Bioethics Outlook

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In This Issue ...

JOHN HUBERT PLUNKETT

"Who is he?" "Did he make a large **donation** to set up your Centre?" "Do you mean **Oliver** Plunkett?"

When the Senate of Australian Catholic University formally established its first Research Centre at St Vincent's Hospital in Sydney, it named the centre the "John Plunkett Centre for Ethics". The editorial writer in the *Sydney Morning Herald* of 4th March 1856 predicted that no name would shine brighter than Plunkett's in the pages of Australian history! However, from the puzzlement which greets mention of his name, it is clear that this has not happened. Why, then, did Fr Edmund Campion suggest to the present writer that the Joint Centre be named after Plunkett? Who was John Plunkett?

Historical Significance

John Hubert Plunkett was a prominent Catholic layman in New South Wales in the nineteenth century. He was the first Catholic Solicitor-General, and then the first Catholic Attorney-General of New South Wales. He was, at various times, a member of both the Legislative Council and the Legislative Assembly. He was a member of the first Senate of the University of Sydney, and an early Vice-Chancellor. He was the first Chairman of the Board of Education of New South Wales. He was a founding fellow of St John's College at the University of Sydney. And he was a great friend and benefactor of the Sisters of Charity in Australia, playing a leading part in the establishment of St Vincent's Hospital at Potts Point. It will be this last fact which will be of interest to those in medical circles, and more especially to those who value the contribution of the Sisters of Charity to health care in Australia. Of this, more later.

John Plunkett was born, the younger of twins, at Mount Plunkett in Roscommon, Ireland, in June 1802. On his mother's side he was related to Oliver Plunkett. Though he came from a committed Catholic family, he was educated at non-Catholic schools and went to Trinity College, Dublin, where he studied Arts. He graduated in 1823, and went straight to the Irish Bar where he practised for five years.

Heart And Pride

In 1830 he requested an appointment outside Ireland: the best explanation of this desire to change his circumstances is that a broken romance wounded not only his heart but also his pride. He was offered, and accepted, the position of Solicitor-General of the penal colony of New South Wales. By the time he sailed from Cork in February, 1832, he had married, and was accompanied by his wife (Maria Chartell McDonougha), his young sister, his friend Fr John McEncroe, and a domestic servant.

Chief Law Officer

John Plunkett took up the position of Solicitor-General in June, 1832. In 1836, he was appointed Attorney-General. In the climate of the times, it was a remarkable thing that an Irishman, and a Catholic, should take up this position which is that of senior legal advisor to the Government. As chief law officer, Plunkett made an important contribution to the slow and difficult process by which the penal colony of New South Wales (which, until separation in 1850, included Victoria, or as it was then known "Port Phillip") developed the institutions of a free society:

he was largely responsible for the technical form of the legislation by which the equality of all before the law was established.And in those days, that was no academic issue. It went to the very heart of relations between convicts and settlers, and between convicts and emancipists.

His first act of draftmanship was the Magistrate's Act which abolished summary punishment, the administration of justice in private houses, and the excessive use of the lash. He extended jury rights to emancipists (against opposition from those who thought this was the thin end of the wedge which would result in the eventual introduction of emancipists into the field of representative government!). He extended the protection of the law to convicts and assigned servants, and successfully argued for the abolition of convict assignment. And, after the Myall Creek massacre in June 1838, Plunkett secured the conviction of seven white men for the killing of an Aborigine - in fact a whole tribe was massacred - and thus extended the protection of the law - for the first time - to the Aborigines. Henceforth, as John Molony points out in his excellent biography of Plunkett, there was to be equality before the law for all whether white or black.[1] He was, as T.L. Suttor remarks, a man of "austere impartiality".[2]

The Church Act of 1836

However, Plunkett himself considered the Church Act of 1836 his most important single achievement. It dis-established the Church of England, and established legal equality between Anglicans, Catholics and Presbyterians. Its provisions were later extended to Methodists, and Plunkett hoped that both Independents and Jews would also be included. A Catholic who knew what it was to be emancipated, he was motivated by tolerance and a desire to extend religous freedom to all. What, then, was his relationship to the Sisters of Charity?

The Sisters had arrived in Sydney from Ireland in 1838. John Plunkett was there to meet the boat and, from thereon, he took a special interest in their affairs, first at Parramatta and then, seventeen years later, in Sydney. When rents increased with the population explosion associated with the gold rushes, the Sisters found themselves without accommodation. John Plunkett gave them the use of his recently-acquired house on the corner of Hunter and Macquarie Streets until they could find a satisfactory alternative. It was a characteristic act of generosity.

When, in 1855, the Sisters made a Public Appeal to establish a hospital in Sydney, John Plunkett was once again at their service. He decided that, for such an appeal to be successful, the public needed to be informed about the Sisters of Charity themselves and about their charitable works. He took it on himself to write a small brochure about them. As it happened, he inadvertently used as source material a book about the Daughters of Charity, a French order of women! However, the parallels were close enough for no-one to notice the mistake, and the appeal quickly raised £5,000!

Soon after, Governor Fitzroy was approached about the granting of a narrow strip of land along the newly-opened Victoria Street in Darlinghurst to the Sisters. The land had gone to auction, but had been passed in. Governor Fitzroy granted this strip of Crown Land to the Trustees of the Sisters of Charity in January, 1855: the three Trustees were Sr Alicia de Lacy, Sir Charles Nicholson, and Mr John Plunkett. The land, however, was both narrow and unimproved.

