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'Sanctity' and 'Quality': where is the conflict?

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In this issue

It sometimes happens that students ask us for copies of the first article in this edition of *Bioethics Outlook*. It originally appeared in *Bioethics Outlook* in 1992. John Quilter has taken the opportunity to revise and expand his discussion of the claim that one cannot consistently believe in both *sanctity of life* and *quality of life* considerations. He asks whether there genuinely is a clash between these two ideas and, if so, what that disagreement is.

Our second article was originally delivered as the Occasional Address to students graduating in health sciences at Australian Catholic University.

We are pleased to publish, for the first time, an Index to the first ten volumes of *Bioethics Outlook*. It forms an insert to this edition. Many thanks to Linda Purves for the painstaking work that went into its preparation.

In thinking about the idea of the sanctity of life, it is important to take our departure from examples that do not confuse the issues or introduce themes that complicate our reflections. I say this because of the prominence in ethical debates that notions of individual autonomy have come to have. For it is arguably something of a prejudice, that has developed from focussing on cases where patient autonomy is a prominent but under-appreciated issue, to think that human dignity is to be seen primarily and in the first instance in the exercise of autonomy and individuality. I do not want to challenge the idea that autonomy and individuality are *foci* for the notion of human dignity. I merely want to suggest that they do not exhaust the notion. Indeed, there are many ways in which we register the thought that human beings are somehow intrinsically valuable, sacred or values in themselves. This is the idea I want to explore and, in particular, its relationship to issues of quality of life.

The two cases which follow concern infants about whom realistic questions about their autonomy will not sensibly arise. Our question, then, concern two issues: (i) the sense in which these infants, or their lives,

may be understood to be "sacred" or inherently valuable, rather than valuable *by virtue of others' responses to them*; and (ii) how this idea can be squared with taking seriously 'quality of life' considerations in medical end of life decisions.

Baby Doe

In April 1982, a baby boy was born in Bloomington, Indiana, diagnosed with Down's Syndrome and a tracheoesophageal fistula. A complication like this fistula is found frequently among children with Down's Syndrome, much more frequently than among the population as a whole. Reconstruction surgery is normally the "indicated" treatment. Operating on a newborn always involves risk, but the prospects of successful restructuring of the malformed passages are good. In most cases of surgery, the child is able to eat normally. If no treatment were given for the fistula, Baby Doe would not have been able to eat, and stomach fluids would have reached the lungs. Non-treatment would with certainty have led to Baby Doe dying fairly quickly either by starvation of by pneumonia (contracted from the fluids in his lungs). The parents opted to forgo the surgery and chose to withhold food and treatment, to "let nature take its course".

Baby Jane Doe

In October, 1983, Baby Jane Doe was born in a community hospital in Port Jefferson, New York, and transferred to University Hospital at Stony Brook suffering from spina bifida. She had myelomeningocele, hydrocephalus and microcephaly. Doctors estimated that without any surgery Jane Doe might live for several weeks to two years. She could have easily contracted a fatal infection via the lesion in her back; or death might have followed from the continued pressure on her brain due to the hydrocephaly. Surgery would have included an operation to close the lesion in her spinal column and one to place shunts to drain the excess fluid from her head. With surgery, doctors thought that the baby could survive twenty years, though she would have had paralysis and double incontinence, epilepsy, a likelihood of recurrent urinary tract infections and likely repeated operations to clean blocked shunts and replace drainage tubes, along with severe mental retardation. The parents decided against surgery, opting for conservative treatment which included antibiotics to protect against infection.

Two Initial Views of the Cases

When people discuss these cases they often divide into two camps. In one camp, there are those who uphold the idea of the 'sanctity of life' and condemn those who endorse the decisions of the parents in these cases as guilty of discriminating against the handicapped, guilty of treating them unjustly, on the fatuous ground that lives characterised by handicaps are of insufficient quality to be worth living. In the other camp, there are those who, in defending the parents, will allege that their opponents are condemning these children[1] to a life of burdensome, mostly uncompensated drudgery or suffering, a life which lacks what makes human life worth living, all in the name of a principle that not even a humane, kind God could support; a life, moreover, that is likely to put immense strains on the families involved leading to more overall bad consequences than it justifies; and that this is most unfair especially since the person who condemns the parents for their decision to forgo treatment is herself unlikely to be prepared to take up those strains if the family is unprepared to do so.[2]

These two positions represent ends (or near-ends) of a wide spectrum of views concerning this kind of case. We will not discuss all the relevant issues here. What I propose to focus on here is the thought, illustrated by these two views, that there is a *clash* between upholding the idea of the sanctity of the life of the babies on the one hand and taking notice of what gets called the quality of their lives on the other.

