
BIOETHICS OUTLOOK

John Plunkett Centre for Ethics in Health Care

Volume 7 Number 3

September 1996

Health Promotion: Promises and Pitfalls

Judith Kennedy and John Quilter

Health promotion is a desirable element of a developed society's health policy. However, there does not seem to have been a great deal of discussion about ethical issues related to health promotion and its place in the debates about the ethics of resources allocation. In this paper, we want to provoke discussion of this question.

Health promotion: how good it is

At the Annual Conference for the Australian Association for Cognitive and Behaviour Therapy, held in July 1996 at Manly in NSW, health promotion attracted attention as a growing field for psychologists. This is appropriate since the purpose of health promotion is to bring about a healthier population by inducing changes in voluntary actions, and changing behaviour is what the practice of psychology is about.

There is little onus to argue the case for funding health promotion out of the public purse: health care costs will be lower if demand

is lower. One way demand can be made lower is if the sick cease to want high quality health care. But a more plausible way of lowering demand is by people not getting as sick, as often, in such great numbers. This will be achievable to some extent if people live healthier lifestyles. As health services go, health promotion is relatively inexpensive. It provides a very efficient "value for the dollar" investment.

It is also worth noticing that this argument applies not only to publicly-funded health care systems. It also applies to systems of health care delivery that are funded from private sources: healthier consumers do not require as much health care as unhealthy ones. A society whose citizens lead lifestyles which are healthier overall than a society whose citizens lead less healthy lifestyles will have less demand for health care. Hence, health care costs as a proportion of gross domestic product can be expected to be lower. Whether in a third-party-payer system, or in a pure out-of-pocket, fee-for-service system (or in some mix of these), total health care costs will be lower and, *ceteris paribus*, this will be reflected in lower health care fees or insurance premiums.

In the long run, prevention is better than cure for economic reasons: it is a better dollar-for-

Inside

- ◆ *Ethical Guidelines from the NHMRC: An update* 6
- ◆ *The Re-emergence of Eugenics* 9

dollar investment than rescue medicine. It is better also for other reasons: it is less traumatic to individuals in the long run, and each person's (and hence, society's) flourishing is enhanced by good health. It can hardly be denied that there are strong arguments in favour of good health promotion.

Changing "Lifestyle" Behaviour

There are three general ways to bring about behavioural (attitudinal) change: changing how we think and what we know (education); changing what we are free to do or the costs of various options (for instance, by legislation); and changing how we feel (emotions). If significant change is brought about in any of these areas (say, we start to think a certain act is dangerous and stupid), then a corresponding change in the other areas will tend to follow (for instance, we will not do it, and we may even begin to think badly of people who do). This process applies whether or not the change is induced with the awareness of the subject.

Using an educational approach, health promotion has had a successful track record in public education with programmes promoting, for example, the use of suntan creams and hats and other public health measures and with the HIV infection-containment education programmes. There has also been success following legislative changes such as changes in tobacco and alcohol laws and laws relating to public and industrial safety.

Utilitarian Ideology?

The philosophical approach behind health promotion appears at first glance to be an ethics of Utilitarianism. The basic idea is that the individual's choices are to be seen in the light of the social health consequences they have. Everyone chooses what they will and will not do, but each is also responsible for the consequences of his or her decisions, for example, adverse health and the increased social demand for health care arising from it.

The aim of health promotion is the good of society in the form of healthier lifestyle choices by individuals together with decreased demand

on health care. If actions bring about bad consequences, then those actions themselves are bad and need to be changed in the interests of the (social) good of lowered health care demands. Hence, evaluation of health promotion strategies primarily examines outcomes and apparently it relegates constraints such as individual autonomy to a subsidiary role.

Aims of Health promotion vs Values of a Liberal Society

The potential conflict between programmes to change behaviour for better health on the one hand and citizens' rights to pursue legitimate freedoms even if society will not be as healthy on the other is an interesting one. To illustrate, one of the key features in a liberal society is respect for autonomy, and autonomy is infringed by paternalism. Yet health promotion is to some extent a paternalistic enterprise: (a) decisions as to what is good for people are made for them, and (b) the attempt to convince them of it, so as to bring them to change their behaviour, is initiated without consulting them.