Generosity to Sisters of Charity

When, soon after, the Chancellor of the University of Sydney put his house at Potts Point with its surrounding grounds on the market for £10,000, the Sisters of Charity bought it and established their first hospital there in 1857. John Plunkett helped the Sisters pay off the debt they incurred in buying the property. He looked after their finances, and they became the first customers of what is now the National Australia Bank. St Vincent's Hospital, which had opened its doors at Potts Point was relocated in 1870 to its present site in Victoria Street, Darlinghurst.

Plunkett's two great recreations were the violin and Irish folk music. He gave many public lectures on the latter, illustrating them musically himself. He died on 9th May 1869 in East Melbourne, and was buried in Sydney's Devonshire Street cemetery. He was survived for many years by his wife. Although they had no children various relations, including his twin brother, settled in Australia.

St Vincent's Hospital, Sydney, is one of eleven such hospitals in Australia, each of them called "St Vincent's". Thousands of Australians, of every religious belief, and of none, have experienced the first-class health care that is offered and inspired by the Sisters of Charity. And many others have had the benefit of an education from the Sisters here in Australia. There are, thus, many Australians with reason to be grateful to John Plunkett, for his kindness to the women who founded the Sisters of Charity in Australia, and for the sheer practical help he gave them in their first twenty years here.

Bernadette Tobin

[1] Molony, J.N. *An Architect of Freedom: John Hubert Plunkett in NSW 1832-1869*, ANU Press, Canberra, 1973

[2] Suttor. T.L. "John Hubert Plunkett" in *Australian Dictionary of Biography, Vol 2, 1788-1850, I-Z*, Melbourne University Press

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ON THE VERY IDEA OF "CATHOLIC BIOETHICS"

In *The Foundations of Bioethics*, H. Tristram Engelhardt describes the emergence of Bioethics as "a special secular tradition that attempts to frame answers in terms of no particular tradition, but rather in ways open to rational individuals as such" (p. 5)[1]. According to Engelhardt, only a secular bioethics can offer a "peaceable neutral framework" for resolving conflicts over the morality of medical procedures and practices in our modern pluralist societies. However, those of us working in the John Plunkett Centre are committed to conducting research and education in Bioethics from within the Catholic tradition. If Engelhardt is right, it is almost a contradiction in terms to talk of a "Catholic Bioethics". In this article, I would like to defend the validity of a distinctively Catholic approach to Bioethics.

Morals and Ethics

Matters of morals arise for human beings because when they act well, they act on the basis of reflective choices as to how their actions either promote or harm the well-being of the agent, of other human beings, and of their living and non-living environment. Moral judgments concern what ought to be done, judged with respect to the human good. We need to make, and do make, such judgments in all aspects of human life: in our social and business relationships, in our sexual and familial relationships, and in our relationships with the environment. Maturation as a human being involves "the formation of one's conscience" which issues in practical judgments as to what is, and what is not, a right course of action. Not to recognise the force of moral considerations is to a greater or lesser extent to exclude oneself from the human community.

Ethics is theoretical reflection on the practice of morality; it is the attempt to understand just how the human good is constituted, what human well-being consists in, and how moral decisions ought to be made and justified. The well-known theory of Utilitarianism, for instance, which enjoins us "to act so as to maximise the happiness of the greatest number" is a typical "ethical theory", though an inadequate one because it fails to recognise crucial aspects of moral experience and decision-making in addition to "the consequences" of an action.

Morality involves not only actions and outcomes, but also agents and intentions. A "Virtues theory" is better placed to offer a more inclusive and complete account of human morality because it attends to the dispositions of character, of attitude, feeling, reasoning and choice from which human action springs. On this account, right action can only be adequately understood in terms of the good person, or virtuous agent, the person of practical moral wisdom.

Ethical theories are intended to refine, test, and sometimes reform, our initial moral judgments, which are often largely intuitive. Ethical theory does not replace the conscientious judgments of individuals in particular situations. Ethical theory is no substitute for "moral wisdom", and those whose practical wisdom we respect may well be unacquainted with the text books of ethics. But for those of us less endowed with moral wisdom, ethical reflection enables us to explore the foundations and the consistency of our judgments, and their application in new or disputed situations. We need such reflection, for example, in order to determine whether or not, as some would have it, the rights we accord to human life should be extended to other members of the animal kingdom.

"Bio"-ethics is thus that branch of ethical reflection which bears on the morality of actions affecting the health and illness of human beings, of medical treatment and research, and of health care services more widely.

Religious Belief and Ethics

What then is the connection between religious belief and ethical reflection? In the first place, one's religious beliefs impact on one's moral life, because much of what one feels obliged to do, for example, to practice one's faith, flows directly from one's religious convictions. A non-Christian will in all good conscience not be so obliged. For the Christian, being and becoming a good human being and being and becoming a good Christian is one and the same project.

Yet, while religious considerations may shape and extend one's moral life in this way, a Christian's (non-religious) moral consciousness can, conversely, clarify and shape his or her religious understanding. One may come to recognise the **moral** shortcomings of religious traditions, e.g. the portrayals of a vengeful God in the Old Testament, or the religious intolerance of former times. Religious wisdom thus, to some extent, **presupposes** moral wisdom.

The study of the Christian moral life - in its obligations and responsibilities, its virtues and motivations - is the subject of what was traditionally called Moral Theology. Nowadays one is more likely to hear of Christian Ethics. As always, the change of name is significant. The old

name highlighted the controlling context of faith, tradition and authority. The new name emphasises a purported commonality of subject matter between religious and non-religious inquiry. Whereas "Moral Theology" declares its theological presuppositions from the outset, "Christian Ethics" prompts the question of the relationship between religious beliefs and ethical argument.

