// BIOETHICS OUTLOOK

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St Vincent's withdraws from supervised injecting room

by Gerald Gleeson

In this issue

Our previous issue was devoted to a symposium on St Vincent's proposal to trial a 'supervised injecting room' for injecting drug users. Australian readers will now be aware of the fact that the Vatican's Congregation for the Doctrine of the Faith expressed the view that it would be unacceptable for a Catholic health care facility to operate such a service and required the Sisters of Charity to withdraw from the project. In this issue, Dr Gerald Gleeson reflects on the history of the debate about this project, the ethical issues it raised, and the issues which now remain.

Fr Jean Kitahara-Frisch, a Belgian Jesuit who lives in Tokyo, contributes the second article. He argues that there are important similarities between state-sponsored 'eugenics' programs and some individually-chosen reproductive decisions.

In a brief final note, Bernadette Tobin recommends to readers the recently-published *Issues for a Catholic Bioethic*. She thinks that Catholic health care professionals struggling with questions about whether there is a distinctive role for Catholic hospitals in contemporary secular society will find the articles in this book an invaluable aid to the deepening of their understanding of the challenges facing Catholic health care.

In reflecting on the decision of the Sisters of Charity Health Service (SCHS) to withdraw from its proposal to operate a supervised injecting service in Darlinghurst, I will explore three topics of interest: First, the history of the project. Second, the ethical debate. Thirdly, the issues that remain.

The story so far: what exactly happened?

It is only now that one can piece together the events which have led to the SCHS withdrawal from the injecting room project. Although I was involved at some points, I was not involved at other points, and so I am relying for this narrative on published comments by others, along with some educated guesses about how the events unfolded.

From the outset, the project was the initiative of the Darlinghurst Regional Board and Executive, which had been in discussions with the NSW Government. I first became aware of it in my capacity as a National Board member of the SCHS. The National Board endorsed the direction being taken by Darlinghurst, and I made some suggestions as to how the Darlinghurst Board's Policy Statement on services for people engaged in illicit drug use could be strengthened by the addition of references to the Church's

teaching on the conditions that would have to be met to justify a harm minimisation strategy such as a safe-injecting room.

Like many, I was initially hesitant both about the likely benefits of the room, and about what can appear to be the "defeatist" attitude behind a decision to maintain addiction, rather than foster rehabilitation. However, I was persuaded that the proposal was worth trying, subject to our being able to meet the ethical conditions set out in the Darlinghurst Policy Statement. These conditions refer to the need to locate the service in a suitable place, to ensure that it does not lead to increased drug abuse, and to educate both our staff and the general public about the true goals of the service.

The announcement that St Vincent's would operate the injecting service proposed by the NSW Government in response to last year's drug summit led to mixed reactions in both the Church and the wider community. My reading of these responses is that more people were supportive than critical. Among the critics, however, were some who were vocal, well-organised and well-connected. In due course, it was apparent they had taken their concerns to several offices in the Vatican and to the United Nations Organisation. Presumably, these critics thought their opposition would not gain official support here in Australia.

In early October, the Archbishop of Sydney, Cardinal Edward Clancy, informed the Sisters of Charity (the Religious Congregation, that is, not the Health Service) that the Vatican's Congregation for the Doctrine of the Faith (CDF) was investigating the proposal. It seems that at this point the Cardinal sought an authoritative ruling from the CDF to settle the local controversy.

When told of the CDF inquiry, the Sisters of Charity took the initiative of preparing a letter addressed to the Cardinal, along with some attached documents (e.g. the Darlinghurst Policy Statement and articles by theologians examining some of the principles that would justify an injecting service). I was not involved in the discussions between Cardinal Clancy and the Sisters, nor in the preparation of the letter they submitted to him, and it is unclear to me just where their submission was directed. It reads primarily as a "briefing" for the Cardinal himself, rather than for anyone in Rome, though presumably it was also intended that it be passed on to the CDF. The letter concludes with the Sisters "seeking an opportunity to present [their] case" personally to the Roman authorities with the assistance of two theologians (including myself, as I later learnt). I surmise that the difficulty for the Sisters in preparing this submission was that they were not aware of the precise case being mounted in Rome against the proposal. Accordingly, their letter sought to open a dialogue; they did not see it as a final submission in a process about to terminate.