However, the people targeted for this "intervention" are private citizens pursuing legally-legitimate interests. Further, respect for autonomy requires that we consult them and obtain their agreement before we do things to them. In a free society, some form of consent is always required. For instance, this is the core idea of the shift in Medical Ethics away from traditional Medical Paternalism. So, while an intervention might be for the community's good, society's practical needs for professional health promotion should not presuppose transfer of power or necessitate compromising the fundamental values of a liberal society. There is no place for coercion, trickery, manipulation or the like, no matter how subtle. A valid and informed "community consent" of satisfactory shape and form must be secured.

The main construct behind any utilitarian approach holds that an action-choice is the right one if and only if it promises to produce the maximally-socially-beneficial outcome. If health promotion comes to be grounded on a purely utilitarian conception of its values, its place in a liberal society seems problematic. For

maximally-socially-beneficial outcomes may be most effectively served by methods of behaviour change which are incompatible with the values of a liberal society. Conceptions of the importance of health promotion are mistaken which come to be seduced into thinking that changing lifestyle choice towards the healthier is so important that it should be secured by the "most effective methods".

The professional ethics of health promotion

Indeed, if health promotion is to be a justified profession, it must pursue its professional goals effectively. But in a liberal society it must do so in a manner which is ethically-defensible and compatible with the values of such a society. To do this, both the practice of health promotion professionals and the allocation of funds to it must respect these values. It must respect individual autonomy and justice, and professionals must act with compassion, honesty and respect for persons (cf. Beauchamp and Childress (1994) and Gillon (1994)).

There has not been a lot of thought given to the "ethical profile" of health promotion as a profession. Beyond the platitude that health promotion aims at inducing people to adopt healthier lifestyles, little thought has been given, in the public arena, to the constraints on the ways one should do this or to the reasons why one should do this beyond the economic ones.¹

We have suggested that there is one obvious constraint that should be observed in the practice and funding of health promotion: as with any profession, health care should be conducted in a manner which respects the personal autonomy of citizens. However, it is also arguable that health promotion, as an educational activity, *serves* individual autonomy: for it explains to people the health consequences of their lifestyle options. This is perfectly compatible with liberal values. Indeed, it supports them.

The more difficult questions arise when enhanced levels of individual knowledge are not enough to induce the lifestyle changes which health promotion aims at. How should

the health promotion professional respond when her efforts to convince others that healthier lifestyles are better do not induce behavioural change? How far should she go in getting others to become healthier?

We want to insist that the answer is "not far": if her educative efforts do not induce change in others, the health promotion professional should shake the dust from her feet. One of the marks of a liberal society is to tolerate individual choices that are within the law, *even if people choose unwisely and their health is compromised and this causes social levels of unhealth to remain unnecessarily high or even to grow*. Once health promotion becomes coercive, manipulative or otherwise bullying, it ceases to belong in a liberal society. For instance, a health promotion unit has no role in ensuring that the law is kept by checking that shopkeepers do not sell cigarettes to children under 16, or in policing the abuse of illegal substances.

Health promotion's role, and this is important enough, is to educate and offer persuasive reasons for living healthily. It should not demur from educating the community about the social costs of unhealthy individual lifestyle choices. It should support autonomy, not overcome it. Its service to the good of society must be to give its citizens real opportunities *voluntarily* to choose more wisely and more mindfully of the consequences for all of us. But it does not have to *ensure* that the citizens so choose.

Nevertheless, even in the matter of informing the public, there are important considerations to bear in mind in developing and supporting decent health promotional practice. The need to evaluate outcomes of its educational efforts is obvious. Responsible management of health promotion resources implies this. Certain points come readily to mind to which more attention deserves to be paid. Health promotional activities need the support of inbuilt auditing of outcomes, in the form of (for instance) longitudinal studies of both lifestyle choices and health, and of how various health promotion strategies affect them. (But, as with any auditing, the auditing should not consume a disproportionate amount of the resources for the activity being audited.) Again, populations

change over time and become inured to repeated education programmes. The programmes then lose their impetus and become stale. A "project-oriented" approach to health promotion seems sensible and the need to plan periodic repetition of some educative projects (eg. with respect to the dangers of smoking and abuse of alcohol) seems obvious. Attention to such issues is the warp and weft of health promotion.

Of course, in contrast, if every decent health promotion effort to convince us to become healthier fails to get enough of us to change our ways for social health care costs to show its impact, money spent on it could be wasted. But there is no evidence of this, and, until proven otherwise, it is implausible that persistent, intelligently-conducted health promotion, and support of it, will have such a weak effect on the behaviour of individuals.

