insofar as no man is legally justified in violating the physical integrity of another apart from the subject's informed consent.

Legally, persons lacking the capacity to consent should not be used for any clinical investigations merely because they are convenient or available. At present there is no adequate legal defense for such action—neither arguing the benefit available to society nor the

13. William J. Curran, "Government Regulation of the Use of Human Subjects in Medical Research: The Approach of two Federal Agencies," *Daedalus*, *op. cit.*, pp. 542-3.

14. *Ibid.*

15. *Ibid.*, p. 545.

16. Morse, *op. cit.*, pp. 748-57; and Mulford, *op. cit.*, pp. 102-5.

17. Morse, *op. cit.*, pp. 751.

minimizing of risk to the subject. These latter arguments are very unstable legal grounds.

The second major principle of the common law bearing on human experimentation is the investigator's duty to exercise reasonable care. A person is liable when his negligence has caused injury to the person or property of another. This standard is applicable only to situations where improper care by the investigator can be related to injury to the subject. It is likely that the applicable standard in such cases would be determined by the testimony of other investigators regarding common research practices of reasonable care.¹⁸

In summary, the present legal requisites for legitimate, liability-free non-therapeutic experimentation can be described in three points:

1. the exercise of due care in administering the procedures;
2. soundness of experimental design, in that it must not be incapable on its face of producing significant results and its known hazards must not be disproportionate to the ends sought;
3. informed, voluntary consent.¹⁹

IV

The most hotly debated issue in non-therapeutic human experimentation is that of free and informed consent. It is the issue which historically has been most controversial as well as that point at which legal experts and others not involved in medical research most often enter into the debate. This is largely due to the central place of consent as the determining factor in adjudicating between individual rights and social rights. Consequently a large number of articles have been written which deal with this subject and in varying degrees of idealism and realism.²⁰ Realistic treatment of the subject has suffered due to the lack of research into the dynamics of the consent situation. Currently, however, work is being done on what actually goes on in the consent situation.²¹

One point often forgotten has to do with the various *levels of consent* involved in a human experiment. This matter has been obscured by calling the subject's action a "consent" and the doctor's

18. *Ibid.*, p. 760.

19. Freund, *op. cit.*, p. 321.

20. For an excellent review of the consent issue and a good bibliography, see John Fletcher, "Human Experimentation: Ethics in the Consent Situation," *Law and Contemporary Problems* (1967), 32:620-49.

21. *Ibid.*; see also Lynn C. Epstein and Louis Lasagna, "Obtaining Informed Consent," *Archives of Internal Medicine* (1969), 123:682-8.

action a "decision." In essence, of course, both the subject and the investigator consent to the experiment. A medical experiment is conceived in the mind of the investigator who pursues his hypothesis as far as possible in ways other than human trials. When he has reached the limit of testing his hypothesis on non-human subjects, he faces the decision of whether to try the experiment on human beings. This involves a moral decision on the physician's part. He must try not to allow his enthusiasm or pride to influence unduly his decision-making process. It is essential, for a relatively free decision on his part, that the investigator understand his motives in making his decision. Thus, introspection and a good understanding of ethical decision-making, as well as a definite set of values consistent with his profession, are essential for good clinical investigation. He should also be fully aware of the implications that his consent might have for the lives and well-being of others, in both a beneficial and a harmful sense. He must carefully weigh the possible benefits, risks, and hazards which he can predict. Primarily because of these considerations, the best guarantee for suitable human experimentation is "an intelligent, informed, conscientious, passionate, responsible investigator."²²

The "golden rule" has been suggested by some to be a guide for the investigator. Superficially this appears satisfactory, but it breaks down on practical, legal, and ethical grounds. Practically, one criticism has been that if an investigator submitted to his own experiment, it would not be a valid test because "those who are conducting the procedure, who will be his colleagues and very likely his subordinates, are likely to exercise particular care (with him). So that the element of risk may appear the same when the identical experiment is performed on others, yet it may actually be greater."²³ There is also the obvious health difference between a patient who is presumably suffering from a disease that has brought him to the hospital and the doctor who is supposedly in good health. Ethically and legally, an investigator's willingness to experiment on himself is not justification for repeating the experiment on a patient.²⁴ As one forceful critic has put it, "Some people deliberately expose themselves to stupid risks . . . but this does not entitle them to expose others to these risks, or to make others submit to their folly."²⁵ Thus, the golden rule does

22. Beecher, *op. cit.*, p. 1360.

23. Pappworth, *op. cit.*, p. 80.

24. Blumgart, *op. cit.*, p. 260.

25. Pappworth, *op. cit.*, p. 80.

not provide an absolute answer to the investigator's decision-making process, although it can no doubt provide valuable data for the decision-making process. In this regard, Guttentag suggests that the motivation for self-experimentation is important. If the investigator's motivation is to identify more with the patient and thus help the patient in his decision-making, such self-experimentation would be beneficial. However, if the purpose is to sway the patient unduly, then the investigator is hindering the patient's freedom of choice. Guttentag goes on to point out the difficulty in determining the physician's motivation.²⁶

After the investigator has consented to try his hypothesis on human subjects and has formulated a protocol for the experiment, it becomes the task of a committee of his peers under the National Institute of Health guidelines²⁷ to examine once again the purpose and protocol in order to weigh among themselves the proposed possible benefits against the possible risks involved. Risks to be considered should include not only the foreseeable hazards to a subject who might participate but also risks to the very basis of the social order. As has been pointed out, an experiment is moral or not at its inception and does not become moral *post hoc*.²⁸ Thus, an experiment whose basic nature is inconsistent with affirmed social values should not be allowed to continue regardless of possible benefit. It is the task of the committee, acting as representatives of the social order, to evaluate this risk. Under this rule, it is possible for a committee to reject an experiment for which persons have already volunteered. The criteria for this committee's consideration should be primarily moral in nature and should not be influenced by the availability of volunteers.

In addition to the institutional committee's consent, there is also the consent of the staff at NIH. The decision of these two groups comprises the second level of consent.

Between the second and final levels of consent is the question of who will be approached as a potential subject. In some instances this group will be extremely limited due to the experimental requirements. However, the investigator should be aware of the criteria he

26. Guttentag, *op. cit.*, p. 208.

27. The NIH guidelines are reviewed in Curran, *op. cit.*, pp. 574-80. However the guidelines were revised 1 May 1969 and therefore Curran is not always accurate. To obtain a copy of the current guidelines write: Director, Division of Research Grants, National Institute of Health, Bethesda, Maryland, 20014.

28. Beecher, *op. cit.*, p. 1360.

is using in selecting potential subjects because this has a direct bearing on the third level of consent, namely, the freedom with which the subject may decide to participate. Approaches to potential subjects should minimize undue influences and avoid expediency and availability. Jonas suggests in this regard, "The poorer in knowledge, motivation, and freedom of decision (and that, also, means the more readily available in terms of numbers and possible manipulation), the more sparingly and indeed reluctantly should the reservoir be used, and the more compelling must therefore become the countervailing justification."²⁹

The third and most debated level of consent is at the point of obtaining the free and informed consent of a subject. It has been said that this is the most important single aspect of human experimentation inasmuch as it is decisive for the patient's sense of being respected as a person and the point at which the society's welfare and the individual's welfare are balanced and harmonized. There is no disagreement in principle that free and informed consent is necessary for all non-therapeutic human experimentation. In fact, it is basic to any society or system which places value on individual rights. If the person is denied the right to volunteer freely or to abstain from participating, he is denied a basic human freedom. Likewise, if he is denied any information that might affect this decision, he is also denied his humanity and reduced to a mere passive thing.³⁰ Insofar as the investigator withholds such information and thus denies a subject his humanness, in the same act he forfeits his own humanity and contradicts the very principle upon which the integrity of his experiment is based. "To violate a structural value (of the society that has enabled the experiment) is to violate the very structure which makes benefits meaningful."³¹ Thus stripped of the requirement of a reasonably free and adequately informed consent, experimentation and medicine itself would rapidly become inhumane.

In principle, then, there can be no objection to requiring that the potential subject be allowed optimum freedom and maximum information regarding the experiment in which he is being asked to participate. The "rub," however, arises when one moves from theory to practice. Investigators, while agreeing with the theory, point out

29. Jonas, *op. cit.*, pp. 236-7.

30. *Ibid.*, p. 235.

31. John Fletcher, "Informed Consent: The Nature of the Art," Unpublished paper, p. 8.

that each case is different in terms of the makeup of the subject and the design of the particular study. All men are not equal in their ability to comprehend the intricacies of an experiment. Moreover, all the risks and hazards of any particular experiment are not always knowable in advance. It is difficult to determine what information about an experiment is important for informed consent. It is questionable whether a person is ever absolutely free in the sense that no external influences are affecting him. Thus, the whole issue of free and informed consent is highly ambiguous and it is little wonder that in a recent study investigators spoke of it as their chief difficulty.³²

We have indicated that a serious problem in obtaining free and informed consent is the question of how much information is needed for the subject to be informed. Ideally, informed consent exists when the subject understands all essential aspects of the experiment—that is, what his consent means in terms of his rights, the types and degrees of risk, the detrimental and beneficial consequences, if any, as well as the procedure and objectives of the experiment. Prior to understanding the aspects of the experiment, however, the subject must understand that the procedure to which he is being asked to consent is not part of his treatment and has no direct relationship to his therapeutic treatment. As has been noted in recent studies of the consent relationship, this has not always been the case. “Patients tend not to distinguish between research and treatment and hence entertain an inner sentiment that the procedure, even when they are told it is non-beneficial, holds out some hope for their improvement.”³³ Thus, in the use of hospital patients as subjects for non-therapeutic experimentation, the responsibility weighs very heavily upon the investigator to impress the non-beneficial nature of his experiment upon the patient. In all non-therapeutic experimental situations the responsibility for informing the subject always rests with the investigator; he is not to assume that merely answering the subject’s questions constitutes informed consent.³⁴ This is only one essential element of an informed consent.

V

Two recent studies in the dynamics of the consent situation might aid the investigator in insuring a more adequately informed consent.

32. Fletcher, “Human Experimentation,” p. 627.

33. *Ibid.*, pp. 635-6. See also Pappworth, *op. cit.*, p. 102.

34. Pappworth, *op. cit.*, p. 83

In a study using three different written explanations of an experiment, Drs. Epstein and Lasagna found that "comprehension, maximum retention of information and ability to utilize information intelligently is obtained when the presentation of data is brief and to the point."³⁵ In tests following the informing process, it was discovered that the subjects who received the shortest forms in which the pertinent information was included, without detailed elaboration, retained more of the important information than did those who received more detailed forms.

In a study by Professor John Fletcher of several consent situations at the NIH Research Center in Bethesda, Maryland, three interesting conclusions resulted.³⁶ Professor Fletcher found that giving consent is actually a series of decisions rather than one solitary decision. He suggests that such decisions begin for the patient when he enters the hospital. In addition, the informing of the patient actually takes place over the course of several meetings prior to the actual formal consent request. Also the outcome of the formal request is largely due to the previous meetings rather than the formal request meeting. Within the meetings, the relationship between the investigator and the patient is extremely important. Fletcher notes three forces at work in this relationship: the illness of the patient which influences understanding and motivation; the investigator's expectations of himself, of the patient, and of the institution for which he works; and the perception of the doctor by the patient. These forces seem to have the greatest influence on whether the subject and the investigator conclude with informed consent. On inquiring into the patients' reasons for giving consent, three considerations were predominant. First, the patients were satisfied with the investigators' explanation of the risks and the procedure. Second, the patients were affected by the idea that they would be participating in a valuable medical project. Third, the patients trusted the investigator as a person and as a physician. On the basis of these studies, it seems that informed consent does not depend so much on the quantity of information as on the attitudes of the investigator and his sensitivity toward the subject in their relationship.

The quality of the informed consent not only depends on the quality of the information the investigator imparts but also the manner with which he imparts it. The investigator's ability to explain the

35. Epstein and Lasagna, *op. cit.*, p. 685.

36. Fletcher, "Informed Consent," pp. 18-22.

technical aspects of the study in lay language is very important. This includes not only the procedure which will directly affect the patient but also the purpose of the study.³⁷ Due to the patient's lack of education and sophistication in scientific matters, and/or his lack of health, it is difficult for the patient to understand the full implications of the procedures and the purpose of the experiment even when these are carefully explained.³⁸ In response to this situation, it has been suggested that a physician who has no direct connection with the experiment counsel with the patient in an attempt to help him understand that to which he is being asked to consent.³⁹ The physician would assume the traditional role within the physician-patient relationship and would act as a "physician-friend" in helping the patient to understand and respond to the investigator. This proposal does seem to offer an added measure of assurance that the patient will better understand the experiment and his own feelings toward it. Also, it helps the patient to distinguish between therapeutic and non-therapeutic procedures by personifying them in the physician-friend and the investigator. While there are criticisms of this procedure, we believe a person who is well-informed about the experiment and who acts as a counselor with the potential subject could be a great help in insuring the proper understanding and clear thinking of the patient.

Another area of difficulty in fully informing the subject is an area also largely unknown to the investigator. The question of risk involved is often unknown. Investigators are frequently hesitant to inform patients that the consequences of an experiment are ultimately unpredictable.⁴⁰ If the investigator is working under the NIH guidelines, he may assume that if his procedure has been approved by the committee of his peers and he believes it to be the lowest possible risk or hazard to the subject, the experiment is, in fact, as safe as possible. However, to express this belief as anything more than an imperfect judgment based on insufficient information is to contradict the requirement of informed consent. The subject should understand that ultimately the result of the experiment is unpredictable even

37. Fletcher, "Human Experimentation," p. 637.

38. Henry K. Beecher, "Experimentation in Man," in Newman and Ladimer, *op. cit.*, p. 8.

39. Otto E. Guttentag, "The Problem of Human Experimentation: The Physician's Point of View," in *Ibid.*, pp. 126-33.

40. Pappworth, *op. cit.*, p. 191. See also Louis G. Welt, "Reflection on the Problems of Human Experimentation," in Newman and Ladimer, *op. cit.*, pp. 126-33.

though its probable outcome is predictable. The investigator's tentative judgment should never be given as absolute. In this situation also, the "physician-friend" could help the subject to evaluate the evidence. Objection has been raised from some physicians and investigators "whether such a principle is always capable of application or even desirable."⁴¹ Often the objection is based on the difference of such a role from the physician's traditional role "which is to provide hope for and comfort to the patient."⁴² However, in non-therapeutic human experimentation, the traditional role of the physician no longer is applicable to the investigator-subject relationship. In non-drug experiments fully informed consent of the subject is always desirable.⁴³ If for any reason the person is incapable of giving a fully informed consent due to unconsciousness, then under normal circumstances any non-therapeutic procedure is impermissible.⁴⁴ It has been suggested that this might also be the case for children and mentally incapable persons.

Regarding the ideal of totally free consent, much the same ambiguity exists. Total freedom in the consent situation is impossible due to the very nature of the human creature. What a man is cannot be separated from the past influences upon him and his dreams of the future. All of these influence him in the decision-making process. Likewise, man does not exist apart from other men; he is a social being influenced by his many and various social relations. For example, a man whose wife or child had died of cancer would be greatly swayed in his decision if asked to participate in a cancer research project of no benefit to him. The aim of the investigator should be to allow the greatest amount of freedom possible. In response to the enormous difficulty in determining a man's motivation, some persons have suggested that perhaps too much emphasis is being

41. Louis Lasagna, "Can the Public Be Overprotected?" p. 15. A copy of this article was given the authors, but we are unable to supply full bibliographical data.

42. Comment by Edward Freis in *Medical Ethics in Research: A Symposium* (Veterans' Administration, Department of Medicine and Surgery, 17th Annual Medical Research Conference), VA monograph 10-2 (Cincinnati, 1966), p. 6.

43. Drug experiments constitute a different problem due to the blind and double-blind experiments and the placebo effect.

44. Jonas, *op. cit.*, p. 240. "Normal," as used here, refers to a time when only an average number of persons is in danger of disease at any given time as opposed to an epidemic situation when large numbers of the population are endangered simultaneously, thus raising the danger to society as a whole.

placed on freedom due to "an excessive ethical fastidiousness."⁴⁵ An alternative to the ideal of disinterestedness, the standard of "fairness," is substituted, by which the writer means "what in retrospect will seem fair to him (the subject)."⁴⁶ The problem here, however, is that at the time the subject has to make the decision he does not have the perspective that is required for retrospection, namely, a view of himself after the experiment. If "fairness" can only be determined at the end of the experiment, what good does this do for the patient's decision-making? Also, this proposal is based on the assumption that the ethics of an experiment are determined by its ends—but this is contrary to the view proposed above, namely, that the moral nature of an experiment is determined at its inception. This proposal, therefore, is inconsistent with the goals of society and the research itself.

While it is correct that complete disinterestedness is unattainable, some reasonable criteria needs to be employed to insure the minimization of coercive and undue pressures on the freedom of the subject to decide upon participation in an experiment. It is this reasoning that makes the issue of free and informed consent central in all major attempts at establishing codes for the ethical conduct of human experimentation.⁴⁷ The writers of these codes, who were in most cases themselves physicians and investigators involved in human experimentation, realize the complexity of the issue of informed consent; but they also realize the necessity of some standard by which investigators might be guided with their ethical sensitivities. As one prominent writer in the field said, "a requirement of 'voluntary, informed consent' . . . is far from the be-all and end-all of legal and ethical safeguards but it is a valuable check. . . ."⁴⁸

The weakness of the codes, as indeed of any legalistic answer to informed consent, has been justly acknowledged by both professional and lay critics.⁴⁹ In the last analysis there is danger in either too strict or too lax statements about informed consent. Here again the ambiguity involved in the issue of free and informed consent is evident. The functional basis upon which decisions about this issue

45. Louis L. Jaffe, "Law as a System of Control," *Daedalus*, *op. cit.*, pp. 423-6.

46. *Ibid.*, p. 424.

47. For an analysis of codes and consent, see Fletcher, "Human Experimentation," pp. 629-31. Cf. Mulford, *op. cit.*, pp. 102-5 and Morse, *op. cit.*, pp. 764-70.

48. Freund, *op. cit.*, p. 323.

49. Henry K. Beecher, "Consent in Clinical Experimentation: Myth and Reality," *Journal of the American Medical Association* (1966), 195:34.

will be decided is a certain anthropology affirmed by those involved in the various levels of consent mentioned above. Their attitudes about the nature of man, and the ways in which these attitudes are implemented in actual research processes, tends to determine in large measure the moral quality of non-therapeutic human experimentation. It may, therefore, be here, most appropriately, that the Christian theologian makes a significant contribution to the discussion.

Euphenic Engineering for Clinical PKU

MELVIN DOWDY, RICHARD RICHARDS, AND LINDA VAN TASSEL

The primeval inorganic slime gave forth the first elementary forms of life nearly 2,000,000,000 years ago. From that time on evolutionary history was marked by the interaction of DNA and the environment. 3,000,000 years ago the species *homo sapiens* was born and is today a mere adolescent in evolutionary history. In the near future, however, evolution may no longer follow the whim of the laws of probability, but the direction of man!

