Bioethics Outlook

ACU Centre For Ethics
St Vincent's Hospital, Darlinghurst, Sydney

ISSN 1037-6410
Vol 3, No.1, March 1992

In This Issue ...

Editorial	Bernadette Tobin	1
Australian Hospitals: Access and Financing	Colleen Leathley	3
Abortion: A New Perspective	Gerald Gleeson	6
Review: Ethics and Human Nature	John Quilter	8
Moral Decision-Making and Gender	Liz Hepburn	11
Note Book	Bernadette Tobin	12

ISSUES IN THE EUTHANASIA DEBATE

Bernadette Tobin

In November last year a referendum on physician-assisted suicide in the State of Washington in USA was defeated by a vote in which 54% of those who voted said "no". The referendum, known as Initiative 119, would have legalized "aid in dying" as a medical service to be performed by a physician on request from a patient suffering from a terminal illness which would result in death within six months. Proponents of the proposed legislation called it "death with dignity". Opponents saw it as a corruption of the vocation of medicine in which doctors would be encouraged to become not only healers but also, on occasion, killers.

The result of the referendum was surprising since, a few days before it was held, a nationwide poll (sponsored by the Boston Globe and the Harvard School of Public Health) had found a majority of Americans (64%) were in favour of the proposal, and the figure rose to 79% when adults over 35 years old were questioned.

Why was the proposal, which seemed so certain to be accepted, in fact rejected? No doubt some of the voters in Washington State would have been influenced by publicity associated with both Jack Kevorkian's so-called "suicide machine" and with the suicide of Anne Wickett Humphry, a co-founder with her then-husband, Derek Humphry, of the Hemlock Society. And equally certainly many voters would have been convinced by arguments against the wisdom of the proposal advanced by Catholic hospitals in the State of Washington and by such groups as "Physicians Against 119".

But we need to ask not only why the proposal was rejected, but also why it came so close to being accepted. Why is there such a groundswell of opinion in favour of euthanasia, and indeed in favour of the **active intervention** of a doctor in the care of a patient in such a way as intentionally to bring about the death of that patient? This has always been distinguished, both medically and morally, from the decision to withdraw or to withhold overly-burdensome and/or futile medical treatment. Let us start with the wording of the referendum.

Initiative 119

Initiative 119 stated (in part): "The people find that adult persons have the fundamental right ... to death with dignity through voluntary aid-in-dying if suffering from a terminal condition ... "Aid-in-dying" means aid in the form of a medical service, provided in person by a physician, that will end the life of a conscious and mentally-competent qualified patient in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive."

Confusion between morally-distinct practices

Thus the Initiative did not distinguish between two very different practices: a doctor's taking of steps with the direct intention of bringing about the death of a patient on the one hand, and a doctor withholding

or withdrawing certain forms of treatment because they have become overly-burdensome to and/or futile for the patient on the other. It conflated these two morally-distinct practices, and so, no doubt, contributed to the confusion about the morality of euthanasia which exists in the minds of ordinary people today. This confusion works in favour of those who wish to legalize euthanasia.

But this is not the only confusion. In public discussions about the legalization of euthanasia, several different ideas are interwoven. It is often hard to disentangle them, and then to consider them one by one. Cumulatively, they have the effect of disposing people to favour a change in the law. The following five ideas are among the most powerful.

The sheer power of modern medicine

There is, first of all, a widespread feeling that modern technological medicine is able to keep us alive in poor condition. People fear becoming powerless in such circumstances. And so, failing to make a distinction between active intervention by a doctor to bring about death and passive withholding or withdrawing of certain treatments, people lump both practices together and say they are in favour of euthanasia.

Economic Costs of Care for Certain Groups

Second, there is concern about the economic cost to a society of providing health care for an increasingly-aged society. To some, the care of the elderly, the senile, those in a "persistently vegetative" state, etc., seems a waste of much-needed and expensive health care resources. Better, some say, to spend these resources on preventative medicine for **future generations** than to expend them on the presently **unrehabilitative.**

Dismissal of Distinction Between Killing and Letting Die

Thirdly, there is an increasing tendency to dismiss an important moral distinction between killing and letting die. Some people, thinking that the **consequences** of our action are all that matter from a moral point of view, (and excluding from moral evaluation our motives, the circumstances in which we act, etc.,) assume that there is no such thing as an action that should never be done whatever the consequences. They argue that, since whether one kills someone or merely allows that person to die, the result (or consequence) is the same, there can be no moral difference between the two acts. But the distinction, though not easy to state in a few words, is an intuitive and sound one.

Personhood and its significance

Fourth, an idea that was until recently found only in academic philosophy is now gaining ground in the popular culture. It is that personhood is something that comes and goes in an individual, that some individuals are not yet persons (embryos and foetuses), that certain individuals are **never** persons in any strict sense of the word (handicapped newborns, for example), and finally that other individuals are **no longer** persons (the senile elderly, those in an irreversible coma, etc). When this idea - that one can be a human being but not be a person - is put together with the idea that the general moral prohibitions against both killing and letting die apply **only to persons,** it is not surprising that many come to the conclusion that, though we may not cause unnecessary pain to such individuals, there is no general moral prohibition against killing them or letting them die.

Autonomy: the fundamental moral principle.

Finally, moral philosophers since Aristotle have recognized that independence of mind or "personal autonomy" is a distinguishing feature of moral wisdom. And they have insisted that in a just society, this aspect of individual human well-being should be respected and enhanced by social institutions such as schools and hospitals. Today, however, autonomy in decision-making is often taken to be not just an important moral principle but rather **the** fundamental moral principle, the one which must be respected **before all others.** And so it is said: competent, informed adults have the right to make their own medical decisions, however wise or unwise their actual choices are, and doctors must comply with those choices or at least refer their patients to others who will.