Funding health promotion: Against including it in health care funding

There is a number of arguments against funding health promotion as part of the health care system. We should consider these.

Our argument has been that the role of health promotion is educational. Furthermore, health promotion is not an entirely separable element of social life. There are many things not usually thought of as "health promotion" which promote health. Clean air and water, good sewerage, thoughtful civil and environmental planning and humane living conditions are obvious examples. In addition, in our society there are notable instances of the dissemination of health information: via the school systems (Personal Development/Health is a compulsory part of the School Certificate syllabus in NSW), the mass media and other advertising (the Norm campaign, Slip-Slop-Slap campaign, Drink & Drive campaign) and restrictive laws (such as those requiring a minimum age for purchasing cigarettes and liquor, enacted through a democratic political system that respects the values and conflicting views within its population).

Against this background, some will be tempted to think that health promotion should be funded externally to the health care system. This could be justified on the basis that promoting better health takes various forms such as we have indicated. These avenues are outside the health care system and the medical paradigm of treatment regimes and therapeutic or palliative interventions. Moreover, there is a risk that incorporating health promotion into the health care system will encourage it to adopt medical paradigms and lose its distinctively educative, preventative self-conception. This could distort the ethical orientation of health promotion in various ways. Health care and health promotion need different institutional arrangements. It could be thought that this risk is a reason to keep funding of health care and health promotion separate.

Further, two trends may support sympathies of this sort. The first is the trend of reduced or static funding for the public hospital system. The second is that a number of hospitals or area health regions have adopted their own health promotion units. Health promotion, as a distinctive health-related activity, has, to some extent, become a competitor with medical services for constrained funds. It is easy to understand why some will greet spending on health promotion with hostility, while funds to care for the sick are contracted.

Finally, recognition of the need to bring health promotion into the "mainstream" of the "health system" does not necessarily imply that health promotion must be funded as part of the health care system's funding. The best system of funding health promotion is not something written in the fabric of the universe.

Funding health promotion: an alternative argument

These are not compelling arguments for the intended conclusion. First, most of the improvement of health this century has been due to non-medical factors. The fact that this is so serves only to make the distinction between health policy and health care policy. But it does not show that health promotion funding should not be part of the health care system's funding. Health promotion *should* be part of health

policy. However, the nation's welfare will arguably benefit from making the relation between the health care system and health promotion close. It has ever been so in health policy.

It cannot be doubted that health promotion and services for the sick should not be rivals for funds. Services for the sick should be properly funded. Health promotion should not be supported at the expense of the sick. But the failure of governments (that is, taxpayers) to fund services to the sick properly is not a reason to reject the importance of health promotion. And it is important. Its functions cannot be served by relying solely on the informal, unsystematic efforts of the sort listed at the beginning of this section. As an educational venture, health promotion should have its own place in the health system sun. Further, its relationship to the health care system should arguably be close. The traditional health care professions have always held the health of the nation at the centre of their values. This is a reason why the institutional arrangements for health promotion should be informed by the traditional health care professions.

Certainly, there are no "rails in the ethical cosmos" which will enable us to "discover" the best methods of funding either health promotion or the health care system. If we arrive at a better funding system than we have had, it will be by a mix of ethical-political vision, downright ideology, suggestions from health care economists, the interplay of interest groups (doctors, insurers, hospitals, political parties, and all too quietly, the general community) and a certain amount of experiment. Arrangements will need review with changing circumstances and if such experiments turn out not to work justly. This is all quite normal for a healthy democratic society.

But this does not show anything about what we should do now. There is a strong case for mainstreaming disease prevention education, education for wellness, as an important part of health policy. We ignore health promotion at our peril in the next forty or fifty years. Health promotion should be closely informed by the traditional health care professions. And as an

incipient allied health profession, health promotion will benefit from the status associated with the health care industry. However, it should not develop at the expense of the care of the sick.

Perhaps, then, if we nurture health promotion as part of the routine activity of the health care system, more money should be injected into the system, and a generous bit of it devoted to establishing and underwriting health promotion, with an eye to our future as a society prone to the diseases of affluence. And of course, we should expect the unconditional financial support for health promotion from those industries which contribute significantly to health problems caused by lifestyle decisions that are unhealthy.