In 1831 a young Cambridge theologian, who had a yen for beetle collecting, set out on a five-year voyage aboard the H. M. S. Beagle. The subsequent years found Charles Darwin struggling to integrate his observations of variability with a theory to explain them. In 1859 he published *The Origin of Species*, which not only summarized his reflections upon the theory of natural selection, but caused an intellectual uproar in both science and theology. In 1870 he added further fuel to the debate when he published *Descent of Man*.

At approximately the same time, an Austrian monk was conducting experiments in plant breeding in a small monastery garden. Gregor Mendel, heralded as the father of the science of genetics, published a paper in which he described the basic principles of the science of genetics. He observed that some characteristics remain relatively constant from one generation to another. He determined that genes interact in pairs, having similar functions and positions along the chromosome. He also found that the pair of genes may not be complimentary, i.e., one may dominate the other. Thus he found that the same gene may have a dominant form and a recessive form; and he named these differing forms of the same gene *alleles*. A recessive trait can only express itself when the pair of genes are both recessive. Mendel also discovered that when the genetic material duplicates itself, the alleles, or paired genes, will separate and reunite with other genetic material independently; this he called independent assortment. His laws were innovative and highly significant as the first descriptive explanation of genetic functions. His discovery

remained largely unnoticed until William Bateson brought Mendel to the attention of the scientific world around the turn of the twentieth century. It was Bateson who gave the modern science of genetics its name.

An English mathematician, G. H. Hardy, and a German physician, Wilhelm Weinberg, simultaneously came to the same hypothesis about gene frequency and random mating in 1908. The Hardy-Weinberg law states that a balance of distribution or an equilibrium would prevail in a population with respect to the number of persons carrying a genetic trait. If certain factors held constant, they found that it was possible to determine mathematically the number of dominant, recessive, and mixed gene pairs in a population. By using the mathematical formula of Hardy-Weinberg, it is possible for modern geneticists to determine the occurrence of a deleterious gene in a particular gene pool (population) and predict its occurrence in the future.

The study of human genetics began in earnest about 1900 when another Austrian, Karl Landsteiner, discovered the A, B, and O blood groups. The study of human heredity was given its greatest stimulus by medical genetics. This was most noted by the discovery of "in-born errors of metabolism" in 1908 by Sir Archibald Garrod. These were metabolic diseases (inability to digest certain nutrients) which had baffled physicians until Garrod demonstrated their hereditary nature. Interest in genetic influence on and participation in disease processes has gained significantly ever since and has added abundantly to current therapy procedures.

The science of genetics continued to advance in all its subdisciplines, discoveries in one adding knowledge in others. But it was not until 1953, when J. D. Watson and F. H. C. Crick published their landmark article in *Nature*, that an adequate model was proposed which would explain the four essential functions and properties of the genetic material: specificity of genes, sufficient coding capacity for multiple genes, self-replication, and mutation. Watson and Crick proposed that the chromosomes are made up of a macromolecule of deoxyribonucleic acid (DNA) in a double helix (spiral chain). DNA is made up of four bases: two single ring bases, thymine and cytosine (pyrimidines), and two double ring bases, adenine and guanine (purines). This discovery made it possible for the genetic code to be broken and for a dictionary to be compiled which lists the messenger RNA codons (specific protein compounds which carry messages from

a gene to the cell). These two discoveries have brought the science of genetics to a place where, in theory, scientifically knowledgeable men can manipulate the very biochemical structure of life.

Jim Shapiro and others reported on their success of isolating the "lac Operon DNA" gene.¹ Because of this discovery, it is now technically possible to isolate a single gene. With this new insight, scientists may well be able in the near future to learn how genes act as administrative watch-dogs, administrating the activity of cells, as well as what substances activate the gene itself. Such a discovery could ultimately be the beginning of learning to correct defective genes and thus *cure* (rather than just treat) hereditary diseases.

After nearly 3,000,000 years in the evolutionary history of the species *homo sapiens*, a new day is dawning and once unimagined possibilities in man's control of his genetic destiny are now near realization. As scientists perfect their technology and gain greater control over its effects, they will be able to offer alternative genetic futures to their neighbors. Leaving aside, for a moment, the debate over whether our wisdom will match our technical powers, the moral question is raised in the problematics of a situation in which one has to choose among several alternative futures. Our capacity to challenge and change our hereditary endowment, both now and in the future, raises a decision-making moment with which men have not had to deal previously.

Manipulation of our genetic future falls into three general technological categories: eugenic engineering, or the selection and recombination of genes already existing in the "gene pool" of the population; genetic engineering, or the change of undesirable genes to more desirable forms by a process of directed mutation; or euphenic engineering, or the modification and control of the expression of existing genetic information of an organism so as to lead to a desirable physical appearance.

Eugenic engineering involves selection for or against certain genotypes. Herman J. Muller, a noted geneticist of our century, argued that men ought to practice this type of intentional selective breeding to improve the gene pool of the human race. There exist today at least two techniques which could accomplish these ends: artificial insemination by a donor (A.I.D.) and ovum implantation.

1. Jim Shapiro, Lorne Machattie, Larry Eron, Garret Ihler, Karin Ippens, and John Beckwith, "Isolation of Pure lac Operon DNA," *Nature* (1969), 224:768-74.

On the horizon are improved freezing techniques by which sperm and ova could be collected and preserved until such time as they were desired for conception. All of these techniques have been used successfully in the breeding of animals. Currently, A.I.D. is used by some physicians in the treatment of human infertility. The most formidable problem facing positive eugenics (selecting for positive or desired traits) is the establishment of criteria upon which "good" sperm and ova could be chosen. The problem arises in delineating the specifics of the word "good." Another problem lies in the fact that even the best genomes may carry between four and ten lethal recessive genes. In addition, because of the nearly infinite variety of gene combinations within any particular gamete (egg or sperm), it would be difficult, if not impossible, to guarantee that any particular sperm or ovum specimen contained the best combination of genes. To top off the problems faced by positive eugenic engineering is the debate over the importance of genes versus the importance of environment in the development of persons.

Eugenic engineering also includes negative eugenics. This is the selection against deleterious genes to lower or eliminate defective genomes from a population's gene pool. Men have at hand various techniques to select against the propagation of these genes. The most effective technique, and perhaps the simplest, is sterilization: tubal ligation in women and vasectomy in men. There are also other less final, but nevertheless effective, methods of contraception which can assure that certain genomes are not passed on to other generations. Selection against deleterious traits is much easier than selection for a positive trait. By the technique of amniocentesis (a surgical procedure for observation of the developing fetus) it is possible to identify certain genetically defective fetuses in the womb and either treat them prenatally, abort them, or allow them to be born and attempt to treat them post-natally. Medical genetics coupled with more precise testing equipment and techniques of other sciences is becoming able to diagnose not only the homozygote, a fetus which has a high possibility of being affected by the negative characteristics, but also the heterozygote, who is a carrier of the negative characteristic in his genetic makeup while he may or may not be noticeably affected by it. For example, the heterozygote carriers of the deleterious genes which cause phenylketonuria, muscular dystrophy, Down's Syndrome (mongoloid idiocy), or the Cru Di Chat Syndrome are all able to be identified in the heterozygous state. Such carriers, when identified,

can be given the needed information about the chances of passing the gene on to their progeny, the techniques to prevent this from happening, the treatability of the disease. On the basis of this information, such persons may be ready to make a decision for negative eugenics.

Another procedure by which we may manipulate genomes in the future involves direct intervention to change the composition of the chromosomes by mutation. This is known as genetic engineering. This science is still in the earliest stages of research with human subjects. Although we have the power to cause mutation we are not, as yet, able to control and direct the process of genetic mutation with sufficient precision. Experience with X-rays, LSD, and Rubella indicate at least three ways that mutations can be caused. The biggest problem with genetic engineering at present revolves around the inability to make precise point mutations or precise interchanges of healthy genetic material for strands of DNA. At present, geneticists have not mapped human chromosomes completely enough to know where the affected loci are. There are, however, some techniques being used in other facets of genetics which look promising for the future. For instance, significant genetic engineering is adding to our knowledge of deleterious genes, especially as they may relate to cancer and leukemia. Studies with cancer and leukemia are adding to evidence for the use of viruses to re-program affected strands of DNA.

Another way to change a person's genetic complement is the process known as transformation.² This is the incorporation of a segment of DNA from one cell into the genetic material of another cell, thereby transforming the affected cell into a normally functioning cell. It has also been found that certain micro-organisms and chemical compounds have this mutagenic power.³ This means that they can induce changes in the genetic material which can mutate a gene from one form into another. There is some evidence that this can be done in a non-random fashion and, thus, controlled mutation may be possible some day. Genetic engineering is still very much in the experimental stages of development, but may offer the greatest potential of genetic control and perfectability available to man.

2. Elizabeth H. Szybalska and W. Szybalska, "Genetics of Human Cell Lines: I. V. DNA-Mediated heritable transformation of a biochemical trait," *Proceedings of the National Academy of Science* (1962), 48:2026-34.

3. Donald Huisinck, "Should Man Control His Genetic Future," unpublished paper.

Euphenic engineering is perhaps the most common and perfected procedure for genetic manipulation. This refers to the modification of gene expression by manipulation of the genetic environment or the interference in the way a gene would "normally" express itself. For instance, there is evidence that diabetes is a genetically inherited disease and it is treated by injections of lacking insulin. Agammaglobulinemia, characterized by the inability of the body to produce gammaglobulines, is treated by the routine addition of these blood constituents. Among "inborn errors of metabolism" which are treated by euphenic engineering is galactosemia; it is a genetic disease caused by the inability of the affected person to metabolize galactose to glucose because of a lacking enzyme. If the disease is allowed to take its normal course, the affected infants die at an early age from large concentrations of galactose in their blood. This can be avoided by the use of a diet which does not contain the amino acid, enabling the child to mature into an adult, otherwise normal.

Not altogether dissimilar to galactosemia, phenylketonuria (PKU) is a genetic disease caused by the inability of the affected person to oxidize the amino acid phenylalanine into the amino acid tyrosine. Unlike galactosemia, this disease is not easily treated and may result in infant death, mental retardation, or both. Because of the significant number of persons affected by this disease, and the apparent neglect of confronting the problematics of treatment by genetic manipulation, the authors of this paper have chosen to examine the nature of possible treatment of phenylketonuria, including genetic engineering and its correlated ethical considerations. We have selected a representative case to focus upon salient issues and to offer a tentative prospectus for a total medical and ethical treatment. This is an innovative task and one which cannot be conclusive at this time. However, the hope lies in doing an ethical exercise which may prepare us for future discussions.

PKU is a disease inherited as an autosomal (the genes are one of a pair of chromosomes other than the x or y) recessive trait. Since it is a recessive condition, the individual who exhibits the disease is a homozygote; i.e., he has two recessive, defective genes. The normal or dominant gene produces the enzyme phenylalanine hydroxylase (a catalyst or agent which causes chemical changes to occur). The recessive allele, or genes which carry PKU, prevents or fails to produce this enzyme. This failure is its only genetic defect, but it has a variety of effects on the organism.

Phenylketonuria was first described by Følling in 1934.⁴ Since then, the biochemistry of the disease has been conclusively demonstrated to be a disruption in the normal metabolism of phenylalanine. This disruption results in an abnormally increased level of phenylalanine and a lower incidence of tyrosine in the blood. As the primary channel of metabolism by which phenylalanine would normally be broken down is blocked, the body finds other pathways to rid itself of the excess phenylalanine. Much of it is transformed into phenylpyruvic acid and is excreted in the urine. Because of this, the disease is easily detected by the testing of urine with a solution of ferric chloride. This is a very simple, inexpensive test which is reliable for the detection of the disease, and provides a method for *early* detection, which is vital for treatment. The abnormal amount of phenylalanine can also be demonstrated by a blood test which is conclusive proof of the presence of the disease. The blood test is required by law in most states and is performed on newborns before they leave the hospital.

Heterozygotes, persons who carry both a dominant and a recessive gene for PKU, can be detected by the phenylalanine tolerance test. Because these people carry the defective gene they are not able to metabolize phenylalanine as well as a normal person, thus the excess can be detected in the blood. It has been found that these people are twice as likely to suffer from mental disorders and mental deficiency as the normal population.⁵

Phenylketonuria has an incidence of 1/25,000 births and PKU patients make up about 1% of institutionalized mentally defective people. This disease expresses itself phenotypically in severe mental retardation. In the first few weeks after birth it is not unusual for the PKU infant to be very irritable, have epileptic seizures, or vomit severely.⁶ As far as physical appearance is concerned, some PKU victims may be slightly stunted, have lighter coloration than their siblings, and have abnormally vigorous reflex responses.⁷

The exact physiological cause of retardation is not known for sure, but there are several theories. One popular theory is that "it

4. W. Eugene Knox, "Phenylketonuria," *The Metabolic Basis of Inherited Disease*, ed. T. B. Stanbury, J. B. Tyngaarden, and D. S. Fredrickson (New York: McGraw-Hill, 1966), 2nd ed., p. 258.

5. *Ibid.*, pp. 279ff.

6. David Yi-Yung Hsia, *Inborn Errors of Metabolism*, I (Chicago: Yearbook Medical Publishers, 1966), 2nd ed., p. 135.

7. H. Harris, *Human Biochemical Genetics* (Cambridge: Cambridge University Press, 1962), pp. 36ff.

results from the toxic action of one or another of the various metabolites which occur in unusual amounts as a consequence of the blockage of phenylalanine hydroxylation.”⁸ Pathologically, autopsies have indicated that the brain weights of PKU victims are two-thirds normal weight. But, more importantly, the most consistent problem was deficient myelin formation in the central nervous system and brain. “Not only may the myelin formation in phenylketonuria be deficient, but also the myelin itself may be defective, so that it ultimately breaks down.”⁹

We have already seen that failure to metabolize phenylalanine causes the disease phenylketonuria. It has been stated that the resulting symptomatology is a severe arrest of intellectual processes which normally develop beyond the basic sensory-motor behavior. We cannot conclusively say that the resulting mental retardation is caused by the deleterious gene for PKU.

There are several factors which contribute to the intelligence of a given person; i.e., environment as well as innate ability affects the intelligence. Our study leads us to assert that intelligence has a genetically derived basis in the total organization of a person. A person is a highly complex organism with sensory-motor systems, kinesthetic (or moving) systems, central nervous system, and so on. The unity of all these systems and others comprises the biological structure of a person. The biological structure has as its property the capacity to receive from or to extend oneself into the environment; the dynamic equilibrium between the assimilation of the environment; and the accommodation to it is basic to learning.¹⁰ Initially, intelligence develops in this person by means of sensory-motor behavior. He learns by doing, before he learns through abstractions. It is the nature of human behavior to seek active interaction with an adaptation to the environment. Adaptation to one's environment is manifested in the ways in which one copes with himself in relation to the world around him; in the degree to which his behavior corresponds to the resources and the limits of his environment, we say that he has begun adaptation. This is an over-simplification; however, the fundamental

8. *Ibid.*, p. 135.

9. Knox, *op. cit.*, pp. 266-7.

10. Many disagreements exist on this issue. R. C. Tyron and others have argued experimentally for a hereditary basis for intelligence; while others have produced contradictory evidence from “free versus deprived” environmental experiments. Moreover, experiments with identical twins, who were separated at birth, have not given conclusive evidence in either direction.

notion is apparent. Intelligence itself is not inherited; only the biological structure necessary for its development is inherited.¹¹

It is precisely this organization of genetically determined biological structure which is impaired by the unmetabolized amino acid. Thus, we do not attribute to the untreated PKU patient "bad," "wrong," or "illogical" thinking. Rather, we simply recognized an arrest of development prior to the emergence of integrated rational processes, or at least a dysfunctioning of adaptive behavior, issuing from the disorganization of the basic structure. The untreated PKU patient will not develop at the expected rate, and he may not develop beyond the most infantile behavior. For example, his behavior may remain rigidly imitative, copying the motions of others without any awareness of the purpose or meaning of these movements. He may never develop a concept of number or any notion of the permanence and constancy of objects. He may never develop an ability to discriminate the differential size of objects, or that the size of some objects remains constant.¹² Thus, while his cognitive capacity to understand his world is severely impaired, this handicapped person lives within a mysterious world of frightening fluctuation and change.

We must keep in mind that the handicapped PKU patient does not fail to develop cognitively without also failing to develop related socio-emotional abilities. During the years before the age of seven, we may observe the normal child learning to focus upon an object from a perspective different from his own; we call this capacity "decentering." This ability to decenter is in contrast to the perception of the former stage, egocentrism (prior to three years). The surrender of egocentricity is the early manifestation of social consciousness and is a necessary developmental shift if the child is to learn to cope with the social world. Thus, we observe in the untreated PKU patient a lack of true social consciousness, a pervasive egocentricity with manifest infantilism.

There are other behavioral and somatic symptoms which indicate an arrest of development. In the case of one particular patient, she did not sit without support at the expected age of six months; rather sitting occurred at twelve months. She did not walk at twelve months, but at four years. Her speech remains infantile and meaningless, even

11. John Flavell, *Developmental Psychology of Jean Piaget* (New York: Van Nostrand, 1963).

12. B. Inhelder and Jean Piaget, "Diagnosis of Mental Operations and Theory of the Intelligence," *American Journal of Mental Deficiencies* (1947), 51:401-6.

at age twenty-eight. She discharges pervasive hand tremors and seizures. She also suffers from skin lesions, a common somatic condition among PKU patients.

The girl, who will never score above the two year level on standard intelligence tests (Stanford Binet, Gessel Block Test, and so on), is a tragic example of the underdeveloped child. What appears more tragic is that the neurological damage could have been prevented. In addition to this, she was one of four children, all of whom suffered from a deleterious genotype. Her birth might have been prevented, provided our society had sought early diagnosis of the genotype and legalized limitations to reproduction. No institutional care, regardless of its altruistic intentions, will substitute for the quality of life this child lost. The potential for conquest, achievement, self-awareness, and interpersonal relationships—these qualities commonly shared and understood to be a meaningful contribution to humanness will never be fully experienced by this patient. In this regard, she has lost distinctly human possibilities.

Since the time of the disease's discovery in 1934, several treatments have been tried to alleviate the symptoms without much success. In 1952, Bickel was the first to institute the diet low in phenylalanine. He had good results and this has become the treatment of choice since his discovery.¹³ The purpose of this diet is to lower the blood level of phenylalanine and at the same time promote growth through good nutrition. It was found that a certain amount of phenylalanine was necessary for proper synthesis and general growth; thus, the diet is not devoid of the amino acid.¹⁴ After a time, the dietary treatment diminishes the excess phenylalanine in the body and the patient establishes a "normal" metabolic pattern.¹⁵ Presently, the diet is available in commercial formula.

The administration of the diet should be started as soon as possible, for, the sooner the treatment is begun, the better the chance to prevent any further cerebral damage and deterioration. The diet does not seem to correct any damage already present.¹⁶ Centerwall states that if treatment is begun by the age one month, the affected child should develop normally. If treatment is begun by age two months, the person's mentality should be normal, but may be 10-15 I.Q.