The Apostolic Nuncio in Canberra, Archbishop Canalini, has since stated that it was he who forwarded to the CDF a collection of documents, including the Sisters' letter to Cardinal Clancy, along with a covering letter in which he explained the political situation in NSW and expressed his own opposition to the project. The Sisters' letter to Cardinal Clancy was dated October 8th, so the Nuncio's submission must have been after that date.

Around the 21st October, Cardinal Clancy informally told the Sisters of Charity that he understood a letter was expected from Rome the following week, and that the letter would give a "negative" ruling on the injecting service. On October 26th, the Cardinal wrote to Sister Annette Cunliffe advising that he had received from Cardinal Ratzinger, on behalf of the CDF, a letter saying that it was "not acceptable" for a Catholic health care facility to operate a safe injecting room. Cardinal Clancy accepted the judgment made in Cardinal Ratzinger's letter, and asked the Sisters to comply with it by withdrawing from the programme.

The timing of the letter from Rome cannot have been coincidental: the NSW Upper House was due to vote on the Government's Bill in Response to the Drug Summit that very week. The Government and the Sisters of Charity jointly agreed to announce the SCHS withdrawal at 5.30 p.m. on Thursday, October 28th. When the vote was taken later that night, the Bill was approved and will in due course go to the Lower House where it is expected to be passed.

Reactions to the Sisters' withdrawal were swift. Some, including the Prime Minister, were delighted; a majority of people, however, were angered by the decision and/or by the way it appeared to have been made. As to the project itself, the Government is seeking other sponsors, but it is unclear at this stage just who will be licensed to operate the service. St Vincent's will continue its existing work in drug and alcohol rehabilitation in the Darlinghurst area.

The ethical issues

Readers of this journal will know from the articles by Anthony Fisher and myself in the previous edition that there were *two* distinct ethical issues surrounding the injecting room proposal. The most obvious issue concerned the likely effects of the injecting service, which would no doubt have been both good and bad. The hoped for good effects were chiefly those of saving lives and of increasing the chances for rehabilitation. The possible bad effects were chiefly those of sending the wrong signals about drug use and of confirming people in their addictions.

The perhaps less obvious, but no less critical, ethical issue concerned the legitimacy in-principle of doing something that would be of assistance to people using illicit drugs. This is the issue of "formal" or direct cooperation in wrongdoing, discussed on several occasions in *Bioethics Outlook*, and most recently by Anthony Fisher and myself. It is significant that Cardinal Ratzinger's letter does not rely on an in-principle objection to an injecting service. To be sure, the extracts from Cardinal Ratzinger's letter which have been released begin by speaking of the proposal being "not acceptable", but the letter goes on to conclude that the proposal is "not practicable". Cardinal Clancy remarks that Cardinal Ratzinger "does not address the more complex moral principles" – viz. the question of formal cooperation – but rather the practical consequences of the service.

What the CDF finds unacceptable are the unintended side-effects which it fears would flow from the fact that *a Catholic facility* was operating the service (e.g. the signals that might be given about illicit drug use). The CDF judges that these side-effects are not warranted by the likely benefits of the service, and so concludes that the SCHS proposal is "not practicable".

The question of whether some bad side-effects would be justified in view of the hoped-for good effects of an injecting service was always the contentious issue in this debate. This issue calls for a "prudential judgment". As with all prudential judgments, there is scope for reasonable people to differ about what is the practically wise course of action. The CDF has reached a different prudential judgment from that reached by the Darlinghurst Board of the Sisters of Charity. Because Cardinal Ratzinger's letter has not been released, its canonical status remains uncertain. In any event, Cardinal Clancy has accepted the CDF judgment, and in so doing has made it authoritative policy for the Church in Sydney.

Formal cooperation?