Yet, whether one does Moral Theology or Christian Ethics, the overlap with secular inquiry is central. In both cases we are chiefly concerned with "common human morality", the goodness (or evil) of human actions just in as much as they are human actions, irrespective of an agent's religious beliefs. This is the area which traditional Catholic moral theology has described as falling under the "natural law".

"Natural Law"

"Natural law" is not an account of what human beings typically or "naturally" do. And it is not a "law" to be found in a code book or a set of statutes. What the ethical theory of a "natural moral law" seeks to express is first, that the goodness or evil of human actions must be understood in terms of what it is to be human, and secondly, that in recognising the obligatory force of this kind of assessment, human beings are acknowledging the "law" of their being. To be human is to be moral. If a kind of action is "contrary to the natural moral law" (e.g. self mutilation, or killing the innocent), its evil derives just from the type of action it is, an action which directly attacks the worth of persons, human dignity and integrity, and so on. It is a kind of action which involves evil - not just by Christian standards, but by straightforwardly **human** standards.

When Catholic Christians enter the arena of what is now termed Bioethics, they do so from the perspective of a natural law tradition (with or without the name). They are engaging with other thinkers in precisely the area of **common human morality**. Two critical kinds of problem for any natural law approach now need to be addressed. First, how is the natural moral law constituted, and how it is to be ascertained? What is the "human nature" against which the goodness or badness of actions is to be assessed? Perhaps Bioethics raises the ultimate ethical question of whether there really is any human nature at all? To what extent, if at all, are human beings permitted to reconstruct what has been taken to be their nature?

Secondly, given that natural law theory concerns common human morality, how is Christian faith - the evidence of Scripture, tradition and ecclesial authority - at all relevant to it? If certain reproductive techniques, for instance, are said to be evil because "against the natural law", it must be possible, in principle at least, to show that this is so from the perspective of human reason, with arguments which do not rely on theological assumptions.

The Paradox of Human "Nature"

Both sets of problems can be clarified by considering three claims which acknowledge the paradoxical character of human "nature".

First: It should be granted that the natural law cannot be just "read off" from a description of what human beings usually do, nor from the standard biological functioning of their bodies and organs, and so on. Human "nature" is open to shaping by reason and will (or desire, adequately understood). Ultimately, what human nature requires is just what human reasonableness and right desiring prescribes. The measure of what is truly human would be a person of practical wisdom whose reason and desire were unified in pursuit of the good and the true. There are thus no quick answers as to what "natural law" prescribes, no ways of avoiding arduous inquiry into what is truly reasonable in given circumstances of history, culture and technological possibility.

Secondly: It should be recognised - here on theological grounds - that it is of the nature of human existence to be open to the self-communication of God. Christianity proclaims that true human existence is "life in Christ", an elevated life of grace, which alone fulfils so-called "human nature". If nature is shaped by reason, reason is in turn shaped by faith and grace. The norm of human existence and action, from this perspective, is nothing less than "the mind of Christ", wisdom Incarnate in the life and death of Jesus.

These remarks may seem to leave little place for talk of "natural law". But the chief concerns of natural law theory are preserved: First, the focus of ethical inquiry is the human person adequately understood ("the nature of the human person and his acts", as Vatican II put it). Secondly, religious insight into the moral life still needs to be articulated in terms accessible to all men and women of good will.

Thirdly: The Christian and Catholic Christian traditions may well reflect the "mind of Christ" on matters about which human reason alone has not as yet reached satisfactory consensus. It is possible for the Christian tradition to embody insight into the morality of a kind of action (into "human nature"), while as yet lacking convincing rational justification of that insight. These insights may in

particular bear on the creative intentions of God, such that Christians recognise limits to human dominion over their bodies, over their genetic endowment and over their physical environment.

Christian ethics finds common ground with philosophical ethics in upholding the intrinsic value of the human person, as always an end, never a mere means to the end of our actions. But, going beyond a secular ethics, Christian ethics is informed by beliefs as to the origin and destiny of human life, and so as to what truly constitutes personal worth and human well-being. The human destiny is ultimately the possibility of relationship with God, and of human relationships shaped by the love of Jesus Christ.

Faith Convictions and Rational Argument

In their dialogues with secular thinkers, Christians may find that they are sometimes only able to gesture towards the beliefs and consequent values which underlie their conclusions. A central issue in Christian Ethics today concerns just how the links between faith convictions and rational ethical argument are to be forged. For some, it is a matter of the Gospel, the Christian story with Jesus as its exemplar, providing perspectives, themes and insights into how particular ethical problems should be approached. For others, Christian ethics takes up the theme of the value of the human person, which can be central to a secular ethic, and provides the ultimate explanation of the worth of persons, and of why it ought never be compromised.

The link between faith and ethics is especially relevant today when it is being increasingly recognised that the secular assumptions of modern culture need critical evaluation - and that evaluation will draw upon the long-standing resources of our various religious traditions which affirm that there is more to human existence than science or the dogmas of modern "liberalism" allow. In a pluralist culture where there are competing views of the human good, our challenge is discover a more inclusive vision of human life drawing on the resources of all our religious and non-religious traditions, rather than fall back on a minimalist "peace keeping" ethic of secular toleration.

What then of Catholic Bioethics?

Like all ethical inquiry, Bioethics in the Catholic tradition is the search for a reflective understanding of what is truly good human activity, and in the dispositions of character from which it proceeds. The measure of such goodness is practical wisdom, which includes the willingness to dialogue with all engaged in the same endeavour. Christian moral wisdom should never be regarded as an esoteric discourse, intelligible only to the initiated. Only by sharing, comparing, challenging and refining insights - whatever their origins - can the quest for what is truly reasonable succeed.