13. *Clinical Team Looks at Phenylketonuria*, U. S. Department of Health, Education and Welfare (Washington: U. S. Children's Bureau, 1964).

14. Harris, *op. cit.*, p. 41.

15. Hsia, *op. cit.*, p. 139.

16. *Clinical Team, op. cit.*, p. 33.

points behind other persons of that age level. However, if treatment is put off until after the child is six months old, there will be extensive retardation. Regardless of when treatment is begun, there always seems to be some behavioral improvement.

How long does one have to continue on the diet? This is a question that is still debated. There is some evidence that indicates that the cerebral damage does not continue too long after three years of age. Others say that the treatment should continue until adolescence.¹⁷

If a PKU woman becomes pregnant, evidence indicates that she should return to the diet throughout the course of her pregnancy. However, there is conflicting evidence in this situation. Some reports indicate that the mother's high level of phenylalanine may cause fetal damage, regardless of the diet. On the other hand, it has been reported that some PKU mothers have given birth to normal children.¹⁸

Though the medical profession is inclined to end a discussion of treatment with the introduction of a diet, control of seizures, and so on, we must argue that this treatment only relieves the symptoms; i.e., it does not cure the disease. Moreover, treatment implies "total care" and, as such, must extend into non-medical interests. We would like to demonstrate the possible areas involving total care with which the medical profession and others must deal.

Recently, a southeastern institution for the care of mentally retarded faced a difficult decision. During the course of treating hundreds of patients, a clinical case of phenylketonuria was admitted, examined, positively diagnosed, treated for one year, and then discharged by the request of the patient's parents. At no time during her custody at the institution, nor after her discharge, were the parents or the patient informed of the nature of the diagnosis. Nearly five years elapsed when, to the panic of the resident physicians, the institution received a formal wedding invitation from their former patient and her family. Evidently, the patient and family knew of no reason why this marriage would be undesirable.

The physicians immediately notified the patient and her family of the nature and consequences of her condition. The response was

17. Willard Centerwall and Seig Reid Centerwall, *Phenylketonuria, An Inherited Metabolic Disorder Associated with Mental Retardation* (Washington: U. S. Department of Health, Education, and Welfare, 1965), pp. 16-7.

18. *Ibid.*, p. 17.

threefold. On the one hand, her parents were outspoken in their opposition to the extent of consulting their clergyman and their attorney about possible religious and legal prohibitions to the marriage. The parents would have followed through with a formal request to the state Eugenics Board for the mandatory sterilization of their child, but it was felt that this would be undesirable and likely to alienate the child permanently.

The prospective husband was apparently undisturbed by the physician's appeal and generally refused to accept that any genetic deformity existed. (This appears as insensitivity and ignorance on this man's behalf.) In fact, the physicians adjudged him to be less intelligent than the patient. The patient, who has a mid-range I.Q. of 50 and who is in her late teens, did not oppose her prospective spouse. The two of them were married. Under the law of that state, either the institution or a local welfare officer could have formally requested the patient's sterilization prior to their marriage. In that state no statute provides for sterilization once the couple is legally married.

The problem of Pandora (name fictitious) was made evident as a result of the forthcoming marriage. However, the beginning of this problem occurred five years prior to the wedding announcement, when the physicians neglected to inform the family of the nature of the patient's illness. In an attempt to correct this initial mistake, the doctors, at the time they received the wedding announcement, informed the family about the nature of phenylketonuria.

This then created a problem for the parents. They were afraid of insisting on sterilization for Pandora for fear of alienating her in light of the forthcoming marriage, a condition which did not exist five years earlier. Thus, the decision about sterilization was passed on to the future spouse. The institution informed him of the situation. His reaction was to deny that any genetic condition existed. The result of this series of discussions is that Pandora is given the full weight of responsibility which incorporates a decision that she is incompetent to make.

The theologian and the humanist will both agree to the intrinsic claim of human life to health. Christian ethics is not needed to justify this claim; it seems to be self-evident. Yet, Pandora is among those persons deprived of this natural claim, and, while no single individual can be held responsible, each decision preceding her present condition and dilemma has had a relative contribution. The relative nature of

each contribution, however, indicates to us the need for joint decision-making in which each person, professional or friend, is informed by the other. The time when we can remain isolated within a private exercise of our own will has long ago passed away. To encourage this private modality is to encourage apathy, impotence, and enlarged ambiguity. Besides, Pandora's future, together with the future of all other PKU patients, directly and adversely affects the future of yet unborn persons, persons who also have claim to a healthy life. A responsive decision cannot ignore these unborn individuals, nor can it afford to neglect all the resources available through the joint decision-making context.

The Christian ethicist especially will appreciate the call of this situation to the intrinsic claims of the PKU person. In Tillich's explication of Christian love (*Love, Power, and Justice*), he defined the response to this intrinsic claim as love fashioned after the love of God. Similarly, Tillich asserts that the whole body of persons, the community, also has claim to this love. Thus, we are faced again with an ethics of joint management *between* individual and society, as well as management *by* the individual and society. This two-sided tension is the balance of two legitimately based self-interests: 1) patient's interest in health, and 2) society's interest in protection from defective genes such as the PKU gene. But as a tension, lest either pole dominate the other, we are faced with a situation of potentially enlarged ambiguity and alienation. In the case of Pandora, neither her legitimate self-interest nor the legitimate self-interest of the community-at-large was adequately managed. The results were painful, especially for Pandora and her family. Her family was left with an ambiguous situation, a situation in which no clear and just alternative was available. And they were faced with a potentially alienating situation, a situation in which they stood to lose the understanding of, rapport with, and respect of their daughter and her prospective spouse. Theologically, we abstract from this concrete situation the existential notion of sin.

Certainly, much of the potential for alienation was implicit in the nature of the disease. Yet, the responsive person must not allow this threat to immobilize his capacity for an ethical management. The responsible person cannot abandon the PKU patient to the natural, deleterious whim of the disease. For, such an abandonment acquiesces to the tragic consequences, to impeded development and its implications for the remainder of the life-history. The full and complete

joint management of responsibility is what is called "total care," and it is noteworthy that such care extends beyond medical, technological treatment. Explicating "care" as a psychological and theological phenomenon, Rollo May has developed upon the usage of care by Martin Heidegger. In his book, *Love and Will* (W. W. Norton, New York: 1969), May described care as "moving toward the other," becoming involved, establishing relational qualities in community. As such, care is diametrically opposite to a laissez-faire and apathetic management of decision. Care is total pouring out of oneself in responsive love to the intrinsic claims of individual and community; i.e., the Christian principles of neighbor love.

Returning to our dilemma, we may observe the PKU patient requiring care (neighbor love) that extends from conception to death; i.e., total care in the historical as well as the technological sense. For a complete treatment program, all concerned persons are called to a decision on behalf of the patient (or potential patient) and on behalf of the community-at-large. When these persons are not jointly involved, partial treatment results in enlarged ambiguity and potential alienation. Moreover, the most responsible decision will hold in tension the legitimate self-interest of both patient and society. With these responsibilities in mind, three alternatives are immediately obvious:

- 1) to refrain from the dietary treatment and, thus, condemn the child to retarded growth in the community;
- 2) to offer the dietary treatment and place the solution of his social alienation totally upon his shoulders; or
- 3) to couple the dietary treatment with a socially responsible solution which limits ambiguity and potential alienation.

Operating from the principle of legitimate self-interest and the principle of total care, the first alternative is eliminated. It is in the legitimate self-interest of society to have individuals function at their fullest capacity. The diet allows for an increased capacity for socialization, personal development, self-care, and overall social functioning. In terms of the obligation to love the neighbor, we hold that the treatment enables the affected PKU to enter more fully into a qualitatively fuller, richer, and more personalizing relationship. It is our responsibility in care to provide both an environment and a treatment (in this case) in which this person can enter as fully as possible the process of personhood.

The second alternative provides for the partial fulfillment of society's legitimate self-interest and the total care principle but complicates the context. Once we decide to treat the PKU, we provide for his entrance into society's life and future. He is now subject to its laws and to a second facet of its legitimate self-interest. The treated PKU person, who is intellectually developed and sociable, has simultaneously become a potential parent who could pass on his deleterious trait and in that sense, he may propagate an ambiguous and alienating condition. This is embodied in the threat to society's physical well-being, and to his potential offspring, which results in a breakdown in community with the patient. He suffers from alienation perpetrated in the treatment of his disease. Thus, the community participates, through the medical treatment, in the genesis of his and future persons' alienation.

Whatever we mean by responsible decision-making, prerequisite to it are intelligent responsiveness and the ability to relate socially. Although the low phenylalanine diet does seem to allow increased development of all these capacities, just how effective it is remains debated by physicians. The genetic incidence indicates that mental damage probably occurs or begins occurring prenatally. Persons such as Pandora are not recognized as legally competent to make decisions for themselves. Adolescents are also held to be legally incompetent. It is precisely during adolescence that PKU persons reach the age of fertility, and, as we have seen, become a threat to society's future. Normally, society does not hold children responsible for the decisions that they make.

The later stages of the decision-making context are centered on whether or not this person is going to be allowed to procreate, since procreation is the sole vehicle of PKU. We would argue that the ability to procreate is not an unlimited nor an absolute license. It is influenced by contextual and social circumstances and claims. Thus, it is a social function and subject to social responsibility; i.e., joint-management. We also assume that no individual genetic endowment has an unlimited and absolute right to survival. Consequently, we affirm that there is an appropriate time for certain genotypes to expire. With the limits placed upon these affected persons, considering the age at which such a decision would have to be made, and remembering the social implications of not making a decision about procreation, all these indicate for society to assume the responsibility for joint-management and for the risk involved.

The discussion has examined the concept of total care as it encourages us to establish the conditions and community in which persons can reach the fullest potential in their relationships with other persons and with God. Consequently, we would opt for the use of the diet to enable victims of PKU to become as fully human as they possibly can, while recognizing the various responses and successes that that treatment holds for these people.

The paper has also discussed the various facts which have to be recognized and accepted regarding PKU. There is damage prenatally in PKU patients; the diet is not 100% effective, i.e., the test does not assure treatment. A corollary to these facts is that decision-making requires a certain amount of intelligence. Intelligence is a prerequisite for knowledge and freedom, which are essential elements in decision-making. Considering the facts and the corollary to them, we have persons whom society cannot trust with whether or not they should procreate. Society must assume that responsibility, if it is to assume the responsibility for treating PKU patients. In other words, total care of PKU persons is required, both as patients with a biological disease and as patients with a disease of radical social consequences, requiring joint-management. It is the conclusion of this paper that for total care the diet be coupled with sterilization. Therefore, we propose that all detected PKU homozygotes be treated with the diet and sterilized. Also, we propose that heterozygotes receive adequate information and counseling about the disease they carry and its effects, and, in the event that they have a child with PKU, they should at that time be sterilized.

As long as treatment for PKU persons is limited to a treatment of the symptomatology and not a treatment of the enzymatic condition, this proposal stands. If an artificial or a synthetic enzyme is produced which allows for normal metabolism of phenylalanine to tyrosine, the proposal would be modified because we would then be treating the disease and not the symptoms. Such a state of affairs could potentially remove the problem of alienation, since the danger from the deleterious gene would be muted!

Medically Induced Drug Addiction

GEORGE ENNIS, ROBERT MCCONATHY, AND MORGAN PETERSON

Drugs are tools of the physician for treatment of the sick and protection of the healthy, and the medical doctor participates at every stage in their creation, development, evaluation and use. It is the physician's responsibility to relieve pain by eliminating its cause if possible. In the treatment of patients with chronic or painfully incurable conditions, it is purportedly ethical practice to administer morphine-like drugs over a prolonged period when all reasonable procedures have failed. Generally, this situation is most frequently found in cases of terminal disorders.¹ On the other hand, "continued administration of drugs for the maintenance of dependence is not of itself a *bona fide* attempt at care, nor is it always ethical treatment."²

According to John J. Bonica, M.D., in his book *The Management of Pain* (p. 578):

The complications which are inherent to the administration of opiates for the relief of pain make it mandatory that when employing those drugs one should observe and adhere strictly to the fundamental principles of good therapeutics: namely, (1) to give a specific indication, (2) to administer the drug in optimal doses, *i.e.*, the smallest amount which will cause the desired effects, (3) to administer it by the optimal route. These entail individualization of type and amount of drug and the route of the administration for the particular patient and the particular pain. Routine uses of opiates is haphazard therapeutics and should be avoided.³

It is in the process of individualization that problems arise in the evaluation and use of drugs.

Medically speaking, drugs having a stimulating or calming effect on the central nervous system may produce psychic dependence. A number of these drugs lead to a physical dependence that manifests itself by a typical abstinence syndrome when the drug effects are interrupted by its sudden withdrawal. According to one medical

1. *Drug Dependence: A Guide for Physicians*, American Medical Association, Committee on Alcoholism and Drug Dependence (Chicago, 1969), p. 83.

2. *Ibid.*, p. 83.

3. John J. Bonica, *The Management of Pain* (Philadelphia, 1954), p. 578.

source addiction is a condition that develops after continued administration of certain drugs.⁴ It is characterized by altered physiological processes and psychic craving when the drug is withheld. Somehow the drug has become essential to the maintenance of ordinary cellular activities. (Tolerance is also manifest in true addiction.)

In treatment of pain the risk of dependence occurs with potent analgesics of morphine type and with other central nervous system depressants. The mechanism leading to physical dependence on morphine and allied substances is set in motion with the first therapeutic dose. Such dependence has been observed to occur less rapidly in the use of barbiturates, sedatives, and tranquilizers.⁵ Therefore, addiction is problematic prior to the first administered dose.

In order to avoid, or at least delay, the development of dependence, good clinical management will endeavor to keep dosages at the lowest effective level and to change between drugs within the same type or to combine representatives of both types. The alternation between substances of the same type is ineffective, however, because of the rapidly developing cross-tolerance within each of the types in question here.⁶ While the techniques of management are clear, other problematics make management of drugs an oftentimes ambiguous activity for the medical doctor. Aside from the management of addictive drugs are the problems of the subjective reactions to pain on the part of the house staff. These will be mentioned later.

The legal aspects of this situation of narcotic drug addiction are monumental. At present it is difficult to define where the legal jurisdiction of drug addiction ends and the medical jurisdiction begins; so much so that at present physicians are reluctant to handle such cases. For instance, the doctor may feel that he has a responsibility to cure a medically induced addiction which he has perpetrated, but due to present legal and enforcement standards he may be reluctant to fulfill his responsibility. In such a situation as this, the question of who is responsible for medical drug addiction becomes more complex.

Religious views of medically induced addiction and its participants differ. One may view pain as a means whereby, in God's presence, one can assure growth and maturity of the soul. Pain may also be seen as an interloper in the Divine-human drama. Consequently,

4. B. S. Bergersen and E. E. King (eds.), *Pharmacology in Nursing* (St. Louis, 1966), p. 107.

5. H. Halback, "Treatment of Pain and Risk of Drug Addiction," *Pain*, ed. A. Soulairac and J. Charpentier (London, 1968), p. 500.

6. *Ibid.*, p. 500.

patient and doctor may be said either to be participating in a process that immorally interrupts that which is naturally good or to be facilitating an unnatural state for the sake of another good. Differences in religious attitudes should not be lightly regarded, since it is at this point that the foundation of morality is established. Medically induced drug dependency prompts queries about the nature of pain, the status of that which is natural, and the moral dilemmas which often occasion a choice between the lesser of two evils.

Fourteen per cent of all narcotic drug addicts in the United States are medical or accidental addicts. Accidental or medical addiction caused through therapeutic means falls under the same laws and legal standards as non-medical addiction. The existing legislation does not deal directly with medical addiction. Nowhere in the world is it a crime to have an incurable or a curable disease either due to mental or physical illness; yet it is a crime, punishable by some form of incarceration, to be helplessly addicted to a narcotic drug in twenty-eight of the United States. In all fifty states it is a crime to possess any form of narcotic drug without a prescription. Although it is not a crime to be an addict in many of these states, mere possession brings the addict under the condemnation of the law. Whether narcotic drug addiction, medical or non-medical, is a crime or a disease is debateable. Drug addiction is treated as a disease by some experts, a symptom of a mental disease by others, and a crime by many legal standards.

In the United States the physician has generally been deprived of an appropriate and an adequate role in the treatment of drug addiction. The doctor may often find that the operation of the law prevents him from acting in the interests of the addict patient. Although the Federal Statutes allow for the treatment of addicts by physicians, due to the interpretations of these statutes by the Supreme Court and The Federal Bureau of Narcotics and Dangerous Drugs, doctors have been stifled in their treatment of addicts. Through the interpretation of these laws, doctors have only been allowed to treat addicts with the intention of cure. The policies established by the Federal Bureau of Narcotics and Dangerous Drugs are basically derived from federal statutes and Supreme Court decisions on the "good faith" of a doctor and "bona fide" medical practice as prescribed by the laws. According to these policies, no continued dosage is permitted either at a constant or an increased level. The dosage of the narcotic drug must be gradually decreased in order for addiction treatment to be within the bounds of the law.

It is usually taken for granted that one of the functions of medicine is to relieve unnecessary pain and suffering and to keep patients in relative comfort. Yet the medical doctor who seeks to apply these principles to drug users is usually threatened with criminal prosecution. Prevention of withdrawal is often prohibited and withdrawal is often more detrimental to the addict's health than the drug itself. On the other hand, in the hospital setting, there is no legislation to control the dosage of a narcotic analgesic drug that a doctor may give to a patient to relieve pain. In this case, the doctor is permitted to administer drugs as he sees fit, even where drug addiction is virtually certain.

The medical addict, although often able to receive prescriptions for his addiction, is, because of the Supreme Court's interpretation of the law and the enforcement policies of the Federal Bureau of Narcotics, a type of criminal, punishable by harsh laws. The medical addict is invariably treated in the same manner as the non-medical addict and must face the same laws, prosecutions and other consequences, even though these laws are generally inadequate in dealing with drug addiction.

Overall, laws have tended to become increasingly stringent and inflexible concerning narcotic addiction, and seem designed in the interest of police expediency rather than the structures of justice. In the entire process, the man feeling the brunt of condemnation has been the addict. His degradation and hopelessness have been increased by denying him the benefits of adequate care from the medical profession and by turning the unsolved medical problem of addiction over to the law enforcement agencies.