The Sanctity of Life: What It is Not

The idea of the sanctity of life is often taken by its *critics* to imply claims such as that it is

wrong ever to take human biological life or not to save it where one can, or that all human life is equal on the mere basis of our shared membership of the human biological species. Nowadays, the classical critics of this kind are Peter Singer and Helga Kuhse.

Broadly speaking, their criticism takes the form of attempting to argue that the idea of sanctity of life gives rise to inconsistencies which, when analysed carefully, invite a radical shift in the basis of our decision making concerning medical end of life decisions.

These critics point out that proponents of the idea of the sanctity of life generally allow that one may be justified in taking the life of an attacker (even an insane, and so, innocent one) if that is the only way to defend oneself or protect the innocent. They also allow that it is morally permissible to let someone die under certain conditions, even where we may be able to do something, which would keep her biologically alive. A very frail old person who is ready for her dying, and for whom further intervention to resuscitate her is unreasonable, is an example. The traditional explanation of the permissibility of the withdrawal of treatment in a case like this is that the treatment is futile, extraordinary or unreasonably burdensome for the patient.

Another example on which the critics focus is the administration of narcotic analgesia for the purposes of relieving pain due (for instance) to untreatable bone cancer of a patient near life's end. The usual explanation here is the application of the Principle of Double Effect. On the sanctity of life account given thus, one may admit that hastened death is foreseeable, but argue that it is ethically misleading to describe the (good willed) healthcare worker who administers the narcotic as a *killer* of the patient.

The issues here are complex indeed. Among them are (a) whether there is an intrinsic moral burden borne by the notions of killing and letting die, and (b) whether, even so, there is a moral distinction to be drawn between letting a person die, in certain circumstances, and killing that person; (c) whether the distinction required by the Principle of Double Effect between foreseeing consequences and intending them is justifiable.

In the midst of such complexity, I wish to dwell a little on the relation thought to obtain between the idea of the sanctity of human life and the prohibition on killing another human being. (In so doing, I shall assume that (a) and (b) above can be made out in the affirmative.) For it is crucial to the critic's position that a defender of the sanctity of life idea takes it as *axiomatic* that, because life is sacred, it must not be taken.

A question of method in debate arises at this point. For while it must be allowed that a proponent of a given position could fail to see inconsistencies in her view, it has to be admitted that it serves the argument of a critic poorly to ascribe a view to her opponent, as part of her argument for the inconsistency of her opponent's position, that her opponent does not hold. Arguably, this is exactly what we have in this case. For nowhere has the sanctity of life position seriously maintained that there are literally *no instances* where letting another die, or even killing another human being, is ethically alright.

For clearly, the proponent of sanctity of life does think that withdrawing life sustaining treatment is morally acceptable *under certain conditions*. Further, she does not take the administration of narcotic analgesia to be impermissible, again, *under certain conditions*. Moreover, it is clear that she does not take such judgements to be incompatible with the thought that human life is sacred. In the light of such exceptions to the idea that it is wrong to kill and to let people die, one may justly complain, against critics of the sanctity of life principle, that they make their destructive job easier by attacking a *straw man*. The proponent of sanctity of life does not require that literally everything that can be done to save human biological life must always be done.

Sanctity of Life: A More Plausible Interpretation

Making this point, however, does raise the following question: What is distinctive about the principle of the sanctity of life? Does one mean that *biological life* – the heaving chest of respiration, the flow of blood through the

arteries, the electrical activity of the brain – must be preserved? Or does one mean "life" in the thicker sense of *"what makes human living worthwhile"*: friendship, love, intellectual discovery, aesthetic experience, the fruition of one's projects or the like?

I doubt that either of the two possibilities just suggested is what one is trying to express in the claim that human life is sacred. Specifying what it means has proved difficult. And it has to be admitted that not all proponents of the sanctity of life idea have served it well in their formulations.

Perhaps a useful approach to appreciating the idea is a thought, usually associated with the Prussian philosopher Immanuel Kant, that each human person is a centre of "unconditional worth": that is, each person is unconditionally deserving of a least a minimal level of moral deference and, we might say, awe.