To engage on this quest from with the Catholic tradition, is to draw on a tradition of moral wisdom, both customary and authoritative, which in so far as it concerns common human morality is in principle accessible to all. However, its perspectives and ideals may at times only be appreciated by those who have truly put on the mind of Christ. The ultimate embodiment of the commandment of love, to lay down one's life for another, is presumably not an obligation arising within the sphere of common morality. For a Christian it could well be the evident demand of his or her particular life situation.

Challenge of Pluralism

The pluralism of contemporary western culture clearly presents a new challenge to Catholic ethical reflection, which in the past has been more at home in cultures in which Catholicism is the predominant if not established religion. However, there are resources within the Catholic tradition for allowing for diversity of moral belief and practice, and for showing positive respect for the consciences of others. Bioethics in the Catholic tradition needs to develop a Christian response to moral diversity, and with creativity and imagination find forms of collaboration with those of different beliefs in common ventures such as health care - forms of collaboration which do not jeopardise Catholic truth.

In the face of the complexity of issues, the tragedy of circumstances, and the sheer perplexity we ought to feel in so many of the new situations that arise, it is easy to be fearful, and to cling to past answers in desperation rather than with open-minded trust in their continuing power to illuminate. Bioethics in the Catholic tradition might challenge these fears with the reminder that "the spirit God gave us is no cowardly spirit, but one to inspire power, love and self-discipline" (2 Timothy 1:6).

Gerald Gleeson

Reference:

1 Engelhardt H.T. *The Foundations of Bioethics*. Oxford University Press, New York, 1986

ETHICS AND HEALTH CARE: A CASE FOR THE VIRTUES

Twenty years ago it was often said that one could not talk of moral truth or falsehood. Some claimed this because they thought that morality was a matter of personal opinion ("If I think that X is wrong, then it is wrong **for me**"), others because they thought that morality was a matter of cultural convention ("We think that every human being has rights, but if they deny this in the case of blacks, then who are we to say they are making a mistake?").

Today, most moral philosophers **agree** that morality **is** a matter of what is true and what is false. What they **disagree** about is how to explain moral truth, how we ought to work out what is morally right or wrong, permissible or impermissible, good or evil.

Two **theories** of moral truth have dominated the discussion: Utilitarianism and Deontology. Neither of them offers, I think, an adequate account of morality. It is fortunate, then, that a third approach, a so-called "Virtues-Based" Theory of Morality, is gaining ground, and nowhere more so than in some recent writing about the ethics of health care.

Since an understanding of ethical theory helps to refine and test our moral intuitions, those sometimes-spontaneous and sometimes-considered judgments we make about the rightness or wrongness of particular actions or practices, it is useful to be able to recognize the ways in which these theories influence our thinking. I shall outline all three theories and show why I think Virtue Theory is preferable to the others.

Utilitarianism

Utilitarians ask us to consider what morality is **about**. It is, they say, about the promotion of human welfare. We ought always do what we can to promote human happiness, and not only to promote it but to maximize it.

Now, given that we are often undecided in practical situations about what **will** promote human happiness, we need a principle to help us to decide. The principle we need is the principle of "utility": "Do whatever action which will tend to maximize the welfare of all parties affected". Actions are right in so far as they tend to maximize the welfare of all parties affected and wrong in so far as they fail to do that. For the goal of morality is the greatest happiness of the greatest number.

There are several different forms of Utilitarianism. But they all have the following four features in common:

First: Utilitarians accept the principle of utility, the idea that one must always maximize the good or, if only bad consequences can be achieved, minimize the bad consequences .

Secondly: Utilitarians have a theory of what is "the good which should be maximized". Some see this as something **objective**: the good to be maximized is something objectively good (say, health or knowledge or fairness), something which any rational person would recognize as good in itself. Others see it as something **subjective**: the good to be maximized is what the people affected would subjectively prefer.

Thirdly: Utilitarians are consequentialists (for which reason some people call the theory "consequentialism"). The rightness or wrongness of a particular action depends on its consequences, and on **nothing other** than its consequences. An action is right, and in fact obligatory, if it maximizes good consequences, and wrong and prohibited if it does not.

Fourth: Utilitarians are committed to an impersonal universalism. All the parties who will be affected by an action must receive equal and impartial consideration. There is to be no discriminating between persons on the basis, say, of friendship or family ties or professional relationship. Each person is to count as one and each is to be treated alike.

Problems

How adequate a theory of moral truth is Utilitarianism? Let us note three problems.

Certainly Utilitarianism captures a part of what is true in morality. Very often it would be just irresponsible not to take into consideration the likely consequences of our actions: for example, in driving a car when one has had a few drinks; in reprimanding a child in front of her friends; in admitting this person rather than that one into an Intensive Care Unit, etc. But the question is: Just **how much** consideration ought to be given to the consequences of our actions? For at least sometimes it seems clear that an action is wrong **independently of its consequences**. Whatever the consequences, administering a lethal injection to an elderly, troublesome patient in a nursing home against her will is wrong, seriously wrong, **in itself**, no matter what good consequences follow.

In addition, Utilitarianism asks too much of us. It says that one should always act so as to maximize the good. If you can help those who are worse off than you by giving **all** your surplus income to charity (over and above what you need for the bare necessities of life), then that is what Utilitarianism says you ought to do. But though we may admire people who have such generosity, we do not think that people who keep some of their income for their own holidays or hobbies are

thereby acting immorally.