The Darlinghurst Board of the SCHS can take some satisfaction from the fact that the CDF's judgment was based on prudential grounds, rather than in-principle grounds. The CDF letter thus gives no support to those critics within the Church who continue to assert that operation of an injecting service must involve formal cooperation in wrongdoing. Nonetheless, because these critics' claims can have a superficial plausibility, it is worth taking the time to see why they are mistaken.

The critics have two lines of argument against the very idea of an injecting service. First, there is a claim about one's intentions or purposes, viz. the claim that it is not possible to operate an injecting service without at the same time intending that drug abuse take place. That is to say, these critics argue that intending to make drug abuse safer (in an injecting room) necessarily involves intending that drug abuse occur, and so involves formal cooperation in wrongdoing.

The second argument is based on the *physical facilitation* of drug taking that is involved in operating an injecting room. The claim is that just providing the facilities for drug taking (like providing the facilities for abortion) is a case of "immediate material cooperation": one is so closely involved in the drug taking that one must be thereby directly cooperating in it.

I believe both these line of argument are mistaken. The latter argument is mistaken for reasons noted by Pope John Paul II in *Veritatis Splendor* 78 : viz. that the moral meaning of one's actions cannot just be read off from a physical description of what one does. (One cannot tell just from a photograph whether a nurse turning off a ventilator is intending to kill a patient or is removing burdensome treatment.) Rather, the Pope tell us, in order to appreciate the "moral object" of one's action we must take up "the perspective of the acting person", that is, we must understand what a person is trying to achieve and what means he or she is using to achieve it. What is crucial to the evaluation of an injecting service is not the physical proximity to, or causal facilitation of, drug taking, but the goals and purposeful actions of those operating the room.

Turning therefore to the critics' first argument, we must examine whether the "purposeful actions" of those operating an injecting room constitute formal cooperation. As I have argued previously, operation of an injecting service *could* involve formal cooperation (e.g. if the operators were criminals selling the drugs and wanting to encourage business!), but it need not do so if one's intentions and chosen means are rightly ordered towards rehabilitation and saving lives. In saying this, I am not saying that a "good end" justifies a bad means, nor that an injecting service is the "lesser of two evils". I am saying that the moral evaluation of what one is actually choosing to do (e.g. allowing drug injecting to occur where there is medical supervision on hand) depends on the accurate description of one's intended purpose and of the relationship between one's action and that purpose (as indicated in *Veritatis Splendor* 78).

In summary, therefore, the critics' claim is that intending to cooperate with wrongdoing such as substance abuse (albeit with a view to doing good or reducing harm) necessarily involves intending that the wrongdoing take place. Their mistake is to fail to distinguish between two quite different ways in which one's cooperative action may be connected to the wrong action of another. Consider the following two cases of "cooperation".

Case 1: A Catholic hospital agrees to allow some doctors to perform abortions within the hospital in order that the hospital maintain its public funding. (Let us suppose the government of the day has decided that abortion must be available in all publicly funded facilities.) In this situation, the Catholic hospital would be cooperating formally in the wrongdoing of abortion: in permitting the abortions to take place, the hospital would be *intending* that the abortions be performed *as a means to the end* of retaining government funding. In this case, the cooperation involves intending the wrong of abortion, because unless the abortions take place the hospital will not achieve its goal of maintaining government funding.

Case 2: A Catholic hospital agrees to operate a safe injecting service with a view both to preventing deaths from overdoses and to linking drug users with opportunities for rehabilitation. In this situation, the Catholic hospital would not be cooperating formally in the wrongdoing of drug abuse: although *permitting* drugs to be injected, the hospital need not be *intending* that drugs be injected.

Indeed, the goals of the service would best be met if the addicted person desisted from injecting and immediately enrolled in a rehabilitation programme. In this case, it is simply not true that cooperating with those abusing drugs means intending that they abuse drugs, because a key goal of the injecting service (rehabilitation) does not depend on drugs being injected. And even if the clients of the service do inject themselves with drugs, the goal of the service is not that they do so, but that assistance be on hand should they choose to do so and suffer an adverse reaction.