In one way, it is odd to claim Kant as an ally in the notion of the sanctity of life. For his typical formulation places great stress on the concept of a requirement to respect "rational nature" in a human being, and conspicuously, in this debate, many human beings lack such a nature. This is so in our two cases, for instance. Neither potentially, nor actually, does either child enjoy what is normally meant when it is said that human beings are "rational". Yet, the proponent of sanctity of life will naturally enough want to defend the unconditional worth of these "two small people". Needless to say, I want to emphasise that aspect of Kant's thinking that focuses on the idea of "unconditional worth" rather than any alleged basis of that worth. This is an important point. For it is *prima facie* odd for one who talks about the *un*conditional worth of a human being, in his next breath to seek a "foundation" for this worth, as doing so, in fact, places a condition on the worth adverted to.

Part of the thought involved in the sanctity of life idea is that the person's being in this way unconditionally worth our moral solicitude and deference is such as to impose on the way we treat her a moral obstacle to merely using her or, for example, to killing her in the spirit of "putting her out of her misery" in the way one does a sick animal, or for example, to killing a wicked person in the spirit of "ridding the world of vermin"[3]. A human being is such as not to be owned as a pet, or a beast of burden, or as stock (as in "stock animal"). Nor is a human being to be killed for food, or even eaten for food (if, perchance, one were to come across one as roadkill, as one might take home and eat an animal found so). A dead human being deserves burial and his or her mortal remains "demand" some kind of *proper* treatment. The sense of "taboo" that is struck by the thought of using the remains of the dead for play or sport or as an object of ridicule marks this sense of the un-negotiable nature of the worth a human being in a certain sense has (even when dead). Violations of such limits on the ways we may treat each other initially prompt suspicions that the perpetrator must be insane, so impenetrable is the idea that one of us could treat another of us so.

Of course, many will point out that people do, occasionally treat each other so. Indeed, some cultures, for instance, permit cannibalism. This is not the point. The point is that they should not, that something has gone radically, even chillingly, wrong in their perception of another if they think they legitimately may do so. Thinking of another as a candidate for such treatment is to think of that person no longer as one of us, no longer as a fellow human being. The point is well made in the movie, *The Silence of the Lambs*, where the abductor of the young woman refuses to name her, and constantly talks to and about her as "it". Those we name as our fellows, or who are such as to be apt for naming as our fellows, are a certain kind of utter limit on our will, and are unconditionally deserving of a kind of deference and solicitude that partly marks morality out as a distinctive kind of thought, and vision of others (or – to put in another way – marks out a distinctive kind of morality). Human beings are precious and are not to be treated in ways that undermine this.

Perhaps we could put the idea by saying that 'each person *is* a value' rather than 'each person is valuable *because of such and such properties or characteristics*': a human being is worth our moral solicitude *unconditionally* upon, for example, being rational, having a continuing sense of self, or having good

character, or being capable of enjoying things which, as we say, "make life worth living" or the like. Thus an infants (and other human being), as one of our kind, (now not a merely biological kind) is one of us, our "fellow", and precious in the sense that is underscored by our treatment of her being subject to similar constraints to which we have gestured.

The Practical Significance of the Sanctity of Life Idea

We began our reflections on the sanctity of life idea by pointing out that its critics attribute to its proponents the thesis that, because human beings are sacred, it is always and everywhere impermissible to refrain from saving their life and to take it. We pointed out that this attribution ignores the broader context in which the language of sanctity of life is called into play. This is a context where, under certain circumstances, there are exceptions both to the prohibition on not saving lives and to the prohibition on killing; and where the application of the Principle of Double Effect argues that narcotic analgesia is alright, that it is not to be described, for ethical purposes, as an act of killing. Thus the prohibition against killing is unaffected by the manifest common sense of administering narcotic analgesia in certain circumstances.

I have just argued that the idea of the sacredness of human life is to be understood in terms of the unconditional value of a human being, in the sense sketched above. But while I have pointed out that this underwrites the thought that even the most black hearted of evil people should not be killed in the spirit of "ridding the world of vermin", in utter contempt, it would be precipitate, on *this* basis, to conclude that killing such a person might under absolutely *no* circumstances be a possibility for a decent person. The question is then: If one speaks like this, is one walking into the kinds of inconsistency that its critics allege against the proponent of sanctity of life?