And finally, since Utilitarianism is oriented to a consideration of the **net** benefits of an action for **everyone** affected, it pays little attention to both individual rights and to the moral significance of special relationships. What is beneficial to a **group** may involve an injustice to an **individual**. And generally, we think that special relationships, such as those between parent and child, teacher and student, doctor and patient, generate their own **particular** moral responsibilities (independent of the overall consequences for others affected). A good moral theory will recognize not only our general obligations such as the duty to drive in a way which does not endanger the life of **any** other road-user but also our particular obligations (such as our special responsibilities to friends, children, neighbours, patients, etc.).

Utilitarians have answers to these problems, and a good deal of ethical debate these days centres on questions about the adequacy of their answers. However, let us leave Utilitarianism aside and consider now the other theory which shares the limelight.

Deontology

The most famous Deontologist was the great German philosopher, Immanuel Kant, who argued that what matters most in the moral life is not the consequences of one's actions but the **motive with which** one acts. One ought always act out of a sense of **duty**. (Kant's significance is measured by the fact that the theory is often called simply "Kantianism".) It is not enough that you do what is morally-correct. What matters is your motivation. You must act for the sake of fulfulling your duty. If a doctor asks a patient to consent to a procedure before he performs it, but does so only because the law requires this of him, that is not good enough. He does the right thing, but he does it for the wrong reason. He ought to be motivated by a sense of his duty to respect the patient as a person. Kant himself went much further. According to him, the **only** morally-worthy acts are those done from the motive of duty. (The Greek for duty is *deon* : hence the label "deontology" for this moral theory.)

Now, not all Deontologists attach **such** importance to the motive with which one acts (nor indeed to the motive of duty). But what all Deontologists have in common is the idea that features of actions **other than their consequences** often determine whether they are right or wrong.

What features of action are morally significant? Keeping one's promises, repaying a debt, living up to the terms of a contract one has entered into, making a fair distribution of resources, respecting someone's autonomous choice, acting in the best interests of one's child or student or patient: these are **right-making features** of actions which are independent of their consequences. Similarly: cheating, torture, lying, breaking a promise, over-riding an individual's rights, taking more than one's fair share of some common good, killing one innocent person in order to save several others: these are **wrong-making features** of actions which are independent of their consequences.

These features can be expressed in "fundamental" principles of morality from which one can derive general rules of conduct. When the principles or rules are applied in particular circumstances, they tell you what is right and wrong. In the health care contexts, the two main principles which ought to guide one's actions are **acting so as to further the best interests of the patient** and **respect for the autonomy of the patient.**

To my mind, Deontology represents an advance on Utilitarianism in its recognition that there is **more** to moral evaluation than a calculation of likely consequences. However, it has its own problems.

First: Since there is more than one fundamental principle in morality, in any situation these principles may conflict, and the theory says nothing about how the conflict is to be resolved. Any doctor or nurse will have experienced situations in which it is impossible **both** to respect the patient's autonomy **and** to act in the patient's best interests. And any hospital administrator will have experienced the clash between the demands of fairness to a particular group of patients on the one hand and the need to maximize overall good consequences for all patients in the hospital on the other. Deontology **in itself** cannot help to solve the dilemma.

In addition, without the context provided by the commandments of a religion (Christianity or Judaism, for example), it is difficult to see what ultimate justification these "fundamental" principles have. Kant thought that, given the conditions in which human life is lived, **pure practical reason** grounded these principles. But if that is not a satisfactory justification for them, the suspicion arises as to whether they are only **intuitions** for which we cannot give a rational justification.

And finally: There is, surely, more to living the moral life than doing one's duty. Even if one accepts that a morally-good person faithfully fulfills her duties, are there not **other** things which are essential aspects of her moral goodness - for instance, her feelings of compassion for those who suffer hardship or pain, and her feelings of love and affection for her friends? Do not these feelings generate much of what is morally-desirable in our lives? Dutiful conscientiousness is only a part, though admittedly an important part, of what it is to live well.

Let us turn, now, to a theory which recognizes the importance of considering the likely consequences of our actions, which pays due regard to realizing certain non-consequential principles of conduct in our actions, and which introduces the idea that, in order to act well, one needs "practical wisdom".

Virtue Theory

Imagine someone who always acts with proper regard for the interests of others. Imagine that she is quite scrupulous about this, that this is an ingrained disposition. However, suppose also that she hates having to do this, that what she really wants to do is to put herself first. What kind of moral assessment would we make of her? Would she be a good model for our children? Surely not. For in spite of the fact that she might regularly do what both Utilitarian and Kantian theory call "the right action", she lacks something of critical importance in morality: the possession of a morally-desirable attitude or feeling. She does not **care** about the interests of others.

According to virtue-theory, the goal of morality is the living of human life **well**. In order to live human life well, one needs to have acquired certain deep qualities of character (known by that rather old-fashioned word "virtues") which are expressed not only in what one does but also in one's feelings, attitudes, priorities in life: fairness, courage, friendliness, benevolence, strength of will, conscientiousness, truthfulness, gentleness, good-temperedness, ambition: these are the character-traits of someone who lives human life **well**.

What is the connection between having these character-traits on the one hand and knowing what is the right thing to do in a difficult situation on the other? It is this: In acquiring these **moral** virtues, you also acquire a certain **intellectual** capacity which Aristotle called "practical wisdom". Practical wisdom is the capacity to know how to act in particular circumstances: for instance, to know how much weight to give to the likely consequences of an action, to know how to strike a balance between competing considerations (say, between respecting someone's autonomy and acting in that person's best interests), in fact a capacity to see the morally-salient features of a situation. It is not the kind of thing which even a very clever young person could have, since it comes with experience of life's difficulties. Human affairs are often deep and complicated. It is often difficult to know how one should act. In the end one needs **wisdom** rather than **principles**. For morality, like medicine, is about what to do in this **particular** situation here and now, and the wisdom involved in knowing **that** can never be expressed in any **general** rule.