Tackling the Issues Separately

It is now over ten years since the Netherlands became the first modern society to tolerate active physician involvement in the death of patients. The referendum in Washington State is only the first of a series of such referenda: similar ones are in the pipeline in California, Oregon, Florida and Washington DC. Granted the smallness of the margin by which the proposal was defeated, it may only be a matter of time before the vote will go the other way. Christians, of course, have their own reasons for opposing the legalization of voluntary active euthanasia. But anyone (Christian or non-Christian) who wants to contribute to the public debate about euthanasia by **opposing** its legalization needs to disentangle each of these idea in the fabric of the debate and, treating them one by one, to try to show the mistake that each involves.

Bernadette Tobin is a Research Fellow at the Centre.

AUSTRALIAN HOSPITAL SERVICES: ACCESS AND FINANCING

Colleen Leathley

In 1990, the Minister for Health, Housing and Community Services in the Commonwealth Government initiated a review of the Australian hospital system. This "National Health Strategy Review" is the first of its kind since Medicare was introduced in 1983. To date, seven "Background" papers and two "Issues" papers have been published as part of this Review. Comments from interested parties have been sought for the purpose of a reassessment of Government policies.

In the following article, Colleen Leathley does three things. She sets out the main features of Issues Paper No 2: Hospital Services in Australia: Access and Financing, which was published in September, 1991.[1] She then summarizes the main points in the first response of the Australian Catholic Health Care Association (ACHCA), which was sent to the Commonwealth Government in December, 1991.[2] Finally, she outlines how far there is agreement between the position of the Australian Catholic Health Care Association and the position advanced by the Australian Private Hospitals Association.[3]

1. HOSPITALS IN AUSTRALIA

The need for an examination of Australia's hospital services was recognised in 1989 by the Australian Health Ministers' Advisory Council (AHMAC). A working party group was subsequently established to identify issues and problems evident in the existing system and to canvass possible approaches for its reform.

A major aim of Issues Paper 2 is to generate public debate on how the operation and financing of Australia's hospital system might be improved. The Review Team's analysis of primary and secondary data identified the current issues facing the hospital system as:

- Significant inter-state variations in hospital utilisation;
- Marked inter-state differences in the ratio of hospital beds to population;
- Private elective-surgery patients receiving preferential treatment in public hospitals due to financial incentives for treating private patients in public hospitals;
- Inappropriate waiting times/lists for elective surgery in most states;
- Long waiting lists for elective surgery despite increased admissions;
- Significant intra-city differences in elective surgery waiting times;
- Improved co-ordination of states' hospital and health services through Area Health management;
- Lack of agreed, comprehensive and published metropolitan hospital plans;
- Lack of incentives for public hospitals to improve productivity;
- Major shortcomings in existing governmental arrangements for the planning, financing and administering of hospital services;
- Funding decisions based on historical allocations;
- Considerable variations in doctors' remunerations in public hospitals;
- Balance and respective roles of public and private hospitals reflects past financing systems rather than a planned approach to an optimum system;
- Rationalisation of public and private beds, facilities and numbers is needed;
- Increasing admissions and occupancy levels in private hospitals placing pressure on private health funds;
- Unclear long-term viability of private health insurance due to deteriorating membership levels and profiles;
- Bed-days expected to drop due to projected growth in admissions being offset by reduced lengths of stay.

Noting that health is a difficult and often divisive issue, the writers of the Review despair of finding one "true" way to finance hospital services. They claim general public support for the Medicare system, however, and would like to see it refined, rather than abolished. They see considerable merit in having capital funds injected into Australia's public hospital system to improve efficiency, achieve a more equitable distribution of beds and meet appropriate bed norms. The core reforms they advocate are:

- Area health management
- Population-based resource allocation models
- Price mechanism based on casemix
- Strategic hospital plans having Commonwealth and State involvement
- Judicious restriction of public and private bed supply
- Altered internal organisation structures in hospitals
- Improved quality assurance mechanisms
- Statewide management of elective surgery waiting lists
- Improved public hospital productivity
- Improved information systems
- Resolution of Commonwealth/State roles and responsibilities
- Revision of relativities in Medicare Benefits Schedule

Acknowledging that such changes will take time, the Review proposes the following **incremental**

measures: treating some public patients in private hospitals; changing re-insurance arrangements; transferring 'nursing-home type patients' to the Commonwealth residential care programme; and reviewing assessment criteria.

Three Options

In an effort to encourage and inform public debate, the Review presents three possible options through which Medicare's universality and efficiency might be enhanced. They are:

(1) institute equal patient status in public hospitals (ie. remove financial incentives preferentially to treat private patients in public hospitals)
(2) extend choice of doctor and hospital to all through a national insurer
(3) extend choice of doctor and hospital to all through a national insurer and private health funds under an opting-out arrangement.

A fourth option implicitly identified in the Review is to introduce the core reforms and some incremental measures without altering financing arrangements.

2. A CATHOLIC RESPONSE

Approximately 10% of Australia's hospital beds are owned and operated by the Catholic Church, including 9% of the nation's teaching hospitals and almost half the major private hospitals. Twenty two public hospitals, thirty six private hospitals, over two hundred nursing homes and hostels, and numerous home and community care services are Catholic. The Australian Catholic Health Care Association therefore has a substantial interest in the National Health Strategy Review.