In short, in *Case* 2 the hospital's goals in cooperating do not require intending that drug injecting occur; indeed those goals will best be met if injecting does not occur. It follows that the hospital is not intending the wrong of drug abuse either as an end or as a means. (On a theological note, unless there was such a distinction between *permitting* wrongdoing and *intending* wrongdoing, God would have to be held responsible for all human wrongdoing!)

Of course, the operators of an injecting service will assume that many of its clients will in fact use drugs. The point remains, however, that with respect to the reasons for operating the service, drug abuse is being *permitted, not intended.* There is no "formal cooperation" in wrongdoing, there is simply what the Church calls "material cooperation".

Once this point is understood, our attention can move to the prudential question whether providing an injecting service will do more good with less harm than would not providing an injecting service. This is where there is a need for informed debate, and this is where reasonable people may differ in the conclusions they reach. "Material cooperation" may or may be justified, depending on how its likely consequences and side-effects are evaluated.

Of course, in the evaluation of consequences and side-effects, people will be influenced by their "presuppositions" about a number of prior issues: e.g. about whether substance abuse is wrong in itself, about the extent to which the state should act to prevent someone harming himself, about the extent to which addicted persons are able to embark on rehabilitation, about the messages the service will send, and so on. Apart from debating the effectiveness of an injecting service, it will be important that as individuals and as a society, we also take the time to grapple with these various "presuppositions" which, though often hidden, are crucial to the judgments we make.

The issues that remain

Granted the issue is one of prudential judgment, the next question to be considered concerns *who* properly should make this judgment. In general, of course, prudential judgments are best made by those who are best acquainted with the relevant facts and the local situation. This is why a judgment from Rome looks so anomalous. On the other hand, the Catholic Church is constituted by the "communion" of many local churches, and from this perspective decisions by local churches can never be entirely "local", since even the most local of decisions can have a "universal" significance that needs to be taken into account. The CDF is an appropriate body to register this wider significance of a prudential decision.

While acknowledging this wider significance and hence the legitimate role of the CDF, the Church's teaching on subsidiarity is also relevant. The principle of *subsidiarity* is a key element in the Church's social teaching. It requires us to recognise where responsibilities for decision making properly lie, with respect to the individuals affected by it. Decisions that can be made at "lower" levels in an organisation or society should not be taken over at "higher" levels. The question of subsidiarity here concerns when and how a body like the CDF should

be involved in a prudential decision within a local Church.

There is an analogy here with judgments about the orthodoxy of a theologian's writings. The importance of subsidiarity was recognised earlier this year when the Australian Catholic Bishops Conference approved a Statement of Policy on The Examination of Orthodoxy.[1] This Policy outlines the procedures to be followed when the orthodoxy of what a theologian has said or written is called into question, whether by critics here in Australia or by an official body like the CDF. At the heart of this Policy is the principle that, as far as practicable, matters should be handled in Australia, with the advice of local experts, and under the direction of the Bishops' Committee for Doctrine and Morals.

What is regrettable in the present case is that the question of a Catholic facility operating an injecting service was not able to be dealt with first through an extensive and expert inquiry here in Australia. While the SCHS may have disturbed some people outside Australia, there can be little doubt that this incident has done serious damage to the image of the Church in this country. As the narrative above suggests, several factors and circumstances contributed to the inadequacy of the process by which the final decision was reached. In retrospect, at least, it is apparent that the SCHS would have been wise to seek more extensive ethical advice and to identify and address the crucial "political" issues at work both in the Church and in the wider society.

To be sure, there will be some who believe that the urgency of the present issue precluded a local process. But questions of urgency also call for prudential judgment, and here again reasonable people may legitimately differ. As Cardinal Newman reminds us, the Church is promised infallibility in the formal teaching of "faith and morals". But the Church is not promised infallibility in her prudential judgments. Indeed, Newman wrote, "nothing but the gift of impeccability granted to her authorities would secure them from all liability to mistake in their conduct, policy, words and decisions, in her legislative and her executive, in ecclesiastical and disciplinarian details; and such a gift they have not received".[2]

The major lesson for the future, therefore, concerns the "groundwork" required when a Catholic healthcare facility is about to undertake new initiatives which provoke difficult ethical questions. The "groundwork" involves formal ethical advice and consultation, as well as strategic thinking about the relevant stake-holders who need to be informed and consulted, both locally and internationally. Finally, this unfortunate event reminds us of the need to promote subsidiarity and transparency in the Church's decision making processes.