My answer is that it is not. For it is useful to distinguish between standards and criteria that pertain to the making of practical or concrete decisions, and other concepts that provide us with an abstract background or a light in which we see the making of decisions, as a whole. Let me illustrate.

Compare the following two scientists. One is a Hong Kong-ese physicist whose specialism concerns nuclear particles and their behaviours. By day, this man conforms to the paradigms of scientific objectivity. He is a stickler for good evidence, he resists hasty generalisations, he assembles statistics patiently and uses them cautiously. He does not overdraw his conclusions, and his explanations of things that happen are in strictly scientific terms. Then at night he goes home to worship and propitiate his ancestor spirts, and cast joss sticks to assess his fortunes for the coming year. He will run to the harbour to watch for the coming good luck of seeing mermaids near the docking ships. The second scientist is an Anglo Australian who is imbued with the materialism that is normally associated with science in Australia. No ancestor spirits for him: when we die, that's the end of it. No praying, no romancing any stones to tell fortunes, no such hocus pocus, and certainly no mermaids. Our two scientists will meet at conferences on nuclear physics debate the debates of their discipline, think up and devise tests for hypotheses in the manner of nuclear physics. They will understand each other, they will admire each other's scientific expertise and imagination. Yet, each sees what they do in their shared discipline, their shared form of life, very differently. People can share a common life, but see this life, *as a whole*, in very different ways.

The idea of the sanctity of life is more like the light on which moral questions are seen than like a particular principle or value in whose terms delibaration about what to do will be conducted. This is not to claim, implausibly, that one's believing in the sanctity of human life will make no practical difference: as if one who propounds it and one who rejects it will be able to agree without residue on all moral questions. This is clearly not the case. But it is to say that the precise relation between the idea of the sanctity of life and particular prohibitions on killing or letting die is not determinate in advance, or obvious, or must be thus and so. This is where the critics of the sanctity of life idea go wrong. The way we characterise in general the idea of the sanctity of life, and the formulation of the prohibition against killing and its

difference from the prohibition against letting die, are distinct issues. On the other hand, of course, it is hard to see that if one sees other human beings in the light of the idea of the sanctity of life, one would be insouciant about whether one kills another or refrains from keeping her alive, where her burdens and the indignity of the necessary interventions are unreasonable. Even where, say, there is no choice but to *take* the life of an evil man to protect the innocent from his cruelty and brutality, the proponent of sanctity of life would have to conduct such extreme measures with real remorse, and it would be entirely understandable if her sense of guilt for having killed another, even such an evil man, got the better of her.

So, my point here is that properly to understand the idea of the sanctity of life, or the preciousness of a human being, does not settle all the important questions concerning the prohibitions against killing and letting die. In particular it cannot be said that the sanctity of life idea is *ipso facto* inconsistent with allowing exceptions to the obligation to save life and not to kill.

Do all exceptions to the obligations to save life have nothing to do with the person's quality of life?

Those who defend the sanctity of life against the likes of Baby Jane Doe's parents are often critical of those who endorse the parents' decision on the ground of the poor quality of the baby's life. Thus, the principle of the sanctity of life has commonly been thought to oppose the relevance of quality of life considerations in this sort of decision. If this is so, since the sanctity of lifer does not believe that there is an obligation, literally always and in all possible circumstances, to do everything one might do to keep, for example, the biologically-ill alive, the explanation of the apparent exceptions will have to omit all reference to considerations of the patient's quality of life.

There is a variety of gambits proponents of the sanctity of life use to explain the sorts of exception we have noted. These include appeals to the "futility" of treatment, a distinction between ordinary and extraordinary treatments, "what the reasonable person would decide" or to the applicability of the Principles of the Double Effect. Unfortunately moves such as these, parading as realistic limits on the obligation imposed by the sanctity of life to save lives, often serve only to conceal what really is an appeal to quality of life considerations.

Thus, for example, when one considers the sanctity of lifer who agrees that it is permissible to forgo artificial ventilation for one who is in an irreversible coma on the grounds that one does not have to apply extraordinary means of life support in such circumstances, the distinction between interventions that are ordinary and those which are extraordinary is one *which turns in part on the benefit to the patient of such intervention.* Consider the classical definition of "extraordinary means" of Fr. Gerald Kelly, which makes explicit reference to the idea of "unreasonable burden" to the patient[4]. Whether an intervention is of benefit to the patient or an unreasonable burden is not a morally-neutral judgement but, on the contrary, a moral judgement an aspect of whose form is an answer to the question "will the life the patient will have the opportunity to have if she continues to breathe be valuable enough to her to be worth, for her, the burden or indignity she will have to suffer in our continued intervention to keep her breathing?" That is to say, the distinction between ordinary and extraordinary means of life support is shot through with moral judgements, and one of the things relevant to these judgements is a patient's quality of life prospect.