Background

Catholic hospitals have a long tradition of serving ordinary people, local communities in provincial centres and disadvantaged groups in the community. With Medicare, however, Catholic private hospitals have been pushed into serving a smaller and more 'elite' community group. A funding system which enables Catholic public and private hospitals to be used by the wider community is now sought.

Vision

ACHCA's underlying vision is "to see the people of Australia achieve and maintain a health service which is fully accessible to all Australians and which, through its standards of care and concern for the dignity of the person, exemplifies values as inspired through the healing ministry of Christ".

Values

The social values underpinning this vision may be summarized as: respect for the dignity of all persons; a preferential option for the poor; pursuit of the common good; responsible stewardship of resources; and the principle of subsidiarity. In addition to these quite general principles, ACHCA has a set of secondary principles specifically concerning health care: universal access to public health care; high quality health services; choice and pluralism for individuals, families, communities, and health care agencies; integration and continuity of care to meet the needs of the whole person; careful determination of resource allocation priorities; efficiency and accountability; and a primary orientation towards responding to people's needs.

ACHCA's Position

ACHCA concurs with many of the Review's findings and recommendations, with some notable caveats. It notes that:

- Current access and funding systems are inequitab' and will increase existing imbalances in the public and private hospital systems and private health insurance;
- The current system of funding public hospitals based on historical patterns is flawed. (ACHCA supports a funding system based on cases treated, which would reward efficiency and restore positive servicing incentives to public hospitals. It notes that funding for those requiring on-going or extended care would need to be assured);
- A move towards Area health management, with separation of purchaser (Area) and provider (hospital), is desirable. This might involve corporatisation of government enterprises and the contracting out of management to independent bodies. Future health plans need to involve all relevant parties, including Catholic public and private hospitals;
- A funding system based on a case-mix pricing mechanism is desirable;
- The future of private health insurance is uncertain as the aged, the chronically ill and low-income earners are increasingly bearing the cost of private insurance. High out-of-pocket costs for private hospitals could see these people opting for preferential treatment in a public hospital, increasing pressure on both public hospitals and the uninsured;
- The overall bed supply in Australia should not be expanded without better controls on excessive utilisation;
- Fundamental reform measures are needed.

ACHCA does not consider that the Review's core reforms will in themselves be sufficient to address the current substantive access and financing problems.

Noting the difficulty of designing and implementing fundamental reform in a short period without causing

major disruption, ACHCA supports the Review's incremental measures and offers suggestions for meeting them.

Regarding the Review's three options, ACHCA sees merit in Option 3 which gives choice of doctor, hospital, and health insurer to all Australians. It is consistent with the principles of universal access, choice and pluralism, equity in financing, efficiency and accountability. Prerequisites for this scheme would be:
- Public hospitals continuing to provide some free medical care and avoiding excessive charges;
- Continued flexibility for medical charges in private hospitals;
- No out-of-pocket costs for public hospitals;
- Private hospital fees and reimbursement levels being negotiated by health insurers;
- Determination of the amount by which Government will subsidize 'basic health insurance cover';
- A regulatory environment to ensure flexibility of private health funds;
- Clarification of the role of Area Health Authorities and the provision of a comprehensive mix of non-inpatient services.

3. AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION

The Australian Private Hospitals Association (APHA), in its contribution to this review of hospital services, also endorses Option 3, with three significant additions to its provisions:

(1) that Medicare continue to cover hospital costs of 'cardholders' and provide free access to public hospitals, and that choice of doctor in public hospital and $200pa for having private health insurance be introduced;
2) that a subsidy scheme be introduced to encourage 'non-cardholders' privately to insure;
(3) that private health insurers cover shared-ward accommodation and in-patient medical treatment costs.

The APHA proposal is designed to be cost-neutral to Government. The Australian Catholic Health Care Association supports it on the understanding that it is universal, that cost-control measures are introduced to prevent private health insurance becoming too expensive, and that medical and hospital charges in public and private hospitals are resolved. People not electing privately to insure would still need to have a basic level of health insurance to cover medical costs.

The Profit Motive in Health Care

The Australian Catholic Health Care Association is concerned that any new financing system should be motivated by a responsiveness to the genuine health care needs of the community, and not simply by a profit motive. Those typically disadvantaged by a profit dynamic in health care are the chronically ill, those needing unpredictable episodes of care, and low income earners. ACHCA regards these groups as high priorities for care and rejects a system driven purely by market or profit motives.

The Australian Catholic Health Care Association seeks a public hospital system with better morale and stronger incentives for quality and innovation, and a more accessible private hospital system. It accepts that a more balanced funding system needs to be developed and welcomes the chance to make a contribution to this process.

Regarding the Review to be a good starting point, rather than an end, the Australian Catholic Health Care Association calls for a major Commonwealth-State research effort into hospital services. The project should give particular attention to the allocation of resources and care of the frail aged and chronically ill.

Australian Catholic Health Care Association welcomes comment on their submission from interested parties. Their address is: PO Box 57, Monaro Crescent, ACT 2607.

References:

1 National Health Strategy: *Hospital Services in Australia. Access and Financing. Issues Paper 2.* DHHCS, ACT, 1991

2 Australian Catholic Health Care Association: *Response to the National Health Strategy's Issues Paper 2.* ACHCA, ACT, 13 December 1991

3 Australian Private Hospitals Association:*The APHA Hospital Financing Policy.* APHA, Deakin, 1991.

Colleen Leathley is a Research Associate at the Centre.