References

[1] This policy will be published in a forthcoming issue of *the Australasian Catholic Record.*

[2] John Henry Newman, *The Via Media of the Anglican Church*, 3rd edition, (London: Basil Montague Pickering, 1877). See Newman's Preface to the third Edition, p.xliii.

Price Rise

For the first time in almost ten years' publication, we have had to increase the price of annual subscriptions to *Bioethics Outlook*. From the first issue in 2000, the cost of an annual subscription will rise from $35 to $40 for individual subscribers, from $50 to $65 for institutional subscribers and from $15 to $20 for students and pensioners. We trust that our readers will understand the need for this modest rise: in ten years the costs of production have gradually increased.

Enclosed with this issue is a subscription form. We would be very grateful if readers would renew their Associate Membership as soon as possible.

Assisted Reproductive Technology and Eugenics

Jean Kitahara-Frisch, S.J.

Eugenics has long had a bad reputation, due chiefly to the horrifying and humanly degrading experiments performed in its name by the Nazi regime. However, it has often been claimed that eugenics as a policy enforced by the State ought to be sharply distinguished from private decisions freely taken by individual couples aiming at optimising the quality of life of their children. Some may even claim that this second kind of eugenics practice should be regarded as one aspect of the "reproductive rights" that were vigorously defended at the 1994 United Nations Cairo Conference on Population Problems. It is therefore opportune to examine more closely the origins and social background of eugenics and to consider how basic the difference is between eugenics as a State policy and freely individually practiced eugenics. Nazism provided an abhorrent example of the first kind of eugenics. But why, it may be asked, could not one recognise as legitimate, and even beneficial, the possibility for parents to bring forth healthier children, children who possess some of the qualities they themselves highly value?

This second kind of eugenics, called by some 'utopian eugenics'[1] and by others 'privatised eugenics'[2] is in fact already widely practiced through the use of assisted reproductive technologies (such as pre-implantation genetic analysis of embryos) which apply our steadily more accurate knowledge of the genetic basis of human diseases as well as of other characteristics of our offspring. Such practices, by the eugenic mentality they foster, constitute a grave threat to future human society. Steps should therefore be taken to make sure that recent reproductive technologies do not promote a type of eugenics that would offend the dignity of human life.

The origins of eugenics

As has often been observed, Darwin's natural selection hypothesis, though based on abundant scientific data, was formulated in a specific historical context, namely the economic liberalism and free competition that characterised the rapid industrial and commercial expansion in nineteenth century England. Following Adam Smith, economic prosperity and social progress were considered to be the fruit of free trade and competition. These were seen to allow economic selection to eliminate ill adapted enterprises and let only the fittest survive. Although Darwin is said to have been unaware of the social implications of his theory, many saw how the theory suggested a similar selection to have occurred in the history of human life and to be at work in nineteenth century English society and economy. In both cases progress could easily be seen to result from the selection of the better adapted and the elimination of those who failed to adapt.

It is also important to notice how, beyond Darwin, these ideas further developed into what was eventually called "Social Darwinism". According to that doctrine, since free competition and selection were the motor of progress in society as well as in biological evolution, no attempt should be made by society to help the physically or economically poorly adapted. Helping the economically weak or physically handicapped by public laws would, it was argued, constitute an obstacle to social progress. Such human laws would indeed run against the basic laws of Nature.