Alternatively, others who defend the sanctity of life and reject the relevance of quality of life considerations to death and dying issues make appeal to "what the reasonable person in the position of the patient would decide". But here the ruling thought is that of the practically wise person, whose moral thinking is sound. When one asks what such a person looks to in determining whether continued life-supporting intervention is obligatory, mention will be made, correctly, of the benefits to the patient or the lack thereof represented by continued intervention. From here the argument goes as above.

Or again, some will speak of the "futility of

further treatment" as if such a consideration is either a morally neutral fact about someone's medical predicament or a moral feature of the situation that has no relation to the quality of life prospects of the patient. But this is not so. For the application of the life-saving intervention is not futile if one's objective is the maintenance of biological life: the ventilator will keep the chest heaving, the blood flowing, the brain firing. The futility of that is what is meant by describing the intervention as futile: for there is inadequate value or quality of life for the patient to compensate the indignity or burden of being kept alive so.

As I have said, there is a variety of strategies that proponents of the sanctity of life employ to explain why it is morally respectable not to apply all interventions that might keep a patient alive without appearing to make appeal to judgements on the quality of life the patient has the prospect of enjoying with continued intervention. I have only mentioned a couple. However I have, I think, said enough to show a connection between exceptions to the obligation to save life and the patient's quality of life.

Understanding Quality of Life Properly

The fact is that the prospects of a patient for quality of life are relevant in the sort of matter we are considering. The quality of a person's life, in this situation, is a measure of the benefit to the patient of continued life-sustaining intervention given the burden to the patient such intervention will represent.

Some may object that the notion of quality of life that I am using is not the one that critics of the sanctity of life employ. To this my reply is that it is not. I agree. Anyone who employs a notion of the quality of life as a foil to the idea that all human persons are unconditional values does not have the same concept of quality of life as I do. But it is similar. For it takes the question of the value to the person of continued maintenance of biological life to be relevant to our decisions about whether we must do all we can to maintain such life. It also takes seriously the thought that to operate and otherwise treat aggressively many infants suffering from severe problems could well be to condemn them to life that is unreasonably burdensome, whose quality of life may be insufficient to compensate the person the baby is and will become for this burden and indignity. To this extent, I would urge it is more honest of the sanctity of lifer to join her critic in debate on this common ground rather than simply to talk past her critic.

One final point of clarification is necessary. "Quality of life" talk is fraught with a temptation that "benefit/burden" talk avoids. For quality comes in degrees ranging from the excellent to the extremely poor. We sometimes think of the latter degree of quality as a negative amount of quality, as if a low-quality life form is a harm. But this is a deep and dangerous mistake. For to say that something lacks the benefits of some conditions is a far remove from saying that it, thereby, suffers harms. The lack of sight is not a good thing for humans, to be sure, and in the Aristotelian tradition of metaphysics it is thought of as a natural evil. But is not a moral harm to be blind, it is simply disappointing or the like. So, we do not have to let the blind die because they are suffering a harm by living. Lack of a benefit is not, in general, equivalent to suffering harm. Thus lacking the quality of life of a normal human being is not necessarily to suffer a harm, as low as the quality of life may be. Whether it is or is not depends on many other things, conspicuously, the medical condition of the person in other respects.

Treating Handicapped Newborns

It should now be clear where there is an important substantive divide between the critic of the decision of Baby Doe's parents and its defenders. The divide lies in the thought that, in general, a life characterised by mental retardation is of insufficient quality or value to the person the infant is or will become to imply that we have an obligation to do what we reasonably can to save that life where it is threatened. The proponent of sanctity of life will, rightly reject this idea. But the *ground* for this rejection is the crucial point. It is not that all human life is sacred in the sense that suggests that all quality of life considerations must be irrelevant[5]. It is rather a difference with the proponents of the baby's parents' decision over what makes life of such a quality as to be of sufficient benefit to the person to be worth living given what is involved in

keeping this life going. The critic of the parents of Baby Doe has it in mind that life with mental retardation is sufficient compensation in point of benefit to the patient for the relatively small (though admittedly not inconsequential) burden of surgery to correct the fistula[6] to justify surgery. In particular, life for Baby Doe is not a harm just because he is retarded.