According to the law, narcotics can only be dispensed for legitimate medical purposes and in the course of a doctor's professional practice. When administering narcotic analgesics to patients in the hospital setting, the doctor must take into account the fact that while attempting to alleviate pain there is also the possibility that the patient may become addicted. According to legal and medical ethics, the hospital physician is permitted to administer narcotic drugs to alleviate pain. The doctor is entitled to employ solutions of narcotic drugs as local anesthetics in the performance of operations and may prescribe preoperative narcotics for a patient on whom he intends to operate. He may use narcotic drugs for the relief of pain in acute conditions such as pneumonia and for the relief of pain due to chronic ailments such as arthritis. A doctor is also considered to be legally justified in

dispensing narcotic drugs in adequate amounts to keep the victim of an incurable disease from suffering unnecessary pain during the last days of life. He may also administer narcotics to an aged or infirm patient whose collapse and death might result from withdrawal of the drug to which he is accustomed.⁷

The only regulations for a doctor to prescribe narcotic drugs are that he must have a narcotics license and a license to practice medicine in his particular state. He is also required to register with the Bureau of Internal Revenue which requires a tax on all narcotic drugs dispensed. Legislation policies, treatment policies and public attitudes generally reflect a judgment that narcotic addiction is an evil to be stamped out at any cost. The application of increasingly severe penalties in an effort to stamp out the use of narcotics except by patients suffering from serious pain from illness other than that resulting from addiction presents several problems. The narcotics laws present several ambiguities concerning the dispensing of narcotics within the hospital setting and by the doctor in private practice. There seems to be a tight web of enforcement on medical treatment outside of the hospital setting, while a *laissez-faire* attitude exists toward the dispensing of narcotics by physicians to relieve pain and suffering in the hospital setting.

Early Supreme Court rulings concerning the relationship of doctors to narcotic addicts were based upon cases involving physicians who prescribed large quantities of drugs to many patients in an indiscriminate manner. These early rulings formed the policy for law enforcement officials and began the process of severing addict-doctor relationships. The Supreme Court rulings seemed to be moving toward the idea that the physician could not legally prescribe drugs to relieve withdrawal distress or to maintain the addict's habit, but could provide drugs only to an addict undergoing institutional withdrawal and then only in diminishing doses.

Several Supreme Court cases are monumental in the formation of Federal Bureau of Narcotics and Dangerous Drugs policy. In 1919, a Dr. Webb was convicted of selling drugs indiscriminately to his patients. In the case of *Webb vs. the U.S.*, the court upheld the doctor's conviction on the grounds of an illegal prescription.⁸ This

7. B. Shartel and M. L. Plant, *The Law and Medical Practice* (Springfield, 1959), p. 308.

8. Edwin M. Schur, *Crimes Without Victims* (Englewood Cliffs, 1965), p. 130.

particular case was the beginning of a constant action in court decisions to curb the illicit use of drugs by expressing the feeling that the only responsible reply to drug addiction is the cure of the addict. For the court, the cure of the addict meant either gradual or abrupt withdrawal but not sustaining the addict on a constant or an increased level.

Even though a new direction seems to have been taken by the court in the Linder Case,⁹ Federal Bureau of Narcotics policy remained unchanged, and many doctors were convicted for prescribing narcotics to sustain addiction. The Courts constantly ruled on the "good faith" of the doctor and the doctor could only know the legitimacy of his act after the trial. The federal courts have done little to restrict their jurisdiction in narcotic addiction treatment in a manner consistent with their own theory that addiction is a disease. Although the courts seem to be more lenient after the Linder case, the Federal Bureau of Narcotics' policy has remained stringent. In numerous court cases that followed, the good faith of the doctor was constantly left up to the judgment of twelve jurors. In cases such as *Hawkins vs. U.S.* in 1937 and the *U.S. vs. Brandenburg* in 1946 the good faith of the doctor was decided by the jury on the basis of the frequency and quantity of the prescription issued.¹⁰

Federal Bureau of Narcotics policy presents several issues because it seeks to police the use of narcotics by private practitioners while being relatively lenient in policing the administration of narcotics in the hospital setting. The policing of narcotic drugs outside of the hospital setting is basically done by agencies which have little or no interest in the medical cure or treatment of addicts. Their major interest in treatment occurs only in so far as it deals with the prevention of illicit narcotics and the prosecution of violation. It would seem that the medical profession has a responsibility not only to police narcotics use more closely within the hospital setting but to take a greater role in policing narcotic addiction treatment in the private clinic or doctor-patient relationships outside of the hospital setting.

In the hospital setting, the doctor can legally supply a patient with an addicting narcotic analgesic in any amount for severe degrees of pain, with the possibility of making that patient an addict. Outside

9. *Drug Addiction: Crime or Disease*, Joint Committee of the ABA and AMA on Narcotic Drugs (Bloomington, 1961), p. 70.

10. *Ibid.*, p. 79.

of the hospital setting the physician is limited in treating addicts, although the physician can legally treat an addict but only with the intention of curing him. Because of Federal Bureau of Narcotics policy, a hospital physician may supply a patient in pain with all of the narcotic drugs he may require on the basis that relieving pain is *bona fide* medical practice, yet the relief of withdrawal distress outside of the hospital setting is not considered to be *bona fide* medical practice. The basic issue of whether any treatment of addicts, whether medical or non-medical, is *bona fide* medical practice remains unsettled by the Harrison Act. In essence the policies controlling narcotic drug use are less stringent in the hospital than outside of the hospital setting; being too harsh outside of the hospital and too lenient within the hospital.

Applied to the medical or accidental addict, these conditions are multiplied and the magnitude of the addict's dilemma is increased. The medical addict being forced into the drug situation comes under the constant surveillance and jurisdiction of the Federal Bureau of Narcotics and Dangerous Drugs. In many states if he attempts to supply the needs of his addiction or his disease, he is incarcerated and labeled a criminal.

In general, the doctor has no criteria or standards to guide him in dealing with drug addicts since each case is different. Doctors may legally treat addicts and prescribe narcotic drugs to an addict under the Harrison Act. Moreover, they must act in good faith and according to proper medical practice. But the medical profession should not leave the problem of determining proper medical standards and good faith to an *ex post facto* judgment made by so-called experts in the enforcement agency alone, who have differing views as to the treatment of narcotics addiction. The courts have not renounced their right to rule on the good faith of the doctor or to submit this question to a jury. Because no definition of "good faith" has ever been created, the doctor can only discover whether he acted legitimately after the trial itself. Other legislation provides the same problems as the Harrison Act. The Boggs Act of 1951 and the Narcotic Drug Control Act of 1956 only provide for more severe penalties and inflexible penalties for addicts.

Generally, the laws regarding addiction in this country tend to offer a simplistic solution to a problem which is for us both complex and morally ambiguous. It is morally preferable to be free from drug dependency than to be drug addicted. If one is addicted, the treat-

ment of choice would be that which would free one from drugs. To this point we can share common value with current statutes. Rarely, however, can a complex human problem like drug addiction be resolved on the basis of a single value choice. As we will demonstrate in the following sections, there are situations in which it may be morally preferable to support an addiction. Such an action is not legal, however, at this time. Since this paper deals with the problem of medically induced drug addiction, the apparent double standard between in-hospital and out-of-hospital drug regulations is a cause for moral concern.

Within the hospital setting, several groups of drugs have proven problematic in that they all may lead to addiction. Two of these groups are barbiturates and analgesics. Some physicians have expressed concern over the misuse of barbiturates. These drugs are classified as central nervous system depressants and have many uses, two of which are as hypnotics and as sedatives. The extent of effect varies from mild sedation to deep anesthesia. Some of the side effects and toxic effects include:

- (1) addiction if given over a prolonged period;
- (2) marked symptoms of hangover—listlessness, prolonged depression, nausea, and emotional disturbances;
- (3) skin rash, urticaria, swelling of the face, and asthmatic attack;
- (4) bad dreams, restlessness, and delirium.¹¹

A recent editorial in the *Journal of the American Medical Association* expressed concern over the negligent use of barbiturates. It read:

When it is remembered that 200 mg of a barbiturate or the equivalent of another hypnotic is what is almost routinely order for sleep in hospitals (not so much for the patient's sleep, we suspect, as for the house officer's sleep), these findings deserve serious consideration. It is not common to hear of patients who first received hypnotics in a hospital and then continued to use them after discharge for an indefinite period, often for years. Over a period of years tolerance to quite high dosages can develop.¹²

The clinical manifestations of barbiturate addiction are similar to those of chronic alcoholism. Because of the poor motor coordination,

11. Bergersen and King, p. 266.

12. "Sleep Now, Pay Later," *Journal of the American Medical Association*, 208 (May 26, 1969), p. 1485.

patients may fall and be injured. Often they are unable to work, and they constitute a real hazard if they attempt to drive power machinery, e.g., an automobile. Furthermore, their judgment may be so impaired that they take additional doses of their drug when they are already seriously intoxicated. Some authorities feel that the addiction resulting from the overuse of barbiturates is, in some respects, more dangerous and undesirable than the addiction resulting from the misuse of opiates.¹³

In another recent issue of the *Journal of the American Medical Association* a physician complains about the therapeutic misuse of the barbiturates. He asserts, "Perhaps I am in error, but it appears so obvious! Sedatives and hypnotics are given for insomnia. Insomnia is almost invariably due to depression. Barbiturates are central nervous system depressants. When are we going to stop giving depressants to treat a symptom which is due to depression."¹⁴

The other group of drugs, to which we have already alluded, that induce dependence are among the analgesics. Basically, analgesics are drugs that relieve pain without loss of consciousness. Opium and its derivatives, related synthetic compounds, and aspirin belong to this group.

A drug of the analgesic group which is addicting and often used is meperidine hydrochloride (demerol). Essentially, meperidine is a synthetic substitute for morphine to produce analgesia. When so used it has the advantage of producing much less sedation and constipation. It is suited to the management of intermittent pain such as renal colic. An average dose varies between 50 mg and 100 mg, although 150 mg may be given for relief of severe pain. Most important, it is addicting.

Side effects of meperidine include dizziness, nausea and vomiting, dry mouth, sweating, headache, fainting, and drop in blood pressure. In addition, toxic effects include dilated pupils, mental confusion, tremor, incoordination, convulsions, respiratory depression and death. Toxic effects are said to produce more physical impairment than any of the narcotic drugs.¹⁵

As with the barbiturates, the mismanagement of meperidine has resulted in drug dependence for some patients. According to one report, the number of meperidine addicts at the U.S. Public Health

13. Bergersen and King, p. 271.

14. W. C. Ellerbrock, "Barbiturate Addiction," *Journal of the American Medical Association*, 209 (August 18, 1969), p. 1089.

15. Bergersen and King, p. 246.

Service Hospital, Lexington, Kentucky, has risen from six per year in 1945 to one hundred and forty-four per year in 1953 and 1959. It is purported that nearly all meperidine addicts begin the use of the drug as a result of therapeutic administration by physicians, and depend on physicians for their supply of drugs.¹⁶

Since the analgesics are used for the relief of pain, and, because it is as a consequence of this action that the danger of drug dependence exists, a consideration of the nature of pain and pain relief would be in order.

In determining the amount of analgesic drug which is to be administered, several factors must be considered, including the age, weight, and physical status of the patient, the reflex irritability of his nervous system, the intensity of pain, and the presence of co-existing disease. However, excepting extremes in age, the intensity of pain is the most important factor determining the amount of analgesic medication required for relief. Thus, it is essential that an attempt be made to estimate the degree of pain before giving the initial dose of the drug.¹⁷

Though drugs are often prescribed for the alleviation of pain, progress in the field of analgesia has been hampered by lack of knowledge of the fundamental physiology of pain and of the mechanism by which drugs can relieve pain. Everybody knows what pain is from personal experience, but none of us can define it. Even so, one of the points which aid in understanding the problem is that pain involves two main processes, the perception of noxious impulses giving rise to the sensation of pain and the reaction in response. The reaction in response to pain is seen, moreover, as a complex physiopsychologic process which involves the highest cognitive functions of the individual. Basically, it represents the emotional and physiological expressions resulting from the perception of pain.¹⁸ According to H. K. Beecher, the pain for which medication is needed is a combination of a response to a physical stimulus and psychic modification of the sensation, which could better be called 'suffering,' in distinction from simple 'pain' as a response to a stimulus."¹⁹ In any case, it is a contention of this paper that the presence of pain should instigate

16. John O'Donnell and John C. Ball (eds.), *Narcotic Addiction* (New York, 1966), pp. 171-172.

17. Bonica, p. 578.

18. *Ibid.*, p. 73.

19. Charles A. Winter, "The Physiology and the Pharmacology of Pain and its Relief," *Analgetics*, ed. George DeStevens (New York, 1965), p. 12.

study of its underlying causes, rather than mere relief of the patient's discomfort.

To the Christian ethicist who holds to the belief in a benevolent God, the existence of pain and evil is a problem. While pain is often seen as having a soul-making characteristic, adherent in its nature, such an understanding seems to be an assessment made after the fact. Moreover, while the existence of pain and mutilation which interferes with the humanizing process remains a theological problem, there is the equally difficult question of an appropriate response to that pain.

In his book, *Evil and the God of Love*, John Hick makes a distinction between pain and suffering. Pain is a biological phenomenon, while suffering is a spiritual and psychological interpretation of that pain. This distinction has been suggested frequently in medical research. It is for this reason that we hold tenaciously to the crucial importance of the patient in pain to receive not only medical relief from his pain but widespread and comprehensive care in dealing with his suffering that accompanies both the pain and the dependency which relieves the pain.

We are open to the theological interpretations of pain, and sympathetic to understanding pain as a "soul-making process." Ultimately, however, we find no necessity so to justify that which is natural in the world, and note that the existence of pain can often interfere with and become a hindrance to one's ability to relate to and respond to other persons. It is just this humanizing process which we value most. We therefore favor elimination of pain, even by the use of addictive drugs, when that pain seriously interferes with one's capacity to relate to the neighbor.

Such value choices are predicated upon theological commitments at several points. (1) We believe that God reveals himself in and acts through history. (2) We believe that God reveals Himself in and acts through nature. He acts through an ever-changing process of actualizing creative possibilities so that the world, history, and human life are ever in the process of becoming. (3) We believe that God has revealed himself uniquely in the person and ministry of Jesus Christ, and that this is a full and sufficient revelation. Christ reveals the nature of God as *agape*. This love is made incarnate in the person and ministry of Christ in his relation to both man and God.

From such theological affirmations, we can begin to discern certain ethical foundations from which the morality of medically induced drug addiction may be analyzed. While the natural world is

seen as a part of God's creation, it need not be viewed as completed or perfect. The natural world is still becoming, and one of its frontiers is the frontier of human health. The doctor not only has the possibility of interfering with natural illness but the obligation to do so as well. His is not an unprincipled participation, but one which occurs within the framework of what it means to be fully human.

At least part of what it means to be human is the capacity for relating and responding to our neighbors. To be fully human is to have one's life characterized by *agape*; such is the norm for human existence. The humanizing process is that of growth and maturation in relationship to God and fellow man toward the end goal of perfect love. God's love for man is therefore the basis of Christian virtue and action; it is the ground of our love for the neighbor and the self's aspiration to perfection. Yet an abstract ethic of love is not to be desired over the equally concerted effort to translate tradition into its appropriate counterpart for contemporary man.

For the moralist, the immediate problem is the translation of *agape* into the realm of contemporary and existential life. We see pain in all its aspects to be the enemy and destroyer of that which is human. There are cases in which the administration of addictive drugs within the hospital setting will produce side effects that are more problematic than the pain they are intended to relieve. It is the physician's responsibility, as earlier stated, to insure that the side effects of addictive drugs will not be disproportionate to the therapeutic effects. It is the patient's obligation to discriminate choices in light of that knowledge and to seek out the course of action that allows optimal realization of himself in relationship to the neighbor and to God. This also means that there will be cases in which no simple choice is available and where the options are frankly morally ambiguous. Administration of drugs which will eventually lead to and foster dependency may well be the only moral choice open to physician and patient, not only in times of terminal illness but also in extreme cases where pain disrupts that which is distinctively human. The translation of *agape* at such times will not be encapsulated in uncritically accepted solutions.

When operating out of the Christian tradition, rules and laws for all occasions are not to be found. Jesus was not a lawgiver. "What Jesus was concerned about was not rules but principles, not obedience to commands but purity of heart. It was love to God and man, and a transcendent and holy will that he required of man, and

these are timeless.”²⁰ Again, one is thrown back upon the grace of God in the individual’s imperfect translations of that which is perfect.

In a word, to use Bonhoeffer’s terminology, the love of God is indicative and not imperative. In faith and hope, men carve out tentative arrangements of perfect love in relation to one another in an imperfect world, arrangements that are always new and changing but ever faithful to the principle of love as set forth in the incarnation, arrangements in constant need of the redeeming grace of God. And that is what it is to be human. That which maximizes man’s response to God and his fellow man is morally desirable; that which diminishes his capacity for love and service is morally undesirable.

It is out of such a beginning that we have made some proposals relating to the person who is dependent upon drugs which we feel maximizes the possibilities for his being fully human. The following case study will help to intensify and exemplify the reasons for such proposals.

Jane Smith (name fictitious) is an attractive, twenty-two year old female who is married and the mother of one boy, aged four years. In 1965, during pregnancy for her only child, she was noted to have enlarged glands in the left supraclavicular node diagnosed as Hodgkins Disease. During five subsequent hospitalizations through 1969, she received radiation treatment. During these hospitalizations, further complaints ensued, the most notable being ulceration of skin nocules on the left shoulder and pectoral regions, cervical vertebrae damage, and subsequent plastic surgery from the left thigh to the pectoral region. Her latest admission was for severe pain in the neck requiring large doses of narcotic analgesics, accompanied by the characteristic signs of addiction to Demerol such as constipation, anorexia, and sleeplessness. At this time, she was diagnosed as having stage IV-B Hodgkins Disease and Demerol addiction. The question was whether to continue administration of Demerol or to find alternative methods of treatment which had previously failed, notably radiation therapy. The moral question the staff faced was, “Ought we try to withdraw this young woman or should we continue to administer Demerol?”

Here is the situation the staff faced. Mrs. Smith works as a clerk in a grocery store in a small, Southern community. Mr. Smith works in a factory in their home town. Mr. and Mrs. Smith live in a trailer

20. George C. Knudson, *Principles of Christian Ethics* (New York, 1943), p. 299.

court. They have used their savings for a house to pay for the expenses incurred during her frequent hospitalizations. Social contact seems to be minimal. Mrs. Smith's son is a regular attender of Sunday School. She has indicated membership in the Holiness Church on previous admissions, although on this last admission she declared that she had no religious preference.

During hospitalization, many persons remarked how pleasant a person Mrs. Smith was. Most of the ward personnel found themselves invested emotionally with her. Conflict was in evidence when Mrs. Smith became depressed or would make tearful demands for relief from intense pain. Visitors consisted of the patient's mother, aunt, and husband. The mother was observed to be protective, fostering a dependent relationship. Both the aunt and mother entertained considerable religious talk between themselves and Mrs. Smith, centered about the necessity of her repentance in order for God to heal her. Mr. Smith impressed the staff as being the younger of the couple, dependent upon his wife. He communicated infrequently with the staff. During the last hospitalization, the mother and husband were noted to be reversing their patterns of behavior with favorable effect upon the patient.

Mrs. Smith's prognosis is indefinite. In most cases, Hodgkins disease races to a fatal conclusion, but the course is extremely varied and it is impossible to predict what changes will occur and when. While in some cases patients have died within a few weeks after admission into the hospital, others have gone away to live useful lives for the next ten years.²¹

The attending physician decided upon continuation of Demerol therapy after a careful and sustained study. Although we might uphold his action as being within the context of the principles outlined in the preceding sections, there are a number of additional ethical questions which arise.