Similar ideas were also found at the origin of what Francis Galton, Charles Darwin's cousin, called "Eugenics". According to

Galton, social and scientific measures should be taken so as to promote the uninhibited working of natural selection by eliminating less well adapted and weaker individuals and to favour the reproduction of the more vigorous and better adapted. "With characteristic Victorian confidence, Galton did not offer a critical discussion of the values underlying his judgements about proper and defective births. Assuming that his readers would agree about the characteristics that should be promoted, he set about the business of promoting them".[3]

In Germany, Ernst Haeckel, the well known embryologist and champion of evolutionism, believed it was the function of morality to favour natural selection. He therefore considered it to be the mission of the state to practice eugenic policies through the artificial selection of more vigorous individuals. Haeckel was particularly fond of praising the ancient Greek city of Sparta where only the perfectly healthy and well formed newborns were allowed to survive, the weak or physically handicapped being sacrificed shortly after birth. Thus, always according to Haeckel, the Spartan population enjoyed a continuous health and vigour not seen in other cities, an example which (he thought) should be followed in Germany. He also suggested that an appropriate commission (made up of physicians) should identify sickly and handicapped individuals so as to eliminate them by means of a painless injection or drug. This, he added, would be a benefit to these individuals and to society as a whole.

Needless to say, Haeckel's program was put into practice a few years later in Nazi Germany, with the horrifying results that gave rise, after the war, to the Nuremberg code of medical ethics and to the birth of Bioethics as a new discipline. It is important however to recall that similar policies had been proposed, well before Hitler, by biologists and physicians in a number of other countries including England and the United States.

Arthur L. Caplan has pointed out that " ... in the United States for much of the first half of this century, the mentally ill, and the retarded, alcoholics, recent immigrants ... became the object of government-sponsored sterilisation efforts aimed at preventing the spread of "bad" genes to future generations."[4] For her part, Margaret Sanger, the well-known propagandist of birth control "constantly spoke of children who should never have been born, those children who pollute the race and drain the world of its resources".[5] Similar ideas privileging the strong at the expense of the weak can also be found in other countries, and can be seen in books published in pre-war Japan.

Enforced and utopian eugenics

Examining the historical, scientific and social context of eugenics in the recent past may help us better to understand how to evaluate the possible long term social consequences of modern techniques for prenatal genetic diagnosis aiming at selecting the birth of healthy babies. Although it may be claimed that the selective abortion of handicapped or diseased foetuses proceeds from the free choice of individual couples and cannot be compared to the policies enforced by the State, it should not be difficult to see how prenatal genetic diagnosis, when accompanied with the abortion of foetuses carrying grave hereditary handicaps or diseases, can be inspired by ideas similar to those that guided the policies advocated by Ernst Haeckel. This is well perceived by groups of handicapped people and their families who see selective abortions as denying their right to life. Theirs is seen as a 'wrongful life' whose birth could have been prevented by a better medical technology. Accordingly, given recent progress in genetic diagnosis, "people who do bring handicapped children into the world will be looked upon as foolish and irresponsible".[6] Indeed it is not hard to see how individual choices will progressively alter society's view of handicaps.

Emphasising the distinction between compulsory and freely chosen eugenics may be thought to ignore the fact that individual choices are never made in a social vacuum. Certainly, the immediate motivation in the two kinds of eugenics may differ: there legally enforced, here freely chosen. But the long term social effects of both practices remain the same. Thus, enforced and utopian eugenics may be closer by their nature and their effects than currently imagined by many. To deny

1. A radical measure would be to restrict the use of IVF to cases of medically ascertained infertility. Such a restriction, however, is not likely to be readily accepted.

2. Public financial support for prenatal or pre-implantation genetic screening could be restricted to couples considered to be at risk of giving birth to severely handicapped children (because of previous such births). One could thereby avoid genetic screening becoming routinely practiced in all pregnancies, independently of the wishes of the mother.

3. All kinds of genetic diagnosis should be obligatorily accompanied by competent genetic counselling.

4. The target of pre-implantation or prenatal diagnosis should be limited to incurable, serious hereditary diseases or disabilities, preventing thereby a slide from negative eugenic practices to positive, quality enhancing eugenics. In this way one may hope to avoid the eugenic selection of embryos on account of their sex or because of preferred qualities (intelligence, good looks etc.).

However, it will be evident to many that the slide from negative to positive eugenic practices will not easily be prevented by mere legal regulations. The debate should rather be about where good eugenics shades into bad, and we can only make that judgement on the basis of our total view of life.