From this angle, we may have to leave open the possibility that where an infant's disabilities (be they mental or physical) are severe and may require such a number or nature of interventions as to be so burdensome or such indignities as not be compensated by the value or quality to the child of its future life, they may be permissibly omitted. Indeed, it may be that, on occasion, this is so *as a matter of honouring the dignity of the person the infant is.* It may be that, depending on the details of the particular case of myelomeruingocele spina bifida, a decision like that of the parents of Baby Jane Doe is morally reasonable for the child's sake. One would have to consider, one by one, the problems of different sorts of birth defects such as Tays-Sachs or Lesch-Nyhan Syndrome, where the prospects for quality of life for the infants is not very great, the merits of the details of these conditions and the treatment options.

The doctrine of the sanctity of life, properly understood in terms of the unconditional worth of the human person, does not imply that quality of life considerations are irrelevant. It ought to be properly understood as a measure of the benefit for the patient of the life made possible by continued interventions, given the burden or indignity these interventions represent for the patient.

Notes

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1 Or, following Helga Kuhse and Peter Singer in *Should the Baby Live*? (Oxford University Press, 1985, pp. 129-146) the persons these children will become. Many defenders of this view tend to think that the newborn is not a 'person' or perhaps less a 'person' than a self-conscious human being. I do not wish to comment on this issue here. (See note 6) For the present point, this question can be ignored.

2 cf. Kuhse and Singer, ibid.

3 These examples are Raimond Gaita's in his *Good and Evil: An Absolute Conception*, Macmillan, London, 1991. They are discussed in Bernadette Tobin's Book Note in *Bioethics Outlook*, Vol. 2, 1991. I will assume without argument that infants deserve the minimal moral deference and moral solicitude that we owe each other, that is, that they are persons. In another place, I have made a suggestion about the proper understanding of the place the notion of a person has in ordinary thinking (see 'IVF: its moral evaluation', *Bioethics Outlook*, Vol. 2, 1991). It should be noted that I do not think that only human beings must be persons: maybe certain higher primates are and maybe we will build intelligent systems that turn out to be persons. I cannot be accused of 'speciesism' in this regard, even though I do think that there is little reason to be confident that any non-human persons exist.

4 In his *Medico-Moral Problems*, Catholic Hospital Association, St. Louis, 1958, p.129.

5 cf. G. Grisez and J Boyle, *Life And Death with Liberty and Justice*, University of Notre Dame Press, London, 1979, chapter 9, passim. The authors apply this sort of rational-substitute decision-making to the case of the incompetent who have never been competent. But there surely is nothing to the thought that there is some way such incompetent persons would have thought about their predicament, given they have never been able to think at all. At the other end of the spectrum of Catholic moral theology, McCormick does the same thing for young children in arguing that, were they rationally competent, they would see the benefits to others of allowing themselves to be experimental subjects, and so one can feel justified in using them as experimental subjects. This strategy, however, assumes what just is not the case: that there is any content to the notion of there being some way such an incompetent would think were he or she competent. One might as well ask that time it is on the sun!

6 My claim here requires even more careful formation. For in the case of many critics of Baby Doe's parents' decisions, the effect of the thought that Baby Doe is a person of unconditional worth is to silence the idea that the quality of life of Baby Doe (or the person he will become) is relevant to determining whether we should operate to repair the fistula. (For the idea of one moral consideration's silencing another moral consideration, see John McDowell, "Are Moral Requirements Hypothetical Imperatives?", *Proceedings of the Aristotelian Society*, Supplementary Volume 52 (1978). 13-29, #9-10.) The important point for our discussion is that this does not imply that quality of life considerations are never relevant to such decisions. They are, though they may not be in this case. In allowing that the weight, relative weight or relevance of a consideration such as quality of life is not constant in moral deliberation across variations in the situations facing it, I part company from Utilitarians or other Consequentialists who think of all moral deliberation as if it were a process of weighing. Thus I reject Proportionalism in moral theology.