I think that this theory, Virtue Theory, offers a better starting-point than do either of the other, more popular theories. It would, however, be wrong to pretend that it is without problems. A common criticism goes as follows: It is all very well to talk about qualities of character which enable a person to live human life **well**. What we need is a theory which will tell us what to do **here and now**, and virtue theory cannot do that. It is not action-guiding.

Is Virtue Theory Action-Guiding?

How damaging is this criticism? Certainly, some things can be said in defence of Virtue Theory here. First: Virtue Theory rules out in advance certain possibilities. What should you do if to save ten people you must kill one innocent person? Whereas Utilitarianism invites us **at least to consider** killing the one innocent person, Virtue Theory rules out in advance any act of injustice. This is a mark in its favour, for we all need on occasion to be **strengthened** against the temptation to get out of a tight situation by doing something evil. A second thing which can be said in defence of Virtue theory is that it does **recognize** that some practical situations are genuinely difficult - even tragic - and it does not try to redescribe them so as to force a "solution". And a third thing. Someone who has moral wisdom recognizes his or her limitations. The Intensive Care Unit in your hospital may be full of people who **need** to be there. There are others who should also be admitted? What should you do? You do your best, that's all. You ought not to be paralysed into inaction by the realization that you cannot always do everything for everyone. Finally, if it is a criticism of Virtue Theory that it does not tell you precisely what to do in particular situations, then the same can be said of any moral theory. For instance, Utilitarianism tells you to maximize good consequences without settling the issue of what constitutes a good consequence. And though Deontology tells you not to lie, it cannot help you to decide whether (for example) not telling the whole truth is **in these circumstances** lying. This is just the point where having the virtues (and thus having practical wisdom) matters most of all: for these are just the kinds of things you need to get right if you are to act well.

Sometimes it seems that in debates about health care you must be **either** a Utilitarian **or** a Deontologist. I hope I have said enough to suggest that this is not so, and to invite interest in Virtue Theory as a basis for health care ethics. The harder task, that of detailing the positive contribution a Virtues-based approach can make to health care ethics, I leave to another occasion.

Bernadette Tobin

NURSING ETHICS: A NEW CHALLENGE

The dominant model for expressing the moral profile of Nursing today is that of "patient advocate". This model of Nursing is both misleading and unnecessary. If Nursing is to live up to the professsional independence it deserves, it should stop trying to express itself in terms of other professions.

Several historical factors have contributed to the process by which nurses have come to think of themselves as "patient advocates". They are worth recalling.

Failure Of A Principle

The first important development was the failure of the principle of *respondeat ad superioram* as a defence nurses could use at law when accused of professional negligence. The 1929 case of the Fillipino nurse, Lorenza Somera, is famous. Somera was found guilty of manslaughter because, though following a doctor's orders to administer cocaine, she was found to be responsible for the patient's consequent death: it was argued she did not question the doctor's order and was held to have an independent responsibility which the fact that the doctor was in charge did not alleviate.

Of course, the nurse who questions, as in fact Somera did, and decides to disobey directions is equally subject to sanctions though not necessarily legal ones. Her situation is invidious. She should be understood to have her own independent responsibility for the patient even when administering treatments under doctor's orders. But this implies her right to ask for the doctor's rationale for her orders and the right to refuse to comply if she has good reason to think them wrong or misguided.

The Autonomy Of Nursing

The second development lies in the fact that much contemporary nursing care is performed in a context where there is considerable practical independence from the direct supervision of the doctor. In the past, health care tended to be rescue medicine where the doctor's orders were of immediate importance for the preservation of life. This has changed considerably as our ability to keep people alive where they would have died in an earlier age has improved.

People's recovery from illness takes place more commonly in hospital without any need of the doctor's being about. Many people live in nursing homes with only occasional exposure to a doctor. Nursing care has become specialised and sophisticated independently of the specialised scientific expertise of the doctor in response to this situation. And Medicine has become so specialised that Nursing has picked up responsibilities which earlier generations of doctors would have had[1]. Nursing, then, has become autonomous from medical care in a way it has never been, both technically and administratively (though admittedly, this is not socially nor, in lamentably many ways, legally recognised).

Protection of Patient's Rights

Finally, from two directions[2] the need to protect patient's rights has attracted considerable attention. From the American civil rights movement's idea of the individual's rights vis-à-vis traditional authorities, there has developed a public recognition of the patient having rights which she should be permitted to exercise. Secondly, the revelation of ways in which the rights of patients have been violated by the medical profession has prompted the idea that these rights need protection. In particular the right of the patient to make an autonomous choice concerning what treatments she is prepared to submit to needs protection against those professionals who are prone to acting paternalistically towards the patient on the incorrect assumptions that knowledge of their medical problems will get in the way of healing and that, anyway, patients either do not want to know such things or could not understand them if the time is taken to explain them. Again, health care in the modern world needs a *system* of delivery, and this poses its own threats to respect of the individual patient's rights. Patients, then, need their rights defended. Because of her intimate knowledge of the patient on the ward, it is argued that no one is better placed than the nurse to act as the patient's advocate defending the patient's rights.[3]

Using Metaphors

The first point I wish to make is that the Patient Advocate model is a metaphor. Its success in clarifying the moral profile of Nursing as a profession depends on the success of the use of that metaphor.