Footnote

¹ An exception is Tountas, Y, Garanis, TN & Dalla-Vorgia, P, (1994)

References

Beauchamp, TL & Childress, JF (1994), *Principles of Biomedical Ethics*, Oxford: OUP

Gillon, R (ed) (1995), *Principles of Health Care Ethics*, John Wiley & Sons

Gillon, R (1994), "Medical Ethics: Four Principles plus Attention to Scope", *British Medical Journal*, vol. 309, 16 July: 184-188

Tountas, Y, Garanis, TN & Dalla-Vorgia, P, (1994), "Health promotion, Society and Health Care Ethics" in Gillon, R (1995), pp. 844-854

Authors

Judith Kennedy, a clinical psychologist, has recently completed her Master of Arts in Applied Ethics at Australian Catholic University. John Quilter is a Lecturer in Philosophy at Australian Catholic University and on the staff of the John Plunkett Centre.

Our Genetic Future: Ethical Issues

Instead of holding an Advanced Bioethics Course, the Centre is sponsoring a one-day seminar on some of the ethical questions raised by new genetic approaches to health care.

Please see the accompanying insert for details of this seminar.

Ethical Guidelines from the NHMRC: An update

Gerald Gleeson

The Australian Health Ethics Committee, a principal committee of the National Health and Medical Research Council (NHMRC), has recently released for public consultation two important documents: (1) draft ethical guidelines on Assisted Reproductive Technologies and (2) four draft discussion papers of the ethics of organ donation and transplantation. These documents will be of great importance to the future practice of medicine in Australia. They have been prepared by the Australian Health Ethics Committee (AHEC).

Assisted Reproductive Technology

The Catholic Church's teaching limits the use of reproductive technology far more strictly than most people in our society would do at present. The Catholic position was well summarised in the recent US Bishops' *Directives*: technology may assist, but not replace or substitute for, sexual intercourse, so that every child conceived should be able to look back to its origin in an act of marital love.

It would be unrealistic to suppose the NHMRC would adopt this same standard with respect to artificial reproductive technology (ART). Still it is both realistic and essential that the NHMRC employ a defensible and consistent ethical framework for its Guidelines. The present draft is divided between "Governing principles" and "Regulations". The proposed governing principles are, by and large, sound, despite the lingering appeal to the "interests" of all involved in ART procedures. Principle I requires *"respect for, and protection of, human embryos from their beginning"*. Just what this respect amounts to, however, becomes dubious in the light of the proposed regulations which would allow *"non-therapeutic"* and even *"destructive"* experimentation on embryos.

The subsequent proposed regulations are often at variance with even a liberal reading of the governing principles, especially with respect to the questions of *"surrogacy, discarding of embryos, and destructive embryo research"*. The draft guidelines say that surrogacy *"should not be encouraged"* and then permit it with the lame requirement that *"the interests of the surrogate mother, the child to be born and the infertile couple are protected"*. But how are they to be protected? Surrogacy inevitably sets up a situation in which these interests must conflict, and there simply is no ethical, legal, or human basis for resolving such a conflict (and much evidence as to the anguish and damage to persons which this conflict has already occasioned). The draft guidelines require that embryos not be created unless there is a reasonable expectation they will be implanted and allowed to develop normally, and that excess embryos not be created. But they go on to permit destructive research on surplus embryos up till 14 days (8.3; 8.5)! The contradiction here is manifest. If the draft guidelines were complied with, there would be no surplus embryos, and thus there would be no scope for such research. Furthermore, destructive research is clearly inconsistent with the principle of respect for embryos from their beginning.

The draft guidelines are also ambivalent on the question of a child having the right to know who his or her genetic parents are. They affirm such a right, while limiting it by allowing donors to remain unidentified. The child's right here ought not be so restricted. If it is objected that requiring identification of donors may lead some potential donors not to donate, the reply is simply that if this is the case, then this is good reason to conclude these people should not be donating.

One final point: it is to be hoped that any talk of *"using embryos"* will be eliminated in the forthcoming revision of this draft version. The

draft begins well enough, describing ART as including a "range of methods used to overcome human infertility". Then it goes on to talk of "using embryos". Human beings ought never be simply "used". If talk of "use" can be confined to methods and techniques, then the ultimate ethical question of what these techniques are used for can be brought into focus. Technology should always be directed to the integral human good, the good of persons and their relationships with one another. That the draft guidelines can so glibly talk of "using embryos" illustrates how shallow their ethical foundation is.