HEALTH, LAW AND ETHICS CONFERENCE: TORONTO '92

The third International Conference on Health, Law and Ethics will be hosted by the Canadian Institute of Law and Medicine in Toronto, Canada, from 19-23 July 1992. Topics to be presented include: national health care systems; women's health; AIDS; epidemiology and public health; reproductive health; and transplantation

Further information is available from:

Lawrence Gostin, JD
Toronto 92
American Society of Law and Medicine
756 Commonwealth Avenue
Boston MA 02215, USA
Ph: (617) 262-4990
Fax: (617) 437-7596

RENEWING THE DEBATE OVER ABORTION

Gerald Gleeson

A regular feature of Bioethics Outlook will be a review of current writings in bioethics which are judged of special interest to our readers. In this first review, Gerald Gleeson examines a recent contribution to the philosophical discussion of abortion.

• • • • • • • • • • •

Arguments over the morality of abortion have become increasingly polarized and seemingly intractable. The moral seriousness and the political complexity of the issue are well recognized by all sides to the debate. The sheer number of abortions annually in Australia should be enough to engage all our resources of wisdom, courage and political will. But finding common ground on which to build moral consensus is hampered by at least three factors.

First, for those convinced that human life is to be respected as personal from its very origins, compromise would seem to be ruled out in advance: since nothing could ever justify the deliberate taking of new human life, any talk about the right to abortion is misplaced.

This impasse is compounded, secondly, by the fact that those who advocate a woman's rights to control her reproductive destiny are usually so focussed on defending these putative rights that they ignore the possibility that someone might nonetheless do wrong when exercising them. They thus overlook the possibility of agreeing with their opponents that in many cases, at least, abortion is unjustified.

Thirdly, in so far as it is relevant to arguments on both sides of the debate, disputes about the status of the zygote and foetus continue - as they must - to defy resolution in terms of some agreed, morally-neutral criterion. Whether newly-conceived human life is a person, has a 'soul', or has the right not to be killed, could not be the subject of some new scientific discovery, or some additional piece of information that we do not yet possess. But, in the absence of agreement over the status of the foetus, we are left with simply a confrontation of moral attitudes.

In the context of these three factors, Rosalind Hursthouse's recent article,"**Virtue Theory and Abortion**"[1], is especially enlightening. Hursthouse has a wider project: the defence of a virtues-based theory, rather than deontology or utilitarianism, as the most adequate way of doing ethics. I will not examine that wider issue here; instead, I wish to highlight some of the ways in which she applies virtue theory to the abortion debate, ways which, I believe, are helpful in overcoming the impasse noted above.

I begin with her account of these three rival theories. The **deontologist**, she writes, explains **right action** in terms of its agreement with some rational **moral rule** (derived from nature, or reason, or God, etc.). The **utilitarian** explains **right action** in terms of its **consequences** being conducive to human happiness. **Virtue theory** explains **right** action in terms of a **virtuous agent**: An action is right if and only if it is what a virtuous agent would do in the circumstances.

A virtuous agent is one who acts virtuously, that is one who exercises the virtues, where virtues are character traits a human being needs to flourish or live well. Virtue theory acknowledges that acting rightly is often difficult, and calls for great moral wisdom. When faced with the question, "What should I do?", virtue theory advises one to ask: "If I were to do such and such now would I be acting justly or unjustly (or neither), kindl, or unkindly [and so on]?" (p. 227). Moral wisdom thus presupposes a good moral upbringing which has among other things, educated one in the virtues of human living, in what counts as a worthwhile and valuable human life, and has helped one attain sensitive discrimination as to what virtue requires in a given case.

Turning to the morality of abortion, Hursthouse's approach sheds new light on the second and third factors identified above: on the relevance of women's rights, and on the status of the foetus. [Since, she believes that abortion may sometimes be the right course of action, though usually involving some evil (pp. 242-3), her account will not as it stands satisfy those who believe abortion is always wrong.]

Women's Rights

With respect to a woman's rights, Hursthouse notes that even if the right to abortion exists, "in exercising a moral right I can do something, cruel, or callous, or selfish, light-minded, self-righteous, stupid, inconsiderate, disloyal, dishonest - that is, act viciously, ... people do not live well when they think that getting what they have a right to is of preeminent importance" (p. 235). It follows that attention to the various virtues and vices under which our conduct may fall takes assessment of the morality of abortion far beyond the narrow, and often rather arbitrary, concern with rights.

Status of the Foetus

With respect to the status of the foetus, Hursthouse argues that moral wisdom does not turn on recondite knowledge, or the discoveries of philosophers and scientists. She advances the "startling conclusion" that "the status of the fetus is, according to virtue theory, simply not relevant to the rightness or wrongness of abortion (within, that is, a secular morality)" (pp. 236-7).

More precisely, all that is relevant are the familiar biological facts about human reproduction, along with all the emotions and attitudes we humans have towards them:

> *"I mean such facts as that human parents, both male and female, tend to care passionately about their offspring, and that family relationships are among the longest-lasting ... The premature termination of a pregnancy ... connects with all our thoughts about human life and death, parenthood, and family relationships...*
>
> *... to think of abortion as nothing but the killing of something that does not matter, or as nothing but the exercise of some right or rights one has, or as the incidental means to some desirable state of affairs, is to do something callous and light-minded, the sort of thing that no virtuous and wise person would do. It is to have the wrong attitude not only to fetuses, but more generally to human life and death, parenthood, and family relationships" (pp. 237-8).*