Let us consider the use of metaphor in order to express ideas about things. In essence, the use of metaphors involves likening one thing to another in order to say something about the first.

For instance, the lion is the king of the beasts, as the old metaphor goes. That is, the lion stands to the other beasts in a relation which can be illuminated by that between a king and his subjects. But a king may stand in many relationships to his subjects: a king and his subjects share the same nationality; a king rules his subjects; a king rules a territory to the legal exclusion of rule by others. But lions are not the same nationality as other beasts; nor does the lion rule other animals in any literal sense or exclude others from territorial hegemony by legal support. So we dismiss these

obvious dissimilarities.

What is it about the relation between a king and his subjects that makes it a *helpful* way of expressing something interesting about the relationship between lions and other animals? It will be a similarity between the relationship between kings and their subjects and that between lions and other animals that is thus helpful. But which similarities are the helpful ones? We do not use the metaphor to suggest, for instance, that lions control territory to the exclusion of control by other animals *in the same way* that kings do. Or that if an animal becomes involved in a fight with a lion whom we can expect to win, the latter can rely on the assistance of, say, a tiger to fight off the challenger (as a king might expect a related aristocrat to come to his defence).

To work out what similarities matter and *how* they matter in order to make the point about lions in comparison to other animals, we need to distinguish the helpful similarities from the unhelpful ones and we need already to know how the lion and the king differ. That is, we need already to know the important things about the natures of kingship and the lion. But if this is the case we could just as well do away with the comparison to the relations between kings and their subjects and explain only the resemblances that we want to exploit. That is, we could do away with the metaphor.

Where we do not already know the nature of one of the terms of the comparison, there is the real risk of taking some feature of one of the terms and imputing it to the other. If we knew only about kings and their subjects, for instance, we might be lead by the metaphor to suppose that lions have the support of a standing army of animals much as a queen bee has drones and nurses.

With these words about the use of metaphors, let us now turn to the metaphor of "patient's advocate" for Nursing. I wish to suggest that the patient's advocate model of Nursing deserves criticism and ultimately should be abandoned.

Advocacy: Adversarial Implications

While there is agreement that nurses are to be the patient's advocate, there is less than consensus about what this **means**[4]. That is, we seem to be in a situation rather as if we knew only about kings and their subjects but not about lions.

If we take our lead from the notion of advocacy, we get some **distorted** ideas about the place of Nursing in the delivery of health care. Advocates act on behalf of their clients in a context that is paradigmatically adversarial. The advocate is out to defeat the client's opponent. In speaking on behalf of her client, the advocate must do her best to allow the opposition no quarter, no room for manoeuvre into a position of advantage from which to have her will to the exclusion of the client's. The advocate will defend the client's interests no matter what, using whatever strategy she can legally get away with to protect the client's interest. Often the advocate has to override the client's preferences in order to protect her interests in the adversarial legal setting. Personal matters the client would rather not air before others may have to be brought into the open to defend the client or further her case against the aims of the opponent. At other times, it is better for the advocate not to know the full facts about what the client has done in order to defend her better especially where the opposition may lack evidence it needs given burden of proof. The advocate's service to the client is technical and that of an expert in a field.

Health Care Not A Court Room

If we relied on these central aspects of advocacy to characterise the profession of Nursing, we would be led to deny some important facts about health care delivery. First, it is important that the setting where nurses serve patients is not necessarily adversarial. Doctors usually care about the good of the patient and when approached with evidence that a patient is not comfortable with a decision, will not usually be callous. Or again, if faced with evidence that the patient could be helped more than the doctor's suggestions are achieving, the doctor will typically be impressed with the nurse's positive attitude and efforts.

Of course there are doctors who stand on an immature enjoyment of the privilege of their professional status in the community and who care more about their fee or convenience than about the patient. Also, some doctors, trained to look for pharmacological or surgical treatments, will overlook more simple measures or perhaps not even think there is a medical problem if medical science has no scientifically grounded account of the patient's difficulties. In such cases, nursing care and nursing persistence can be the difference between the patient's regaining a good degree of health and being left to get worse because scientific medicine has no well-grounded approach.

But, despite these situations and others where a nurse's sticking up for a patient can lead to tension with the doctor, the setting of health care delivery is only unhelpfully assimilated to that of the court room. The patient-doctor relationship is not that of the prosecution to the accused in the dock.

Again, the nurse who would override patient preference and act as advocate in defence of patient rights is a paradoxical defender of autonomy. Like doctors, nurses only have a right to apply cares on the patient's behalf conditional upon the patient's

willingness to submit to them. Further, nurses are never better positioned to serve their patients by being ignorant of their health situation. Just as the doctor should cooperate with the nurse in caring for the patient, the nurse should cooperate with the doctor. There is no question of the sort of competition for the sympathy of the judge and jury that is at stake in the courtroom.

Thus, the notion of patient advocacy as a model for nursing is less helpful than the prevailing orthodoxy in the nursing profession would suggest. We already know more about the nature of Nursing - its moral characteristics - than the debate about the meaning of patient advocacy suggests.

Against Derivativeness

In fact, Nursing only goes part of the way towards becoming a fully mature profession while it persists in characterising its moral profile in terms of other activities, in particular in terms of other professions such as advocacy. The assertion of professional autonomy over against medicine as an integral element of health care delivery rings hollow while we explain the nurse's moral vocation in derivative terms borrowed from other walks of life. What is called for is for nurses to be nurses plain and simple. Nursing ought to explain itself on its own terms. It is a distinctive profession. There is nothing it is like enough to use to explain itself but itself. Nursing admits of sufficient varieties of practice and context to require more flexibility in formulating its moral vocation than a single, trusted metaphor. Rather, Nursing needs to dispense with metaphors and get down to the business of formulating its moral ideals on its own terms, in terms of the distinctive profession it is. Some progress has been made in this direction. We will be much better placed to make more if we drop the use of misleading directions of thought prompted by the Patient Advocacy Model.