Conclusion

From what is written above, it will be clear that the basic question raised by the new methods of assisted reproduction and genetic diagnosis is that with which much of modern technology confronts us today. Shall we make use of technology for technology's sake? Or shall we use it only when it helps us and society to become more human? In other words, shall we become the servants of technology? Or shall technology remain at the service of our human ideals? Beyond individual choices, the new possibilities opened to us by advances in the Life Sciences once more force us to re-examine our basic values, what sort of society we wish to live in and leave to our children.

Obviously, a social mentality privileging the stronger and more richly endowed is inimical to the basic values proposed by Christianity. Not only does a Christian view of man regard all people as equal but it also sees in each of them a beloved "child of God". Christ himself, indeed, gave us the example of a preference for the sick, the weak and socially disadvantaged, those who are called "blessed" in the Sermon on the Mount. This is why, in the eyes of Nietzsche, Christian ethics was despised as an "ethics for slaves".

The recent tragedy of Nazism reminds us of how, even in a highly cultured Christian country, the way society looks at people, its commonly accepted value judgements, can influence the future of society and make it either less or more humane. The practice of genetic screening, far from being merely a matter for personal choice, must be seen in all its far reaching social and human consequences. As John-Paul II once said when visiting Hiroshima: "To remember the past is to become responsible for the future". The universally condemned crimes that resulted from the eugenic mentality of the Nazis should constitute a powerful reminder of the possible (not to say the likely) consequences of genetic screening and assisted reproduction technology as now practiced.

References

1 **Kitcher, Philip,** ***The lives to come,*** **Simon & Schuster, 1996.**

2 **Appleyard, Brian.** ***Brave New Worlds. Staying Human in the Genetic Future,*** **Viking, 1998.**

3 **Kitcher, Philip, op cit p 191**

4 **Caplan, Arthur, 'Handle with Care: Race, Class and Genetics', in Timothy Murphy & Marc Lappe (eds)** ***Justice and the Human Genome Project,*** **University of California Press, 1994. See also Ludmerer, Kenneth M.** ***Genetics and American Society: A Historical Approach,*** **Johns Hopkins University Press, 1972.**

5 **Murphy TF & Marc Lappe (eds) op cit, p 8**

6 **Appleyard, Bryan, op cit, p 135**

7 **Appleyard, Bryan, op cit, p 80.**

this would be to close one's eyes to the impact of private choices on society as a whole. "For me it is all too obvious that those who deny the title eugenics to anything other than coercive, socially targeted control of reproduction are doing so because they wish to avoid the Nazi taint.' [7]

Assisted Reproduction and Eugenics

More recently, in vitro fertilisation (IVF), a technique developed as a remedy for infertility, proceeds one step further in the same direction as prenatal diagnosis. This is because IVF, as now widely practiced, nearly always involves the production of so called "spare embryos". It therefore has led naturally to the analysis of the genetic qualities of the early embryos before implantation in the mother's womb, the embryos judged to present a genetic "risk" being discarded and only those possessing characteristics valued by the parents being selected for implantation. It therefore becomes evident that some of the procedures closely associated with IVF tend to foster in society a eugenic type of mentality that most people in our society once used to find deeply repugnant. This is a mentality that values people not for their humanity but for the qualities they possess. Moreover, as the practice spreads, there is little doubt that IVF will soon be used not only as a remedy for infertility but also as a means for choosing the qualities of one's child. In such a society, people with handicaps will then increasingly be regarded as the result of technology's 'mistake' or parents' 'irresponsibility'.

When discussing the ethical implications of in vitro fertilization as a technique for assisting reproduction, attention has often been drawn to the number of sacrificed human lives that accompanies each successful birth. Indeed, in discarding 'spare' embryos, we appear to take for granted the legitimacy of using abortion for promoting the 'quality' of human lives. For those who believe that human life begins at conception, this would seem to be a powerful reason for questioning the morality of in vitro fertilization and embryo transfer.