Since it is the patient who is going to suffer the possible side effect of the drug, possible addiction, and possible criminal prosecution for medically induced addiction, should not she have a choice in whether or not addictive drugs are administered to her during the course of her hospitalization? Our considered opinion is, within the

21. Lloyd Craver, "Treatment of Hodgkins Disease," *Treatment of Cancer and Allied Disease*, ed. George T. and Irving M. Ariel (New York, 1964), p. 57.

limitations of a context of severe illness and pain, a patient has the right to know as much as he can understand about the proposed drug therapy and has the right to enter into the decision-making process. Or, to put it differently, the attending physician has an obligation to inform his patient about the nature and consequences of addictive drug therapy prior to the administration of the initial dosage of an addicting drug. We are assuming that the choice for or against the use of addictive drugs should be a shared responsibility. At the same time we would opt for the right of a doctor to act in the best interest of his patient and withhold addictive drugs.

There are a number of other morally significant questions which surround the initial dosage of drugs. Is a physician justified in lending sleep and relief from pain when it is the patient who pays in terms of side effects and/or after effects? Does a physician have the right to addict a patient as a solution to another problem such as chronic illness or severe pain? On what model and for what reasons are addictive drugs administered? Should a doctor be allowed to addict a patient in the patient's own best interests? The preceding paragraph hints at our proposal for answering these questions; however, these queries are in need of much further discussion, investigation and research than can be covered in the space of this paper.

In cases such as Mrs. Smith's, we would opt for the patient's right to enter into the decision-making process. In cases where the patient is addicted as a result of medical treatment, he should be apprised of the various avenues of treatment, withdrawal, continued addiction, increased dosages of drugs, and the rest. The attending physician should still retain the obligation to act in his patient's best interest, if the patient is not capable of doing so. We recommend that this not be a lonely decision, but done rather in the company of disinterested persons not associated with the patient's immediate care—such as, perhaps, another physician, a psychiatrist, a clergyman, or a social worker.

Whatever the decision for withdrawal or continuation of drug dependency, comprehensive care for the patient should include more than just the removal or administration of addicting drugs. This could be accomplished by the creation of a narcotic team whose job it would be to review and advise cases of medically induced drug addiction. We favor increased research into non-addicting drugs which would have the same pain relieving qualities of morphine type drugs.

Finally, we think that revision of state statutes, to bring them into more accord with the reality of the situation of drug addiction, is urgently needed. Special attention should be given to specific legal protection of medically or accidentally addicted persons and their treatment under the law.

Abortion: Responsibilities and Relationships

RICHARD FISHER AND PAUL MORRISON

Induced abortion has been a special problem for all civilizations since the beginning of recorded societal life. The specific methods employed to induce the abortion have varied widely; it has, moreover, been performed under a variety of circumstances. Many societies have readily accepted induced abortion as merely another birth control measure with no major moral complications. However, as the staff of the Kinsey Institute has pointed out: "The attitude toward abortion takes on a particular intensity when abortion becomes a matter of religious rather than purely secular concern."¹ Christianity appears to have been greatly influential in raising questions concerning the moral implications which induced abortion might have for a society.

Before we proceed further, we need to define our terms in order to avoid any possibility of confusion at a later point in our discussion.

Abortion is the expulsion of a living fetus from the uterus before viability.

Spontaneous abortion is that which results from accident or disease.

Induced or voluntary abortion is that which results from man's intentional interference with the normal course of pregnancy.²

According to Dr. Frederick J. Taussig:

. . . for the present, and perhaps for some time to come, the lower limit of viability may be taken to range between the twenty-sixth and the twenty-eighth week of fetal life.³

In this discussion we are concerned with induced abortion, i.e., intentional expulsion of a living fetus from the uterus by deliberate interference with the course of pregnancy.

1. Paul H. Gebhard, Wardell B. Pomeroy, Clyde D. Martin and Cornelia V. Christenson, *Pregnancy, Birth and Abortion* (1st edition; New York: Harper and Brothers Publishers and Paul B. Hoeber, Inc., Medical Books, 1958), p. 190.

2. Charles J. McFadden, *Medical Ethics* (4th edition; Philadelphia: F. A. Davis, Co., Publishers, 1956), p. 135.

3. Frederick J. Taussig, *Abortion, Spontaneous and Induced: Medical and Social Aspects* (St. Louis: The C. V. Mosby Co., 1936), pp. 21-22.

I

There need be little argument with the statement that induced abortion is a problem in the United States today. An indication of a few of the statistics concerning the social incidence of induced abortion may be helpful in discerning just how great a problem such a phenomenon is. Dr. Harmon L. Smith has stated that :

According to reliable estimates, about one million abortions are performed annually in the United States. Of this number, approximately 99 per cent are estimated to be illegal. About 1,000 deaths annually are attributed to illegally performed abortions and, beyond these fatalities, thousands of other women suffer irreparable mutilations.⁴

Some other estimates are more conservative. In either case we have a picture of the possible extent of the problem. The Kinsey staff has done considerable research on the subject of induced abortion. Unfortunately their figures are a dozen years old ; but they still offer one of the best breakdowns of the social distribution of induced abortions.

In analyzing "270 females who account for 355 pregnancies that ended while the females were unmarried" it was discovered that "the great majority (316) terminated in pre-marital induced abortion."⁵ This rather alarming statistic may be set within the context of a larger group of women who had married at some point in their lives. A survey of this group revealed that

. . . in their reproductive lifetimes about three quarters of them experienced a live birth, one quarter had a recognizable spontaneous abortion, and one fifth to one quarter had had an induced abortion.⁶

Speaking of divorced or widowed women the researchers reported :

Of the 157 terminated post-marital conceptions, 4 per cent resulted in live births, 10 per cent in spontaneous abortion, 79 per cent in induced abortion, and 7 per cent were carried into a subsequent marriage.⁷

The researchers reported that induced abortion is most prevalent among women aged sixteen to twenty years, and that it decreases consistently in incidence of occurrence after the age of twenty.⁸ This helps us further to define the limits of the group with which we are con-

4. Harmon L. Smith and Louis W. Hodges, *The Christian and His Decisions* (Nashville and New York: Abingdon Press, 1969), p. 233.

5. Gebhard *et al.*, *op. cit.*, p. 54.

6. *Ibid.*, pp. 93-94.

7. *Ibid.*, p. 147.

8. *Ibid.*, p. 94.

cerned, although we are by no means dealing with women within this age group exclusively.

Negative social consequences following an induced abortion appear to be infrequent. As might be expected, the women who receive these unfavorable social reactions are the single females who would likewise have received the harshest societal treatment if they had continued their pregnancies rather than choosing to terminate them.

So far as the medical complications resulting from induced abortion are concerned, it appears that if the abortion is performed under sanitary conditions and with the proper technique and supervision it carries with it about the same risks as a tonsillectomy. Boeth's comment concerning the technique of dilation and curettage (D&C) (in this case, in illegal abortions) is helpful in understanding the procedure employed in many cases :

The operation itself is quick and simple: the cervix is stretched by a series of increasingly large dilators. Then the abortionist uses a tiny, rake-like instrument called a curette to scrape the embryo from the wall of the womb. If there are no complications, the patient can go home the same day. If there is trouble, any hospital will take her if she has but sense enough to go to one—without recriminations from the law.⁹

It also appears that, like any other operation, abortion becomes safer the more experience the person performing the operation has. There is a good deal of speculation that many doctors are becoming quite skilled in the performance of such a procedure. Dr. Mary S. Calderone has made the following observation concerning the improved quality of abortion techniques :

. . . abortion, whether therapeutic or illegal, is in the main no longer dangerous, because it is being done well by physicians.¹⁰

The state of medical science in relation to this operation is rather highly advanced. There are at least five accepted techniques which are successful and indicated at different times, depending upon the duration of the pregnancy. D&C (described above) is indicated in the first twelve weeks of a pregnancy. An alternate D&C procedure involves vacuum aspiration of the uterus, a procedure which employs a suction curette and is relatively safer than D&C, since the suction curette is not as apt to puncture the wall of the uterus as the surgical

9. Richard Boeth, "The Anatomy of Abortion: 1968," *The Washington Post*, June 16, 1968, p. 2.

10. Mary Steichen Calderone, "Illegal Abortion as a Public Health Problem," *American Journal of Public Health* (1960), 50:949.

curette. After 16 weeks an intravenous injection of a concentrated drug brings about premature labor. If the pregnant woman is not to be sterilized and is fairly far advanced in her pregnancy when she comes for the abortion, a hysterotomy may be done. Sometimes a caesarian section of the pre-viable fetus is done, in which case future pregnancy is not foreclosed. If the woman is to be sterilized, a hysterectomy will ordinarily be done, i.e., the removal of the uterus and the tying of the fallopian tubes.¹¹

There is a growing body of opinion that psychological reaction, though generally rare, may be the most serious complication to arise.¹² Dr. Harold Marcus, Associate Attending Psychiatrist at the Mount Sinai Hospital in New York City, has addressed himself to this subject:

The question might be asked, does abortion do any harm psychiatrically? Do these women suffer? Is the abortion harmful to them rather than therapeutic? This, of course, is a very valid question. It is a question that we are in the process of studying right now at Mount Sinai. We are following up all of our women who have therapeutic abortions. We see them before and after the abortion in an attempt to find out just what are the effects of a therapeutic abortion and attempt also to survey the population that comes from therapeutic abortion. We have not been doing it long enough to come up with any real definitive results although we certainly have not had any adverse effects.¹³

In one of the most complete studies of the subject, Dr. Martin Ekblad (Stockholm, 1955) checked the psychiatric reactions of 479 women who had been granted induced therapeutic abortions for psychiatric reasons. The results of his study are, in part, as follows:

With reference to the women's statements concerning their attitude to the abortion at the follow-up examination the material has been divided into four groups. 65% had been only satisfied with the abortion and had not felt any self-reproaches, and another 10% had also not felt any self-reproaches, but had thought that the operation itself was unpleasant, 14% had felt mild self-reproaches and 11% had felt serious self-reproaches or regretted the operation.¹⁴

11. Alan Guttmacher, "Techniques of Therapeutic Abortion," *Clinical Obstetrics and Gynecology*, Vol. 7 (March, 1964), p. 102; Jaroslav F. Hulka, *Therapeutic Abortion: A Chapel Hill Symposium* (Chapel Hill: Carolina Population Center, 1968), pp. 75-95.

12. Gebhard *et. al.*, *op. cit.*, pp. 208-9.

13. Symposium on "The Social Problem of Abortion," *Bulletin of the Sloane Hospital for Women* (Fall, 1965), 11:70.

14. Martin Ekblad, *Induced Abortion on Psychiatric Grounds: A Follow-up Study of 479 Women*. (Stockholm, 1955), p. 233.

In speaking of a smaller group of women within the group mentioned above, Ekblad noted:

Detailed case-histories are given for the 54 women (11%) who had felt serious self-reproaches or who had regretted the operation. A closer study of the case-histories of these women with serious self-reproaches shows that even if their subjective sufferings due to the abortion were severe, from a psychiatric point of view their depression must in general be designated as mild. It is only rarely that the women's working capacity has been impaired or that they have needed to consult a doctor on account of their mental troubles.¹⁵

Further examination of the statistics in the above citation reveals that only five cases (10%) required consultation with a doctor. Of these five cases, four reactions could probably be linked to desertion by the male partner after the abortion. Thus in only one case (2% of the 54 women who had felt serious self-reproaches) was the reaction inexplicable.

II

The opinions of Jewish, Roman Catholic, and Protestant theological authorities appear in works on medical ethics with varying degrees of frequency and clarity. It is essential that we understand the opinions of the various faiths in order to formulate our own opinions and determine how they compare with established attitudes.

The orthodox Jewish opinion on induced abortion can be neatly summarized in a quotation from Jakobovits' *Jewish Medical Ethics*:

The point at which human life commences to be inviolable and of equal value to that of any adult person is . . . distinctly fixed at the moment when the greater part of the body—or, according to some versions, the head—has emerged from the birth canal.¹⁶

Such an attitude plainly leaves the option of induced abortion open for the woman and the physician. Since the life of the fetus is considered to be of a lesser value than that of an adult person, the disposition of the fetus can take a position of subordinate importance to the disposition of the life of the adult involved. Jewish ethicists have also held that the fetus can, under certain circumstances which endanger the life of the mother, be considered an aggressor against her and dealt with accordingly.

15. *Ibid.*, p. 234.

16. Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Bloch, 1962), p. 184.

Roman Catholic ethicists have taken a very strict position on the inviolability of fetal life. Their concern seems to center on a concern for the innocent soul which is endangered by induced abortion. Charles McFadden has stated the Roman Catholic position on induced abortion in the following manner:

Direct and voluntary abortion is a moral offense of the gravest nature, since it is the deliberate destruction of an innocent life. The very nature of direct abortion is such that it involves the deliberate and direct removal of the inviable fetus from its natural situs, the womb of its mother, to an environment in which it cannot possibly live. *Such an action is essentially murder.*¹⁷

Roman Catholic theologians, however, have added the distinction between "direct" and "indirect" induced abortion. A summary of this distinction is indicated in the following quotation from Fr. McFadden's *Medical Ethics*:

Induced abortion may be of two types: direct and indirect abortion. By direct abortion we mean any instance in which means are specifically employed to procure the expulsion of the fetus.

By indirect abortion we mean any instance in which a treatment or operative procedure is performed for some other purpose but incidentally and secondarily does cause the expulsion of the fetus.¹⁸

Applying the rule of double effect to the problem of induced abortion would seem to be arbitrary and perhaps even cruel, placing a tremendous burden on the individual physician as to how he will interpret the intended results of a procedure which he may undertake.

Canon P. Tiberghien, observing the way in which this distinction has been handled in practical application, suggests an interesting reservation for the Roman Catholic position:

A distinction must . . . be made between 'direct abortion,' which is always forbidden, and 'indirect abortion,' permitted for grave reasons.

Experience shows that this distinction, when left to the doctors, is very often badly handled by them. Abortion is really indirect only if the removal of the foetus is not willed, either as *end* or *means*. Now, doctors very often convince themselves that, when they decide to save the life of the mother by an abortion, it is the safety of the mother they aim at and not the removal of the foetus. In certain cases, it is quite true to say that the safety of the mother is willed as the end; but the removal of the foetus is *also* willed as the *means* to save her. This is very clearly so for the moralists, and therefore the operation is forbidden.

17. McFadden, *op. cit.*, p. 138.

18. *Ibid.*, p. 136.

Let no one plead 'purity of intention.' There is no 'purity of intention' which renders lawful an act contrary to moral principles. 'Purity of intention,' as thus understood, is merely the disguised masquerading of the false principle that the end justifies the means.

We must therefore eliminate the term 'indirect abortion' from our phraseology, and supply a definition which answers only to direct—always unlawful—abortion.

Here then is the proposed definition: 'Abortion is the medical intervention, by operation or medical treatment, which has for its *object* to expel a living, non-viable foetus from the mother.

Abortion is here defined by its object. A clear distinction is also made between the *object* or the action and the *motive* which places the action and which can vary. *What* one wishes is distinguished from *why* one wishes it.¹⁹

Tiberghien's comments are not a part of official Roman Catholic doctrine, but they do offer a good illustration of what would result from an absolute application of the rule of double effect.

Unfortunately Protestant theologians have written comparatively little on the ethical standards involved in induced abortion. In what follows we will include quotations from several Protestant thinkers on various aspects of the question of induced abortion. Thereafter we will attempt to derive some conclusions from these citations.

Paul Ramsey has pointed out:

The legal reason for prohibiting abortion is not because it is believed to be a species of murder; it is the religious tradition, we shall see, and not the law which inculcates the latter view. The law's presumption is only that society has a stake in the pre-human material out of which the unique individual is to be born.

.....

The theologians debate the question, *when* between conception and birth the unique not-to-be-repeated individual human being has arrived on the scene. Wherever the line is drawn, the direct destruction of a fetus after that point will, by definition, be murder, while before that point its direct destruction would fall under some other species of sin or grave violation.²⁰

Dr. Harmon Smith has spoken of abortion in relation to the subject of personhood:

19. Canon P. Tiberghien, "Principles and Moral Conscience," *New Problems in Medical Ethics*, edited by Dom Peter Flood and translated by Malachy Gerard Carroll and Norman C. Reeves (Cork, Ireland: The Mercier Press Limited, 1953), pp. 141-142.

20. *Life or Death: Ethics and Options*, edited by Ed Shills, Norman St-John Stevas, Paul Ramsey, P. B. Medawar, Henry K. Beecher, and Abraham Kaplan (Seattle and London: University of Washington Press, 1968), p. 64-65.

To be a human person is not a matter of *statically* being a certain kind of substance, but rather a matter of *becoming* personal through temporal duration.

. . . In some important sense being and becoming a human person means entering into both inter- and intra-personal relationships.

In the final analysis 'personhood' or 'being personal' may be an empirical concept, but in the process of becoming-personal-in-time the personalizing relationships of other persons exercise continuing antecedent priority.²¹

Joseph Fletcher has taken a considerably more radical stand on the issue of induced abortion. Speaking of the fetus in induced abortion, he has stated:

. . . an embryo in therapeutic abortion has no personal value or development at stake and cannot exercise the moral qualities of freedom and knowledge.²²

Thus it appears that Protestant thought on the subject of induced abortion covers a broad range. The more moderate Protestant thinkers seem generally to feel that abortion may be justified under a variety of circumstances but that man, in taking such an action, can never claim moral exemption from the consequences which may sooner or later follow upon his choice. "Caution" seems to be the key word in most Protestant consideration of induced abortion.

III

In the United States the designation of abortion as a crime is fairly recent.²³ The first U. S. anti-abortion law was passed in Missouri in 1835; and it was not until 1943 that the last state (North Dakota) adopted an abortion statute. The state laws remained generally unchanged until 1966; typically, they provided that any abortion save one to preserve the life of the woman is a crime. Four states, in substance, allowed no abortions.²⁴ All states in 1966 defined abortion as a crime; the definition of therapeutic abortion is found in the exceptions.²⁵

The laws remained vague for several reasons; among them that

21. Smith and Hodges, *op. cit.*, pp. 248-9.

22. Joseph Fletcher, *Morals and Medicine* (Boston: Beacon Press, 1954), p. 205.

23. Louis J. Regan, *Doctor, Patient and the Law* (St. Louis: 1956), p. 320.

24. Louisiana Revised Statutes, Sec. 27, 1285. Massachusetts General Laws, Ann. Ch. 272, Sec. 19, 1957. New Jersey Revised Statutes, Sec. 2a:87-1. Pennsylvania State Ann. title 18, Sec. 4718 (1963).

25. Regan, *op. cit.*, p. 321.

in the few cases brought to trial, the defense has usually been to deny the act. Modern abortion law reform is related to a notable English case: *Rex vs. Bourne*. In this 1939 test case, an English physician was brought to trial, under an 1861 law, for aborting a fifteen year old girl who had become pregnant as a result of rape. In the charge to the jury, the judge instructed them to find the defendant "not guilty" if they were convinced that Bourne had performed the abortion for the purpose of preserving the physical and *mental* health of the girl. Mr. Bourne was acquitted.