7 There are other divisions between the sanctity of lifer and the proponent of the Baby Doe's parents' decision. An important disagreement between Kuhse and Singer and the line taken in this paper is the assumption I make about the personhood of the infant. This imposes constraints on permissible ways of thinking about how we may treat the infant that Kuhse and Singer's approach will not have.

Health care: career, profession, vocation?

Bernadette Tobin

As you graduate from a course which has prepared you for service in a vocation of health care, I would like to invite you to think – once again - about some contemporary ethical questions. How will you think about challenges to your professional ethics? What will be good reasons for accepting or rejecting various opportunities for the exercise of newly-acquired knowledge and skill which may come your way ? Indeed, what is the purpose of the knowledge and skill gained by students in the health sciences ? I shall sketch five scenarios.

** When the next Chinese woman, pregnant with her second child, who has fled from the one-child policy, is forcibly returned to China, will you do as you are told and use your nursing skills to sedate her and then help her on to the plane?*

** As a GP with a sports medicine practice, will you prescribe EPO to a sportsman friend who has recently been ill and who needs it for a short period to bring his endurance workload back to normal levels? If you won't, and if he can get it on the black market , will you at least monitor his use of the drug? You know its potentially harmful side-effects. After all, if you won't, someone less knowledgeable than you probably will.*

** George W Bush recently took a break from campaigning to reject a last-minute plea on behalf of someone sentenced to capital punishment. Will you use your nursing skills to administer a lethal injection to a duly-convicted criminal? Your training has prepared you effectively: you know what poison to use, how to prepare it, how to insert a cannula into a vein in each arm. And death by lethal injection is more humane, and indeed more economical, than death by electrocution.*

** When a professional golfer asks you to remove one of her breasts which is interfering with her golf swing, will you do it? She knows the risks as well as you. She's prepared to pay. And, as a breast surgeon who specializes in oncology, you can certainly do the procedure safely and well.*

** When a woman from the Pacific Islands asks you to circumcise her twelve year old son who seems reluctant even to be in your rooms, let alone to undergo the proposed surgery, will you do so? The procedure is culturally required, and once again if you won't do it, someone else less able than you no doubt will.*

Since, on the whole the law reflects good healthcare practice, we might start by thinking about the legal status of what is proposed. The fact that it is illegal to use performance-enhancing drugs says something about the responsibility of a doctor or a nurse in supplying them or supervising their use. And given Australian law, using one's technical skills to undertake capital punishment is luckily no more than a

theoretical possibility for us today (though one of our state premiers is currently flirting with the idea of following the lead of many states in the United States and re-introducing it). Even so, relying on whether or not a procedure is legal will be just a starting point: the law can always be changed (as some urge that it should be with respect to drugs in sport: since they are everywhere we should level the playing field and allow everyone to cheat!). And in any profession, there will always be a difference between thinking of one's responsibilities in a shallow and legalistic way ('what is our legal duty of care?) and thinking about whether there are responsibilities beyond those that the law requires us to fulfill.

Perhaps then the concepts we need are those of what is 'professional' and what is 'unprofessional'. Was it unprofessional of that nurse to sedate the pregnant woman being returned to China? Is it unprofessional of the paediatrician to ignore the reluctance of the twelve year old boy and impose on him a procedure which (as is generally the case) responds to no therapeutic need? How could it be unprofessional of a surgeon to remove a woman's healthy breast at her request when a part of the same profession is currently engaged in a trade war to secure solely for itself the right to mutilate perfectly healthy women in the name of youth and beauty?

Health care (medicine, nursing, human movement, etc.) genuinely is a profession, unlike many of the prestigious occupations which merely claim that they are. And the proper flourishing of its professions as professions is critical to a good society. So as we enter the professions of health care, each of us should come to care about the standards of our part of that profession.

However, notions of what is, and what is not, professional have their limitations. For instance, they are often deeply cultural. In some societies it thought to be unprofessional of a doctor to be frank with the patient about diagnosis, treatment options and prognosis. Indeed, until very recently, Australian standards of professional communication in health care often did not live up to what is characteristic of a genuine profession: they often did not enable the person who seeks help to make her own right and good decisions, as Mrs Whitaker knows to her everlasting regret. To put the point bluntly: a whole profession can get things wrong. Even if the nursing and medical professions as a whole had endorsed the sedating of a pregnant woman being forced on to a plane against her will, that would not have settled the matter for us. What was striking about that disgraceful event in our treatment of so-called 'illegal immigrants' is that there was no public outcry from the healthcare professions. Did anyone say: 'A good nurse would never do that.' Did anyone say: 'A doctor should never have asked a nurse to do that.'