There is much more in Hursthouse's article, and in her book, *Beginning Lives,*[2] both with respect to abortion and to virtue theory more widely. A virtues-based ethical theory enriches moral debate by directing our attention to the whole gamut of our feelings, attitudes, reactions, beliefs as they concern what we regard as worthwhile, as intrinsically good for human beings, and to the practical wisdom required for human flourishing. In the context of abortion, virtue theory directs us to:

> *"... our thoughts about the value of love and family life, and our proper emotional development through a natural life cycle. The familiar facts support the view that parenthood in general, and motherhood and childbearing in particular, are intrinsically worthwhile, are among the things that can be correctly thought to be partially constitutive of a flourishing human life" (p. 241).*

It follows that very often the primary moral judgment about abortion will concern the circumstances which make it an option: circumstances which "will be a ground for guilt if getting into those circumstances in the first place itself manifested a flaw in character" (p. 243). Hence, while Hursthouse allows that at times, abortion may be the 'right' decision, she argues that "it can still be the reflection of a moral failing" because of the deficiencies of moral character which led one to be in such circumstances.

Secular Morality

This conclusion will not be strong enough for those who believe that abortion is always wrong, no matter how difficult the circumstances. Whether virtue theory can - or should - be developed to include the recognition that innocent others have an absolute right never to be killed remains a difficult question. It should be noted, though, that Hursthouse is writing as a philosopher concerned with the morality of abortion regarded in secular terms. Clearly, religious convictions may also further enrich a virtues-based approach.

Nonetheless, the virtues approach is a great advance on the narrow focus of both deontology and utilitarianism. It provides a much richer vocabulary and more discriminating parameters for moral assessment. It helps to clear the ground for moral agreement, bringing light rather than heat, to the debate over abortion.

References:

1. Rosalind Hursthouse, 'Virtue Theory and Abortion', *Philosophy and Public Affairs,* 20 (1991), 223-246

2. Rosalind Hursthouse, *Beginning Lives,* Oxford: Blackwell, 1987

Fr. Gerald Gleeson is Co-Ordinator of the Centre for Ethics.

INTERNATIONAL ASSOCIATION OF BIOETHICS CONGRESS

The inaugural congress of the International Association of Bioethics will be held in Amsterdam, the Netherlands, from 5-7 October 1992. Organised and hosted by the Health Council of the Netherlands, a focal point of the Conference will be international and cross-cultural aspects of bioethics.

The Association was convened by Prof Peter Singer, Dr Helga Kuhse and Prof Dan Wikler. It currently operates under a 22-member, 16-countries interim Steering Committee. At the October Conference a constitution will be presented for approval and a Committee and Executive elected to govern the Association. The Conference will examine cross-cultural issues through presentations, informal workshops and discussion groups.

For further information on the Conference, contact: Mrs Tineke Stegeman
Gezondheidsraad
Postbus 90517
2509 LM's-Gravenhage
The Netherlands
Fax: 31 70 383 71 09

For further information on the International Association of Bioethics, contact:
Mrs Kay Boyle
International Association for Bioethics
Centre for Human Bioethics
Monash University
Clayton VIC 3168
Fax: (03) 565-3279

ETHICS AND HUMAN NATURE

Ethics, Politics and Human Nature, edited by Ellen F. Paul, Fred D. Miller, Jr., and Jeffrey Paul, Oxford, Basil Blackwell, 1991; xii pp., 191 pp.; ISBN 0-631-17885-6.

Reviewed by John G. Quilter

There are ten essays in this collection. The first three could be described as dealing with the notion of human nature at work in the moral thought of the Modern period. With characteristic clarity and precision, Jonathon Barnes writes with a focus on Alexander Pope's *Essay on Man.* Annette Baier sympathetically discusses Hume's ideas on the importance of natural human motivations for moral theory. David Gauthier advances an interpretation of Rousseau's autobiographical writings connecting them very illuminatingly with the educational and political material.

Evolution and Human Nature

The authors of the next four papers are all dedicated to the proposition that the theory of evolution by natural selection can throw great light on human nature. Michael Ruse's offering is a bridge between the first three articles and the next three. Ruse casts about for intellectual ancestors of his own "Darwinian" theory of the phenomenon of morality in human culture. Alexander Rosenberg then gives a largely unoptimistic rational reconstruction of what he takes to be the most plausible place biological science might have in an account of morality. In the next two articles, Richard Epstein and Andrew Oldenquist sketch their more sanguine versions of the light Biology throws in the account of morality.

Contemporary Ethical Issues

The papers of Christina Sommers, Zbigniew Rau and H. Tristram Englehardt, Jr. deal with contemporary issues to which the idea of human nature is salient. Sommers discusses critically the claims of radical, gender Feminists that the received notion that there is some fixed and gendered human nature is a fiction of male domination and critically scrutinises the authoritarian character of the claims on which the politics of this school of Feminism is based. Rau considers the thesis that a political vision of the good society can be based on a conception of potential human nature, by examining the example of such a vision worked out in Communist Europe and The Soviet Union. Finally, Englehardt argues that there are no non-theological arguments to be derived from the concept of human nature against the moral acceptability of germline genetic engineering of a therapeutic nature.

A Significant Omission

All ten papers are original for this collection. The authors write clearly and economically and generally provide reader-friendly, necessary background. As a group, they represent quite well the main trends in the study of human nature as an idea important for moral and political philosophy.

A minor criticism is that more interaction is desirable between some of the lines of thought expressed in the book. A more substantial criticism is that since the announced theme of the book is the exploration of the importance of human nature to moral and political philosophy, the omission of an examination of the Aristotelian tradition is a mistake. Ruse discusses Aristotle with some approval but ultimately distances himself from Aristotle's view of the objectivity of moral thought. But that is a.. There has been so considerable an amount of interesting and important work in moral philosophy from the angle of what an Aristotelian approach to human nature might have to say to ethics and politics that such an anthology as this would have done well to have included it.