Another cause of vagueness, also adding to the physician's liability, is that the term "abortion" in law does not take into account the medical nuances which distinguish "miscarriage" and "premature birth" from each other and from abortion. Abortion is most commonly defined as the administration of any drug to a woman or the use of any instrument on her for the purpose of procuring an abortion or miscarriage. Under this definition, the majority of states punish even an attempt to bring about an abortion. In a number of states there is no requirement that the woman be pregnant—the performing of the prohibited acts upon the woman *with the intention of producing an abortion* constitutes the body of the crime.²⁶ In an Iowa case, the substance used in an attempt to produce an abortion was tobacco. An expert medical witness testified that tobacco would not produce miscarriage, but the court ruled that this fact did not prevent the conviction of the defendant for attempted criminal abortion!²⁷

The medical profession has not reacted to the vagueness of the laws in a uniform manner. Some physicians refuse to perform any abortions; most work under a system of elaborate safeguards and rationalizations. One physician claims that in order to rationalize an abortion on medical grounds the facts are distorted. Abortions are done for hypertensions "because pregnancy in such cases may lead to a heart attack or stroke," whereas the actual risk of these complications in pregnant hypertensives is not significantly higher than the risk in nonpregnant hypertensives.²⁸ To obtain an abortion on psychiatric grounds often means the risk of suicide is exaggerated.²⁹ Whatever the reason, and although the laws are vague, the courts have been at times lenient with the physician acting in "good faith." The New Jersey Supreme Court, for example, in 1967 held that:

26. *Ibid.*

27. *State vs. Fitzgerald*, 49 Iowa 260, 31 Am Pep 148 (1878).

28. Robert Hall, *Ethical Issues in Medicine* (New York: 1968).

29. *Ibid.*

. . . when a physician performs an abortion because of a good faith determination in accordance with accepted medical standards that an abortion is medically indicated, the physician has acted with lawful justification within the meaning of the statute and has not committed a crime.³⁰

It was not until 1959 that the American Law Institute incorporated in its Model Penal Code the suggestion that an abortion be permitted if:

(1) a licensed physician believes that there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or the pregnancy resulted from rape . . . or from incest; and (2) two physicians, one of whom may be the person performing the abortion, have certified in writing their belief in the justifying circumstances.³¹

Since 1966 the legislatures of twelve states have enacted laws patterned to some extent on this model, and permitting abortions to be done in hospitals by licensed physicians. In 1967 the House of Delegates of the American Medical Association approved the ALI model penal code. This was the first policy change by the A.M.A. in 96 years! (The North Carolina Abortion Act of 1967 is similar to the revised laws mentioned above.)

The more permissive laws have thus far resulted in no convictions of medical doctors. However, the fact that the freer laws have not made abortions more generally available to other than the middle and upper class has had an effect on certain pressure groups in this country. Instead of trying to get abortion laws changed, a strategy is now evolving which seeks to have the laws declared unconstitutional. The *New York Times* of November 12, 1969, reported that an anonymous donor recently gave the James Madison Law Institute \$60,000 to challenge the constitutionality of the State laws. In addition to three suits in New York, this institute is in cooperation with the American Civil Liberties Union in suits being brought in Indiana, New Jersey, South Carolina, South Dakota, Pennsylvania, and California.

Roy Lucas, a lawyer who is contesting the constitutionality of New York's law in a federal suit, claims that 90% of the women who get legal abortions in New York are white, while 90% of the women who die from illegal abortions are black or Puerto Rican.

30. Gleitman vs. Cosgrove, 49 N. J. 221, 1967.

31. *Model Penal Code*, Section 230.3 (2), (3). Proposed official draft, 1962.

The issues raised in the New York suit therefore include the following major points :

1. that the law allegedly discriminates against poor women and denies them the equal protection of the laws by prohibiting them from obtaining medically safe abortions ;
2. that it is so vague that physicians grant legal abortions at their peril, thus denying the doctors and the women due process of law ;
3. that various provisions of the Bill of Rights create a right of marital and sexual privacy—similar to the right that overturned Connecticut's ban on the use of contraceptives—which the state cannot invade by regulating abortions.

In the District of Columbia, U. S. District Judge Gerhard A. Gessell ruled on November 11, 1969, that the District of Columbia's 68 year-old statute which permits abortions only where necessary "for the preservation of the woman's life or health" was unconstitutionally vague when applied to physicians and when it placed upon the defendant the responsibility for proving that the abortion was necessary. Therefore, ruled Judge Gessell, any "competent licensed practitioner of medicine" could legally perform an abortion in the District of Columbia for reasons satisfactory to himself and his patient. At the same time the judge invited the U. S. Attorney's Office to appeal to the Supreme Court. The Justice Department has announced that it will appeal the ruling.³²

Judge Gessell also upheld a similar indictment against a hospital nurse's aid, on grounds that the Government could properly outlaw illicit medical practice.

The New York Times of December 11, 1969, reported that none of the hospitals in the District of Columbia had announced any changes in their rules or procedures since the court ruling. A committee of twenty doctors and citizens, appointed by the Mayor of Washington, recommended to D. C. General Hospital that the decision "be implemented immediately;" but as of December 11 the hospital had made no statement. Because the decision by Judge Gessell is not binding on any other Federal district judge who might be called to rule in any abortion proceeding,³³ the *Times* reported that doctors in Washington were cautious in proceeding under the ruling. The

32. *New York Times*, November 16, 1969, p. E9.

33. *New York Times*, December 11, 1969, p. 40.

Medical Society of the District of Columbia has formed an *ad hoc* committee to formulate a policy.

IV

It may be a truism that induced abortion is a complex problem, but there is a danger of oversimplifying the matter if we do not recognize this from the beginning. As with any ethical decision this involves many claims and counter-claims which impinge upon the people participating in it. We would therefore like at this point to set forth the various responsibilities incorporated in the problem of induced abortion. The moral obligations appear to fall mainly upon the prospective parents, society, and the ethicist, as together they consider the problem. These three groups obviously cannot be as neatly discriminated in a real situation as we will do in the analysis below, but perhaps an initial consideration in this manner can eliminate some of the emotionalism involved in particular concrete situations.

Prospective parents have moral obligations to the fetus, to the society, and to themselves. The prospective parents have an obligation to each other. Coitus implies responsibility. While this responsibility varies with circumstance, it is never appropriately abdicated. The simple fact is that two persons are directly involved in pregnancy. If coercion, insensitivity, or ignorance are present in the inaugural act, responsibility and obligation may be weighted differently than if the act is one of acceptance, love and knowledge. But it nevertheless remains.

The responsibility of the parents in all cases is to weigh and share obligations and benefits of the pregnancy insofar as biological and personal circumstances admit. This sharing represents an affirmation of the value of each party without an abrogation of uniqueness. Thus, a father does not undergo the struggle of physical delivery of a child, but he does have a responsibility to share in the decision-making which accompanies it. Similarly, the prospective mother cannot share her physical responsibilities as a hostess of a foetus, but she has a responsibility to share with the potential father the burden of moral choices.

It is important to emphasize a reservation for the sharing of responsibility. If either party is incapable of participating in the decision-making process by virtue of biological or mental insufficiency, or if either breaks the covenant of partnership in pregnancy, a re-

assignment of responsibility obviously takes place. Thus a rapist chooses, by virtue of his coercive participation in the inaugural act, to disqualify himself from much of what would normally be shared decision-making. Similarly, the prospective mother's responsibility may be diminished if for any reason she is incapable of making decisions.

The prospective parents' obligation to the fetus includes their responsibility to maintain the expectant mother in such a way during her pregnancy as to insure the child a safe birth. This obligation implies the preliminary obligation to realize such responsibility before they ever participate in an act which may result in the conception of a child. Their obligation to the fetus also implies the obligation carefully to consider the potential mother's ability and willingness to care for herself in such a way as to insure the child's safety. If, after such consideration, they find that she is either unable or unwilling to care for herself (and indirectly for the child) then—within the framework of Christian love—it would appear to be their moral obligation to do the most loving thing for the fetus and consider abortion as an option to endangering the quality of this potential life.

The potential parents have an obligation to society to present a child that is normal and healthy and to make provision for its care, either through caring for it themselves or by providing for its care by others, e.g., through adoption. However, it is important to remember that this obligation to present a normal and healthy child to society is not a final or absolute obligation inasmuch as it is ultimately conditioned by an understanding of the child's and their own relationship to God.

The prospective parents also have an obligation to themselves to maintain and to safeguard their personal and marital integrity. This obligation arises out of their realization that life in an absolute sense is not theirs but the gift and creation of God. Full recognition of the individual's stewardship obligations clearly reveals the necessity of caring for the life given into their care to the best of their ability. Nevertheless, this mandate to care for the individual personal life is conditioned by the impinged relative responsibilities of the framework of Christian love. Therefore the prospective parents are under the obligation to consider the other individuals around them as well as their stewardship responsibilities to God in making their decision concerning induced abortion.

Society has certain obligations to the prospective parents in its

consideration of the option of induced abortion. From the Christian doctrine of the Incarnation, which implies the primacy of human life fulfilled through the exercise and presence of Christian love, we observe that the society's primary obligation to the prospective parents is to provide them with the opportunities for fulfilling their personal worth. This obligation is closely related to a doctrine of radical freedom with its implicit limitations. The couple's freedom, and their fulfilling of their personal worth, are conditioned by their obligation to act in accordance with the Christian injunction to love their fellow men.

Perhaps an even more important obligation which the society has to the prospective parents is its obligation to provide them with all available information concerning the pregnancy and the options which are available as alternatives to that pregnancy. This is particularly important in instances in which the fetus may stand significant chance of being born deformed in one way or another. It is also important in that the society should provide the prospective parents with information concerning the alternatives to an induced abortion (such as adoption of the child after birth.)

The above-mentioned obligations of society to the prospective parents may be thought to apply mainly to the situation after the woman has become pregnant. Therefore it is essential to note the prior obligation that the society has to the couple before the woman becomes pregnant. It ought to inform them of the obligations which they will have to the fetus, the society, and themselves if the woman should become pregnant. In order for them to be qualified to exercise their own decision-making faculties in a proper manner, they must be informed and aware of the possible implications of their actions. In this manner, it might be possible to avoid many of the tragedies which result from situations in which couples are unaware of all of the implications when they decide to participate in relationships which then produce children who must suffer the consequences.

Society's responsibility to the potential child is equally as complex as its obligation to the prospective parents. The central thrust of its obligation to the child is to provide a favorable environment into which it can be born. This includes an obligation to provide an atmosphere of love and justice for it, and also the attempt to insure its ability to participate meaningfully in the relationships which are a part of such an environment.

Society likewise has a responsibility to itself, i.e., those members

of the society other than the pregnant woman and prospective father. Its obligation to itself is basically twofold. It has an obligation to protect its members from the growing menace of the social dangers imposed by deformed or incompetent children that might be born, and also to incompetent mothers who might be incapable of making appropriate decisions. Society also has an obligation to itself in that it must protect itself from the social dangers which often result from the presence of unwanted children. Statistics on juvenile delinquency amply substantiate the opinion that unwanted children pose a great danger to the society, especially if the society makes no provision for their care after they are born into an environment which deprives them of the loving family relationship to which they should be entitled.

The ethicist has many responsibilities when he considers the problem of induced abortion. He has obligations to all parties involved. It is his responsibility to delineate the factors involved in the moral judgments of the situation.

The ethicist has a responsibility to the unborn child in that he is in a unique, i.e., relatively detached position, from which to view the situation and protect the rights of the fetus. This is particularly important since the fetus itself is not specifically protected by law. The ethicist can utilize his position of detachment to act as the agent for both the prospective parents and the society by viewing all sides of the question in relation to the rights of the fetus.

From a Christian perspective, it is apparent that the desired quality of human life is one of love and justice. Under this influence it is obvious that the child has a right to be born into an atmosphere of parental and societal love in conjunction with favorable social and economic factors. The child also has a right to be born a whole person, physically and mentally, in order to participate in the relationships which create the environment of love and justice.

The ethicist is under a further obligation to safeguard the rights of the prospective parents. The rights of the prospective parents include the right to exercise their freedom (within the limits explicated above), the right to know all the available pertinent information about the woman's condition and the options open to them, and the right to maintain their personal mental and physical health through their decisions in light of the information which has been provided them. The ethicist must also point up the prospective parents' moral obligations to them in order to aid them in making their decision.

The ethicist's responsibility to society focuses, moreover, on his

obligation to maintain a fitting societal attitude regarding the character and quality of human life. This is important since, without a proper attitude on this matter, neither the ethicist nor the society as a whole can operate effectively in making decisions regarding any of the related concerns. The ethicist attempts to help the society decide just what its considerations should be, and how to weigh those considerations against its basic system of values. He also has a subsidiary responsibility to remind the society of the consequences which may result whatever their decision may be.

V

Induced abortion is at best an unfortunate and inadequate solution to a problem which man brings upon himself. Man's violation of potential relationship between an individual and God is something which we should strive constantly to avoid.

It would be a better situation if adequate programs of birth control, preconception medical investigation, and comprehensive examination of potential parents could be instituted, thereby largely removing the need for extensive use of induced abortion. It should be possible, with the techniques currently at our disposal, effectively to eliminate any large demand for interference with pregnancy once it is begun. There will probably always be need for some induced abortion—perhaps in cases involving a pregnancy which resulted from rape or incest—but medical, legal, and ethical authorities should do all in their power to reduce that need to its absolute minimum through preliminary checks on potential pregnancies. Until such programs are developed and implemented, however, discriminating utilization of induced abortion appears to be one way to deal with unwanted or dangerous pregnancies.

An Appropriate Time to Die

GREGORY DELL, POWERS MCLEOD, AND JOHN MANN

Man dies. That seems to be one of the few certainties about death. The questions of death's how, when, and where are answered mostly by conjecture. So it is largely a mystery. But it does occur. And because it occurs in a world of men living in finite space and time, the question of the appropriate circumstances surrounding death arises.

Already it is clear that some ambiguities surround this question. These ambiguities are reflected in attitudes toward euthanasia. Basically, these attitudes reflect one or more of the particular formulations of the phenomenon, formulations which fall into the following basic categories: involuntary direct, involuntary indirect, voluntary direct, voluntary indirect. Each of these four types of euthanasia may be further defined by subject: first, concerning the euthanasia of adults; and second, the euthanasia of children.

The defense and prosecution of euthanasia ordinarily focuses on the fourth form, i.e., voluntary indirect. Joseph Fletcher calls this form 'anti-dysthanasia' (against a bad, or inappropriate, death) and says about it:

even though death is brought about quite rationally and deliberately, it is accomplished only indirectly through omission rather than directly by commission. It is, in short, a procedure by which death is not induced but only permitted. In some kinds of Christian ethics and moral theology an action of this kind is called an "indirect voluntary."¹

It is the purpose of this paper to explore the problem of euthanasia, suggest working guidelines for its possible implementations, and examine some of the implications of such guidelines.

Euthanasia of one type or another was a common practice in classical Greece and Rome. This practice seemed to stem largely from the intrinsic bond seen between the welfare of the state and the good of the individual. In general the state's welfare ranked quite

1. Joseph Fletcher, "Anti-Dysthanasia—the Problem of Prolonging Death," *Journal of Pastoral Care* (1964), 18:78. Fletcher sees basically three types of anti-dysthanasia. They are: 1) administration of a death dealing pain killer; 2) stopping treatment (where it has begun); 3) withholding treatment not already begun (p. 79).

high as a priority of concern. The sacrifice of an individual was not regarded as a great loss if done for the good of society.

Theistic conceptual schemes hold a somewhat different position. God is the ultimate value and it is from him that life proceeds. Individual and societal well-being are derivative from that primal and ultimate value. Thus, "society has no natural right to take away what it has not given."² Correspondingly, individuals do not possess or exercise unconditional control over their private existence.

The statements on euthanasia by the various institutionalized faiths of the Judeo-Christian tradition are permeated by this assumption. That they also usually arrive at a negative consensus on euthanasia is the result of this principle's being coupled with and reinforced by a fear of genocide and the introduction of a "wedge principle" into human decision. That is, the reality of Nazi genocide, together with the fear that one permissive action may lead to other more permissive action, bolsters the subordination of society's value to individuals and supports the prohibition against euthanasia.

The precise formulation of the prohibition is complex but we can summarize by saying that euthanasia is identified with murder. And murder violates the commandment, "Thou shall not kill."

It is usually the more conservative, legalistic or fundamentalist branches of Christianity which make this connection most binding. They are, because of this correlation of euthanasia with murder, most likely to be quite vehement against all forms of euthanasia.

Conservative Protestants would tend to agree with this position. Because they eliminate involuntary euthanasia from consideration, they seem to concentrate more on the problem of the relation of voluntary death to suicide. Suicide, like murder, is believed to be wrong, but the prohibition appears to be aimed at taking one's own life for selfish motives, rather than at self-destruction in principle. Society sanctions heroic self-destruction. The Protestant churches endorse this sanction when such heroism is done for "altruistic" reasons. It is, in fact, altruism to which appeal is made for exceptions to the euthanasia prohibition. The sanctions which result apply to both the patient and the practitioner but they are not very frequent.

Where sanctions for euthanasia do occur in institutional religion, they seem to occur first and with the greatest frequency in this

2. William S. Hockman, "Letters to the Editor," *Christian Century* (1967), 84:20.

humanist-Protestant tradition.³ However, the incidence and strength of opposition seems to overshadow the influence of sanctions.

The Roman Catholic view can be summarized by the following points :

1. That mercy killing is murder.
2. That no one except God has the direct right to dispose of human life.
3. That 'self' mercy killing, that is, the killing of a person who asks to be killed, is suicide and therefore wrong.
4. That mercy killing solves no problems and benefits no one. In fact it causes greater evils in that it permits anyone and everyone to judge who shall live and who shall die.
5. That to kill off by mercy killing the incurable, the insane, the crippled, the defective is not justified by science, since science's knowledge of the laws of human heredity is sadly lacking in certainty.
6. That no matter how great the suffering or helplessness of a man, he is useful to himself and to society; if he bears his suffering and offers it to God, he can earn for himself and for others an almost infinite amount of grace.
7. That to permit mercy killing would be to retard the advance of medical science, since the practice would make it almost impossible to do research in diseases that are now considered incurable.
8. That in the Bible, God definitely and emphatically condemns as intrinsically evil this most vicious practice of mercy killing, which is nothing less than murder.
9. That if mercy killing is permitted, patients' confidence in their doctors will be completely destroyed.
10. That the practice of mercy killing will ultimately lead us into the abominable practices that characterized Nazi Germany.
11. It is to be accentuated that we are obliged to use ordinary means of prolonging life, but not extraordinary means.⁴

These reasons should be kept in mind as answers are addressed to the problem of euthanasia.

With the more or less specific (though admittedly ambiguous) responses of Protestants and Roman Catholics presented, it now becomes appropriate to examine some of the basic ethical and theological presuppositions upon which society's *current*, basically negative, attitudes are based.