How then are we to think about the challenges that will surely come our way in our chosen vocation, even if they are less dramatic and more everyday than the ones with which I began: for a doctor, writing a medical certificate for someone she knows not to be ill, for a nurse in a private hospital, going along with a treatment plan which has been adopted more in response to the family's demands than for the sake of the patient's need. My point is that we will have to reflect beyond what is offered to us in contemporary legal and professional standards. We will have to ask: Are the relevant legal requirements and professional standards as they ought to be? Is the proposed activity a good way of being a doctor or a nurse? Is the proposed activity the kind of thing that a good nurse (or a good doctor) would do?

At this point, many will be tempted to give up. Our culture has lost confidence in asking questions about good and bad ways of being a healthcare professional. On the one hand, various forms of relativism encourage us to despair about ever attaining the truth about ourselves and the purposes to which we devote our energies. And on the other various forms of fundamentalism are deeply discouraging in their insistence that some set of rules or some code or bible already contains the complete truth about this matter. But if

we learn anything during our time at university it surely includes two things. First, our human world is actually intelligible. By thinking we can come to see things, including the point of our profession, as they truly are. Our lives, including our professional lives, have a meaning that we do not impose on them but is there waiting to be discovered; Second, to reach that truth we need to dare not just to disagree but also to debate with each other. In his *Summa*, St Thomas Aquinas always starts with the objections of his opponents, not so that he can prove them wrong but to discover in precisely what sense they are right.[2] As today's Master of Thomas' order said to his fellow Dominicans, 'If I speak as someone who knows it all, untroubled by doubt, then people may be very impressed by my knowledge, but they may feel it has little to do with them.' [3]

In reflecting about the purposes to which we put the technical knowledge and skills we have acquired in our courses of study, several things will strike us. First, there is what philosophers call the reflexive aspect of human action. My decisions and choices have consequences not just for other people but also for myself. When I lie to a patient, I may or may not deceive her. I most certainly reinforce in myself the habit of being a liar. When I refuse to go along with a treatment plan in which I do not believe because, even though it would be easier to acquiesce than to stand up to a superior's instructions, I just won't do that to one of my patients, I may or may not benefit that patient. I most certainly will reinforce in myself a certain kind of integrity.

Secondly, there is a difference between what we now can do (as a result of having attained the level of technical knowledge and skill which is marked by a degree from a University) and what we ought to do. A nurse has the specialized knowledge to sedate an anxious person, but she needs also to be able to judge whether doing so is a genuine expression of her skill as a nurse or a perversion of that skill. A surgeon has the knowledge and skill effectively to circumcise a twelve year old boy: but she also needs to be able to judge whether or not that is a genuine expression of a therapeutic skill. If a healthcare professional's activities are not directed towards things like looking after someone who is ill, helping to restore that person to health, helping to relieve pain and the other sufferings associated with illness, encouraging someone to take responsibility for her own health, then, he or she is not acting as a doctor or a nurse. It is not up to the individual, or the society, or even ultimately the profession, to set the activities and goals that are characteristic of a profession. These are fixed by its nature. What counts as good nursing or good doctoring is not just what we make it to be: it's a way of life which allows for great diversity and flexibility but which includes certain inescapable and objective demands. When lived well, the health care professions inspire and require great attentiveness to, indeed love of, people who are reduced by illness and disability. But the knowledge and skill which marks out the best practitioners may be used (often lucratively) for purposes which have little if anything to do with that attentive love. We are each called to live up to the trust which is placed in us as we acquire the knowledge and skill which marks us out as graduates in a health care profession. That requires a kind of thoughtfulness which genuinely is an example of the life of the mind, initiation into which is the primary purpose of a university study.

Notes

This paper is based on an address originally given to graduands in health sciences at a graduation ceremony conducted by Australian Catholic University in Sydney on 28th April, 2000

2 As quoted by Timothy Radcliffe OP in *Sing a New Song*, Dominican Publication, Dublin, 1999, p 20

3 ibid, p 165

St. Vincent's Hospital, Lismore

in conjunction with

Plunkett Centre for Ethics in Health Care

A university centre of Australian Catholic University and St. Vincent's Health Care Campus Sydney

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(Flyer for IBC Course enclosed inside *Bioethics Outlook*)

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