In short, these regulations are in need of much re-writing. To be sure, they are probably more restrictive than many working in the field would like. For others, like myself, they do not sufficiently protect the interests, rights and well-being of the children who are created by these technologies, and they are surely the most vulnerable of all the individuals who are affected.

Organ Transplantation

The discussion papers on transplantation ethics will probably be less controversial. They are "discussion papers on ethical aspects": they carry no regulative force. They are intended "to help members of the community make up their own minds" about organ donation and transplantation. It is well known that Australia has a low rate of organ donation by world standards. The working party was faced with the question whether its "ethical reflections" would, or should, take a stand for or against donation. This raised the question of whether AHEC has the right to take a definite ethical position on an issue like this, and the question of whether ethical reflection can offer guidance and yet respect the diversity and plurality of moral convictions in our society. The Working Party issued four discussion papers for community comment:

- (1) *Donating organs after death: ethical issues;*
- (2) *Ethical Issues in donation of organs and tissues by living donors;*
- (3) *Ethical issues raised by allocation of transplant resources and*
- (4) *Certifying death: the brain function criterion.*

What should we expect from these discussion papers? Each paper obviously addresses important issues of moral principle and public policy. However, there is always a danger, especially in a pluralist culture, that discussion papers will become simply a listing of "what people say": some for, some against; on the one hand, on the other hand, with the implied conclusion, "make up your own mind". Of course, in the end, we do have to make up our own minds, but we should do this by trying to determine where the truth lies, by recognising where the reasons and the evidence lead. I believe these AHEC documents should, as far as possible, take a definite stand as to the ethical justification for our practice in these areas, while acknowledging the rights and responsibilities of individuals to make their own conscientious judgments in particular cases. It is quite consistent to hold *both* that organ donation after death is morally permissible, indeed praiseworthy, *and* that in some circumstances a person would be right to decide against donation. So if ethical discussions are to be of help, they should explain the moral rationale for donation and transplantation (why is it permissible), as well as the various considerations that should guide the particular decisions individuals must make (should I make my organs available for donation after my death?). How well do these draft papers meet these objectives?

The first paper aims "to provide a balanced discussion which will help people think through the ethical issues well in advance of having to make a decision for themselves or on behalf of a relative who has died" (s.1). It emphasises that this is an ethical question because "it expresses a view about how it is best to live, about which choices are ethically-sound and wise". The paper's main ethical discussion is under the heading "Reasons why some people decide, and others decide not, to donate organs after death". The chief reason cited in favour of donation is the *benefit* it can bring to others. The chief reason cited against donation is that the procedure is *invasive* – with respect both to the body of the deceased and to the grief and mourning surrounding death. The paper notes: "Much depends upon how you view the dead body and on your view of what a human person is". The paper's final section examines the difficulties in making a decision about donation on behalf of someone who has just died.

To my mind this first paper remains too ambivalent about the ethics of organ donation. To be sure, people have different views, and AHEC ought not impose a view on everyone. But should not AHEC uphold the principle that organ donation is a good thing, and defend this principle against its critics? Once this is done, the further question whether it is a duty or a free act of generosity might be addressed explicitly, along with the other relevant considerations which might count against donation in a particular situation. This ambivalence is continued in the paper about ethical issues in donation by living donors (e.g. kidney, bone marrow, etc.) which says its aim "is not to say certain sorts of reasons are to be recommended or are better than other, but to outline some of the ways that different people think about the matter" (s. 3). The bulk of the discussion in this paper rightly examines the conditions for "informed consent" which is clearly of major importance in the case of donation by living people who will in some way be harmed or placed at risk by their generous action.

Resource Allocation

The third paper does take a firm stand on many ethical issues: For example it argues that since competence in delivering a transplant service requires sufficient patient numbers and staffing levels, it would be unethical to create new transplant units which would be unable to achieve sufficient ongoing experience. An inevitable consequence is that units are restricted numerically and geographically. Justice therefore requires the "equitable distribution of organs retrieved from regions lacking clinics". The paper reviews some of proposed ethical bases for patient selection: selection of the sickest patient, of the patient most likely to benefit, of patients with a previous transplant, of patients able to pay, of the patient longest on the waiting list; selection by ballot, by the patient's importance for the well-being of others. I think this paper achieves a good balance between exposing the issues for and against, while taking a definite ethical stance where this is appropriate.