I wish now to discuss some matters raised by the articles which are of interest to those working in Applied Ethics. I will start with Rosenberg's argument, paying particular attention to the matter of therapeutic germline genetic engineering and its moral status.

Rosenberg's article assessing the prospects for a biological illumination of morality is excellent. He argues that the most that can be expected from Biology towards the understanding of morality .. that it might provide a plausible story (though on an admittedly thin evidential base) of why the observation of moral constraints emerged in human society. Such a story, being told in terms of the individual's biological-natural approximation of maximal inclusive-fitness, may well have the value of contributing to the traditional philosophical task of explaining why the moral sceptic should be moral. Rosenberg leads the reader through the relevant technicalities painlessly.

The Limits of Sociobiology: Our Other Values

Rosenberg leaves us with the best sort of argument there is for the limits of Sociobiology. Its central plank is his observation that the account of the emergence of morality works only to the extent that we are approximaters of inclusive-fitness maximisation. He makes the point that this is too

easy to prove. For there is absolutely no specification of how closely one has to approximate maximal inclusive-fitness for evolution to select you. One only has to approximate it sufficiently to survive the competition and limitations of one's environment. That one's species is still about shows one's strategies for inclusive-fitness maximisation are approximate enough.

As Rosenberg points out, this view is fairly short on "empirical content". But the problem is really worse than that. For it implies that human beings may indeed act for the sake of other things or act in ways that are not inclusive-fitness maximising and still approximate maximal inclusive-fitness adequately to survive. That is, we in fact have other values than the maximisation of inclusive-fitness.

There are other things which our caring about gets us to do, and these values have survived the sieve of natural selection. But in so doing, they effectively escape **explanation** by natural selection. We have such values but there is no account of how they got there. Our beliefs in, and practices according to them, are part of the raw material natural selection has to "work on". Within the explanatory strategy of positing the competition to be relatively inclusively fit, such values are accidental, just there.

So, from the perspective of explanation in terms only of natural selection, there is no question "Where did these values come from?" susceptible of answer. But surely, various combinations of accident, socialisation and the correctness of these beliefs and practices will fill these gaps left by evolutionary biological theory. Are we then to sacrifice the light to be gained from such non-biological explanations of these matters for the sake of a speculative attempt at intellectual hegemony by evolutionary Biological theory? To say that we should, without better than the best defences of Sociobiology to date, seems preposterous. There is more to us than what our evolution requires.

Mere Nutrition v A Good Dinner

Moreover, biological facts may be relevant to our understanding of ourselves without requiring appeal to evolution. Biological functions or biologically-based features of life may themselves be intrinsically valuable, or aspects of intrinsically valuable activities and projects that have nothing to do with surviving the competition to be relatively inclusively fit. For example, we certainly want **good** food rather than merely nutrition. Part of what seems to explain the importance we place on interesting and diverse food is simply that this is fun or somehow just good on its own account and also that the preparation and savouring of good food is an occasion of social intercourse for its own sake. This has nothing, it seems, to do with our relative inclusive fitness. Good food is part of a decent life, that's all.

Yet, the biological fact that we must have nutrition to survive is obviously part of the explanation of our caring about good food rather than, say, caring about the number and size of the leaves on the trees around us that contribute to beautiful scenery.

So biology can contribute to our understanding of ourselves without requiring appeal to evolutionary theory. This is important, for it weakens the idea that ways in which our biological nature contribute to what we are are themselves the inevitable results of an undoable evolutionary history to whose authority we can only defer. Biology can matter without condemning us to evolution's haphazard successes.

Non-Socialized Gender Differences

It seems plausible that much that separates the genders is "based on" biological sexual differences between males and females. That is, once the effects of socialisation are filtered out in explanations of the patterns of difference between women and men, there remain such facts as that the sexes have different endocrinologies, musculature and different things to cope with in their psychosexual developments. It is likely that these factors will have effects on what individuals find intrinsically valuable.

These factors will also have an effect on what arrangements in relationships with others it will make sense to participate in. But even at the level where sociobiological approaches seem most apt, it is worth pointing out that biological adaptation is selected for relative inclusive fitness **in environments** given the other abilities genetic endowment affords.

Thus it may well be that the specific environmental factors which favoured selection of such gender differences as the traditional sexual division of labour made sense in that environment. Further, Sommers rightly criticises those gender Feminists who assume that women "who want to be women" are necessarily benighted. Such women rightly find value in such arrangements, even great value and it is simply illiberal to condemn that.

This, however, is no aid and comfort to the essentialist view that such sex-related gender distinctions are universal or invariable or that they are necessarily worth hanging onto. Like rotten burroughs and property-based franchise rules, genderised moral types tied to biological sex lose their appearance of inevitability and justification if the conditions that gave them such point as they had disappear and the types become tools of

frustration and manipulation and an excuse for protecting vested interests rather than avenues of liberation and empowerment. Sommers' worthwhile criticisms of certain trends in gender Feminism should not lead us too far from the insight we owe this radical line of thought.

Further, the idea of germline genetic engineering raises the prospect of our deliberate cultivation of the biological determinants of the potentialities with which individuals will be brought into their environment.