John G Quilter

References:

[1] cf. A. MacIntyre, "To Whom is the Nurse Responsible?", in C. Murphy and I. Hunter (eds), *Problems in the Nurse-Patient Relationship*, Allyn and Bacon, Inc., Sydney, 1983

[2] Though not necessarily only two; and indeed, these are not necessarily independent sources of these lines of thought.

[3] cf. e.g. G. Winslow, "From Loyalty to Advocacy: A New Metaphor for Nursing", in L. Walters and T. Beauchamp (eds), *Contemporary Issues in Bioethics*, Wadsworth, Belmont, CA, 1988.

[4] ibid.

NOTEBOOK

WELCOME TO VICTORIAN FRIENDS

This is the first issue of **Bioethics Outlook** to be sent to Associates of the *Centre for Research in Ethics and Health Care* in Melbourne.

The *Centre for Research in Ethics and Health Care* was established some years ago, by Dr Liz Hepburn, IBVM, at the Ascot Vale Campus of what is **now** Australian Catholic University and was **then** the Institute of Catholic Education. The Victorian Centre sponsors an annual series of seminars on bioethical issues. It publishes educational notes on bioethical issues - prepared from the resources of Catholic Moral Theology - for secondary and tertiary students. And, until now, it has published its own quarterly Newsletter.

Since the establishment of the *John Plunkett Centre for Ethics* as the first **Research Centre** of Australian Catholic University at St Vincent's Hospital in Sydney, we have decided to formalize the as-yet-informal but none-the-less-substantial connections between the two centres in Sydney and Melbourne. To this end, we are amalgamating our subscription lists, and from now on subscribers to the Newsletter of the *Centre for Research in Ethics and Health Care* in Melbourne will receive **Bioethics Outlook** from the *John Plunkett Centre* in Sydney every quarter. News of affairs at both Centres will be found in future issues of **Bioethics Outlook**.

We hope that our readers will appreciate this Melbourne-Sydney collaboration.

"ETHICS IN NURSING" SEMINAR

The Nurse Education Division at St Vincent's Hospital, Darlinghurst, Sydney, is to sponsor a two-day seminar on **Ethics in Nursing Practice** at its Darlinghurst campus.

The dates of the seminar are September 3rd and 4th, 1992.

For details of the Conference programme, contact:

Ms Christine Lennon
Department of Nursing
In-Service Education
St Vincent's Hospital
Sydney NSW 2010
Phone (02) 361-2322

THE IRISH ABORTION DEBATE

Abortion has always been prohibited in Ireland. In 1983, the Irish Constitution was amended by popular referendum to oblige the state "as far as practicable by its laws to defend and vindicate" theunborn's right to life.

However, the Irish Supreme court, considering theplight of a 14 year old girl pregnant after rape, hasdetermined that Irish law still permits a limited right to abortion.

Patrick Hannon, Professor of Moral Theology at Maynooth opposed the 1983 Amendment. Writing in *The Tablet* of 14th March 1992, he reflected on thesignificance of the Court decision, noting that:

"It is a source of particular irritation when the fact that Ireland has these debates at all is made a matter of either ridicule or shame."

Hannon's reflections are worthy of extentded quotation. He argues that, in the case of legislation about both divorce and abortion, genuinely difficult questions arise as to how while respecting the rights and needs of individuals the common good can be best upheld:

"Irish people on the whole appear to have a strong sense of the sacredness of life in utero *... If you believe that the embryo is human from conception it is not illogical to try to ensure that it receives, from conception, maximum protection from the law. As it happens, I write as one who opposed the Eighth Amendment in the belief that the existing law provided as much protection of the right of unborn life as any law was likely to be able to do, and on the ground that the working of the amendment must in time give rise to problems which might well subvert the amendment's purpose.*

I believe also that for all its attendant dangers some form of divorce legislation is necessary in order to cope with the facts of marriage breakdown in the Republic of Ireland.

But the point which I wish to make here is that the issues are debatable, and that their solution is not, one way or another, self-evident. And I believe that it is imperative that the validity of the insights which inform other views of these matters should be acknowledged, and that they must help shape the public debate and the legislative response."

Given that further debate is inevitable, Hannon asks what "the Church" will say:

"Presumably the bishops will say what they said before: that human life is sacred from the moment of conception and that the unborn must receive the best protection which the law can give. Presumably also they will make the customary distinction between a moral viewpoint and its embodiment in the law, and they will grant that the latter is a task for the art of the legislator and of the politician, and a matter for the conscientious appraisal of the citizen.

Perhaps this time, though, they might also acknowledge a trust in the sensibility and sense of a morally serious people. And they might encourage a debate whose hallmark is not the rhetoric of the placard but what John Courtney Murray called the idiom of persuasion and pacific argument. They will not have missed the point that in relation to morality the law's role is clumsy and humble.

In closing, Hannon writes:

The Catholic position on the morality of abortion embodies an irreplaceably important insight concerning the sacredness of human life. It is imperative - and not just for Ireland - that justice be done to that insight in the debate which faces Ireland now. Justice will be done only if the moral case is put in terms which are intelligible to all people of good will, and with advertence to the fact that the noblest of moral aspiration is lived out in a flawed world. It is not merely pious to hope that all who join the debate in the name of Christian values would look to the ways of the Founder".

[G.G]