However, even for the many who do not share this view about the moment when a human child begins to exist, the selection process whereby some embryos are discarded and others allowed to further develop by being returned to the mother's womb is bound to raise disturbing questions. Confronted by the possibility of selecting lives, have not many citizens of the affluent democracies already begun to alter their attitudes toward the value of human life? If the desire to avoid the birth of severely handicapped children suffices to justify the discarding of some human embryos, are not we already being psychologically conditioned to eliminate embryos which, for a number of reasons, will probably not enjoy the quality of life their parents expect for their children? In short, does not the increasingly widely practiced IVF and pre-implantation diagnosis lead the individual members of our society to adopt standards and practices quite similar to these advocated as public policies by Haeckel and Galton?

If it remains uncontrolled, the practice of in vitro fertilisation and genetic diagnosis will create a capacity for a kind of "homemade eugenics" where individual families decide what kinds of children they want to have. At present, the kinds they select are those without disabilities or diseases. In the future some couples might have the opportunity, via the genetic analysis of embryos, to have improved babies, children who are judged likely to be more intelligent, or more athletic, or even better looking. How can this slide into eugenics be avoided, or at least its danger reduced?

Possible counter measures

Prenatal diagnosis is probably here to stay and the increasingly widely used methods of assisted reproduction will almost inevitably also lead to the practice of pre-implantation genetic diagnosis. The question asked here is: How can both kinds of diagnosis be controlled so as to avoid their fostering a eugenic type of mentality in society as a whole?

Recommended Reading:

Issues for a Catholic Bioethic

First a declaration of interest. There are three 'plunketeers' amongst the contributors to a newly-published volume entitled *Issues for a Catholic Bioethic:* Gerald Gleeson, Anthony Fisher and Bernadette Tobin. Nevertheless, I wish warmly to recommend *Issues for a Catholic Bioethic* to our readers. In my judgment it represents an outstanding contribution to the clarification of the teachings of the Catholic Church in the context of contemporary western culture, and to the exploration of their implications in the face of new ethical issues arising from developments in clinical practice and biomedical research.

Health care professionals, particularly those working in Catholic institutions, will find in this book a genuinely informative set of readings. Members of Boards of Catholic health care institutions will find plenty to challenge them in their own deliberations about the future of the institutions whose governance lies in their hands. Students of bioethics at both undergraduate and graduate levels, particularly (but not only) those whose course requires them to understand and reflect on the main elements of the Catholic health care tradition, will find it an invaluable resource. No library in a Catholic hospital, university or bioethics centre should be without it.

Issues for a Catholic Bioethic contains all the invited papers and a small selection of the submitted papers given at an international conference held in July 1997 to celebrate the twentieth anniversary of the foundation of the Linacre Centre in London. The Linacre Centre was established to help Catholics working in the fields of healthcare and biomedical research to confront the ethical issues which arise in their professional work in the light of the teachings of the Catholic Church. Distinguished authors who are represented in this book include German Grisez, John Finnis, Joseph Boyle, John Keown, Robert George, JJ Scarisbrick and the Centre's Director, Luke Gormally. The style of the essays is often demanding. However they will repay a careful reading: apart from anything else, readers will come away with a greatly enhanced sense of the points at which secularized Western society is now sharply at odds with medicine's traditional morality.

Contents

The topics covered in *Issues for a Catholic Bioethic* represent a selection of the issues which a specifically Catholic engagement with the field of bioethics must confront. They include the encounter with suffering in the practice of medicine in the light of Christian revelation, the meaning of health as the goal of medicine, collaboration and integrity and the problems of material co-operation, the distinctive role for a Catholic hospital in a pluralist society, the legal revolution from 'sanctity of life' to 'quality of life', the basis and limits of Catholic contributions to public policy debates in secular liberal societies.

Disputed Questions

A feature of the book is a discussion and debate of several 'disputed questions'. In each case much more than two views of the correct answer to the question posed is to be found in the debate between the disputants: each discussion shows how the Catholic tradition of theology and philosophy illuminates the human values at stake in some issue of secular debate.

Order from Plunkett Centre

Issues for a Catholic Bioethic may be ordered from the Plunkett Centre at a considerable saving on the cost of ordering it by airmail from London. Orders received by Christmas will be dispatched in the first week in February, 2000. Please use the accompanying order form.

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