Human life has been given to man by God. Because it is a divine gift, it is regarded with a certain sanctity. Its holy nature is such that

3. Joseph Fletcher, *Morals and Medicine* (Boston: Beacon Press, 1954), p. 179.

4. Bernard J. Ficarra, *Newer Ethical Problems in Medicine and Surgery* (Westminster, Md.: The Newman Press, 1951), p. 95.

it deserves care and respect. Therefore, we may not ordinarily tamper with human life without the consent of that life; nor may we directly terminate life, even with the consent of that life. The only instances in which interference with human life is permitted without consent are those in which organic life would otherwise be lost; consent is unobtainable; or life has lost its recognized sanctity through a forfeiture of innocence.

Because life was bestowed upon an individual, the individual person is granted priority in making decisions affecting his life. Although there is recognition of the existence of and need for communities, the individual typically sees himself as autonomous. Community is therefore supplementary rather than definitive. Man makes contracts with communities when and where he chooses. He does this in the view that community is a potential source of benefit. However, he realizes that a certain serious forfeiture of individual prerogatives is necessary for the community to operate. Community prerogatives thus have a relatively high priority. They tend to be expressed, however, in terms of restrictive guidelines rather than prescriptive formulae (i.e., indicating the points beyond which it is not safe to act, rather than which action is desirable). If there is a very deep conflict between community prerogatives and individual priorities, the individual may exercise his own will, realizing that to do so he must suffer the consequences of a violated or broken community.

One of these consequences may be death. This, however, is a rare consequence; for death, like life, is viewed as an "ultimate." It is a separate ultimate but an ultimate none the less. These two phenomena define man's being. Life is existence; death is non-existence. Man is alive, so death is seen as the enemy; it is the unknown other-than-life fighting for the person. When death comes, it means defeat. Yet, it must come; it does come to all. Death then is omnipotent—it always wins. Because of its power it inspires a certain awe and fear. The fear is predominant. Man does not know what occurs so he will not become involved. Death's mystery inspires fear and causes man to attempt to hide from death.

In his flight man "hangs on," as it were, to the belief that death is only somatic. Death does not really affect the person, only the body. But the sense of loss incurred by death seems sufficient to keep this last assumption more in the realm of hope than of assurance.

At worst, death is God's punishment; at best, it is His cruel joke—the painful initiation into a new and different existence.

Medical Aspects

In face of the present legal structure, there is no place in medical practice for active euthanasia. There is, indeed, no legal sanction for any action which causes or allows one's patients to die. Action on the part of a doctor with the intent of causing the death of a patient may be seen under law as first or second degree murder.⁵

However, when we get into the matter of what has been called passive euthanasia, we must make some different statements. We become concerned here with ordinary and extraordinary means of prolonging life. Doctors feel themselves obligated to do whatever is ordinary to prolong a human life. (This has always been their practice.) Doctors do not, however, feel that it is always in the best interest of the patient or the society to perform extraordinary feats in attempting to prolong life.⁶ One reason for this is that many of the methods which would be termed extraordinary methods are very expensive, very painful, or very inconvenient.⁷

The terms, ordinary and extraordinary, are ambiguous and relative in the present situation. In present practice there are several factors which may determine what is ordinary and what is extraordinary. Medical consensus is one of these factors. Financial considerations and the location of the hospital may be others. What might be ordinary for President Nixon at Walter Reed Hospital may be quite extraordinary for a construction worker in a small North Carolina town.

In cases such as these, tacit legal sanction is given to the practice of not performing extraordinary acts to prolong life in every case everywhere. There have, therefore, been some instances in which what is called passive euthanasia has been practiced by physicians.⁸

5. George Fletcher, "Legal Aspects of The Decision Not To Prolong Life," *Journal of the American Medical Association* (1968), 203:65-8. Fletcher points out that there has not been a single instance in the annals of Anglo-American judicial proceedings in which: 1) a doctor has been convicted of murder or manslaughter for having killed to end a patient's suffering, 2) a layman or doctor has been convicted for failing to take steps that could have averted death.

6. David Daube, "Sanctity of Life," *Proceedings of the Royal Society of Medicine* (1967), 60:1238. See also Mary M. Shiedler, "Coup de Grace," *Christian Century* (1966), 83:1499.

7. Joseph F. Fletcher, "Anti-Dysthanasia—the Problem of Prolonging Death," *op. cit.*, p. 80.

8. Samuel D. Kron, "Euthanasia, a Physician's View," *Journal of Religion*

Tacit sanction is also given to the fact that medical consensus as to what is ordinary and what is extraordinary may, and does, differ from case to case and from place to place. In the present situation this tacit sanction adds to the moral, legal, and medical ambiguity which already exists.

At present, one may observe a change in the medical attitudes toward, and the legal understanding of, the Hippocratic Oath. For nearly two thousand years western practice of the healing art has been greatly affected by the presuppositions behind one particular section of that oath:

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients and will abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel.⁹

Instances of passive euthanasia (i.e., those instances where no extraordinary means are undertaken to prolong life) suggest to us that the Hippocratic Oath is undergoing some informal reinterpretation. Indeed, some doctors have opted for a formal reevaluation of the oath or the formulation of a new oath based, like the Hippocratic Oath, on a deep concern for the welfare and dignity of patients, but also geared to the problems of modern medicine.

What do these present circumstances seem to indicate? They obviously point to some kind of credibility gap between articulated medical values, on the one hand, and certain contemporary medical practices on the other. For while doctors openly affirm a stated interpretation of the Hippocratic Oath, and while they view the role of the doctor as being that of preserving and prolonging life (i.e., biological life), they themselves ineluctably make decisions involving the appropriate time and manner of another person's death.

It often appears that when doctors argue against legalized consideration of the possibility for euthanasia in certain cases, they do so

(1968), 7:335. "There is no question that passive euthanasia is widely practiced, even though this fact is not publicized."

9. L. B. Hohman, in "The Right To Live and The Right To Die," ed. by Cleland, *Medical Times* (1967), 95:1184: "I, personally, would not be critical of a person with incurable cancer who took the suicide route. Again, I would not personally aid such a person to die. That is because something seems to be woven into the mind and feeling of a physician that he must preserve life. *I realize this is somewhat irrational.*" (Italics added) See also Otto Guttentag, "The Meaning of Death in Medical Theory," *Stanford Medical Bulletin* (1959), 17:169.

not because they value the Hippocratic Oath so greatly, but because they would rather make such decisions themselves without interference from other disciplines. Viewing the doctor/patient relationship as a sort of holy of holies, doctors seem to feel themselves the only professionally qualified persons to deal with the problems surrounding death.

We are unwilling to accept the rationale that doctors are the only persons qualified to decide when and if another human being is to be put to death mercifully. While the most obvious aspects of this matter are medical, other vitally important aspects are of social, legal, and theological significance. Doctors should and must have an irreplaceable role to play in the consideration of euthanasia for another human being. But to leave the decision solely to a doctor, or a group of doctors, would be unfair, both to the doctors and to society. No one profession is prepared to deal with the medicine, psychology, sociology, and theology involved in a decision such as this. To make the doctor solely responsible for the decision is to put an awful and unfair burden upon him. Further, our society with its web of family, economic, legal, and religious principles, is not such that other than medical interests can easily and fairly be left out of such a consideration.

Legal Aspects

The current law regarding euthanasia embodies the popular, and largely unconsidered, theological and medical perspectives elaborated previously in this paper. These premises bind the law to awkward and sometimes inconsistent conclusions in actual cases of euthanasia.

One reason for difficulty in the case of mercy-killing is the inability of the law formally to consider the motivation behind criminal activity. Thus, if the facts establish the guilt of the individual, there is no legitimate mechanism through which the motivation may affect the verdict.¹⁰

The immense latitude in practical application of the law demonstrates the inadequacy of the present theoretical presuppositions. Currently the legal situation is seriously compromised, with the following results. Disrespect for the law is fostered, for example, when a judge instructs the jury in a case of mercy-killing that motivations are not to be considered, and that the facts must be weighed in isola-

10. Luis Kutner, "Due Process of Euthanasia," *Indiana Law Journal* (1969), 44:540.

tion to determine the guilt or innocence of the defendant on a charge of murder. The jury may then acquit an obviously guilty party with the result that the entire legal structure loses respect and effect.

The law is compromised also in the measure to which the present structure allows inconsistent sanctions. When doctors are practically immune to punishment for the same activity which nets other citizens years of imprisonment and even death sentences, the justice of law itself is threatened.

Finally, the present system may allow persons who have practiced murder disguised as euthanasia, to go free. Because of lax application of the statutes regarding murder in cases of mercy-killing, some who cause death for less unambiguous and less worthy motives are acquitted. Confusion and contradiction in technical law and practical application hinder sound legal practice.

The specific premise in today's law which permits all of these (we think deleterious) effects is the connection of malice and premeditation. In the statutes concerning murder, the first degree of homicide is established when "malice aforethought" has been proven. Unfortunately, subsequent interpretation of this phrase has not demanded the presence of both, but rather assumed that "malice" was an adverbial qualifier for "aforethought." The establishment of premeditation is automatically supposed to prove malice. This is an especially difficult problem for responsible mercy-killers who act not out of vindictiveness or hostility or frenzied emotion, but painful and responsible decision before-the-fact.

It might also be pointed out that human life is not an ultimate if common practice be any indication. Practices of capital punishment and war make it evident that the debt owed to society or the safety of society are higher goods than a human life. This is to say that a human being may be called on to surrender his biological life for some good seen as higher. Certainly a dying patient could be considered to be in a similar position and voluntarily relinquish his life for what he considers a higher good. Current legal processes make no allowance for this possibility, however.

A Proposal

We argue the justifiability and the advisability of active euthanasia under certain conditions. These conditions and the implementation of the act of euthanasia are described in the following proposal. However, it should be noted that the proposal is intended to do more than

activate machinery which would "legalize" euthanasia. Its primary purpose is to propose an economy of structures under which fair consideration of the issue would be most likely to occur. Thus, it does not assume infallibility, but it does intend to mobilize the maximum potential for just decisions in this highly complex matter. All prescriptions presently used in channeling the decision-making process can realistically have only this intent for their goal. Every situation is unique, and cannot therefore be fitted precisely with a preconceived prescription. Uncertainties and ambiguities will always be present. Thus, maximization of guidelines is the most we can hope for. If this proposal satisfies that criterion then it should, like some of its prescriptive counterparts, be made effective through legislative action on the state or federal level.

Perhaps the easiest way to present the particulars of the proposal is to view it from the perspective of a possible result of its implementation. We present here in order those conditions and criteria which must be satisfied if active euthanasia be advocated.

Three conditions must be present before euthanasia would become a serious option for any person of legal age judged to be mentally competent. First is the presence of an incurable "mutilation" of the person. Such a mutilation could be in the form of physical disability, disease, or mental disability.

The second is the absence of the patient's opposition to the performance of the act. The possibility for altering this second condition (i.e., recognition of a patient's opposition) presupposes the mental awareness of the patient. (If mental awareness were absent, or if the patient's will could not be discovered for any other reason, or if he actively sought the procedure, then this second condition would be established.) It would be the duty of the hospital administration, through an appointed representative (e.g., a chaplain or other professional equipped to inform, understand, and discern the patient's feelings), to discover the explicit wishes of the patient at the time of the consideration of his case.

Such a consideration would take place in the procedures of the third condition, that is, the agreement of three of five members of a panel appointed to deliberate such cases. Such a panel would be activated only if and when the other two conditions were met and if it were notified of the case by a concerned individual or group.¹¹

11. Such notification would start the procedures outlined for condition number 2.

Panels would be appointed preferably by city or county governments and in sufficient number to meet the demand on their services. The appointing body would also *voir dire* prospective panel members in order to establish the absence of an inprincipled objection to the practice of euthanasia. In legal terms *voir dire*, meaning to speak the truth, is a preliminary examination to determine the competency of a witness or juror. It is within the *voir dire* that evidence is sought concerning any preconceived ideas or notions concerning a case or practice. It is often felt that such preconceptions might affect one's ability to weigh evidence fairly under the law.

In this case, the panel members must be free to vote *for* euthanasia should deliberations on the case warrant its exercise. The patient's personal physician and a representative of his religious faith would be the only members exempt from the *voir dire*. The five members of a deliberating panel would be: (1) a physician not otherwise connected with the case or the family; (2) the attending physician; (3) a professional representative of the patient's religious faith, other than the patient's own clergyman.¹² (4) a lawyer or judge not presently involved with the patient; (5) a psychiatrist previously uninvolved with the patient. (The psychiatrist would be the only member of the panel other than the patient's physician who would be able to interview the patient if he felt it necessary to do so.)

The decision of the panel would be binding on the hospital in which the patient was being treated. Individual physicians on the hospital staff could only be prevented from performing certain life-saving or death-assuring procedures by the decision of the panel. All actions, however, must be by licensed physicians. Finally, any decisions of the panel would be made immediately void if the first two conditions were altered.

It remains to outline the criteria upon which the panel would make its decision. The panel is not limited in the scope of its consideration except in one respect. (While it may include in its deliberations any factors it sees proper or necessary for a complete consideration of a case, it must include at least the following.) Further, it would be understood that these required criteria would be weighted in descending order as they appear here:

12. In the case where the patient voices no denomination or faith preference, the last theologian to sit would remain. For atheists, no theological consultant would sit on the panel, but three votes would still be required.

- a. The patient's desire for death or the absence of his opposition to death, and his preference for direct or indirect action.
- b. The patient's same desires as expressed through a legally recognized "pre-will."
- c. The patient's same desire as expressed prior to the present crisis to legally recognized witnesses who thus testify.
- d. The nature and status of the illness and the amount of suffering and duress experienced.
- e. The ability of the patient to engage in reciprocal human relationships.
- f. The presence or absence of the family's opposition to euthanasia for the patient.
- g. Financial considerations.
- h. The presence or absence of spontaneous respiratory, circulatory, and cerebral functions.

In the case of a patient who is a minor or who is judged mentally incompetent the procedure would be altered in the following way:

Since such a person cannot express a legally binding will, the second condition as stated above would not apply. That is, such a patient could not, on his own, express legally recognized preference for or opposition to euthanasia. At least he could not do so with the authority which such a legal requisite demands.

However, such an expression is a valid consideration for the mix of factors which the panel must review in making its decisions. While the law recognizes diminished responsibility, it seldom would contend that any individual's voice is meaningless. Operating on this assumption of worthy, though diminished, expression, the criteria of the panel's deliberation would be changed at four points.

Criterion (f), "The presence or absence of the family's opposition to euthanasia for the patient," would follow criterion (a), "The patient's desire for death or the absence of his opposition to death, and his preference for direct or indirect action," as the second-most important factor.

For reasons stated above, criterion (b), "The patient's same desires as expressed through a legally recognized 'pre-will,'" could not be established unless the patient had at some previous time established a "pre-will" when he had the authority of a competent person of majority. In such a case it would follow criterion (f) as noted above. Criterion (c), "The patient's same desire as expressed prior to the present crisis to legally recognized witnesses who thus testify," would remain in order.

Following this, an additional, parallel criterion (b) would be

inserted stating, "The attitude of the family as expressed prior to the recent crisis to legally recognized witnesses who thus testify."

If Criteria (a), (f), (b), (c), and (i) as they are defined here are all in agreement, they would be recognized, under this proposal, as having the authority of condition #2 concerning the absence of the patient's opposition. If they were not in agreement, or if their agreement did not result in opposition (i.e., the breaking of condition #2), then the panel would be activated for further deliberation.

Such deliberation would follow the altered order as described encompassing the additional criterion in its place and including the remaining criteria as they stand.

The flowsheet for the consideration of criteria would then be as follows:

- (a). The patient's desire for death or the absence of his opposition to death, and his preference for direct or indirect action.
- (f). The presence or absence of the family's opposition to euthanasia for the patient.
- (b). Where possible—the patient's same desires as expressed through a legally recognized "pre-will."
- (c). The patient's same desire as expressed prior to the present crisis to legally recognized witnesses who thus testify.
- (d). The nature and status of the illness and the amount of suffering and duress experienced.
- (e). The ability of the patient to engage in reciprocal human relationships.
- (g). Financial considerations.
- (h). The presence or absence of spontaneous respiratory, circulatory, and cerebral functions.

If, as a result of the panel's action, the three conditions were met and the obligation of the hospital was thus incurred, the question would remain concerning the means and timing of the act of euthanasia.

It is here proposed that the act should take place as soon after the decision as possible. The patient's opposition again should be checked as the minimum preparation. The means employed should be those causing a minimum of duress to the patient and should be checked against his preference for direct or indirect action as it was expressed in establishing criterion (a).

A Theological Basis for the Proposal

The theological and ethical presuppositions and implications of the proposal are central to its understanding. It is of course impossible

to examine exhaustively these concepts or even to bring all pertinent concepts to light. It is, however, possible to examine some of the concepts which have the most immediate and forceful bearing upon the proposal. Death is one of these concepts.

The first thing which might be said about death is that it is universal. It occurs to all men and thus to each man sometime. It is one process in life which is inescapable. It has been said that with man's first breath he begins dying. While this is not strictly true by our definition, it does indicate strongly that death is part of life and that properly it can not be isolated from it.

As has been said, the prevalent attitude about death is to see it as being apart from life. Further, death is seen as the enemy of life. In fact, whether death is seen as a part of life or not, this charge is still levelled against it. It is a correct observation that death has emotional overtones both for the dying and for those around the dying. However, it is arguable whether the emotional impact of death must leave a negative impression. Death is not necessarily an enemy. This can be true for the dying person because death can come to him as one of the processes of life. Indeed it may be a welcomed process, one of relief from suffering and depersonalization. It also may have the positive value of being a deep experience in itself.

Death is not necessarily an enemy to those around the dying person. Being considerate of the patient's state they may find for instance that the void caused by the individual's absence is not as painful as watching the patient suffer. Thus death is not necessarily an enemy and dying not necessarily a horror.

To substantiate this position and to draw out its implications it is necessary to examine the terms life and death, as they operate within our conceptual economy.

Life is created by God. That is, the totality of life as a qualitative distinction is under the influence and jurisdiction of God. *Human life is not a birthright.* It is a given, a gift from God, who seeks continually to work with it. In every situation, from conception onward, God is seeking to work for the enhancement and preservation of the human dignity and personhood which makes life human. Death is not beyond the scope of this influence; it is rather an integral part within it.

Life then, in its totality including the death process, is caught up in a relationship with the Divine. It is from this relationship that life

gains its value.¹³ Insofar as a person is available to dignity and personhood, his life has value and is to be highly respected. But the referent for dignity and personhood—for the humanness of life—is not the isolated somatic system which seems to serve as the present criterion. It is rather the community of systems. The wholistic view of man upon which this proposal is based demands the perception of man as an integrated whole. His somatic, psychological and spiritual aspects are completely interwoven. Further, his individual self which is formed by the mix of these aspects does not become a personal self, a human self, until its social and theological relationships are realized.¹⁴ The individual is still the referent; but it is the individual *in community*.¹⁵ As the disintegration of these interrelated systems becomes irreversible and accelerated, the patient begins to die. Death occurs when the disintegration is seen as accomplished. Personal life is over. The humanness of life is gone.