Brain death

Perhaps the paper most likely to generate controversy concerns the "brain function" criterion for the death of the donor. This

criterion is important for organ donation because it enables death to be certified while the donor's body and organs are still being maintained by mechanical means, including ventilators.

The paper focusses on the understanding of (the misnamed) "brain death" criterion implicit in the Australian legislation. It makes the simple point that implicit in Australian law is the conviction that "the death of a human person consists in the irreversible loss of the integrated and co-ordinated life of the person as a single living organism". The irreversible cessation of brain function is the sure sign that this integrated and co-ordinated life has ended, that a person has died. The main point of controversy – on which the paper does take a stand which, no doubt, will be challenged – concerns the meaning of "the cessation of all brain function". Given more sensitive neurological tests now available, which are able to detect various forms of activity and "functioning" in the brain and the endocrine system, some critics argue that death is being certified in cases where "all function" of the brain has *not* ceased. In response to this criticism, the draft paper takes the view that "all function" should be understood as a "single" or unitary function of the brain (not merely the sum total of numerous brain functions) which is responsible for the integrated and coordinated life of the individual as such. It is consistent with the loss of function in this sense that there be sporadic electrical activity in the brain as well as some endocrine functioning which is relatively independent of the brain.

Notes

1 The Director of the Plunkett Centre, Dr Bernadette Tobin, is a member of AHEC and chairs its Working Party on the ethics of transplantation. I am also a member of this Working Party. While this "progress report" draws upon my involvement in drafting some of these documents, I trust it will also be an objective review, and will encourage readers to consider the issues for themselves. The drafts are available from the Secretariat of the Australian Health Ethics Committee, telephone (06) 289 6931. The closing date for comments on the Draft Guidelines on Assisted Reproductive Technologies has now passed. That for the papers on the ethics of transplantation is September 29th (though comment will be accepted until October 4th).

The Re-emergence of Eugenics

Keith Joseph

"The old eugenics was limited to a numerical enhancement of the best of our existing gene pool. The horizons of the new eugenics are in principle boundless – for we should have the potential to create new genes and new qualities yet undreamed ... I know that there are those who find this concept and the prospect repugnant – who fear, with reason, that we may unleash forces beyond human scale and who recoil from this responsibility. I would suggest to them that they do not see our present situation whole. They are not among the losers in that chromosomal lottery that so firmly channels our human destinies ... We are among those who were favoured in the chromosomal lottery, and, in the nature of things, it will be our very conscious choice whether as a species we will continue to accept the innumerable individual tragedies inherent in the outcome of this mindless, age-old throw of dice, or instead will shoulder the responsibility for intelligent genetic intervention. As we enlarge man's freedom, we diminish his constraints and that which he must accept as given. Equality of opportunity is a noble aim given the currently inescapable genetic diversity of man. But what does equality of opportunity mean to the child born with an IQ of 50?"

This is the noble vision of Robert L Sinsheimer, a leading biologist in the United States, a vision in which we strive towards a better world of greater individual freedom using the techniques that genetics may make available for us in the medium to longer term. I find this vision disturbing and based on dangerous assumptions. In this paper I want to outline the history and prospects of eugenics, and discuss the problems that I believe make it a dangerous vision.

Eugenics - a brief history

Modern eugenics traces its origins to the work of Francis Galton, a British scholar of the late 19th Century, who coined the word "eugenics" (roughly translated as "well-born"). Galton founded the study of biometrics, and from that developed his eugenic theories which were subsequently picked up by supporters both in the United Kingdom and the United States. It

was seen as a scientific theory through which the human race could be bettered by means of improving the human gene pool.

Two forms of eugenics can be seen emerging in the early years of the twentieth century. *Positive eugenics* is the encouragement of desirable traits through judicious matings. *Negative eugenics* is the discouraging of the spread of poor traits; for example, the trait for "feeble-mindedness" which was thought to be a single gene defect by prominent biologists as late as 1930. In the United States the permissibility of negative eugenics was enshrined in law in a number of states by statutes which allowed for the compulsory sterilisation of the feeble-minded.

Eugenics never achieved substantial long-term popularity in the United Kingdom: a Bill to allow for the voluntary sterilisation of the feeble-minded failed to pass through Parliament in 1912 and eugenics failed to regain its popularity following the first world war. In contrast, eugenics flourished in the United States, and in 1927 the constitutional validity of statutes allowing for compulsory sterilisation of the feeble-minded was upheld. This legislation became the model for the legislation which Germany adopted early in the Nazi period, and under which 360,000 "feeble-minded" were sterilised between 1933 and 1945.