The constraints and possibilities our biology represents for us in this morally-important matter reflects upon our understanding of ourselves in non-evolutionary ways. This is obscured by a fascination with Sociobiology. For as an explicit theme of practical deliberation, the idea of ways to improve our genetic endowment is the issue of how to improve our biological nature and there seems nothing to oblige us to restrict the account of the ends for whose sake we may act in this matter to the amelioration of our inclusive fitness.

Other ends can and should come into play. For instance, if inclusive fitness was all that mattered it would seem of little point to worry about correcting genetically-based diseases with germline manipulations and more the point to spend those valuable resources on enhancing the abilities of those already genetically advantaged to let the weak and their line die off.

Correcting Defects v Enhancing Capacities

What of the matter of genetic engineering in the human germline? We tend to endorse the notion where the correction of heritable genetic defects is in view. Englehardt argues as if there is no useful distinction between engineering for therapeutic correction of defects and for enhancement of human traits because in some cases the boundaries are unclear. This seems wrong though, for unclarity in some cases does not imply that the appearance of clarity in the contrast is in many others an illusion.

It does seem a different order of moral question whether we should aim to heal fragile X syndrome from whether we should seek to lengthen the ordinary human life span genetically or boost intelligence across the population genetically. Thus, the question arises what further we can say concerning engineering to ameliorate our biological potentialities besides what can be said in favour of efforts to treat genetic problems people have. We tend to endorse programmes of enhancement of the traits of future adults through education and other deliberate interventions such as baby health programmes.

I think the following sort of question is of particular interest in this matter. Does it matter that germline genetic engineering promises an enhancement of human nature that might obviate the need of educative processes of the familiar sort and of the familiar kind of degree of difficulty?

Superhuman Beings And The "Naturally Virtuous"

Englehardt seems to suppose that such a promise does not matter, that there is nothing intrinsically wrong with trying to develop the superman (or superwoman). Fair enough, perhaps. Even the superhuman being will have her limitations within which she will have to work. Presumably we all have our own form of kryptonite.

What I think is worth bearing in mind here, however, is the matter of how much of the accomplishment of the enhanced redounds to t! credit of the genetic engineering.

Any familiar effort in the direction of the super human being will tend to look a whole lot like traditional education with its familiar pattern of struggle, trial and error and effort on the learner's part to transcend the limitation of her gifts and the current state of her abilities. Persons who for genetic reasons have superior capacities to learn, whether intellectually or morally, would presumably be exempted from the need to struggle with the average limitation most of us unenhanced have to labour under currently. **The acquisition of the virtues through the reflective effort to get things right on the basis of mature experience is something we value in our ordinary life.**

Germline genetic engineering has the whiff populating the future with "naturally virtuous" individuals. It is not clear that, if this is something that ultimately makes sense for human beings, it is of any service to the future to give it to them. Otherwise, the point is that between the laboratory and the future mature adult flows a lot of environmental water and much reflective self-direction on the part of the developing adult herself. And it will be there that what matters most happens.

Let us not let the dazzle of the promise blind us to this basic point about the enhancement of our morally-valuable characteristics.

John G Quilter is a Lecturer in Philosophy and Theology at Australian Catholic University, New South Wales, and a part-time Research Fellow at the Centre for Ethics.

ARE THERE GENDER-BASED DIFFERENCES IN MORAL DECISION-MAKING?

Liz Hepburn I.B.V.M.

Dr Liz Hepburn is interested in the question of gender-based differences in moral thinking and decision-making. She spent two months over the Christmas period working on this research at the Kennedy Institute of Ethics, Georgetown, Washington DC. Here, Dr Hepburn reports on her research.

Are there, as some women philosophers claim, differences between men and women in the area of moral thinking and decision-making? If there really are such differences, then these ought to be apparent in bioethical literature as well as in the psychological work of writers such as Carol Gilligan[1]. Gilligan has criticized the work of Lawrence Kohlberg[2] (in his theory of moral development) for ignoring differences between how men and women think and respond to particular hypothetical situations. If her criticisms are well-founded, then the same gender-based differences (a stress on the social, shared dimension of thinking and an emphasis on the role of feelings in moral decision-making) ought to show up in bioethical literature.

Feminists claim to count experience as important. They wish to be inclusive. They emphasize the social and political dimensions of ethical issues and they include emotion - alongside rigorous intellectual analysis - as an important component of their deliberations.

There are three distinct strands in feminist thinking:
Liberal feminists pay little attention to social and political aspects of our thinking and are just as likely to use the language of rights as any male Kantian or utilitarian. They want to reform the existing social structure and see the achievement of equality as being critical to this.
Radical feminists, by contrast, assume before they begin that the problem is patriarchy and focus their attention on this underlying construction of the world. Tending to adopt an adversarial stance, they run the risk of establishing a new orthodoxy as exclusive as the system they wish to overthrow.
Social feminists see patriarchy as one of the many unjust social constructions of reality. Their project is to reconstruct the social institutions, and their views are akin to those of anarchists. They adhere most strictly to the feminist values espoused by all three groups, although many of their arguments are utilitarian in style and tend to objectify situations and people.

A major difficulty for the feminist theorists is created by their desire to be inclusive. Often, acceptance of pluralism and a prizing of the communitarian possibilities for human life leads them into a moral relativism. A more critical analysis of the operation of tolerance in society should help here.