But "human" dignity is not irrelevant until "human" life is judged as terminated. Thus, while an acceptance and recognition of death is called for, such an acceptance and recognition is not unqualified. As a process in life, dying is acceptable only insofar as it does not unnecessarily interfere with the dignity and personhood of the individual. That is, while the various factors of the integrated self begin to break down and some imbalance will take place, it is not necessary to accept an acute imbalance and disintegration. And it is certainly not necessary to prolong such a misfortune.¹⁶

13. B. Baird and J. Fletcher, "The Right To Die," *Atlantic Monthly* (1968), 221:64: "The sanctity is not in life itself, intrinsically; it is only extrinsic and *bonum per accidens ex casu*—according to the situation." For the Christian the *accidens* is the status of the relationship with God.

14. "For a person to live, he must either be realizing his potential or have the capacity to realize his potential . . . 1. To have a rational awareness and 2. To interact emotionally with other people." (P. Wesley Aitken, "The Chaplain," included in the article by James T. Cleland, "The Right to Live and The Right to Die," *Medical Times* (1967), 95:1186.

15. This is excellently summarized by Adrian Verwoedt, *Communication with the Fatally Ill* (Springfield, Ill.: Charles C. Thomas, 1966), p. 160: "The psychological level . . . cannot exist without the integrated biological function which make possible an intact central nervous system and the resultant mental activity by which man distinguishes himself from lower animals. Even with the psychic apparatus intact, however, man is not complete. He must also function as a social creature. For, just as his intellectual power sets him apart from other animals, his social orientation sets him apart from his fellows and imparts his unique individuality."

16. "The right to life does not necessarily entail the obligation to live, especially when continued existence is so hideous and demoralizing that the

This conclusion is reached by the following reasoning: If, in fact, the dying process is part of life and if God's will is for personhood and dignity to be enhanced, then it can be assumed that God's will is to enhance personhood and dignity in the dying process. When this is not done, then there is in fact a certain evil present which hinders the will of God. Such an evil, and thus such a death, cannot be acceptable. To look at it another way: it is as if the natural arena of God's activity is insufficient in this case for His will to be done. Some "natural" deaths thus go against God's will, disintegrating rather than terminating human life. In such a situation, God's will may be acted out by instrumentalities other than the natural processes. Man has a part to play in such a situation. His role can be seen by exploring the implications of the assumption that God does work through the instrumentality of man. To most men there does not seem to be a ready-made interpretation of God's will for each situation. Further, because man is free he can realize the possibility of choice. Man chooses and his decision may be, in a given situation, better or worse. But even if he does not select an alternative, he has chosen. His choice is simply whether to participate actively in the decision. Such a choice may be relatively good or bad. Since God works through the instrumentality of man and since part of man's God-given dignity is his freedom to act and choose, it can be said that God does work through the choices of men. This is almost tautological. It would not make sense for God to work for dignity and personhood by a means which denies one of the central components of the goal.

Thus man's decision becomes very important in the working out of his instrumentality. He must decide how he will interpret God's will in a given situation. Understanding the limitations of time and knowledge, man is aware that his actions must remain imperfect. But risk of misjudgment does not free man from his responsibility to act in the best way possible to him. Luther's admonition to "sin boldly," and its accompanying concept of munificent grace, seems few places more applicable than here. Where man seeks to do the will of God, and through his finitude fails, forgiveness is available.

Certainly man does not shirk this responsibility in many of the matters of human well being. He freely and properly disseminates services which overcome the minor sicknesses, sufferings, and injuries of life. Further, he is actively engaged in affecting the beginning of

person is blotted out and reduced to coma or ungovernable nerve-reactions." J. Fletcher, *Morals and Medicine* (Boston: Beacon Press, 1954), p. 188.

life as he discusses contraception, practices pre-natal care (including surgery and abortion), and aids in the childbirth process. In all of these instances man can be seen trying to affirm the dignity and personhood spoken of above. He is taking seriously natural events as an indication of his sphere of activity. He is then attempting to enhance the personal-social integrity by the means available to him. The problem arises when man confronts death. As was said, his attitude is one of fear; his actions normally are attempts to prolong life. This seems to be the result of misplaced priorities. Life becomes the object of our veneration and individual existence the center of all meaning.¹⁷

Such an approach not only has touches of blasphemy but perpetrates an inconsistent system of medical ethics. Certain practices used to aid the patient during other phases of his life are withdrawn during terminal phases.¹⁸ An artificial limitation is placed on permissible practices for the patient's care.

This limitation is more often than not the result of restricted conscious deliberation. Medical ethics tells the doctor to save life. If death's process is not recognized as the end of life, ignored as being what it is, then the doctor may ignore its special implications for the care of his patient and continue fighting a hopeless battle or merely allowing, without influencing, the inevitable.

This seems to shirk the responsibility of decision for the best care to the patient. Such decision by default is acceptable neither within the decision-making economy described above nor in the scope of true humanitarian concern for the patient.¹⁹ Responsibility requires

17. ". . . if we are dedicated to preserving life under all conditions, at all cost, then we are wrongly worshipping life as a substitute for God." D. P. Sholin, "Death of a Son," *Ladies' Home Journal* (1968), 85:70.

18. Fletcher points out the irony: ". . . we are, after much struggle, now fairly secure in the righteousness of easing suffering at birth, but we still feel it is wrong to ease suffering at death!" (*Morals and Medicine, op. cit.*, p. 196).

19. The argument may be substantiated in this way: Default activity is the result of a type of rationalization. "We are so afraid that someone will make a wrong decision that we take refuge in the maxim that because we can keep these persons alive, we *must*—a maxim that has been reached not by intelligent and compassionate study but by default, or at best by transferring a sound principle of medical ethics bodily into social ethics." M. M. Shiedler, *op. cit.*, p. 1500. However such rationalization has its consequences. "Still it may be asked whether greater depths of inhumanity are not reached when we allow people to die in isolation, walled off from effective community with others under the cover of medical necessity." James T. Laney, "Death and Ethical Reflection," *Reflection* (1969), 66:4.

that positive decisions be made and implemented.²⁰

In summary what has been attempted by the proposal is the creation of an arena within which God's will for personalization of individuals could be acted upon. It is an attempt to check both natural insufficiency and man's foibles while being aware that it operates within an atmosphere of imperfection and forgiveness.

Fletcher speaks to our position quite well :

The right of spiritual beings to use intelligent control over physical nature rather than submit beastlike to its blind workings is the heart of many crucial questions. Birth control, artificial insemination, sterilization, and abortion are all medically discovered ways of fulfilling and protecting human values and hopes in spite of nature's failures or foolishnesses. Death control, like birth control, is a matter of human dignity. Without it persons become puppets.²¹

20. A course of positive action could be dictated if the assumption is correct that: "When a Christian is dying, a doctor needs to be aware of his patient's sense of values. For such a one a vegetable existence offers no opportunity of living for Christ . . ." Andre Bustanoby, "The Right to Die," *Christianity Today* (1963), 7:39.

21. Fletcher, "Anti-Dyathanasia—the Problem of Prolonging Death," *op. cit.*, p. 83.

Thoughts on the University*

“Brethren, whatsoever things are true . . . think on these things . . . these things do, and the peace of God will be with you.” Phil. 4:8, 9.

I

The nation is deeply troubled. Some universities are in partial disarray; many seethe with unrest. Academic life is disturbed, studies are in jeopardy. Students are aroused and profoundly stirred; teachers are disquieted; administrators alternate between hope and despair. Cambodia touched off the smoldering pile of young adult resentment toward a protracted war that had already amassed an appalling record for debauchery, atrocity, and futility. The pattern of turbulence and closed universities of southern Europe may lie ahead for us. Mass education adds to the problem by geometric progression: not only does it provide arenas for massive ferment, but mass education is itself potentially a massive reservoir of political power, for good or ill.

In the face of these realities, it is, perhaps, already too late in the day to hope for a constructive answer to the question, what is the role of the university in today's society? In some ways, the events of the past three years make the answer all too apparent. For the “new left,” the decision has already been made: it holds that the university is a chief instrument of social revolution. It is just this that astute conservative reactionaries perceive, and it is this which many teachers and scholars, pursuing their researches with time-honored non-judgmental objectivity have been slow to take in.

All decent people, inside and outside the universities, are aghast over the desperate events at Kent State and, now, at Jackson State. They are also bewildered and shocked by recent calculated student indecencies at Princeton in March. These plainly violated standards of academic process and scholarly restraint. Ordinary people do not comprehend disruption of the university when disruption is planned and then justified as an instrument of social protest. They have not,

* A sermon preached by Dean Robert E. Cushman in Duke Chapel May 17, 1970.

up till now, understood the university as the chief instrument of societal change.

They are, perhaps, still thinking of the university in the manner of John Henry Newman's idea of it; namely, as the place of liberal learning where "knowledge," as he said, "is capable of being its own end." In his *Idea of a University*, Newman spoke of university education as "a comprehensive view of truth in all its branches." This "liberal education," he taught, engenders the "philosophic temper." It instills a "habit of mind," serene and composed, which fosters "throughout life the personal attributes of freedom, equitableness, calmness, moderation and wisdom."

For such conceptions of university education, the platform of the "new left" is, on the face of it, unintelligible. From the Newman 19th century perspective, the eloquent defense of Princeton graduate student, Michael Teitelman, on behalf of his fellows charged with disruption and insubordination must seem incredible and outrageous:

"This is a political trial," Teitelman declared, "and that's what we want everyone to understand. We're not on trial here. What's on trial is the ruling class and its racism and imperialism. We have said that the real explanation of all that we do in this trial is to be found in the unhuman, unfree, repressive social reality all about us. We do not deny we organized a demonstration against Mr. Hickel. We explained why we did so and why we thought it *right* to do so." (*Princeton Alumni Weekly*, April 28, 1970, pp. 11, 14).

It is not necessary to enlarge upon the bill of particulars with which Mr. Teitelman indicts the established orders of society, including those of the university. It suffices to observe two or three things:

The first is that, by asserting the "political" character of the hearing for students charged with violating the university code, Mr. Teitelman means to exempt the defendants from the standards pertaining to their membership in a university community. He does so on grounds of the rightness of their political views!

Secondly, and behind this, is the premise that the really sufficient reason for continuing university membership is political "enlightenment" issuing in liberating social action.

Thirdly, that disruption of university practice and academic protocol is non-censurable if it is politically justifiable. The *end* justifies the means! Our ends are *right*, therefore our behavior, however obnoxious, is justified!

But beyond this is the underlying premise about the nature of

the university that justifies this logic of expediency with immunity. It is that the university is, at the least, a staging area for, perhaps even an instrument of, social revolution. Certainly, the "new left" is not above using the university as such under the guidance of ends taken to be, as Teitelman says, "right." So "right," indeed, so valid he believes, is the end in view that even *means* which denature the university are not deterrents to the apostles of social reform, urged on as they are by revulsion against oppressive established orders—both *inside* and *outside* the university.

II

The agony of the present-day university is something like this: it is caught in the pincers of a societal revolution surrounding it, while, at the same time, the university is itself disturbed and disrupted from *within* by morally defensible outrage against maladies *without*. It is caught in the middle between societal inaction and leftist reaction. Meanwhile, often, as at Princeton, the leftist reactors within claim all the immunities of the academy while exhibiting the behavior of fanatics.

The resulting internal conflict is insupportable. For, of all civilized institutions, the university—committed as it is to rational inquiry, persuasion, and the honor code of the gentleman—is most vulnerable to disorder. The discipline of the university is still mainly self-discipline. When the university, however, becomes the focus of the infectious ills of the environing society, it is the first casualty of the prevailing cultural disorder. Liberal education is incompatible with the illiberal spirit; when the latter waxes, the former wanes.

But this special vulnerability is not all that imperils the university. In addition, by its very nature, the university tends to invite, however unintentionally, the disorders with which it is presently afflicted. For, the university is, as the medieval schoolmen understood, a *microcosm* of the world. It is microcosm of the surrounding culture. In so far as there is reasonable working harmony between the ends or goals of a society and its institutional support of them, there is stability. In such a case, there is also stability enough for the peculiar role and function of the university. When the contrary prevails, that is, when there is contrariety between new emerging goals and the institutional vehicles for their realization, then the resulting ferment and strife in the surrounding culture first comes to articulate consciousness in the university—as the microcosm of the macrocosm.

To be more explicit, it is the nature of the academy, from the time of Plato, that it should proceed on the Socratic premise that "the unexamined life is not worth living" and that, therefore, the purpose of the academy is just exactly to examine life as it is being lived to the end of its progressive betterment. In a sense, the academy has always stood in the role of critic of the established or prevailing culture. That is why "the gown" and "the town" have frequently experienced some measure of estrangement and some need of reconciliation. But in times of intense cultural revision, when the *nisus* of history moves toward the renovation of cultural forms in the interest of squaring the practices of society with a larger human good, this pressure frequently has its initial acknowledgment in the university.

Here, the inequality, or the contrariety, between *the things that are* and *the things that ought to be* come first to disquieting awareness. And in our time of immense societal distortion—stubbornly resistant, it seems, to humane solutions by way of present modes of political and institutional response—the university tends to become the home of radical solutions to social ills. All this obtains while the ailing society is laggard either frankly to acknowledge its sickness or to resolve it by finding the cure.

So the university spawns social activists—students and faculty with varying degrees of revolutionary commitment. Among these the most zealous, like those at Princeton, are not above turning the academy into an instrument of social change, disrupting the educational process itself in the interest of radical renovation of the political order and its economic base. Unfortunate as it may be, their strength is that they have too good a case! But, at the same time, they denature the function of the academy by using it as a political tool.

So it has come to pass that the currently ascendant idea of the university is that of the "new left." They hold that the university is properly an agent of societal change. At times they act and speak as if the university should become the Church. It cannot be denied that, in some part, they represent a rebirth of conscience of which the Church should always be the promoter. But prompted by great "righteous indignation," these apostles of social reform have their residence in the Academy. Yet the Academy is not the Church. Unlike the Church, the Academy has not required that its members be regenerate. But apostles of righteousness who are not regenerate may easily become fanatics.

The "new left" does, I think, follow in some part the admonition

of St. John: It comprehends what the academy has characteristically been slow to acknowledge. This, namely, that the Truth is not something to be *known* only, or always to be being sought after, but rather something *to be done*, and *now*. The "new left" in part seems to hear what churchmen ought always to heed: "If we say that we have fellowship with him and walk in darkness, we lie, and *do* not the truth." It is the *New Testament* and the Church which always say that *the truth is for doing*. The "new left" is urging that there is a no more needed pedagogy, and no Christian can deny it. The fact is that the truth for *doing*, as St. Paul declared, is just exactly faith, hope and love. And the exasperating thing is that the "new left" concurs with St. James that faith without works is dead.

Nevertheless the academic apostles of social righteousness are mainly blind, or perhaps uninformed, respecting Isaiah's more authentic apostolic calling. They are unaware that, just because he was a man of "unclean lips" dwelling among "a people of unclean lips," Isaiah could not be trusted with *mission* until he had acknowledged his complicity in the sin and guilt of his people. He could not be trusted *with* mission until he had been cleansed *for* mission. He was not sent until he had received the grace of a diviner forgiveness which preserves "righteous indignation" from supercilious fanaticism. From the *Princeton Weekly* nothing is plainer respecting the academic apostles of righteousness than is declared in *Proverbs*:

"There is a generation that curse their father,
And bless not their mother.
This is a generation that are pure in their own eyes,
And yet are not washed from their filthiness."

The Biblical view of man does not indulge such an interpretation of "the generation gap" as would distinguish between one generation and its successor by the sinfulness of the former and the righteousness of the latter. Nevertheless, only invincible ignorance would deny that the young adult generation are warranted in some of the grave indictments they bring against contemporary American society.

III

What happened at Kent State and, perhaps, at Jackson is a frightening disclosure, I fear, of the moral sickness of our culture. Surely it is a time of peril for any nation when agents of government, charged with maintaining the peace, resort to overwhelming force against an indiscriminate body of unarmed citizenry—especially

youthful ones. Such official excess is probable evidence, as was stated by John W. Gardiner this week in *The New York Times*, that "we are dealing with disintegrative forces that threaten our survival as a society."

As for the universities—and I speak after nearly thirty years' experience in three such institutions—the universities, as microcosms, cannot sustain much longer the inner turmoil engendered by the unresolved ills of the larger society. After nearly three years of internal divisiveness the universities are becoming dysfunctional. It is true, as Mr. John Gardiner also is reported to have said, that "today's divisiveness is not confined to one issue. There are multiple points of conflict," he said, "the war, race, the economy, political ideology. There are multiple rifts—between old and young, between regions, between social classes."

This is all true; yet I suspect—so far as the universities are concerned—it is much as I wrote for the Divinity School Alumni a year ago, namely: ". . . that until the futility of Viet Nam is retired, with its violation of conscience, the scepticism of youth toward the wisdom of their elders and the propriety of established orders will not recede. Viet Nam is the scandalous symbol of the bankruptcy of capitalistic democracy's way of meeting the future or dealing with human destiny by stereotyped and outworn patterns of response. More than anything it epitomizes . . . the frustration of the young with the sheer inertia of the Establishment." And I would affirm again what I then declared that, "Unless creativity replaces inertia, Viet Nam may turn out to be the fatal *nemesis* of the American way of life—its dissolution of confidence."

This past week Mr. Gardiner declared that "a crisis of confidence" is indeed upon us: "We must move vigorously," he said, "to solve our most crucial problems" and we must seek "a healing of the spirit of the nation." It was in commentary upon these words that the *Times* noted that "Almost two years ago, the National Commission on the Causes and Prevention of Violence warned that the greatest threat to American survival was not from *without* but from *within*."

The real enemies are those of our own household: it is this unblinkable fact that simply renders obsolete, I believe, the premises and consequent policies that seemed to justify Viet Nam in the first place. Certainly, they are now discredited for any further extension of the war. And that is the scandal of Cambodia: it not only offends against

the decent opinion of mankind, but flies in the face of reason itself. To many, it seems an invitation to societal suicide.

But if there is to be, as Mr. Gardiner has urged, a "healing of the spirit of the nation," then, surely, there must be, in addition to acknowledgment of our moral blame as a people, a recovery of moral integrity and vision. If, as *Proverbs* has it, "without vision the people throw off restraint and perish," will we as a people give heed to our foundations?

"Brethren, whatsoever things are true, whatsoever things are honorable, whatsoever things are just, whatsoever things are pure, whatsoever things are of good report . . . *think* on these things." So counsels St. Paul. But, more emphatically he enjoins: "these things *do*, and the peace of God shall be with you."

Brethren, our jeopardy as a nation, the threat of our dissolution as a people and as a society, is that we cannot continue to exist in defiance of the moral Universe. At last and inescapably, *the truth is for doing!* But it is the nation, and the individuals who compose it, that must *do the truth*. The universities cannot, in this, substitute for society. Neither can they safely assume the apostolate of the Church. Only this week student activism has resorted to the legitimate avenues of democratic legislative process. This may be a turn of the tide. I pray God the legislators may hear them.

May 17, 1970

Robert E. Cushman