The eugenic measures adopted in Germany were more extreme. They included the positive eugenic measures of the setting up of "love camps" for the procreation of appropriately heroic Nordic children, and the negative eugenic measures of "euthanasia" of the mentally ill. Eugenics was also tainted by the evil of the later Nazi period, for the Holocaust itself was underpinned by an element of eugenic theory.

In the wake of the second world war the theories of eugenics became hopelessly tainted

and grossly unpopular. Nevertheless, a eugenics movement has persisted in the United States even though purged of its more objectionable features such as racism.

The re-emergence of eugenics

There are a number of factors that have led to a recent re-emergence of eugenics. The first is the receding memory of the horrors of the second world war: we forget the uses to which "science" was put in that conflict. Secondly, there are the techniques that have become available through the advances in genetics over the last decade.

Two such techniques are especially relevant to the revival of eugenics. The first is our increasing ability to screen for specific genes. The Human Genome Project is instrumental in this, in that it is mapping out our genetic structure and in the process many genes are being identified. In the short term many single-gene traits are having their gene identified, and genes which contribute to other processes – such as the development of cancers – are also being identified.

The second technique is that of the manipulation of genetic material. At present, we are only able to carry out somatic genetic engineering upon humans. We cannot, at present, manipulate the genes of humans so that the altered gene can be passed onto offspring. We can only alter the genes of non-reproductive cells (such as blood cell precursors). This is useful for treating certain genetic disorders where the person is deficient in an enzyme or protein, by implanting in his or her blood cells a gene which will produce that enzyme or protein. However, this new gene cannot be passed on to offspring, who may well carry the gene for that disorder. Having said this, we have had more success with germ-line engineering of non-human mammals (such as mice) and therefore it is fair to say that germ-line genetic engineering of humans will be possible in the future.

How do these two techniques – gene screening and germ-line genetic engineering – lend themselves to eugenics? Gene screening will

enable negative eugenics to be carried out far more efficiently than has been possible in the past. It will enable foetuses with "undesirable" genes to be identified and subsequently aborted, thus contributing to the elimination of those genes from the human gene pool. Germ-line genetic engineering will make positive eugenics possible, in a far more effective manner than just ensuring suitable breeding. For it will ensure that genes that are seen as being desirable are implanted in our descendants, ensuring their continuing transmission in the gene pool. It could also have a role in negative eugenics by enabling the removal of deleterious genes and their replacement by desired genes (though at present this is likely to be far more effectively done by pre-natal gene screening and abortion).

Thus there now exist powerful new tools by which we will be able to screen out deleterious genes and ensure that desirable genes are passed on. Respectable scientists such as Sinsheimer, quoted above, see this as an appropriate use of these technologies. No doubt he is not alone in this.

Further, it is not necessary for there to be an organised social programme for eugenics to become a reality. If enough parents choose to avail themselves of germ-line genetic engineering for the purposes of improving their offspring's genes, and if the genetic changes they seek are similar – which is a fair assumption given our propensity as humans to succumb to the dictates of fashion – then the overall effect will be eugenic.

The assumptions of eugenics

But eugenics is fatally flawed in its basic assumption that there are desirable genes or genetic structures. Desire is not an objective state of mind. Rather, it reflects social values and prejudices. That which is desirable – be it real estate, fashion, or personal traits – will therefore often be largely determined by social values. In Nazi Germany, blond hair and fair skin were desired, and these desires formed the basis for a positive eugenics in the stereotype of the Aryan warrior. In our society, physical stature and intelligence are highly desired. (This emphasis on intelligence is reflected in the passage from Sinsheimer quoted above.) But

why intelligence? Why not happiness? If we were to look for it, there would be as much evidence of the familial transmission of happiness as there is of intelligence – perhaps more so, given the genetic linkage in the predisposition to depression. Why not try to maximise a person's Happiness Quotient (HQ) rather than his or her IQ? This will seem a strange idea: the reason I raise it is to show how arbitrary is our selection of intelligence as a desirable trait. Certainly, the idea that certain traits are desirable is a value judgement rather than a scientific assessment.

Secondly, there is the assumption that genes are the major determinant of human traits rather than the environment. In fact both environment and genes are necessary to human development, and neither by itself is sufficient. If there is a trait that is disordered or undesirable, why not change the environmental cause rather than the genetic contribution?