Perhaps the most obvious difficulty faced by the feminists is to affirm the experience and concomitant insights of women, whilst at the same time rejecting anything which might be construed as biological determinism. Not all feminists are convinced that there is a gender-based difference between philosophers. For instance, Scheman says,

> *"A recent project of recovery of women philosophers from antiquity onward would bear out the non-necessity of maleness (for engaging in philosophy): many of the rediscovered women philosophized indistinguishably from their male contemporaries, as certainly many women philosophers do today" (p34).*[3]

Nevertheless, there is a clear trend amongst feminists to look to the accounts of our lives together as the source of moral insight, rather than to use the existing, formal, philosophical traditions. Further, they insist that if the elements which guide women's thinking are expressed as principles, this will distort an understanding of the reasoning process typically used by women. The application of principles in traditional philosophical analysis permits the agent to create distance between herself and the particular issue, whereas fundamental to the process of feminist ethics is the context and the maintenance of a receptive disposition: our response within a particular situation is valuable as a guide to action.

However, it is not only women or feminists who are critical of moral theory for its insistence on impartiality, indifference and universalizability. Bernard Williams[4] argues that, in striving for objectivity, we may jettison precisely that which is ours as individuals to contribute to ethical dialogue. This is certainly important. If some men and women believe that experience is a critical source for ethical reflection then there will be some gender differences. The perspectives of both men and women will be important contributions to thinking about how we can bring to birth a more just and loving society.

References:

1. Gilligan, C. *In a Different Voice*, Harvard University Press, Massachusetts, 1982
2. Kohlberg, L. *Essays on Moral Development*, Harper & Row, New York, 1981
3. Scheman, N. "The unavoidability of gender", *Journal of Social Philosophy*, 1990, XXI, 34-39
4. Williams, B. *Ethics and Limits of Philosophy*, Fontana, London, 1985

Dr Liz Hepburn I.B.V.M. is the Co-ordinator of the Centre for Ethics at the Mercy Campus of Australian Catholic University in Ascot Vale, Melbourne

NOTE BOOK

AUSTRALIAN BIOETHICS ASSOCIATION CONFERENCE.

The second Annual Conference of the Australian Bioethics Association will be held 26-28 November 1992 at The Women's College, University of Sydney. Its theme will be **Ethics In Health Care: Co-existence and Conflict**. (The Association's inaugural conference was held last year in Melbourne.)

Abstracts on topics relating to ethics in health care are invited. Topics of particular interest are:

* Technology and ethics in health care
* Defensive medicine and the impact of recent legal developments on health care practice
* Justice in health care - ethical obligations owed to the individual patient and to the community
* Medical research and the role of ethics committees
* Teaching ethics
* Decisions to withdraw or withhold treatment

For further information, registration material and submission of abstracts (200 words), contact: Maree Bancroft, c/- NSW Medical Defence, 103 Alexander St, Crows Nest NSW 2085. Ph: (02) 439-6849.

NATIONAL BIOETHICS CONFERENCE: SYDNEY ADVENTIST HOSPITAL

Sydney Adventist Hospital will hold its 7th National Bioethics Conference on 6th and 7th April 1992. Guest speakers include Prof Jennifer Wilson-Barnett, University of London; Dr Robert Orr, Loma Linda University, California; Dr Paul McNeill, University of New South Wales; and Prof Gareth Jones, University of Otago, New Zealand.

For further information on this annual conference, contact: Dr Tom Ludowici, Sydney Adventist Hospital, 185 Fox Valley Road, Wahroonga NSW 2076, Ph: (02) 487-9346.

VISITOR TO CENTRE FOR ETHICS

Miss Angela Rossetti is currently undertaking an "Internship" here with us at the Centre for Ethics. Angela is an undergraduate student at Pine Manor College, Chestnut Hill, Boston, Massachusetts, where she is studying for a degree in Management in Progress.

Angela is in Sydney on the Boston University Sydney Internship Program. This one-semester course combines course-work in Australian economic, political and cultural affairs during the first half of the semester, with a placement in an Australian institution in the second.

CARE OF THE FRAIL ELDERLY

Is there a crisis in health care in Australia as a result of the aging of the population? Are the elderly getting a fair share of that part of the taxpayer's dollar which is spent on health care? What principles of conduct should guide the provision of care to the elderly in hospitals, nursing homes, and at home? When the best interests of an elderly person conflict with what he or she wants, which should take priority? How do we judge that an old person is competent to make sensible decisions about her own care? When and for what reasons is it permissible to restrain old people in nursing homes? If, in the final days of a terminal illness it becomes appropriate medical care to withhold or withdraw medical treatment, does this apply to the provision of food and water as well, or is their provision always morally required? And, finally, how far have patterns of treatment changed in Victorian hospitals since the passing of the two Medical Treatment Acts in 1988 and 1989?

These questions, among others, were addressed by a range of speakers at the Annual Conference of the **Centre for Human Bioethics** at Monash University in November last year. This one-day conference was made up of four sessions: Frameworks, Practical Matters, Life-Sustaining Treatment and Allocating Medical Resources. Three or four speakers gave papers at each session, after which a short period was set aside for questions and discussion from the floor.

Anyone requiring a copy of the Conference Proceedings should contact the Resources Officer at the Centre for Human Bioethics, Monash University, Clayton 3168 [ph (03) 565-4278]. Estimated price is $15.

BECOME AN ASSOCIATE OF THE CENTRE FOR ETHICS

This *Bioethics Outlook* is, perhaps, the second one that has come to you free. As we are keen to widen our subscription base we hope you will find it sufficiently interesting and informative to consider taking out a subscription. In so doing, you will become an Associate of the Centre for Ethics. The annual fee is $35 for individuals, $15 for full-time students, and $50 for institutions.

Please complete the enclosed **Application Form** and send it with a cheque or money order (payable to Australian Catholic University) to the Centre for Ethics, St Vincent's Hospital, Victoria Street, Darlinghurst, NSW, 2010.