A further assumption that needs to be challenged is that more of a good thing (that is, more of a desirable trait) is itself a good thing. For example, being tall is seen as being better than being short. But if most of society became tall through a programme of eugenics, the comparative advantage of being tall – which made it desirable in the first place – would be lost.

This leads to the issues of social and genetic diversity. A eugenics programme, based on the assumption that there are desirable traits which should be more widespread in society, will also be based on the assumption that there are less desirable traits which we would be better off without. If this was put into practice, then we would have far more of some particular traits at the expense of other traits. Indeed, social pressures would be such that the desired trait would, ideally, proliferate at the expense of the other traits to the point where the other traits become extinct.

However, this predominance of one trait would cause significant loss of diversity. This would be problematic on social grounds, as we would lose the social vitality that comes of

personal diversity. A basketball team comprised only of seven foot giants is not going to be as good as a team which includes a few smaller and more agile players. A society which consists of like people is not going to have the vitality of a society comprised of people with different strengths and weaknesses, which will often be complimentary.

Lack of biological diversity creates further problems. A species with a uniform gene structure will be susceptible to infectious diseases: it was genetic monoculture, for example, that led to the potato blight that caused the Irish famine of 1847. Our current genetic diversity gives us, as a species, considerable advantages. For example, carrying the sickle cell trait gives protection against malaria; and there are reports from the USA of a man who appears to be protected through natural (possibly genetically-mediated) means against AIDS. In a genetic monoculture, both traits may have been lost, giving us no natural immunity against the disease.

Conclusion

Eugenics is enjoying something of a revival, particularly given the new techniques that have the potential to make the eugenic dream a reality. However, there are profound reasons – some of which are canvassed above – to believe that eugenics is based on dangerous assumptions and that if carried out, will have deleterious consequences.

Eugenics is based on the fallacious assumption that there are "desirable" traits which can be safely engineered into humans. However, these desirable traits to a large extent simply reinforce current social prejudices and carry with them the danger of social monoculture based on prejudice, and genetic monoculture based on eugenic germ-line genetic engineering. There are other grounds for being concerned about eugenics (such as safety problems with germ-line genetic engineering). However, even if only the arguments used above are taken into account, I would argue that eugenics is dangerous and morally suspect, and should be opposed.

NOTEBOOK

Studies in Health Care Ethics

Ethics in Health Care or Bioethics is increasingly important in society, in health care institutions and in professional practice. Australian Catholic University offers two programmes in Health Care Ethics:

Graduate Certificate in Applied Ethics (Health Care)

- introductory studies by coursework
- one semester full-time study or one year part-time study

Master of Arts in Applied Ethics (Health Care)

- advanced studies by coursework, with the opportunity for research
- one year full-time study or two years part-time study

Admission Criteria

Graduate Certificate: any undergraduate degree or professional qualification with experience

Master of Arts: professional qualification with experience; or suitable undergraduate degree in Philosophy or Theology.

Modes of Offering

Both courses are scheduled by negotiation with students. The aim is for maximal flexibility to fit in with students' busy lives.

To Whom Might the Course be Valuable?

Each course will be of value to professionals and other citizens interested in the moral and social significance of ethical issues in health care. Each course can be of special value to particular people, such as members of institutional ethics committees.

For Further Information Contact:

John Quilter, Coordinator of Programmes in Applied Ethics, Australian Catholic University, PO Box 968, North Sydney, NSW, 2060.
Telephone: (02) 739 2033 or (02) 361-2869;
Facsimile (02) 739 2024 or (02) 361 0975;
Voicemail: (02) 867 7197;
e-mail 100017.2163@compuserve.com

Bioethics Outlook is a quarterly publication of the John Plunkett Centre for Ethics in Health Care, a Research Centre of Australian Catholic University and St Vincent's Hospital, Sydney.

Telephone (02) 361 2869 Facsimile (02) 361 0975 e-mail plunkett@plunkett.edu.au

Editor: Bernadette Tobin Layout: Barbara Reen

Subscription is \$50 (Institutions), \$35 (Individuals) and \$15 (Students or Pensioners).

John Plunkett Centre for Ethics in Health Care, St Vincent's Hospital, Victoria Street, Darlinghurst NSW
2010 AUSTRALIA
ISSN 1037-6410